Don't TrOOP off the cliff: True out-of-pocket amount poses challenges starting in 2020

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The Medicare Part D program provides catastrophic pharmacy coverage and the Centers for Medicare and Medicaid Services (CMS) annually updates the true out-of-pocket (TrOOP) amount at which catastrophic coverage begins. With the passage of the Patient Protection and Affordable Care Act (ACA) came a modification to how the TrOOP amount was calculated through 2019. With significant other changes to Part D from the Bipartisan Budget Act of 2018 (BBA)[1] and the CMS Final Rule,[2] one provision from the ACA that has gone largely unnoticed is the forthcoming "TrOOP Cliff" in 2020, for which plan sponsors should prepare.

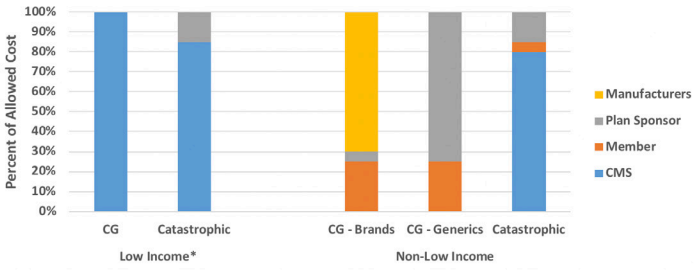
In the absence of additional legislation, the Medicare Part D TrOOP amount is estimated to increase by more than 30%, from $5,100 in 2019[3] to $6,650 in 2020, based on the 2017 Medicare Trustees Report.[4] The driver of the increase is the determination of the 2020 TrOOP amount reverting to the methodology used prior to *and in the absence of* the ACA.

Background

The TrOOP amount is the annual amount paid by a member and pharmaceutical manufacturers through the Coverage Gap Discount Program (CGDP) before catastrophic coverage begins. Prior to reaching the TrOOP amount, pharmacy costs in the coverage gap are shared by the member, plan sponsor, and pharmaceutical manufacturers through the CGDP for non-low-income (NLI) members. The CGDP is available only to NLI members taking applicable brand products and biosimilars, with low-income (LI) members ineligible for the CGDP because their benefit is heavily subsidized by the government.

Catastrophic coverage begins when a member's out-of-pocket cost for prescription medications (including the CGDP) exceeds the TrOOP amount. Financial responsibility for catastrophic costs is shared by the member, plan sponsor, and the federal government through CMS. Plan sponsors' share of allowed cost in each phase is funded through member premium and the direct subsidy.

FIGURE 1: STAKEHOLDER RESPONSIBILITY IN 2020 COVERAGE GAP (CG) AND CATASTROPHIC PHASES



* Excludes a nominal patient pay amount for low-income members.

Determination of the TrOOP amount

Prior to the ACA, the TrOOP amount was calculated by trending the prior year value using the annual percentage increase in the average expenditures for Part D medications per eligible member. This increase is published annually in the Final Rate Announcement by CMS.[5] The ACA amended how the TrOOP amount is calculated accordingly for the following years[6]:

- **2014 – 2015:** Increase the TrOOP amount from the prior year by the annual percentage increase pre-ACA, less 0.25% and round to the nearest $50.
- **2016 – 2019:** Increase the TrOOP amount from the prior year by the minimum of the following and round to the nearest $50:
  - The annual percentage increase in the Consumer Price Index (CPI) plus 2%
  - The annual percentage increase in the average expenditures for Part D medications

1 Bipartisan Budget Act of 2018. Full text is available at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf.

2 CMS Final Rule. Full text is available at https://www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare.

3 Bipartisan Budget Act of 2018, ibid.

4 2017 Medicare Trustees Report. Full text is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf.

5 2019 CMS Final Rate Announcement and Call Letter. Full text is available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf.

6 The ACA-amended § 423.104(d)(5)(iii) and (v) of the Code of Federal Regulations. Full text is available at https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol3/xml/CFR-2017-title42-vol3-part423.xml.

In 2020 and beyond, the ACA states that the TrOOP amount will be calculated using the methodology prior to the ACA and *as though the ACA had not altered the methodology to set the TrOOP amount from 2014 through 2019*. The ACA depressed the TrOOP amounts from 2014 to 2019 compared to those using the pre-ACA methodology as shown in the table in Figure 2. While the TrOOP amount increases varied since inception of the ACA (the most notable occurring in 2016 and 2017 due to high brand and specialty trends), the 2020 TrOOP Cliff is significantly larger. Recalculating the TrOOP amount in the absence of the ACA leads to an increase of just over 30% from 2019 to 2020.

FIGURE 2: HISTORICAL TROOP AMOUNTS, IMPACT BEFORE AND AFTER THE ACA

	TROOP AMOUNT*	
YEAR	PRE-ACA METHODOLOGY	POST-ACA METHODOLOGY
2013	$4,750	
2014	$4,550	$4,550
2015	$4,750	$4,700
2016	$5,300	$4,850
2017	$5,900	$4,950
2018	$5,950	$5,000
2019	$6,050	$5,100
2020	$6,650	$5,200**

* Actual TrOOP values are determined using the post-ACA methodology from 2014 to 2019 and the pre-ACA methodology in 2020.

** Estimated using the annual increase published in the 2019 Final Rate Announcement and Call Letter.[7]

Historically, the actual TrOOP amount has been less than estimates provided in the Medicare Trustees report. Furthermore, the historical TrOOP growth rate using the pre-ACA methodology from 2013 to 2019 has been 4%, yielding an estimated TrOOP amount of $6,300 in 2020. Even this lower TrOOP projection would result in a TrOOP amount increase of nearly 24% from 2019 to 2020. The 2018 Medicare Trustees Report,[8] released immediately prior to this report, estimates the 2020 TrOOP at $6,350.

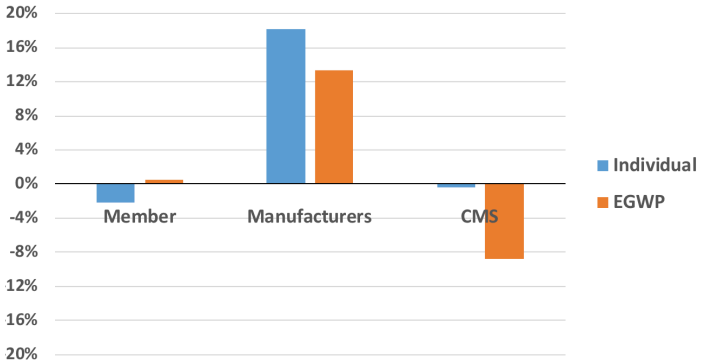
Part D expenditures have historically been approximately 5% higher on average than the CPI since 2014. Provided this relationship continues, and coupled with the post-2020 TrOOP amount based on average Part D expenditures, the TrOOP amount should see larger increases after 2020 than from 2013 to 2019. Indeed, both Medicare Trustees Reports estimate annual increases in the TrOOP amount of $400[9] (i.e., roughly a 5% to 6% increase through 2025). This is greater than the historical average increase to the TrOOP amount of just over 1% from 2013 to 2019 due to the ACA.

Impact on stakeholders

The increase in the TrOOP amount to $6,650 affects the stakeholders for the individual Medicare Part D and employer group waiver plans (EGWPs) differently. The drivers of these differences are variations in benefit designs (EGWPs generally have more generous benefits), member composition (EGWP membership is primarily NLI), and adjudication of claims in the coverage gap (CGDP and straddle claims).

We illustrate the impact to stakeholder costs due solely to the change in the TrOOP amount in Figure 3. While Figure 1 on page 1 shows plan sponsors' share of allowed cost, the changes to the plan liability are ultimately paid by the member in the form of member premium and the government in the form of the direct subsidy. In Figure 3, the member premium and direct subsidy changes are included in the member and government amounts, respectively. Due to CMS margin rules and the competitive aspect of Medicare Part D, plan sponsors are incentivized to lower member premiums and/or increase benefits in response to expected reductions in plan liability. We assume no change to plan sponsor margins or administrative cost for results shown in Figure 3.

FIGURE 3: PERCENTAGE CHANGE IN STAKEHOLDER COST



The impact to individual Medicare Part D stakeholders varies due to the differences in cost sharing between the coverage gap and catastrophic phases and in the distribution of membership by income status, where we assume approximately 35% of members are LI, representing the national average.[10]

7 2019 CMS Final Rate Announcement and Call Letter, ibid.

8 2018 Medicare Trustees Report. Full text is available at https://www.ssa.gov/oact/TR/2018/tr2018.pdf.

9 2017 Medicare Trustees Report.

10 CMS.gov. 2017 Low Income Subsidy Enrollment by Plan. Retrieved May 18, 2018, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/LIS-Enrollment-by-Plan-Items/2017-Low-Income-Subsidy-Enrollment-by-Plan.html.

- **Members:** Member cost includes cost sharing and premium, which includes the low-income premium subsidy (LIPS). Extending the TrOOP amount shifts allowed cost from the catastrophic phase to the coverage gap. This extension increases cost sharing for NLI members who reach the catastrophic phase as the liability for NLI members is greater in the coverage gap than the catastrophic phase. However, the shift in allowed cost reduces overall member premium. This reduction is due to the lower plan sponsor liability in the coverage gap phase (25%/5% for generics/brands, respectively, for NLI members and nearly nonexistent for LI members) than what is in the catastrophic phase (approximately 15% of allowed cost) as shown in Figure 1. If plan sponsors do not change their target margins, the overall member liability would decrease.
- **Manufacturers:** Manufacturer cost includes the CGDP amount but excludes manufacturer rebates. As more brand allowed costs are shifted into the coverage gap from the catastrophic phase, the liability increases for manufacturers.
- **CMS:** CMS costs include the following:
  - Federal reinsurance
  - Low-income cost-sharing (LICS) subsidies
  - The direct subsidy

  Federal reinsurance decreases as there are fewer costs in the catastrophic phase (due to fewer members reaching the TrOOP amount and allowed costs shifting from the catastrophic phase to the coverage gap for those members reaching the TrOOP amount). The LICS subsidy increases as allowed cost is shifted to the coverage gap, where CMS pays nearly the entire benefit cost. With the national average bid amount (NABA) decreasing more than federal reinsurance on a percentage basis, the direct subsidy is anticipated to decrease with all other assumptions unchanged.

  The net impact of the changes to these three components is a slight decrease in the overall liability to CMS. The CMS liability for a plan would increase commensurately with an increase in the distribution of LI members.

The impact to Part D EGWP stakeholders is also driven by differences in cost sharing between the coverage gap and catastrophic phases, but less so by member income status, because EGWP membership is primarily NLI.

- **Members**: Member cost includes cost sharing and premium similar to that for the individual plans. The impact to the member cost sharing as a percentage of total cost is minimal, using a representative benefit design with secondary coverage through the coverage gap (which commonly occurs for EGWPs). Unlike individual plans, the shift in allowed cost to the coverage gap will increase the plan liability and therefore the member premium. The combined impact is a slight increase to the overall member liability.
- **Manufacturers:** The impact to manufacturers is a significant increase in cost because most members are eligible for the CGDP and members who reach the coverage gap are typically brand utilizers. The difference in claim adjudication methodologies from what is used by individual Medicare Part D plan sponsors enhances the impact to manufacturers for EGWPs. While the per member per month (PMPM) change is greater for EGWPs than for individual plans, the CGDP amount is already greater for EGWPs and therefore results in a smaller percentage change. The CGDP amount for EGWPs is larger than that for individual plans due to the higher percentage of NLI members.
- **CMS:** The CMS liability decreases as fewer members reach the TrOOP amount and, for those members reaching the TrOOP amount, a portion of their catastrophic costs are shifted to the coverage gap, where CMS has no financial responsibility.

Although Congress could modify the methodology for determining the TrOOP amount, there are several reasons why that may not occur.

- In general, the reduction in liability to plan sponsors often translates to reduced premiums for members, which is a positive news headline.
- The TrOOP Cliff (technically introduced with passage of the ACA and set in motion in 2014) has not garnered much attention amid other Part D news events, e.g., CMS proposed rulings, recommendations from the Medicare Payment Advisory Commission (MedPAC), and the BBA.
- The TrOOP Cliff may not be as pronounced as estimated based on historical actual-to-expected comparisons.

Methodology

We used a representative benefit design to estimate the impact of the change in the TrOOP amount to individual plan sponsors. This representative benefit design used the 2020 defined standard benefit as estimated in the 2017 Medicare Trustees Report while only varying the TrOOP amount as shown in the table in Figure 2. Part D utilization and costs were projected using Milliman's Medicare Part D manual rates and the Milliman Health Cost Guidelines™ (HCGs) research trended to 2020. This projection was calibrated to an estimated 2020 NABA and member premium. We modeled changes to the national averages and reflected a modified direct subsidy from the TrOOP Cliff.

Similar to the individual plan, we chose a representative benefit design to estimate the impact of the TrOOP amount change on EGWP stakeholders. We used a copay benefit design, estimated 2020 benefit parameters (again, only varying the TrOOP amount accordingly), and a manual rate based on the Milliman HCGs trended to 2020.

The percentage change to each stakeholder is the ratio of the stakeholder cost using the post-ACA (i.e., a TrOOP amount of $5,200) and pre-ACA (i.e., a TrOOP amount of $6,650) methodologies. The CMS liability comprises federal reinsurance, the LICS subsidy, and the direct subsidy. The manufacturer liability comprises the CGDP only in our analysis and excludes manufacturer rebates. We included the impact of the BBA[11] when modeling the impact to various Part D stakeholders.

We made common assumptions for both individual plans and EGWPs. We assumed no changes to formulary, population, contracting terms, or rebates. Furthermore, we did not model potential secondary effects as a result of the change in the TrOOP amount (e.g., behavioral changes or changes in the CMS risk score model).

11 Bipartisan Budget Act of 2018, ibid.

Caveats

The values shown here are based on national averages and representative benefit designs. Results for any particular stakeholder may vary from those presented here due but not limited to varying benefit designs, different underlying populations, and future changes to laws and regulations.

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