

Out-of-Pocket Costs (OOPC) Data Calculations

The Out-of-Pocket Costs (OOPCs) are calculated using the events or incidents of health care usage reported by individual people with Medicare from the Medicare Current Beneficiary Survey (MCBS). The individual reported use of health care records are matched to the individual claims history to ensure that Medicare covered services, as well as services not covered by Medicare, are included in the analysis sample. Two years of survey data (for example, 2010 and 2011) are combined to create a nationally representative cohort of people with Medicare. The pooling of years creates statistically valid and reliable cost estimates.

Individuals are excluded from the analysis cohort if they did not participate in both Medicare Parts A & B for the full 12 months of the year. Also excluded were certain categories of individuals whose claims are paid differently or for whom a full complement of data does not exist. The focus is then on MCBS survey respondents covered by Original Medicare and their associated claims for the same period. The actual Medicare claims payment experience allows total health care utilization for each person with Medicare to be determined.

Average monthly out-of-pocket costs are calculated using this cohort of MCBS data for each Medicare Advantage health plan. These estimates are produced for each of the five self-reported health status categories. Three of the five—excellent, good, and poor—are displayed on the Medicare Plan Finder. In addition to computing estimates by health status, separate estimates are produced by health plan for three high-cost diagnostic conditions—diabetes, congestive heart failure, and heart attack.

To facilitate plan comparisons, the utilization costs for the various service categories are inflated from the survey year (for example, 2010/2011) to the estimated plan year (here 2016) using inflation factors provided by CMS/OACT. The data entered by each plan into the Plan Benefit Packages (PBP) provides the information on the benefits covered and co-payments/coinsurance for each health care service.

The following are the basic assumptions related to the out-of-pocket cost estimates for different plan types.

Medicare Advantage Plans:

- Use Calendar Year 2016 Plan Benefit Packages to define the out-of-pocket cost estimate.
- Use cost shares for in-network providers.
- Use minimum co-payments/coinsurance values if these are stated as a minimum/maximum range.
- Apply service-category deductibles, maximum out-of-pocket cost amounts, and plan limits.
- Apply plan-level deductibles and maximum out-of-pocket cost amounts.
- Do not include Optional Supplemental benefits.

Medicare Medical Savings Account Plans (MSA plans):

- Use the CMS annual contribution amount for Medicare-covered expenses towards meeting the deductible.

- Apply any remainder Medicare eligible expenses (non-covered inpatient or SNF care, dental, and/or prescription drugs).
- Cost shares are zero once the deductible is met—except for any remaining non-covered expenses.

Prescription drugs:

- Map MCBS drug events into RXCUI codes apply to a particular plan's tier-formulary based cost sharing.
- Use Prescription Drug Event (PDE) claims data (2014) for average drug prices.
- Account for relevant deductibles and premiums.
- See **Part D Prescription Drugs** section for more detail.

Note that beneficiaries eligible for low-income subsidies and cost sharing are not applicable to the OOPC calculations.

Medicare and Non-Medicare covered services in the out-of-pocket cost calculations for Original Medicare, Medigap, and Medicare Advantage Plans are:

- Inpatient Hospital Acute Care, Inpatient Psychiatric Hospital/Facility
- Prescription Drugs
- Dental
- Skilled Nursing Facility.

Medicare covered services included in the out-of-pocket cost calculations are:

- Ambulance Services
- Ambulatory Surgical Center (ASC) Services
- Cardiac Rehabilitation Services
- Chemotherapy
- Chiropractic Services
- Diabetes Education
- Diagnostic Radiologic Services
- Durable Medical Equipment
- Emergency Care Eye Exams
- Eye Exams
- End-Stage Renal Dialysis
- Hearing Exams
- Home Health Services
- Medicare-Covered Dental
- Medicare-Covered Part B Prescription Drugs
- Mental Health Specialty Services—Non-Physician
- Occupational Therapy Services
- Other Health Care Professional Services
- Outpatient Diagnostic Tests/Procedures
- Outpatient Hospital Services
- Outpatient Laboratory Services
- Outpatient X-Ray services
- Physical Therapy and Speech-Language Pathology Services

- Physician Specialist Services
- Podiatry Services
- Primary Care Physician Services
- Prosthetics, Orthotics, and Other Medical Supplies
- Psychiatric Services
- Pulmonary Rehabilitation Services
- Therapeutic Radiological Services
- Urgently Needed Care.

Preventive services covered at zero-dollar cost sharing are not included as a separate category.

Medicare Advantage plans offer a wide range of benefits—some of which were not included in the out-of-pocket costs estimates. Some examples of benefits not included in the out-of-pocket cost estimates for Medicare Advantage plans are:

- Foreign travel emergency to cover emergency medical care when travelling outside the United States
- Transportation
- Acupuncture
- Hearing services not usually covered by Medicare
- Vision services not usually covered by Medicare
- Prevention screening services not usually covered by Medicare
- Chiropractic services not usually covered by Medicare
- Podiatry services not usually covered by Medicare.

Part D Prescription Drugs:

The Medicare Current Beneficiary Survey (MCBS) file contains information on the events reported by a sample of individuals with Medicare. Each person included in the MCBS self-reports utilization of prescription drugs (MCBS PME) and prescription drug utilization is also obtained from the claims reported in the Prescription Drug Event (PDE) data.

The estimated OOPC values are based upon the drug information provided for the individual sample members where each record in the MCBS PME file is considered to represent one prescription drug. These data are used in conjunction with the Calendar Year (CY) 2016 Plan Benefit Packages submitted by plans that detail the drug benefit cost sharing and plan coverage as well as the CY 2016 plan-level formulary submissions.

The process of converting these data into a suitable format for estimating the monthly out-of-pocket costs for the current program year involves a series of crosswalk and matching algorithms. Beginning with each MCBS individual's drug prescription record, the name of each drug as described by the beneficiary is identified and linked to appropriate National Drug Code (NDC).

To associate the MCBS drugs to NDCs, a master list of drug names and their NDC is first created using two commercial sources of data—First Data Bank (FDB) and Medispan. Then, each MCBS prescription drug name is mapped to one or more NDCs via this master list. Drugs are identified on Part D sponsor formularies using nomenclature and unique identifiers known as RxNorm concept unique identifier codes or RXCUIs. Each RXCUI on the formulary reference file tool that is used to build plan formularies is associated with a related NDC. MCBS drugs are mapped to these RXCUIs using a crosswalk between the related NDC and the master list NDCs that have

been previously associated with MCBS drugs. MCBS drugs that cannot be mapped to an RXCUI are considered non-covered drugs and their costs are not included in OOPC calculations.

An average price for each RXCUI is calculated using the 2014 PDE claims data which contains information on every prescription submitted for payment under the Part D program. The average price is calculated as the total gross expenditure (drug cost + dispensing fee + taxes + vaccination fee) divided by the number of PDE events, or prescriptions for that drug. Once the MCBS prescription record has been linked to a drug name, RXCUI, and the average price, it is mapped to each plan's formulary and benefit package to obtain the drug cost sharing information. In instances where a drug event has been mapped into multiple RXCUIs, and, therefore, is possibly covered on more than one tier, the RXCUI associated with the lowest cost tier is assigned to the event for that plan. If the RXCUI that represents an MCBS drug is not on a plan's formulary, the drug is assumed to be non-covered and the full cost, as reflected by the average price, is added to a plan's OOPC value. Generic substitution is assumed such that when a generic version of a brand drug exists, and is covered on the plan's formulary, the generic version is the one included in the calculations provided it is lower cost-sharing. However, therapeutic substitution (e.g. drugs in the same therapeutic class) is not assumed.

This data creation process results in a file that includes the total cost of the drug for each MCBS beneficiary and prescription as well as each plan's associated cost sharing structure for that drug. Note that for those plans not offering a drug benefit (MA-Only) and for Original Medicare beneficiaries not enrolling in a Medicare Part D plan, out-of-pocket costs are determined using total drug costs for each MCBS beneficiary.

Using each plan's drug coverage status of the MCBS drugs and PBP-based cost sharing information (deductible, initial coverage limit, co-copayments and/or coinsurance, gap coverage, etc.), the beneficiary's out-of-pocket costs are calculated. The calculations are based upon the assumption that each prescription is for a one-month (30-day) supply of drugs (rather than the 90-day or other-day supply) from an in-network pharmacy. In the event that both preferred retail and standard retail pharmacies exist, the calculations are based on the preferred retail pharmacy cost-sharing.

The OOPC calculations sort the drugs and assigning cost sharing at the various thresholds (e.g., deductible, initial coverage level (ICL), catastrophic). That is, the prescriptions are reviewed sequentially, with each plan's cost sharing structure used through each phase (e.g., pre-ICL, gap, and post-ICL). The copayments are used directly in calculations of costs; the coinsurance amounts are determined by multiplying the coinsurance percentage by the full cost of the drug from the PDE data. Throughout the processing, the lowest cost sharing available for a given MCBS drug is used. Additional plan features are also incorporated into the calculations, such as mandatory gap coverage (both the standard benefit for generic drugs and the coverage gap discount program for applicable drugs) additional gap coverage offered for full and/or partial tiers, and free first fill.

The beneficiary level OOPC values are then aggregated to the health status/plan level using the individual MCBS sample weights in order to yield nationally representative data. The annual costs are adjusted for enrollment to yield mean monthly costs. Note that some other adjustments to the data are necessary to bring valued total drug usage forward from the 2010-2011 survey years. CMS-provided factors are applied to each self-reported MCBS drug prescription to account for initial survey underreporting and for increased annual usage between 2010-2011 and 2016.