Assessing the Impact of MedPAC's Proposed Part D Reforms to Modify Beneficiary Cost Sharing

Avalere Health | September 2016

Avalere Health
An Inovalon Company
1350 Connecticut Ave, NW
Washington, DC 20036

T | 202.207.1300
F | 202.467.4455

avalere.com

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

INTRODUCTION 5

OVERVIEW OF MEDPAC'S PROPOSED OOP CAP AND TrOOP POLICY 5

METHODOLOGY 8

RESULTS

- Beneficiary Impact of Implementing Both the OOP Cap and TrOOP Policy 8
- Impact of OOP Cap on Part D Enrollee Costs 11
- Impact of TrOOP Policy on Beneficiary Out-of-Pocket Costs 13

CONCLUSION 15

This analysis was conducted on behalf of Medicare Access for Patients Rx (MAPRx) with funding provided by the Lupus Foundation of America. Avalere maintained full editorial control.

EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission (MedPAC) June 2016 report to Congress includes a variety of Part D policy recommendations aimed at increasing the program's financial sustainability.[1] In order to assess how these policies may affect Medicare Part D enrollees, Avalere estimated the potential impact of two of these proposals on beneficiaries' out-of-pocket (OOP) costs[2]:

1. Implementing an out-of-pocket maximum in Part D, whereby beneficiaries would not be responsible for any cost sharing in the catastrophic portion of the benefit. We refer to this policy as the "OOP Cap."
2. Excluding the brand manufacturer coverage gap discounts from the calculation of a beneficiary's true-out-of-pocket (TrOOP) costs. We refer to this policy as the "TrOOP Policy."

MedPAC intends for the proposals to be implemented simultaneously and Avalere estimated the out-of-pocket cost impact to Medicare beneficiaries assuming both the OOP Cap and TrOOP Policy are adopted. In addition, since policymakers are also considering these policy changes individually, this analysis considers the estimated out-of-pocket cost impact under a scenario where either policy is implemented on its own. Avalere's analysis examined the potential impact of these proposals over a five-year period, 2017–2021, for all Part D beneficiaries who could be affected by the policies as well as for individuals with three chronic conditions that typically incur high drug costs—those with arthritis, mental health conditions or renal conditions.

Impact of Implementing the OOP Cap and the TrOOP Policy Simultaneously: *Out-of-pocket spending for almost 1 million Part D enrollees would increase while out-of-pocket costs for about 100,000 beneficiaries would decrease each year.*

The combined OOP Cap and TrOOP Policy have significant implications for the Medicare Part D enrollees with the highest drug costs and associated beneficiary out-of-pocket costs. Aggregated across all Part D enrollees affected by the combined policies, total out-of-pocket expenditures would be essentially unchanged. However, the policies would effectively redistribute beneficiary costs by dramatically lowering spending for a few and raising it for many.

- The majority of Medicare beneficiaries who would be affected by the combined OOP Cap and TrOOP Policy would experience increases in out-of-pocket costs. From 2017 to 2021, an average of almost 1 million beneficiaries each year would

[1] MedPAC Report to Congress: Medicare and the Health Care Delivery System. June 2016. http://medpac.gov/documents/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf.
[2] Note: This analysis excludes low-income subsidy (LIS) beneficiaries and employer group waiver plan (EGWP) beneficiaries. LIS recipients who are eligible for the full subsidy have no deductible and fixed copayments until they reach the catastrophic threshold, after which they have zero cost sharing. Sufficient data for EGWP beneficiaries is unavailable.

experience over a 20 percent increase in their spending. For these beneficiaries, total aggregate out-of-pocket expenditures would increase by almost $3.7 billion over the five-year period.

- Medicare beneficiaries who incur the highest out-of-pocket expenditures under current policy would experience very significant reductions in out-of-pocket spending. From 2017 to 2021, an average of around 100,000 Part D. beneficiaries each year would experience decreases of between 49 percent and 59 percent in their out-of-pocket spending. For these beneficiaries, aggregate out-of-pocket expenditures would decrease by approximately $4.3 billion between 2017 and 2021.

Impact of Implementing the OOP Cap: *Approximately 1.1 million Part D beneficiaries would experience lower out-of-pocket costs each year.*

Any beneficiaries who have sufficiently high out-of-pocket costs to reach the catastrophic portion of the benefit would experience savings from the OOP Cap. Individuals with highest drug costs would benefit the most from this policy.

- In each year from 2017 to 2021, around five percent of non-LIS Part D enrollees would experience more than $1 billion in aggregate reductions in out-of-pocket costs each year—totaling about $7.7 billion in savings over the five-year period of the analysis.
- For individuals who reach the catastrophic portion of the benefit, beneficiary spending would decrease by an average of 27 percent in 2018. Beneficiaries with certain chronic conditions would experience greater benefit from the OOP Cap.

Impact of Implementing the TrOOP Policy: *Approximately 1.1 million Part D enrollees would have higher out-of-pocket spending each year.*

The proposed TrOOP Policy would increase out-of-pocket costs for beneficiaries who have high enough drug spending to approach or reach the catastrophic portion of the benefit.

- On average, 1.1 million Part D enrollees would experience higher out-of-pocket costs each year between 2017 and 2021. Total Part D beneficiary spending would increase by about $5.1 billion over the same period.
- Out-of-pocket spending for each affected beneficiary would increase by an average of almost $1,000 per year throughout the five-year period.

INTRODUCTION

The Medicare Payment Advisory Commission (MedPAC) June 2016 report to Congress includes a variety of Part D policy recommendations aimed at increasing the program's financial sustainability.[3] In order to assess how these policies may affect Medicare Part D enrollees, Avalere estimated the potential impact of two of these proposals on beneficiaries' out-of-pocket (OOP) costs.[4]

1. Implementing an out-of-pocket maximum in Part D, whereby beneficiaries would not be responsible for any cost sharing in the catastrophic portion of the benefit. We refer to this policy as the "OOP Cap."

2. Excluding the brand manufacturer coverage gap discounts from the calculation of a beneficiary's true-out-of-pocket (TrOOP) costs. We refer to this policy as the "TrOOP Policy."

MedPAC intends for the proposals to be implemented simultaneously and Avalere estimated the out-of-pocket cost impact to Medicare beneficiaries assuming both the OOP Cap and TrOOP Policy are adopted. In addition, since policymakers are also considering these policy changes individually—see the bill introduced by Senator Wyden, called the "Reducing Existing Costs Associated with Pharmaceuticals for Seniors Act of 2016" (RxCAP)[5]—this analysis also models the estimated out-of-pocket cost impact under a scenario where either policy is implemented on its own.

The analysis estimates how the policies would affect the out-of-pocket spending over a five-year period (2017–2021). It considers the general Part D population as well as Medicare beneficiaries with three chronic conditions that typically incur high drug costs: those with arthritis, renal conditions, and/or mental health conditions. Part D enrollees receiving the low-income subsidy (LIS) are excluded from the analysis because the OOP Cap and TrOOP policies would not alter out-of-pocket expenditures for this population.

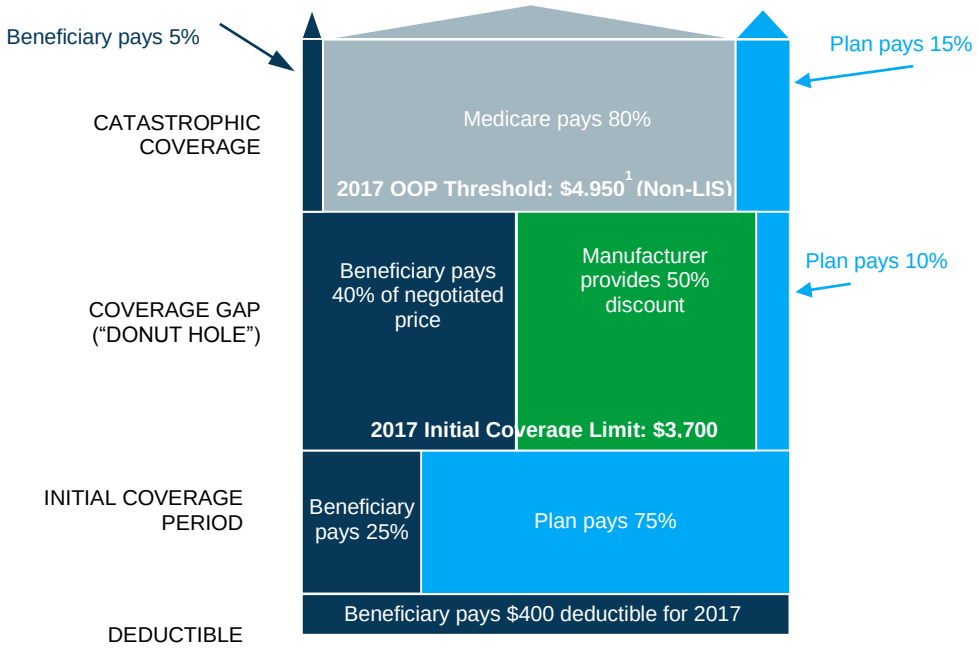
OVERVIEW OF MEDPAC'S PROPOSED OOP CAP AND TrOOP POLICY

By modifying aspects of the Part D benefit design, the OOP Cap and TrOOP Policy would affect out-of-pocket costs for certain Part D enrollees. Under the OOP Cap, beneficiaries would not be responsible for any cost sharing for covered drugs after spending a certain amount in a given year and reaching the catastrophic portion of the benefit. For 2017, the beneficiary out-of-pocket maximum would begin at $4,950 in total

[3] MedPAC Report to Congress: Medicare and the Health Care Delivery System. June 2016. http://medpac.gov/documents/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf.
[4] Note: This analysis excludes low-income subsidy (LIS) beneficiaries and employer group waiver plan (EGWP) beneficiaries. LIS recipients who are eligible for the full subsidy have no deductible and fixed copayments until they reach the catastrophic threshold, after which they have zero cost sharing. Sufficient data for EGWP beneficiaries is unavailable.
[5] Wyden, Ron. RxCAP Act of 2016. Introduced April 27, 2016. https://www.congress.gov/bill/114th-congress/senate-bill/2864/text.

out-of-pocket spending on medications. Today, beneficiaries are responsible for five percent of drug spending that occurs in the catastrophic portion of the benefit (Figure 1).

Figure 1—Standard Benefit for Non-LIS Enrollees, 2017[6]



Part D enrollees move through the benefit by reaching spending milestones. In a standard plan, beneficiaries pay the full cost of their medications until they reach the $400 deductible in 2017. Then, beneficiaries pay, on average, 25 percent of the cost of their medications until they reach the initial coverage limit ($3,700 in total drug spending in 2017). At that point, the beneficiary enters the coverage gap and pays, on average, 40 percent of the cost of his or her drugs until reaching the catastrophic threshold. Under MedPAC's recommended policy, beneficiaries would not have any cost sharing in the catastrophic portion of the benefit, down from the 5 percent of drug spending enrollees experience today.

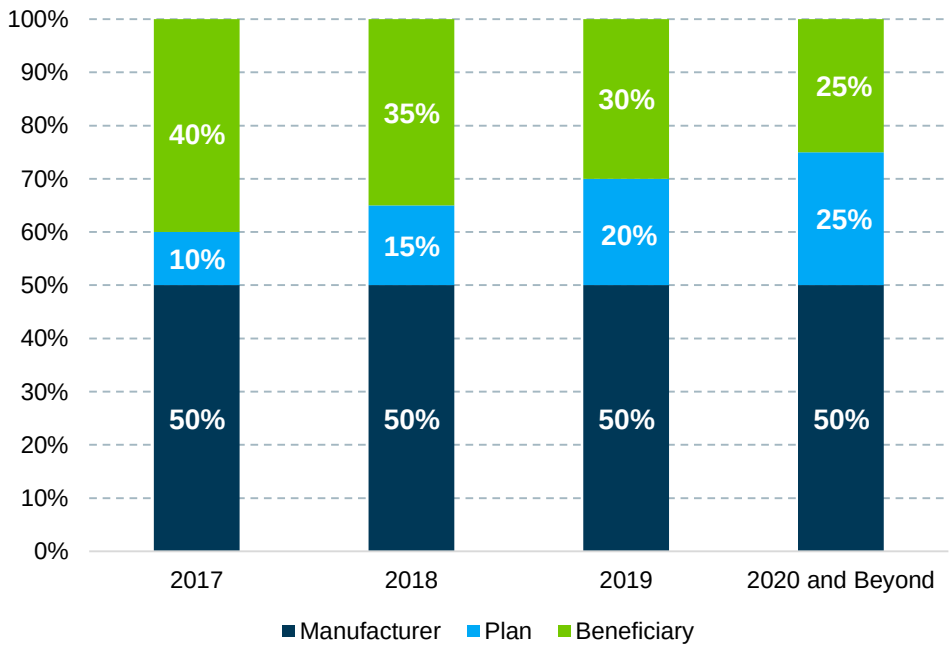
The second proposal would modify how TrOOP is calculated. TrOOP is a measure of which spending "counts" toward moving beneficiaries through the Part D benefit to catastrophic coverage. This change would exclude the brand manufacturer coverage gap discounts (shown in green above) from the calculation of TrOOP. Excluding manufacturer discounts from the TrOOP calculation would affect the number of beneficiaries who reach

[6] This benefit design does not apply to Part D enrollees who receive the low-income subsidy (LIS). Individuals with a full LIS subsidy have income below 125 percent of the federal poverty level. These LIS recipients pay no deductible and have fixed copayments until they reach the catastrophic threshold, after which they pay nothing in cost sharing. For these beneficiaries, TrOOP accrual also includes the subsidized portion of cost sharing that otherwise would have been required for a non-LIS enrollee. For this reason, neither the OOP Cap nor the TrOOP Policy apply to beneficiaries with the full LIS subsidy. They already have capped a maximum out-of-pocket limit, and manufacturers do not pay a coverage gap discount for beneficiaries with full LIS.

the catastrophic portion of the benefit, how much out-of-pocket spending a beneficiary would have in order to reach catastrophic coverage, and at what point in the benefit year a beneficiary reaches the benefits of catastrophic coverage.

Prior to the Affordable Care Act (ACA), non-LIS beneficiaries were responsible for the full cost of prescription drugs while in the coverage gap. The ACA instituted two programs that, together over time, reduce beneficiary cost sharing in the coverage gap to 25 percent by 2020. The first program is the coverage gap discount program—a 50 percent discount paid by the manufacturers of brand-name medications for all beneficiaries with brand-name spending during the coverage gap. The second change requires Part D plans to gradually increase their contribution for all drugs (brand-name and generic) filled during the coverage gap. Each year, the amount the plan contributes increases and the amount the beneficiary decreases, until 2020, when beneficiaries are required to contribute 25 percent—which is the same as the initial coverage period and thus effectively closes the coverage gap (Figure 2).

Figure 2—Non-LIS Payment Contributions for Brand Drugs in the Part D Coverage Gap, 2017-2020



METHODOLOGY

Avalere conducted this analysis using prescription drug data from the 2012 Medicare Current Beneficiary Survey (MCBS) Cost and Use Segment, plan design information from Avalere's proprietary DataFrame database, and other data sources to simulate the effect of the benefit change on a projected Medicare Part D population. The MCBS provides information about beneficiaries, their insurance coverage, their prescription drug claims, and representative weights that can be used to replicate the actual Medicare population. The analysis does not include beneficiaries receiving the Low Income Subsidy, enrolled in an Employer Group Waiver Plan, or in a plan receiving the Retiree Drug Subsidy.

As the MCBS data did not permit Avalere to apply claims to the plan cost sharing requirements in the order in which they were actually incurred, we instead summed the utilization within each drug class category and assumed an equal proportion occurred in each phase of the benefit a beneficiary would incur during the year based on total spending. We applied the cost sharing of our average plan designs with the Part D statutory thresholds and limits to estimate each beneficiary's out-of-pocket responsibility and which beneficiaries were incurring enough prescription drug use to receive the catastrophic benefit. Avalere included an elasticity assumption to model that some beneficiaries may use fewer drugs when cost sharing increases, similar to the Congressional Budget Office's assumptions.

In assessing the impact of the MedPAC proposals, Avalere looked at the effect on particular segments of the Part D population with select medical conditions with significant utilization and prevalence in the MCBS data—arthritis, mental health, and renal conditions. While ICD-9 diagnosis codes that can be used to flag beneficiaries with particular conditions are only available for those in Original Medicare (fee-for-service), the MCBS contains results of survey questions which ask beneficiaries to indicate whether a professional has told them they have various medical conditions. For renal conditions, no adequate survey questions existed so we relied on ICD-9 diagnosis codes starting with 584 and 585 and limited our analysis to the PDP population. This limitation may be somewhat mitigated for this group because beneficiaries who become eligible for the Medicare program due to end-stage renal disease are often limited to enrolling in Original Medicare, although our analysis included those with earlier stages of renal disease and acute renal failure as well. We did not project the counts of beneficiaries with these conditions at a rate different from overall Part D program growth.

RESULTS

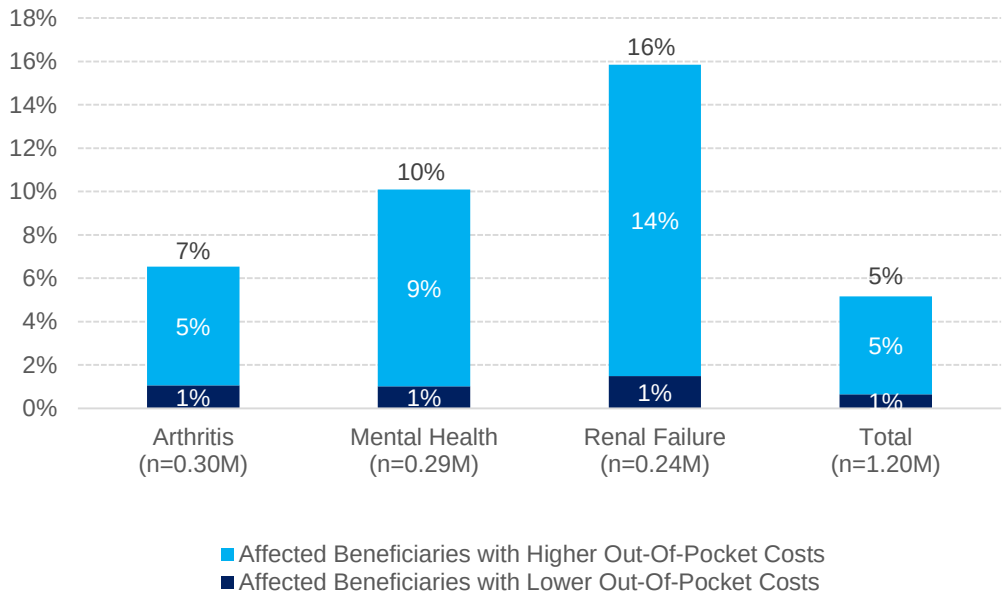
Beneficiary Impact of Implementing Both the OOP Cap and TrOOP Policy

Implementing both the OOP Cap and TrOOP Policy would affect approximately five percent of non-LIS Part D enrollees. Between 2017 and 2021, the policies would increase

beneficiary costs for an average of about one million Part D enrollees each year while at the same time significantly reducing beneficiary costs for the approximately 100,000 beneficiaries each year who have the highest out-of-pocket costs. The number of beneficiaries affected varies by year – for example, around 1.1 million beneficiaries would experience higher out-of-pocket spending in 2018 and approximately 200,000 beneficiaries would have lower costs.

When focusing on beneficiaries with certain chronic conditions, the proportion of beneficiaries affected by the combined policies is higher, ranging from seven percent of beneficiaries with arthritis to 16 percent of beneficiaries with renal conditions in 2018.

Figure 3—Percent of Beneficiaries Affected by OOP Cap and TrOOP Policy, by Condition, 2018



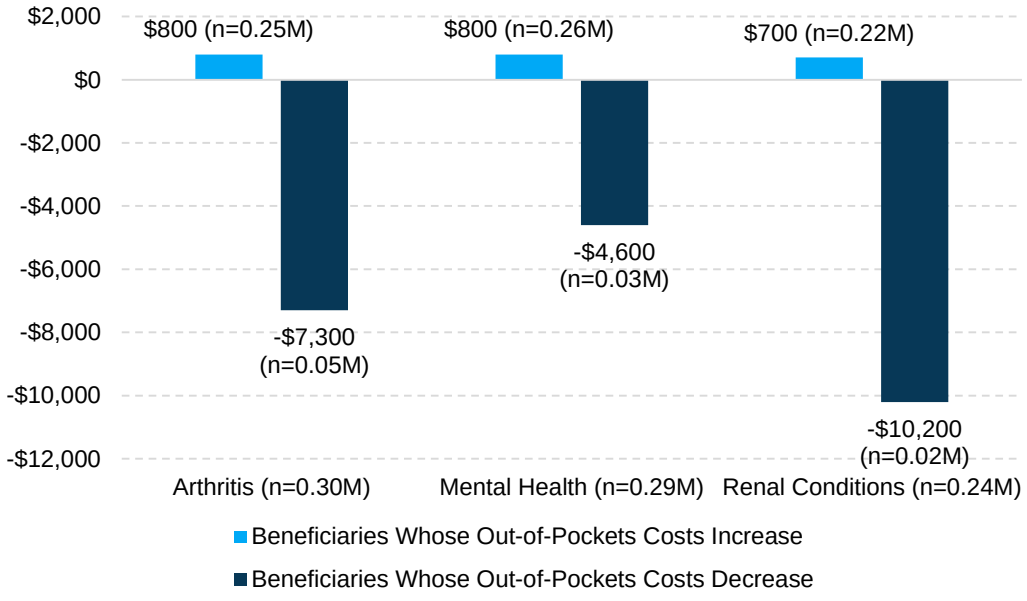
At the individual level, beneficiary spending would be significantly affected by the combined policies (see Table 1). Average per capita out-of-pocket spending for approximately 1.1 million beneficiaries would increase by around 20 percent—from about $3,500 to just over $4,200—in 2018. Over the five-year period, an average of one million beneficiaries per year would experience aggregate higher out-of-pocket spending of around $3.7 billion. For the Medicare beneficiaries who incur the highest drug costs and associated out-of-pocket expenditures, their spending would be significantly reduced. On a per capita basis, around 200,000 beneficiaries would experience over 50 percent reductions in out-of-pocket spending—dropping from $10,600 to $5,200—in 2018. Over the five-year period, aggregate out-of-pocket expenditures for the, on average, 100,000 beneficiaries each year who would experience lower out-of-pocket spending would decrease by $4.3 billion.

Table 1—Impact of Combined OOP Cap and TrOOP Policy, 2018

	Beneficiaries Whose Out-of-Pocket Costs Increase	Beneficiaries Whose Out-of-Pocket Costs Decrease
Number of beneficiaries	1,100,000	200,000
Impact on average per capita out-of-pocket cost	+$700	-$5,400

The impact on out-of-pocket costs for individuals with certain chronic conditions would be even more significant than for the average Part D beneficiary affected by the combined policies. For example, in 2018 average out-of-pocket costs for individuals with arthritis and renal conditions would decrease by $7,300 and $10,200, respectively (Figure 4). Conversely, beneficiaries with mental health conditions would experience less savings in out-of-pocket spending than the average member of the Part D population that experiences savings from the combined policies (savings of $4,600 versus $5,400).

Figure 4—Average Per Capita Impact of OOP Cap and TrOOP Policies on Affected Beneficiaries, by Condition, 2018

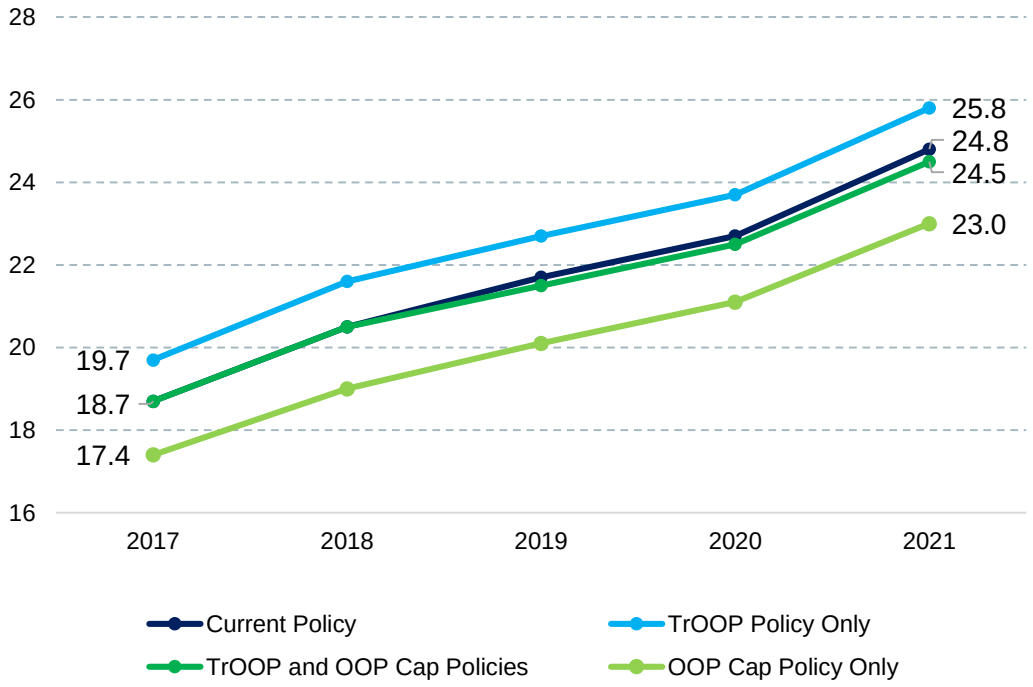


The impact of the combined policies on per capita out-of-pocket spending increases significantly over the five-year period, 2017 – 2021. For beneficiaries with lower out-of-pocket spending under the combined OOP Cap and TrOOP Policy, the average per

capita savings increased from almost $4,700 in 2017 to around $10,400 in 2021. For those who would experience higher out-of-pocket spending should both the OOP Cap and TrOOP Policies be adopted, average out-of-pocket spending would increase by around $700 in 2017 and by approximately $900 in 2021.

The combined OOP Cap and TrOOP Policy would have negligible impact on aggregate Part D enrollees' out-of-pocket costs, despite the significant change in beneficiary costs at the individual level. If either policy were to be implemented individually, beneficiary out-of-pocket costs would change materially relative to current policy, as discussed in the following sections.

Figure 5—Aggregate Beneficiary Out-of-Pocket Spending for Analysis Population Under Current and Proposed Policies, by Year (in Billions)



Impact of OOP Cap on Part D Enrollee Costs

As a standalone policy, the OOP Cap would reduce beneficiary expenditures for those Part D enrollees whose drug spending is high enough for them to reach the catastrophic portion of the benefit. Avalere projects that the OOP Cap would lower out-of-pocket spending for around five percent of non-LIS Part D enrollees, or 1.2 million individuals, by an average of about $1,200 in 2018. This represents a 27 percent decrease in average member costs which would drop from $4,400 to $3,200 for affected beneficiaries. Aggregate out-of-pocket costs for affected beneficiaries would decrease by approximately $1.5 billion in 2018 and around $7.7 billion between 2017 and 2021.

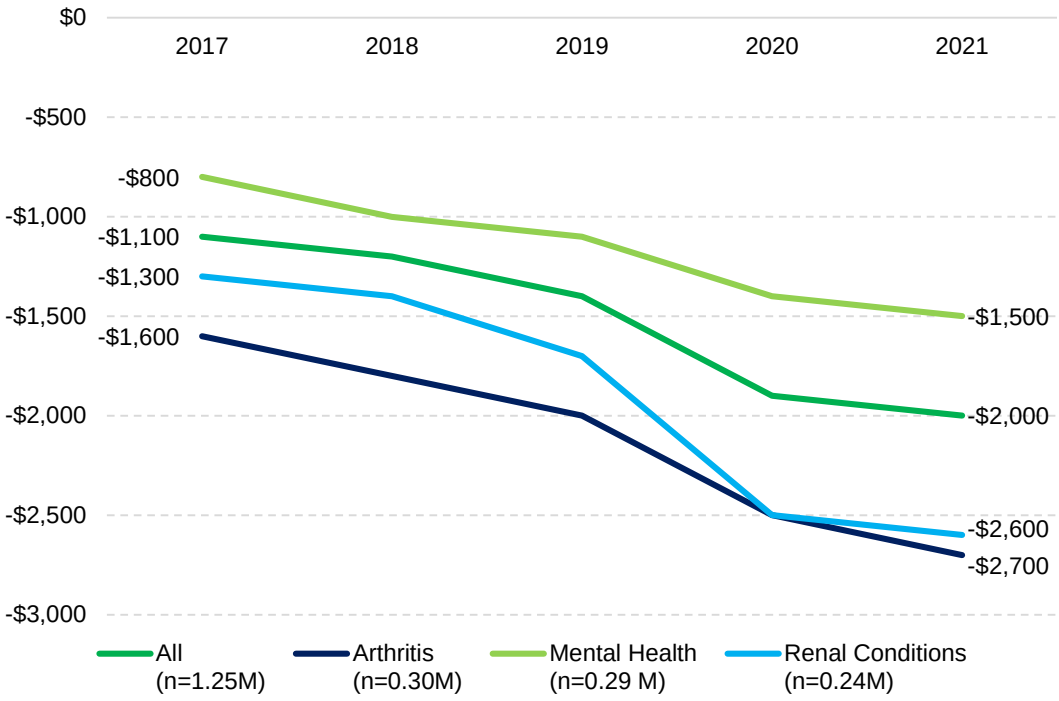
For the three conditions analyzed, the OOP Cap would offer higher average per person reductions in out-of-pocket costs for beneficiaries with arthritis and renal conditions, and slightly lower average reductions for individuals with mental health conditions (Table 2). Reflecting the fact that a higher proportion of beneficiaries with certain conditions reach the catastrophic spending threshold, the percent of beneficiaries with certain conditions who would benefit from the OOP Cap would be higher than the overall average. Whereas five percent of non-LIS Part D enrollees would benefit, among those with mental health or renal conditions, 10 and 16 percent of individuals with those conditions, respectively, would benefit in 2018.

Table 2—Beneficiary Impact of OOP Cap, 2018

	Number of Beneficiaries Affected	Percent of Part D Enrollees Affected	Average Per Capita Out-of-Pocket Impact
All	1,250,000	5%	-$1,200
Arthritis	300,000	7%	-$1,800
Mental Health	290,000	10%	-$1,000
Renal Conditions	240,000	16%	-$1,400

For those beneficiaries affected by the OOP Cap, the average savings would increase in each year of the analysis, nearly doubling across the five year period. Average per capita savings in 2017 would be $1,100 and would reach around $2,000 by 2021. For the conditions studies, the savings trend of a near doubling across the five years of the analysis is fairly consistent, except for arthritis where the average decreases in beneficiary spending would grow more slowly (Figure 6).

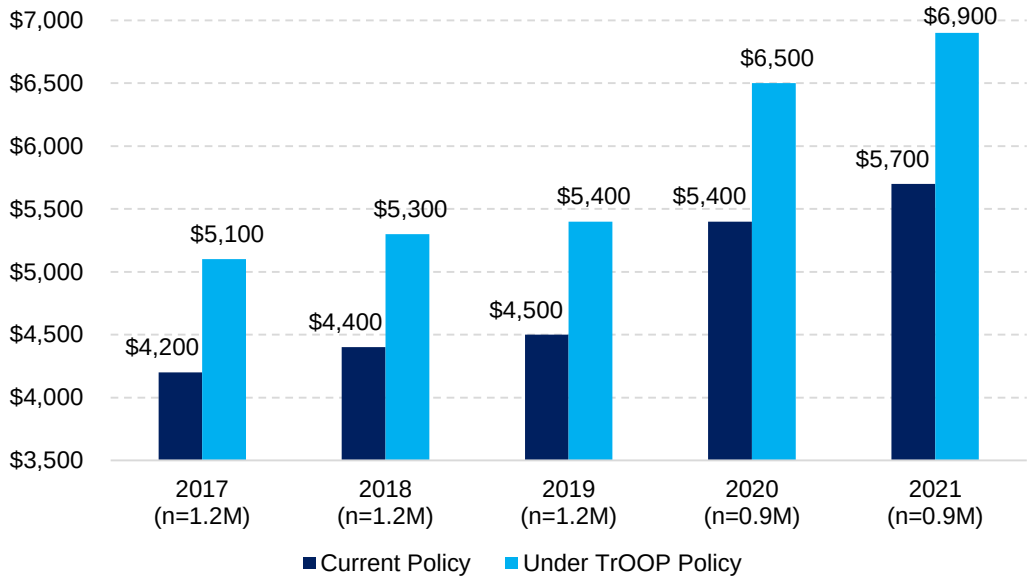
Figure 6—Average Per Capita Impact of OOP Cap on Affected Beneficiary Out-of-Pocket Spending (2017-2021)



Impact of TrOOP Policy on Beneficiary Out-of-Pocket Costs

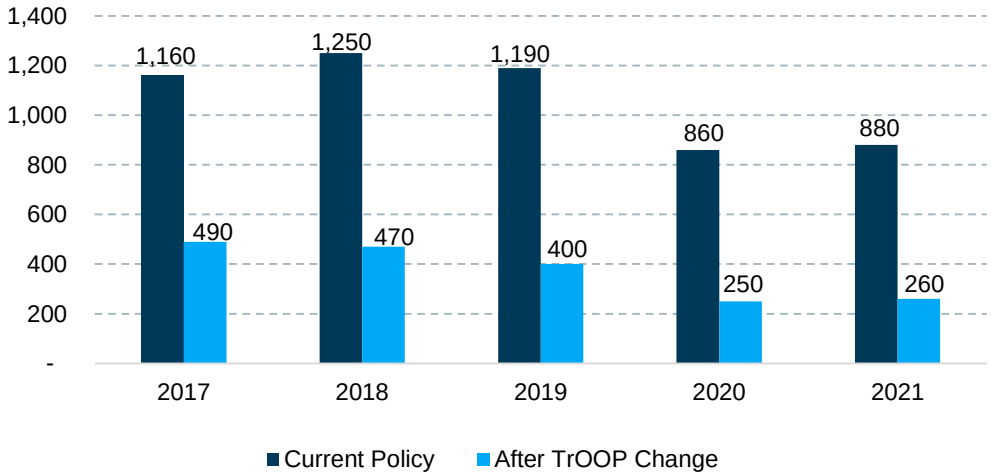
Avalere estimated the effect of MedPAC's proposal to change TrOOP accrual rules to exclude the manufacturer's discount offered during the coverage gap. In total, this proposed policy would increase Part D beneficiary spending by over one billion dollars a year and $5.1 billion, or five percent, over the five years analyzed. Each of the 1.2 million beneficiaries with higher spending under this policy would spend almost $900 more in 2018 and between $900 and $1,100 more in out-of-pocket spending in each of the five years of the analysis. (Figure 7).

Figure 7—Per Capita Impact of TrOOP Policy on Affected Beneficiary Out-of-Pocket Costs, 2017-2021



Further, this proposed policy would substantially reduce the number of people who reach the catastrophic benefit (Figure 8). Avalere estimates that, on average, 66 percent fewer non-LIS beneficiaries would reach the catastrophic phase each year during the analysis period. This policy change would result in 780,000 fewer beneficiaries reaching catastrophic coverage in 2018 alone and 3.5 million fewer beneficiaries reaching such coverage between 2017 and 2021.

Figure 8—Number of Part D Enrollees Reaching Catastrophic Coverage With and Without TrOOP Policy (in thousands), 2017-2021



CONCLUSION

Avalere analysis indicates that MedPAC's OOP Cap proposal for Medicare non-LIS Part D enrollees who meet the catastrophic threshold would reduce annual out-of-pocket spending for approximately 1.1 million beneficiaries by an average of about $1,500 per person between 2017 and 2021. On the other hand, MedPAC's proposal to change the methodology by which TrOOP is calculated—to eliminate the manufacturer discount from TrOOP accrual—may increase annual average out-of-pocket spending for about the same number of beneficiaries by almost $1,000 per person. Implementing both policies together would have a strong redistributional effect among the affected Part D enrollees whereby a relatively small number of beneficiaries (around 100,000 per year on average) would experience significant reductions in out-of-pocket costs, and ten-fold more beneficiaries would experience higher out-of-pocket spending. In aggregate over the five-year period, beneficiaries with higher out-of-pocket costs would spend $3.7 billion more and beneficiaries with lower costs would spend $4.3 billion less. At the individual level there would be significant increases in out-of-pocket spending for beneficiaries who in 2018, for example, would have average spending of $3,500 under current policy.

About Us

Avalere is a vibrant community of innovative thinkers dedicated to solving the challenges of the healthcare system. We deliver a comprehensive perspective, compelling substance, and creative solutions to help you make better business decisions. As an Inovalon company, we prize insights and strategies driven by robust data to achieve meaningful results. For more information, please contact info@avalere.com. You can also visit us at **avalere**.com.

Contact Us

Avalere Health
An Inovalon Company
1350 Connecticut Ave,
NW Washington, DC
20036
202.207.1300 | Fax 202.467.4455
avalere.com