

2016 TECHNICAL REVIEW PANEL ON THE MEDICARE TRUSTEES REPORT

Minutes of the Meeting Day November 1, 2016

The Technical Review Panel met for a second day at 9:15 a.m. on November 1st in Room 738G of the Hubert Humphrey Building in Washington, DC. In attendance were the following panel members and presenters:

- Ellen Meara (Professor, The Dartmouth Institute for Health Policy and Clinical Practice), co-chair
- Michael Thompson (President & CEO Elect, National Business Coalition on Health), co-chair
- Kate Bundorf (Associate Professor, Stanford School of Medicine)
- Melinda Buntin (Professor and Chair, Department of Health Policy at Vanderbilt University School of Medicine)
- Austin Frakt (Health Economist at Boston University and Department of Veteran Affairs)
- Mark Pauly (Professor, Wharton School of the University of Pennsylvania)
- Geoffrey Sandler (Senior Actuary, Health Policy at Aetna)
- Greger Vigen (Independent Health Actuary)
- Dale Yamamoto (Founder and President, Red Quill)
- Don Oellerich (Deputy Chief Economist, Assistant Secretary for Planning and Evaluation at the Department of Health and Human Services)
- Paul Spitalnic (Center for Medicare & Medicaid Services (CMS), Office of the Actuary (OACT))
- John Shatto (CMS, OACT)
- Clare McFarland (CMS, OACT)
- Stephen Heffler (CMS, OACT)
- Mark Miller (Medicare Payment Advisory Commission (MedPAC))

Growth in Prescription Drug Spending—Dale Yamamoto/Mark Pauly

Dale Yamamoto led the discussion around trends in prescription drug spending. Historically, direct subsidy has remained relatively stable since adoption. However, reinsurance costs have been increasing dramatically, which was driven largely by specialty drugs. Overall, Part D costs to the Medicare program have been modestly increasing, with different increasing patterns in direct subsidy and retiree drug subsidy. Part D plans have used a variety of strategies to keep bid premiums low.

Over the 4-year span from 2011 to 2015, the shape of the claim distribution changed dramatically in terms of historical Part D cost patterns. Paul Spitalnic pointed out that the median spending has been almost cut in half. This was due to a large number of relatively expensive brand-name drugs going off patent and being replaced by generics over that time. And at the same time, there was an explosion in specialty cost drugs instead of the high-cost drugs. The shape of this curve has changed, and it is striking how this benefit has changed over a very short period of time.

Paul Spitalnic pointed out that Part D premium is a function of not only direct subsidy, but also reinsurance. Rebates also affect premiums, and influence premiums more than direct drug costs, since beneficiaries will benefit almost 100% from a rebate rather than, say, 50% from a decrease in direct drug costs. Currently for Part D modeling, OACT uses a bottom-up approach to construct a micro model for the first 3 years of the Part D projection (that is based on the Part D experience and changes in price due to patents or new drug entries), and switches to the transition period starting in year four, before turning to the factors model for the long-range projections.

In terms of projected Part D costs, Dale Yamamoto talked about the government share of the Part D program. Overall, government share of Part D is 74.5% of total costs, and government share of reinsurance costs is 80%. Benefits under cost threshold is about 72% after 2020, and reinsurance benefit is about 95%. As the portion of reinsurance grows, direct subsidy decreases. Assuming that recent trends continue, national average direct subsidy will turn negative in a few years in year 2021 or 2022. Given this dynamic, MedPAC proposed in June for CMS to significantly reduce its reinsurance percentage in the catastrophic phase as part of a broader set of changes to ensure program sustainability.

Meanwhile, specialty drugs will continue to grow in the near future, and by 2020, and will represent 55% of all drug spending. Further considerations include finding out whether specialty drugs represent a different percentage of total drug spending for seniors compared to the national population, whether there is additional leveraging effect on the reinsurance portion of Part D, and whether Part D plans can continue cost savings strategies under cost threshold.

In the discussion that followed, Paul Spitalnic asked whether the cost offsets would apply to specialty drugs in the same way as they do to other drugs. A panel member commented that cancer drugs probably don't save very much and spillover effect is probably small. Another panel member commented that results are going to look very different when you break it down by drug class and sector. Dale Yamamoto replied that much of the pharmacy benefit manager (PBM) research is published, which could be a good basis for the short-term projections; however, it is up to the panel in terms of the intermediate and long-range projections.

A panel member asked whether the composition of Medicare beneficiaries is stable, and whether we observe significant differences between MA-PD and PDP. Paul Spitalnic replied that there might be some selection effects, but in general we do not

observe consistent discrepancies and OACT applies the same modeling strategies to both the FFS and MA sectors.

Paul Spitalnic commented that the areas OACT wants the panel to focus on are the validity of the assumptions underlying the Part D projections. For example, there are currently no productivity reductions or specified price updates in Part D, and growth in Part D is significantly faster than the rest of Medicare. Should they consider additional offsets and are there additional considerations that should be made towards the modeling of both Part D and potential offsets?

How does MedPAC use TR Projections?—Mark Miller (MedPAC)

MedPAC uses the Medicare Trustees Reports extensively, as well as the CBO projections. MedPAC is a congressional branch agency established in 1997, and is nonpartisan. The Commission has 17 members with diverse expertise in the financing and delivery of health care services who perform analyses for the Commission. The U.S. Congress can also ask MedPAC for certain analyses. MedPAC looks at analytical data (claims, surveys, cost reports, etc.), baseline and different trends before making recommendations. MedPAC advises the U.S. Congress on payments to private health plans participating in Medicare and health providers serving Medicare beneficiaries. The commission focuses on beneficiary access to needed service, paying providers fairly, and the taxpayer. The first chapter in the MedPAC March report looks at the Medicare Trustees Report and the CBO projections, and talks about the financial status of Medicare as well as the financial environment. The Trustees report informs all of the work of the commission.

When asked how MedPAC does the analyses, Mark Miller said that they use claims data, historical utilization, and possibly trends from the Medicare Trustees Report, and then estimate what's coming in the next 5–10 years. Commissioners want to know the broad impact. Some of the data is not high-level math, but the behavioral predictions can be hard. Analyses are mostly static, i.e. look at the current state, as opposed to 10 years down the road. MedPAC does not talk about assumptions more than 10 years into the future. The MedPAC report often starts out with the broad economic picture, taking into account the gradual depletion of the Medicare Trust Fund and other general macroeconomics conditions. The Medicare Trustees Report and the CBO projections are both instrumental to the MedPAC Report.

On the growth in Medicare Part D spending, Mark Miller pointed out that reinsurance payments have exhibited double-digit average annual growth since 2006 and have become the largest component of Part D spending in 2014. Medicare beneficiaries are highly satisfied with the program. In the March 2015 report, the Commission went through the Part D bidding process and consumer behaviors to understand why that might be the case. It turns out that non-low income subsidy (LIS) enrollees are growing faster than the LIS enrollees among the high-cost enrollees, and are hitting the catastrophic cap more and using more expensive drugs. High-cost enrollees accounted for 47% of spending in 2013 (up from 40% in 2011), and recent growth in their spending is driven by increasing prices in non-generic drugs.

Mark Miller responded to a question from a panel member regarding access. Mark Miller described a phone survey that is conducted on physician access and how quickly a beneficiary can get an appointment. Medicare access has been equal to or better than the private sector.

Mark Miller described the substantial hospital consolidation over the last two decades. Consolidation leads to increased market power, and in turn, higher private sector prices and commercial payment rates for health care services. Hospitals have continued to obtain higher commercial rates despite slower wage growth and declines in uncompensated care. MedPAC analysis finds that hospitals with less financial pressure (i.e., higher commercial reimbursements) have higher costs, and hospitals with higher all-payer margins have very low Medicare margins. Higher private prices creates a disparity in payment rates and some have raised access issues. However, MedPAC does not expect near-term access issues for several reasons. Inpatient admissions are declining while outpatient visits are rapidly increasing. Occupancy rates are declining (urban 61%; rural 41%) leaving excess capacity. Medicare margins are still sufficient to generate a 10% marginal profit on each additional Medicare patient. Further, some hospitals currently accept discounts on Medicare rates from Medicare Select Medigap plans and certain Medicare demonstrations.

On the topic of illustrative alternative, Mark Miller noted that in order to be credible, offering a range is important, especially for long-range projections. Mark Miller noted with regard to the productivity discussion that providers can be responsive and that while there are fixed costs, not all costs are fixed costs. It is possible to send signals regarding costs to move them downward.

When asked about the impact of CMMI innovations on Medicare spending, Mark Miller said that on the ACO program, they expect a 0.5% reduction from baseline spending. Regarding the demonstrations, they expect the reduction to be small.

Finally, Mark Miller mentioned that there is a lot of vertical integration happening between physicians and hospitals because hospitals can increase their reimbursement significantly through the outpatient department. It happens because the hospitals have a lot of market power, and can negotiate with the insurance company. He also reiterated the coding intensity problem in MA, since when Medicare Advantage beneficiaries first enroll, they appear healthier than FFS. But after one or two years into the enrollment, they appear sicker than FFS. A lot of MA contracts do not have this upcoding issue yet, but we are likely to see the problem continuing in the future. Post-acute care (PAC) has seen incredible variation among providers. Although we don't understand why utilization has slowed down, it won't be surprising if utilization creeps up again.

Intensity of Service Provision—Melinda Buntin/Michael Thompson

Melinda Buntin shared a document outlining the issue being discussed. Technologies and services can, over time, move from more intensive (and often more costly) sites of care to less intensive ones as they become more routine or refined. Examples include outpatient surgeries that were formerly done on an inpatient basis and

diagnoses that can be given on the basis of more simple or accessible tests by general practitioners. Changes in setting of care can effect whether the service is allocated to Part A or B which impacts trust fund resources. Simplified drug regimens and movements from brand to generic status are a related change in the Part D arena. Note however, that some types of shifts may be cost-increasing overall, such as changes in the use of specialty hospitals or hospital-affiliated physicians who can bill at higher rates. In addition, the volume of services delivered can be affected by the number of providers who can deliver it safely and accessibly.

Melinda Buntin noted potential alternatives to be considered and the potential advantages and disadvantages of each.

Option 1: Status quo.

Pros: Continuity and comparability with prior estimates.

Cons: Does not account for changes in site of care in an internally consistent way.

Option 2: Explicitly adjust sector growth rates to reflect shifts across sectors.

Pros: Would explicitly and transparently include such shifts in projections of site/sector growth. Might more accurately reflect shifts from Part A to Part B and implications for financing.

Cons: Changes across sites of care are just one factor affecting growth rates, and may not be the major factor for any given site or sector. The number of parameters to be estimated would be effectively doubled as separate growth factors for price, volume, and intensity shift would have to be disentangled. There is not a standard method for doing this.

Option 3: Build model to represent sector interrelationships and their implications.

Pros: A model would formalize the substitutability of services across sectors and allow for a more structured analysis of changes in sites of care.

Cons: Effort and time cost

A panel member mentioned a software that can allocate CPT codes to different buckets and track specific illness shifts from the inpatient hospital side to the outpatient department side. It's a model that is explicit about each FFS claim line, and can be used for this purpose of exploration. The model was developed for California hospitals to track services for management purposes. He suggested that the software could be used to help with the short-term modeling approach since it is a bottom-up approach.

Paul Spitalnic clarified the current assumptions where inpatient is growing at a slower rate, outpatient is growing at a much faster rate and then they start to converge. Is this the right approach?

A panel member mentioned that it would be interesting to know the change in unit cost, particularly as it relates to changes in intensity of services in the outpatient setting. Paul Spitalnic indicated that OACT can look at volume versus price to get a better sense of intensity.

High & Low Cost Assumptions—Michael Thompson/Melinda Buntin

Mike Thompson and Melinda Buntin circulated a document on the topic of how best to reflect uncertainty and a range of alternatives. OACT has to do long-run projections as required by law, but there is a high degree of uncertainty involved. Mike Thompson presented four alternatives for modeling uncertainties: high and low projections, stochastic modeling, sensitivity analyses, and point estimates. Pros and cons of these approaches were discussed.

We do high & low projections in Medicare spending for the long run by varying a whole host of cost and income assumptions together and lumping everything into the plus or minus 2% in aggregate terms. The projections are not to be confused with the illustrative alternative, which illustrates what happens if there is a change from current law. High & low projections provide a range of potential plausible outcomes and describe the variation in outcomes. On the other hand, high & low estimates imply a bound or limit, not just uncertainty.

Regarding a stochastic model, the panel has not yet thought about the parameters that can go into the model. A panel member mentioned the possibility of a fan graph that is shaded around the actual estimates, with uncertainty (shade) growing over time. Paul Spitalnic mentioned that the Trustees stopped using the Part B stochastic model due to the continued overrides of the cuts required by the Sustainable Growth Rate formula. The Old-Age, Survivors, and Disability Insurance (OASDI) Trustees Report has both the high/low predictions and the stochastic model.

There was some discussion on the topic of sensitivity analysis, regarding whether we should be considering changes in assumptions or changes in the parameters that go into the assumptions. There is some sensitivity analyses currently to get the degree of what's driving the results, by varying one assumption at a time. For example, cost growth is extremely sensitive to variation in the real interest rate. However sensitivity analyses do not provide information on the probability of any event occurring. The panelists also discussed the presentation of materials so that readers can understand uncertainty.

Paul Spitalnic suggested review of the current approach and will put together some examples for the group regarding the difference between the plus or minus 2% approach (current approach) and the OASDI approach. More materials could be sent out to inform the panel about the distinction between the two.

Sustainability/Excess Burden—Mark Pauly

Mark Pauly noted three things that are relevant to the sustainability topic: affordability, budget share measures, and excess burden. Regarding sustainability, he said that it is not about whether the prices the market pays are going to keep up with private

prices that maintain access, but rather whether the economy can sustain Medicare spending and health care spending overall.

Regarding the definition of affordability, Mark Pauly cited a journal article by Chernew, Hirth, & Cutler published in 2003 in *Health Affairs*, titled “*Increased Spending On Health Care: How Much Can The United States Afford?*” He discussed the general concept of affordability, i.e., something is not affordable when it affects your consumption of other things.

On the topic of budget share measures for Medicare, Mark Pauly suggested calculating the percentage of total budget being spent on health care in general as well as Medicare (Hospital Insurance and Supplemental Medical Insurance) alone. A measure that calculates the percent of total budget spent on health care is more appealing than the percent of total taxes spent on health care. One complication is that SMI (Part B and Part D) is voluntary (whereas OASDI and HI are generally compulsory), and payroll taxes are not the source of income for Part B and Part D.

Finally, on excess burden, Mark Pauly pointed out that economists will say that tax rates will have to grow to support excess burden. We can take the average marginal tax rate and elasticity of supply of labor, and use a formula to convert it to excess burden, which increases with the square of marginal tax rate. We can show how Medicare will grow and what that implies for excess burden for the economy. The impact of Medicare spending on average marginal tax rates would also be useful to look at, although currently the Trustees Report only focuses on the solvency of the Medicare Trust Fund.

There was some discussion about whether the proposed work on sustainability was out of the scope of the Technical Review Panel, but Mark Pauly said that the audience might be interested in learning about the tax payers’ burden. The old fashioned definition of sustainability is not the depletion of Medicare Trust Fund, but rather the ability and willingness of the economy and tax payers to support the Medicare program. One potential question to put in the report could be: If we weren’t going to raise taxes by X amount, how much deficit would we be raising? These budget share measures and implied marginal tax rates may be more meaningful than the percent GDP measure.

Steve Heffler mentioned that currently we present how health care spending is growing from a GDP perspective. Trustees take it and present the Medicare numbers as a percent of GDP. However, the Trustees Report does not currently look at the broader economic impact beyond a share of GDP, e.g. who’s going to pay for it? They do have a contract with the University of Maryland (UMD) to model long-term industry projections. It could be a supplemental add-on to the Trustees Report, but it requires a lot of faith in the assumptions going into the model. Analytically we have the capability to do this, but it was not in the scope of the Trustees Report. It was later decided that Steve Heffler will share some results from the UMD model and Mark Pauly will follow up on the sustainability topic.

Moving Forward—Ellen Meara

Ellen Meara reviewed the topics that the panel is charged with considering:

1. Sustainability of ACA in MACRA price updates and the future of healthcare productivity
2. Transitioning from the short-term to the long-term projections
3. Shifting of services across Medicare Parts A, B, and D
4. Reflecting uncertainty

Assignments/Next Steps to Move Report Forward

The panel members agree that moving forward, they need to advance to more nuanced deliverables and recommendations on the topics listed below. Panel members can be more explicit on ideas for certain issues. The deliverables can be done at different stages and in different formats, depending on the topic.

Panel chairs will send out the action items for members to review.

Outside Speaker Suggestions for Future Meetings

Michael Chernew is coming in December. A panel member suggested a data visualization expert for the long-term projections. Another idea suggested was to invite some ex-trustees. Regarding long-term view on Medicare Part D, names such as Patricia Danzon and Dana Goldman were mentioned. Other subject matter experts mentioned include stakeholders, congressional staff, hospital management, physicians, and CMMI staff.

The panel will follow up via email regarding potential speakers for future meetings. For the December meeting, the panel will choose a few speakers, but allow enough time for presentations and discussion on action items.

Public Comments

There were no public comments.

The Technical Review Panel adjourned at 2:45 p.m. on November 1st, 2016. The next meeting will take place in person and be held from December 19th, 2016 to December 20th, 2016.