MILLIMAN WHITE PAPER

Medicare Advantage Cost Sharing: Enhancements for Part B Drugs and Other Benefits

Commissioned by PhRMA

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Summary

MA plans commonly improve member cost sharing for certain services relative to traditional fee-for-service (FFS) Medicare benefits. This paper examines the prevalence of enhanced cost sharing on Part B drugs in the Medicare Advantage (MA) market, when compared to other common MA cost sharing enhancements. Key findings from our analysis include:

- Part B drugs are seldom subject to enhanced member cost sharing in MA, beyond the application of a maximum out-of-pocket (MOOP) limit required for all MA plans.
  - When the Part B drug benefit is further enhanced, it is rarely enhanced for all Part B drugs. Rather, plan sponsors will subject a portion of the Part B drugs to reduced cost sharing, while all other Part B drugs receive traditional FFS cost sharing of 20% prior to the MOOP.
  - Enhancing pre-MOOP cost sharing on Part B drugs appears to have a smaller impact on premiums compared to other items, such as inpatient hospital visits and PCP visits, assuming the benefit will not result in unfavorable selection to the plan. However, Part B drug cost sharing is not enhanced very often, which could be because plans have concerns about member anti-selection, or do not believe it is an effective enhancement for attracting membership. Additionally, Part B drugs may not be a benefit often highly considered for members shopping for MA plans, evidenced by the lack of information shown on the Medicare Plan Finder tool.
- The most commonly enhanced benefits include vision, inpatient hospital, and primary care physician (PCP) visits, among others.

Background

PhRMA engaged Milliman to analyze how many MA plans offer enhanced cost sharing on Part B drugs when compared to traditional FFS benefits. We used public plan design information to determine the most common benefit enhancements in 2020, and then estimated the amount of rebate dollars needed to make some of these common enhancements. We also compared this against the rebates needed to enhance the Part B drug benefit.

Part B drugs generally encompass drugs that are not self-administered and include items, such as flu shots, Hepatitis B shots, cancer drugs, insulin used with insulin pumps, and immunosuppressive drug therapies.[1] This differs from Part D drugs, which are prescription drugs generally obtained by a member at a pharmacy and self–administered.

MEDICARE ADVANTAGE PROGRAM

MA is a federally-funded program that allows beneficiaries to enroll in plans offered by private organizations contracting with Medicare to provide Part A and Part B benefits to beneficiaries – collectively known as Part C when offered under MA – as an alternative to traditional FFS Medicare. These Medicare Advantage organizations (MAOs) must offer plans with cost sharing that, in total, is at least as rich as traditional FFS coverage, which is approximately 7% coinsurance for inpatient facility services, approximately 15% for skilled-nursing facility (SNF) stays, 0% coinsurance for home health services, and 20% coinsurance for most other benefits. However, the majority of MAOs offer plans that are richer than Medicare FFS, either through reduced cost sharing or added supplemental benefits, such as gym memberships, enhanced dental coverage, hearing aids, and non-emergency transportation. All MA plans must include a MOOP limit no greater than $6,700 in 2020.[2] The MOOP applies to all services and provides value over the FFS benefit for members with high claim costs.

The amount of reduced cost sharing or added supplemental benefits that a plan is able to offer largely depends on the amount of Part C rebates a plan receives. To calculate the amount of Part C rebates a plan will receive, plan sponsors submit an MA bid to the Centers for Medicare and Medicaid Services (CMS). This bid must cover the costs for traditional Part A and Part B benefits, as well as administrative costs and margin. The bid is then compared to a risk-adjusted benchmark—the starting benchmark (before risk adjustment) is a CMS-published amount specific to each county the plan will operate in and is also based upon the quality star rating the plan receives from CMS. If the bid is lower than the risk-adjusted benchmark (the most common scenario), the plan receives a

[1] *Drug Coverage under Different Parts of Medicare*, Department of Health and Human Services https://www.cms.gov/outreach-and-education/outreach/partnerships/downloads/11315-p.pdf. Accessed June 17, 2020
[2] In 2021, this limit will increase to $7,550 as a result of ESRD members being eligible to enroll in MA plans.

rebate to offer enhanced benefits. If the bid is higher, the plan must charge an additional premium to cover the basic Part A and Part B services.

To determine the amount of Part C rebate a plan will receive, the plan sponsor calculates its savings, which is the difference between its bid amount and the risk-adjusted benchmark. The savings amount is then allocated between the plan sponsor and CMS – the rebate being the portion of savings that the plan retains. The amount retained by the plan depends on the plan's quality star rating, which is a CMS-assigned plan performance metric. Please see Table 1 below for a summary of the savings retention percentages by star rating:

Table 1
PhRMA
Rebate Calculation Percentages[3]

Star Rating	Portion of Savings Retained by Plan
3.0 and below	50%
3.5 and 4.0	65%
4.5 and 5.0	70%

Furthermore, plans can earn an additional 5% quality bonus on their benchmark revenue, or 10% in certain counties, if their quality star rating is 4.0 or higher (subject to a statutory cap on the total benchmark amount). Plans can then use this additional revenue to further enhance their benefit offering, if they choose. According to MedPAC the average rebate level for an MA plan in 2020 is $122 per member per month (PMPM), which is an all-time high.[4]

The following table contains a high-level walk-through of the MA bidding process for a hypothetical MA plan:

Table 2
PhRMA
Part C Revenue Illustration

Quality Star Rating	4.0
County Payment Rate at 1.00 Risk Score	$1,000
5% Quality Bonus Payment	$50
Total CMS Payment	$1,050
Estimated Risk Score	1.10
Risk-Adjusted Part C Payment Rate	$1,155 ($1,050 X 1.1)
Part C Bid	$1,030
Savings	$125 ($1,155 to $1,030)
Rebate %	65%
Part C Rebate	$81.25 ($125 * 65%)
Total Supplemental Benefits (Part D and Part C supplemental benefits, including reduced cost sharing)	$106.25
Member Premium	$25 ($106.25 to $81.25)

As illustrated in Table 2, if the plan would like to offer more benefit enhancements than the bid and rebate cover, member premium is the balancing item. However, as shown in Table 3 below, the majority of MA beneficiaries enroll in plans that offer a $0 member premium:

[3] Advance Notice of Methodological Changes from Calendar Year (CY) 2021 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies – Part II. Released by CMS February 5, 2020.
[4] Serna, Luis and Andy Johnson. December 2019 MedPAC Public Meeting. http://www.medpac.gov/docs/default-source/default-document-library/ma-dec19.pdf?sfvrsn=0. Accessed April 1, 2020.

Table 3
PhRMA
2020 MA Enrollment by Member Premium*

Member Premium (PMPM)	Enrollment %
$0	59.9%
$0.01 to $20.00	5.7%
$20.01 to $40.00	11.8%
$40.01 +	22.6%

**Excludes Puerto Rico and Special Needs Plans.*

Further, all MA plans are required to limit enrollee out-of-pocket costs by including a MOOP limit in each plan, a benefit that is not provided by Medicare FFS. In calendar year 2020, the MOOP ranged from $0 to $6,700, with many MAOs offering a MOOP at the $6,700 level. However, if a plan offers a low enough MOOP (no more than $3,400 for HMO and HMO-POS plans, and $5,100 for PPO plans), that plan can charge higher cost sharing amounts on certain benefits, such as inpatient acute service, SNF stays, and emergency room visits. A distribution of the MOOP offerings by plan and member can be seen in Table 4 below.

Table 4
PhRMA
2020 Medicare Advantage MOOP Levels*

MOOP Value	Plan Count	Plan Distribution	Enrollment	Enrollment Distribution
$0	2	0.1%	1,421	0.0%
$1 to $3,399	279	8.3%	2,167,201	10.9%
$3,400	437	12.9%	2,368,291	11.9%
$3,401 to $5,099	857	25.4%	6,103,678	30.6%
$5,100	17	0.5%	135,954	0.7%
$5,101 to $6,699	696	20.6%	3,517,252	17.6%
$6,700	1,092	32.3%	5,657,639	28.4%

**Excludes Puerto Rico and Special Needs Plans.*

Results

PART B DRUG COST SHARING

CMS requires plans to report cost sharing for two categories of Part B drugs: "Part B Rx – Chemotherapy" and "Part B Rx – Other." We analyzed both of these categories for non-SNP MA plans offered in 2020 and found that a very small number of plans offered pre-MOOP benefits that differed from FFS cost sharing (i.e., 20% coinsurance after the Part B deductible). As discussed above, the MOOP provides value over FFS for members with high claim spending. For example, a member with $50,000 in Part B claim costs would spend approximately $10,000 in cost sharing under FFS, but would be capped at $6,700 under MA. On the other hand, a member with $20,000 in claim costs may never reach the MOOP and will only realize value from any additional cost sharing reductions relative to FFS. Beneficiaries using Part B drugs are more likely to reach the MOOP than other beneficiaries.

The proportion of beneficiaries enrolled in plans that offer further reduced cost sharing on Part B drugs is fairly consistent with the number of plans, as seen in Table 5 below:

Table 5
PhRMA
Part B Rx Cost Sharing Summary for MA Plans*

		Chemotherapy		Other	
	Cost Sharing Level	**Plan Count**	**Distribution**	**Plan Count**	**Distribution**
Plans	FFS	3,142	93.0%	2,997	88.7%
	Non-FFS	238	7.0%	383	11.3%
	Cost Sharing Level	**Enrollment**	**Distribution**	**Enrollment**	**Distribution**
Enrollment	FFS	17,831,999	89.4%	16,999,527	85.2%
	Non-FFS	2,119,437	10.6%	2,951,909	14.8%

**Excludes Puerto Rico and Special Needs Plans.*

For plans that do not offer 20% coinsurance (akin to FFS cost sharing), the most common cost sharing designs offer staggered coinsurance with reduced cost sharing on only a portion of Part B drugs. There are a variety of ways in which the cost sharing is divided, such as 0% for preferred-brand diabetic test strips, home infusion drugs, or inhalers, and 20% for all other Part B drugs. In most cases, the enhancement only applies to a small subset of Part B drug costs, with the majority still subject to FFS cost sharing prior to the MOOP. While some plans offer a $0 cost sharing benefit on all Part B drugs, this is not a very common option. Of

beneficiaries who enrolled in a plan with enhanced Part B drug cost sharing, only 4.9% are in a plan that offered no cost sharing (or only 0.7% of the MA population analyzed).

Enhanced Part B drug cost sharing tends to be concentrated among just a few MAOs. Kaiser Foundation Health Plan and Blue Cross Blue Shield of Michigan account for more than half of members enrolled in plans with some level of enhanced Part B drug cost sharing. Similarly, enrollment is concentrated among just a few states, with about half of enrollment in California and Michigan (the respective locations of the aforementioned MAOs). Nearly 80% of members with enhanced Part B drug cost sharing are located in just five states.

We also analyzed other MA benefits to identify which Medicare-covered benefits most commonly vary from traditional FFS cost sharing. Table 6 below displays the ten most common benefits, as a percentage of enrollment, where a plan offers beneficiaries a pre-MOOP benefit that differs from traditional FFS. Table 6 also shows the most common pre-MOOP benefit type other than FFS and the percentage of beneficiaries who have access to a benefit other than FFS.

Table 6
PhRMA
Detailed Summary of Enhanced MA Benefits - Most Prevalent Non-FFS Benefits*

Benefit	Most Common Non-FFS Benefit	FFS Benefit	Enrollment % with Non-FFS Benefits
Medicare Covered Vision Exams	$0	20% Coinsurance	99.5%
Inpatient Services - Mental Health	$295 / Day for Days 1 to 5 and $0 / Day for Days 6 to 90	Varies by County, typically between 7% to 8%	99.5%
Inpatient Services - Medical / Surgical	$0 to $325 / Day	Varies by County, typically between 7% to 8%	99.3%
Medicare Covered Primary Care Physician Visits	$0	20% Coinsurance	98.9%
Medicare Covered Hearing Exams	$0	20% Coinsurance	98.9%
Laboratory	$0	20% Coinsurance	98.6%
Ground Ambulance	$250 Copay	20% Coinsurance	98.5%
Outpatient Services - Ambulatory Surgical Center	$200 Copay	20% Coinsurance	98.1%
Outpatient Services - Surgery	$250 Copay	20% Coinsurance	97.8%
Outpatient Services - Substance Abuse - Individual Services	$40 Copay	20% Coinsurance	97.6%
Outpatient Services - Substance Abuse - Group Services	$40 Copay	20% Coinsurance	97.6%

**Excludes Puerto Rico and Special Needs Plans.*

In Table 6 above, nearly all MA beneficiaries (more than 97%) have something other than traditional FFS cost sharing, in addition to the MOOP, which applies to all benefit categories. While the list above contains the benefits with instances of cost sharing that differ most from traditional FFS, some of these items do not contribute much to the overall spend of an MA plan. Therefore, to better represent the dynamics of an actual MA bid, we also examined the five benefit categories with the highest allowed amounts for an average bid, as well as the two Part B drug categories. We first estimated the impact of introducing a MOOP. While a MOOP is required to be offered by all MA plans, it is a significant enhancement over traditional FFS benefits where members do not have any limit on cost sharing.

The first scenario in Table 7 estimates the change in member cost sharing and the resulting rebates available to the MA plan when a $6,700 MOOP, consistent with the 2020 maximum in-network MOOP, is introduced to a plan with traditional FFS benefits. Each subsequent scenario builds upon this first step, enhancing the cost sharing for just the service listed, with the $6,700 MOOP applied in all scenarios. The values displayed in the first row reflect all Part C benefit costs for a loosely managed plan, while each scenario below shows allowed and cost sharing for the specific benefit listed. These results are shown below:

Table 7
PhRMA
Summary of Cost Sharing by Major MA Benefit Category

Benefit	FFS Allowed PMPM	FFS Cost Sharing PMPM (with MOOP)*	Alternative Cost Sharing PMPM	Rebate Dollars Used
Addition of $6,700 MOOP	$981.30	$149.50	$124.30	$25.20
Inpatient Services - Medical / Surgical	$298.90	$15.10	$7.50	$9.50
Outpatient Services - Surgery	$70.40	$12.80	$3.50	$9.60
Physician - Specialist Visits	$60.90	$11.60	$19.20	-$9.00
Physician - Primary Care Visits	$49.80	$9.50	$1.30	$10.90
Skilled Nursing Services	$50.60	$4.00	$3.70	$0.30
Medicare Part B Drugs - Other	$62.00	$7.20	$3.00	$3.60
Medicare Part B Drugs - Chemotherapy	$32.50	$3.80	$1.20	$1.90

**FFS Cost Sharing in the first row reflects no MOOP, while all subsequent rows in this column apply FFS cost sharing, but assume a $6,700 MOOP.*

The MOOP is a large driver of the amount of rebates available to the plan. While $6,700 is the maximum MOOP permitted in 2020, some plans may choose to offer a lower MOOP—as the MOOP moves closer to $0, beneficiary cost sharing is greatly reduced, independent of the cost sharing levels on individual benefits. Further, since decreasing the MOOP provides an overall richer plan for the beneficiary, the amount of rebates available to the plan decreases as the MOOP decreases.

The scenarios in Table 7 reflect the average results across the top three non-standard benefit options offered by 2020 plans in each benefit category. A summary of those benefits can be seen in Table 9 of the Methodology and Assumptions section below. Plans generally use rebates to reduce cost sharing on items that most members tend to think about when purchasing health insurance, particularly hospital stays, surgeries, and doctor visits. Table 7 shows the level of rebates required for different benefit changes and in some cases, member cost sharing under an MA plan is actually greater than traditional FFS Medicare cost sharing (evidenced by a negative amount of rebates used). For example, in the 'Physician – Specialist Visits' line, many plans offer copays instead of the traditional FFS cost sharing (i.e., 20% coinsurance and Part B deductible). CMS permits copays of up to $50 on specialist visits, but this copay is generally equivalent to greater than 20% coinsurance. However, beneficiaries often feel a sense of comfort in fixed copay designs compared to more variable coinsurance. When a plan offers a $40 specialist copay, this may cost beneficiaries more than FFS cost sharing; however, it generates additional rebate dollars the plan can use to enhance other benefits.

Table 7 also shows that the amount of cost sharing change to the member does not exactly correlate to the amount of rebates available to the plan. This is for two main reasons—first, as a member's cost sharing is reduced (or increased), the value of the MOOP to the member decreases (or increases) as well. This is because as cost sharing decreases, the chance of the member reaching the MOOP decreases, so the limit on out-of-pocket costs is less valuable. Therefore, some of the reduced cost sharing on a particular benefit is offset when considering total member spend. Second, as cost sharing decreases, members are more likely to use more services. This increases total costs, which can mean a greater amount of rebate dollars are associated with the benefit change than if utilization remained constant.

Additionally, while not many plans offer different pre-MOOP cost sharing than FFS on Medicare Part B drugs, changing the cost sharing amounts before the MOOP uses fewer rebate dollars relative to many other benefits. The low rebate value of pre-MOOP cost sharing reductions is due to the fact that a large proportion of members using Part B drugs will reach the MOOP, even if the cost sharing remains at 20%. As a result, reducing the 20% coinsurance does not have as large of an impact on plan liability, as many members may still reach MOOP. Despite the small impact, since members using Part B drugs typically have much higher total spending than other MA members, many plans may not offer enhanced cost sharing on Part B drug benefits to attempt to remain consistent with competitors and not attract a disproportionate share of these beneficiaries to their plan.

STANDARD MA EXAMPLE

While the above covers many different cost sharing scenarios for Medicare-covered benefits, many MA plans want to enhance the member experience by offering supplemental benefits for services not otherwise covered by Medicare. A list of the most common supplemental benefits in 2018 is shown below in Table 8:

Table 8 PhRMA Most Common Supplemental Benefits – Non-SNP Plans	
Fitness Benefit	Hearing Hardware
Vision Exams	Preventive Dental
Remote Access Technologies	Hearing Exams
Vision Hardware	Annual Physical Exams (Non-Medicare Covered)

To further illustrate potential ways to enhance an MA plan, as an example, we analyzed a hypothetical MA plan for a non-institutionalized, non-Medicaid (NINM) population with total plan costs and revenue based on the Milliman Ages 65 and Over *Health Cost Guidelines (HCGs)*. This hypothetical plan has $20 in rebates to spend on enhancing cost sharing or offering additional supplemental benefits. This plan could offer a $0 copay on primary care visits, $20 copay on specialist physician visits, a $220 copay on ambulance trips, a fitness benefit, and preventive dental benefit.

Similarly, if the same plan were to offer enhanced cost sharing on Part B drugs by reducing the coinsurance from 20% to 10%, the plan could continue to offer a $0 copay on primary care visits and a $220 copay on ambulance trips, while increasing the specialist physician copay to $30. The plan would then be able to add approximately $0.75 PMPM of benefit values to their supplemental fitness benefit or preventive dental benefit, which could be done by enhancing the level of benefits available or charging lower cost sharing for these benefits. While this example illustrates that Part B drug cost sharing can be easily reduced without a large impact on the final plan results, this example assumes:

- No other plan design adjustments are made
- The morbidity of the plan before and after the cost sharing changes remains consistent

The latter is an important assumption, as a reduction in Part B drug coinsurance for only one or a minority of plans could result in a change in population leading to different total costs. MAOs may choose not to enhance cost sharing to avoid this potential anti-selection. Moreover, MAOs tend to compete more on items, such as:

- Medical benefit coverage, such as hospital stays, physician and specialist visits, and outpatient surgery
- Supplemental benefits
- Member premium

These items tend to be more of a draw to beneficiaries than Part B drug cost sharing, which may make enhancing the Part B drug cost sharing a less likely scenario.

Methodology and Assumptions

To perform this analysis, we used the Milliman MACVAT® to identify 2020 MA plans' cost sharing on Part B drugs and other major Medicare service categories, as compared to traditional FFS cost sharing. We then used the Milliman MACVAT to identify the service categories that had the highest number of plans with cost sharing that differed from traditional FFS. Please note, each year CMS publishes copay limits on certain benefits. For example, for 2020 the MA copay limit on PCP visits was $35. Therefore, if any plan listed $35 as the cost sharing, we considered that plan to offer "standard" benefits on the PCP service line, since the plan is not permitted to increase cost sharing beyond this amount. As such, we excluded "standard" benefits from the analysis underlying Table 7, since we believe they do not represent a cost sharing enhancement. We then used the February 2020 MA individual plan enrollment to see which benefits had the most enrollment throughout the MA market.

We removed Cost and Medicare Savings Account (MSA) plans from our analysis, as those plans do not offer typical MA cost sharing structures. We also removed Special Needs Plans (SNPs). SNPs generally have a large portion of dual-eligible membership (i.e., beneficiaries who are eligible for Medicare and Medicaid). Medicaid pays the cost sharing for these beneficiaries, so they are less likely to shop based on cost sharing enhancements. We also did not include any plans from Puerto Rico.

We used Milliman's Standard Medicare Advantage Rating Model (SMART) to model an MA plan in the Phoenix, AZ area, where the risk of the population was consistent with the risk of a NINM population in the Phoenix-Mesa Metropolitan Statistical Area in CMS' 5% sample data. We began by pricing a plan that had cost sharing levels equivalent to FFS and then modeled various cost sharing level changes, using the traditional FFS scenario as a baseline. For simplicity, we assumed no non-benefit expenses. While a true plan would have some amount of non-benefit expenses, this allowed us to isolate the impact of rebate dollars driven by changes in cost sharing alone.

To calculate these alternative scenarios, we looked at the three most common cost sharing scenarios (aside from traditional FFS cost sharing) for each of the benefit categories listed in Table 7. These scenarios, in order of most enrollment, are listed in Table 9 below:

Table 9 PhRMA Summary of Popular Cost Sharing Levels	
PBP Benefit Line	**Cost Sharing Scenario**
Inpatient Services - Medical / Surgical	$0 per admission $325 per day for days 1 to 5 and $0 per day for days 6 to 90 $295 per day for days 1 to 6 and $0 per day for days 7 to 90
Outpatient Services - Surgery	$250 copay per procedure $200 copay per procedure $0 copay per procedure
Physician - Specialist Visits	$40 copay per visit $35 copay per visit $45 copay per visit
Physician - Primary Care Visits	$0 copay per visit $5 copay per visit $10 copay per visit
Skilled Nursing Services	$0 per day for days 1 to 20 and $100 per day for days 21 to 100 $0 per day for days 1 to 20 and $160 / day for days 21 to 62 a and $0 / day for days 63 to 100 $0 / day for days 1 to 20 and $160 / day for days 21 to 100
Medicare Part B Drugs – Other	0% to 20% coinsurance per drug $0 to $47 copay per drug 10% to 20% coinsurance per drug
Medicare Part B Drugs - Chemotherapy	$0 to $47 copay per drug 0% to 20% coinsurance per drug 10% to 20% coinsurance per drug

We then modeled the effect of each of the changes on the cost sharing amount and the impact on rebate dollars available. The results were aggregated by the number of beneficiaries who are enrolled in each benefit during the 2020 plan year.

In changing the cost sharing designs we did not model any anticipated changes in risk levels of populations who may be drawn to certain benefit structures. In our scenario modeling, we assumed a $0 deductible and $6,700 maximum-out-pocket limit. Changes in these values can also affect the amount of rebate that is available to the plan, as well as affect the member behavior when electing whether to have a medical service completed.

Caveats, Limitations, and Qualifications

We developed this report to help PhRMA understand how Medicare Advantage (MA) rebates are used to lower cost sharing on Part B drugs and other MA benefits for MA beneficiaries. This information may not be appropriate, and should not be used, for other purposes. This report is intended for PhRMA. PhRMA may share this information with external parties with Milliman's prior written consent. We do not intend this information to benefit any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

In preparing our analysis, we relied upon public information from CMS, the Milliman MACVAT®, and the Milliman *HCGs*. Actual results will vary for specific health plans due to differences in trends, CMS payment rates, contracting rates, benefit designs, and beneficiary morbidity, among other factors.

The authors are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices. This information has been prepared under the terms of the consulting services agreement between Milliman and PhRMA, dated January 19, 2016, and extended effective December 19, 2018.

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