2016 TECHNICAL REVIEW PANEL
ON THE MEDICARE TRUSTEES REPORT

Minutes of the Meeting Day September 30, 2016

The Technical Review Panel met at 9:00 a.m. on September 30, 2016. This meeting was held using Adobe Connect, a program that allowed the panel to communicate, present, and interact virtually. Present were all of the panel's members:

- 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 VA Boston Healthcare System Department of Veterans 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, DFO

Presentations

The panel heard and discussed presentations by the following people:

- John Wandishin, Center for Medicare & Medicaid Services (CMS)/Office of the Actuary (OACT)
- Paul Spitalnic, CMS/OACT
- Julie Topoleski, CBO
- Tom Bradley, CBO
- Kent Clemens, CMS/OACT
- Richard Coyle, CMS/OACT
- Dsih-Lang (Larry) Liu, CMS/OACT

Paul Spitalnic, John Wandishin—OACT Presentation on Part A HI Short-Term Projections

Paul Spitalnic began the presentation by describing how the upcoming OACT presentations will provide an overview on how they create their projections. OACT will discuss the key drivers and key inputs into Parts A, B, C, and D projections.

John Wandishin (CMS/OACT) presented OACT's analysis of Part A benefits. There are four main Part A FFS benefits: inpatient hospital, skilled nursing facility (SNF), home health agency (HHA), and hospice. For the first three, OACT creates projections in a similar manner. Part A pays by far the most to hospitals (73%), followed by skilled nursing facility (SNF) (16%), and home health/hospice (11%). In regards to the projections, OACT starts with fee-for-service (FFS) enrollment and then applies a utilization factor (units of service per enrollee) and a unit cost factor (how much Medicare pays for a service) as described below.

- **Enrollment** is split by aged, disabled, and end stage renal disease (ESRD)-eligible Medicare beneficiaries minus managed care enrollees. OACT begins its enrollment projections using the demographic assumptions and baseline enrollment calculated by the Social Security Administration (SSA). Generally, Medicare and Social Security enrollment are very similar with a few exceptions; for example, disabled Medicare beneficiaries have to be enrolled in Social Security for at least two years.
- **Unit cost** is calculated based off two components: price and case mix. Price is a function of the market basket for Medicare providers adjusted for productivity and other update reductions. For case mix, changes from one year to the next affect the amount Medicare reimburses. More intense cases yield cost increases and vice versa. Case mix is based upon recommendations from prior technical panels. The 2000 panel suggested that the case mix increase for inpatient hospital, SNF, and home health services have a growth rate increasing at 1% per year. The 2011 panel found that the inpatient hospital case mix-growth was too high while those for SNF and home health were too low and recommended inpatient hospital at 0.5% and SNF and home health at 1.5%
- **Utilization** is calculated using a base trend, an age/sex factor (people use more or less services depending upon their demographic status), and a Medicare Advantage (MA) switchers impact (healthier people leave FFS for MA, leaving sicker people in FFS). The switchers' impact is smaller than in the early 2000s. Prior technical panels have recommended no inpatient hospital change, 1% annual growth in SNF and home health utilization, as well as monitoring of home health percentage shares of Parts A/B expenditures. In the future, inpatient hospital utilization may be impacted by the Medicare readmissions penalties, but this was not accounted for in prior technical panels. In addition, home health is paid on an episode basis, not a visit basis, and utilization is calculated as episodes per visit. Hospice is calculated in a little different manner since the unit of service can vary.

Therefore, OACT takes into account the price and then everything else (the residual). Hospice residual is projected at 5% growth going forward.

At the end of ten years, OACT uses Gross Domestic Product (GDP) in its projections and transitions to the factors model output.

Julie Topoleski, Tom Bradley—How does the Congressional Budget Office (CBO) use the Trustees Report?

Julie Topoleski began the presentation by describing CBO's long-term Medicare cost analysis. She discussed how CBO projects up to 20 years beyond the first 10 rather than 75 years as CMS does. The reasoning for this is that in CBO's view, there a lot of uncertainty as to what health care delivery will look like in the future. For CBO, there are two main drivers for their projections: the number of people receiving Medicare benefits and spending per beneficiary. There are also several adjustments, including the effects of capitation payments and sequestration.

With these factors in mind, CBO projects approximately 0.9% annual Medicare cost growth, which will increase to 1% by 2046, the last year of their projection. CBO forecasts that in 2046, Medicare spending will equal 7% of GDP as opposed to 5.7% of GDP according to the Trustees, in part because CBO assumes lower nominal GDP growth and a weaker economy. These discrepancies are also due to different demographic assumptions between CBO and the Trustees. For example, CBO projects total fertility rates to be 1.9 children per woman whereas the Trustees project it to be 2 per woman. Additionally, CBO estimates slightly higher mortality rates than the Trustees but the two rates have come much closer together with the most recent update in data.

Panel members posed several questions on the CBO versus CMS assumptions. In response to Melinda Buntin's questions, Julie Topoleski explained that in 2026, CBO projects nominal GDP to be $27 trillion as opposed to $30 trillion for the Trustees. In response to a question from Michael Thompson, Julie Topoleski described how CBO's projections are independent of the Trustees, though CBO does look to the Trustees' report, pays close attention to changes in their methodology, and speaks to CMS on a regular basis. A question from Kate Bundorf led Julie Topoleski to discuss how CBO used to conduct 75 year projections but in recent years has refocused on intermediate projections due to the uncertainty incorporated in the longer time period.

Tom Bradley presented after Julie Topoleski and focused on shorter-term projections. He described how CBO makes modest adjustments for 12 months of payments to physicians per year, adjusting for sequestration. After 10 years of output from projections, spending per Medicare beneficiary exceeds GDP per capita. In the long-run, the growth rate levels out after 25 years. In response to a question from Melinda Buntin, Tom Bradley described CBO's rate of growth model, which is based upon macroeconomic forecasts, statutory price increases that apply to the physician fee schedule, and a changing demographic mix. The model also incorporates a baseline projection as well as policy adjustments that affect growth.

Kent Clemens—Part B Supplementary Medical Insurance (SMI) Short-Term Projections (CMS/OACT)

Kent Clemens explained how the primary Part B FFS benefits include physician services (39%), outpatient hospital (24%), lab carrier (3%), durable medical equipment (4%), as well as home health (6%), other carrier (12%), and other intermediary laboratory services (11%). Funding for these services comes from the SMI trust fund with one third administered under Part C and two thirds under Medicare FFS. For Part B projections, OACT uses incurred quarterly claims, monthly trust fund cash outlays, monthly enrollment tabulations, updates, and legislative estimates. Each of these pieces are calculated as follows:

- **Enrollment** is broken down by total aged, total disabled, and Managed Care. Total aged is a share of the total Social Security Administration (SSA) aged projection. Disabled is a share of Hospital Insurance (HI) disabled and Managed Care is Part C enrollment.
- **Updates** relate to economic assumptions and the market basket.
- **Legislation** affects all types of services and most recently included a substantial change to physician payments. In 2015, the sustainable growth rate (SGR), which was overridden by Congress from 2003-2015, was repealed by the Medicare Access and Chip Reauthorization Act (MACRA), a law that specified fee schedule updates for each year going forward. MACRA defined Alternative Payment Models (APMs) as arrangements featuring more than nominal risk. It also introduced the Merit-Based Incentive Payment System (MIPS), which includes budget neutral basic incentives plus additional bonuses totaling over $500 million from 2019-2024 determined separately for each physician.
- **Volume and intensity** is based on historical growth rates. In regards to projections going forward, years 1-4 will be similar to what has happened in recent history, with later years relating more so to longer term historical rates. Volume and intensity are projected to grow at a 1.5% rate, which will increase to 2.5% over the short-term window.

Kent Clemens also noted that in regards to outpatient hospitals, the prospective payment system began in 2000 and the Part B coinsurance has decreased over time to 20%. Similar to inpatient, the ACA legislated payment updates beginning in 2012 to be the hospital market basket update less productivity. OACT projects strong overall outpatient hospital growth at approximately 5% going forward. Kent Clemens also noted that growth for physician-administered drugs is growing rapidly at a rate of approximately 5% annually in future years. These drugs were initially paid for using an average wholesale price but was changed to sales price plus 6%, significantly decreasing growth. Many of these drugs are chemotherapy-related in addition to treatments for macular degeneration, amongst other ailments. Other drugs are related to durable medical equipment (DME), dialysis, and outpatient hospital ambulatory payment classifications (APCs).

Kent Clemens received questions from Greger Vigen, Melinda Buntin, Michael Thompson, and others on his presentation. In response to a query from Michael Thompson, Kent stated that drugs provided during an inpatient stay would be covered by the diagnosis-related group (DRG) but outpatient drugs would be classified within an APC. These drugs are generally provided in a physician office or hospital outpatient department and are administered by physicians. In answering a question from Greger Vigen, Kent Clemens noted that several physician incentive payments are phased out by MACRA such as the Electronic Health Records Incentive Programs and the Physician Quality Reporting System (PQRS) and are replaced by a more comprehensive quality measurement. He also said that there is a 5% bonus under APMs and a $500 million aggregate bonus for high achievers under MIPS but this ends in 2025 under current law. OACT has not accounted for any changes in volume/intensity due to these programs being phased out in 2025.

Melinda Buntin mentioned that for the 2011 panel, the SGR system was still in place. She also asked Kent to further elaborate on the 5% projection for physician-administered drugs and the use of near-term history versus long-term history to inform projections. Kent Clemens responded that OACT considers spending per drug code, underlying base trends year over year, and overall volatility in drug spending, particularly for cancer drugs. There is consideration for single year events as well as for events that will affect the overall trend. Part D projections more closely consider such factors as drug pipelines and patent expirations.

Paul Spitalnic encouraged the panel not to focus on short range projections, but rather mid-term and longer range projections as this will be most valuable. He also noted that CMMI projects targeting more efficient care delivery are incorporated into the projections as evidence becomes available.

Richard Coyle—Part C Medicare Advantage Short-Term Projections (CMS/OACT)

Richard Coyle began by discussing the definition of private health plans under MA. These plans include local coordinated care plans (CCP) such as Health Maintenance Organization (HMO) and local Preferred Provider Organization (PPO) plans, special needs plans, regional PPO plans, private FFS, and other products, including cost plans, Program of All-Inclusive Care for the Elderly (PACE), and Medicare-Medicaid plans. Local CCPs are by far the most common; in 2016, they consisted of 75% of all plan enrollment followed by 12% for special needs plans. The authority for special needs plans expires in 2019. This has expired several times in the past and Congress has extended it, but by current law, they will not be in place beyond 2019.

Richard Coyle then spoke to the changes the Patient Protection and Affordable Care Act (ACA) makes to MA. Two primary provisions of the ACA are to tie MA reimbursements to plan quality and to link MA benchmark rates to Medicare FFS costs excluding hospice. Pursuant to the ACA, plans with higher quality scores are rewarded with higher benchmarks and a greater share of bid savings versus benchmarks to be provided as rebates. In addition, the ACA mandated that MA county-level benchmarks be based on a multiple of estimated FFS costs in the county. The benchmarks for the highest

spending counties, or 4th quartile, are linked to 95% of estimated FFS costs for that county. The next highest benchmarks are linked to 100% of FFS costs; the 3rd highest counties' benchmarks are linked to 107.5% of FFS costs; and then the lowest spending counties are linked to 115% of FFS costs for that county. In regards to MA enrollment, 35% of beneficiaries are in the highest quartile followed by 22% for the next highest, then 22% for the third highest, and 21% for the lowest. The MA market penetration rate for the plans in the highest quartile is 35.5%, for the next highest quartile is 33.3%, then 34.1%, and finally for the lowest quartile, 40%, with Puerto Rico's counties disproportionately affecting this quartile.

MA health plans also receive overall star ratings from 1-5 in increments of 0.5 stars. These ratings connote the plans' quality ratings on 47 separate measures, 32 of which are for Part C and 15 of which are for Part D. Payments to the health plans receive adjustments based upon these ratings. If a plan has fewer than 3.5 stars, it only earns 50% rebate share of bid savings, as opposed to 65 or 70% if it scores higher. Also, higher star ratings equate to higher applicable base payment percentages for a county in a qualifying plan's service area, with a 4 star rating or higher yielding a 5% bonus. These quality-based payments are not budget neutral. There is more room for improvement for lower-rated plans and enrollees may migrate from lower to higher rated plans, which will lead to growth in size and penetration for the latter. Mike Thomson posed a question regarding the star rating cut points and Richard Coyle indicated that CMS can change the cut points used in scoring specific quality measures.

Richard Coyle also discussed how the ACA lowers the average standardized MA benchmark compared to FFS from 114.9% to 104.3% by 2020. This brings the MA rates more in line with FFS. Once ACA is fully implemented the formula is straightforward and equal to FFS costs times the quality rating percentage plus a quality rating bonus. The ACA and subsequent legislation codifies CMS' authority to adjust MA risk scores to account for differences in diagnosis coding practice patterns between Medicare FFS and MA providers (3.41% in 2014 and 5.9% in 2018). It also mandates an annual insurer fee averaging 1.5% of 2014 plan revenues, which will increase to 2.2% by 2018.

MA plans submit bids annually that best represent the projected per enrollee cost of providing standard Medicare Part A and B benefits. Plans below the benchmark generate rebates that can fund cost-sharing, coverage of additional non-drug benefits, and reductions in Part B or D premiums. Plans with bids above the benchmark must charge that difference as a basic premium. Actual beneficiary-level payments made during each month of the contract year equals the county-level bid for the beneficiary's county of residence times their risk score plus a rebate minus the premium for basic benefits. Health plan projection assumptions are based upon FFS United States per capita cost (USPCC) growth rates; the aforementioned risk score adjustment; ACA benchmark phase-in schedule; the ACA quality bonus; and the phase-out of indirect medical education (IME). In response to a question from Ellen Meara, Richard Coyle noted that there is no explicit assumption for beneficiary selection since, in aggregate, MA enrollees are increasingly similar to beneficiaries enrolled in FFS and are not necessarily selected by MA plans for their health status given that capitated payments from CMS are adjusted for beneficiary demographic and risk characteristics.

OACT summarizes MA enrollment by county into 17 different categories with 10 urban, 5 rural, 1 being a cost county (where the majority of enrollment was in cost plans), and 1 for Puerto Rico. OACT then calculates the natural log of the growth in 2011-2015 MA Penetration Rates for the 17 model categories and projects it for 2016-2025 using linear trend methods. OACT uses blending methods to smooth variances and calculates the inverse log of growth rates to project penetration rates for the short range projection years. In total, Part C enrollment went from 7.3 million beneficiaries in 2006 to 26 million in 2025. Overall MA penetration rates have increased from 14% in 2004 to approximately 35% in 2015, with a forecasted level of 39% in 2025. In addition, Medicare Payments to private health plans have risen from $65.2 billion in 2006 to $188.3 billion in 2016, with a projected total of $386.7 billion in 2025.

Paul Spitalnic reiterated the link between fee-for-service payments and MA payments at the close of the discussion.

Dsih-Lang (Larry) Liu—Part D Short-Term Projections (CMS/OACT)

For Part D plans there is a standard benefit structure consisting of a deductible, initial coverage limit, the coverage gap, and a catastrophic threshold beyond which Medicare pays 80% net cost as reinsurance. Part D plans submit individual bids based upon their projected drug costs, rebate, administrative cost, profits, and risk score. The bid amount consists of a standardized bid, reinsurance, and a low-income cost-sharing subsidy. The bid is equivalent to plan benefits minus reinsurance. National average bids and average premiums announced after bids are reviewed and approved by CMS. The plan-specific premiums are equal to the plan bid minus the national average bid plus the national average premium.

Payments to Part D plans incorporate the following elements: a risk adjusted direct subsidy, beneficiary premiums, reinsurance advance payments, a low-income premium subsidy, coverage gap discount advance payments, and year end reconciliation. Types of plans include prescription drug plans (PDPs)and Medicare Advantage prescription drug (MAPD) plans with each type available to individuals or employer groups, and retiree drug subsidy (RDS) plans, which is a 28% tax exempt subsidy with no coverage gap discount though the ACA took away the tax exempt status in 2013.

The Part D Benefits Model methodology consists of enrollment, historical spending data, drug per capita trend, bid data, and legislative impact. Enrollment is differentiated by plan, including MAPD versus PDPs, aged v. disabled, employer v. non-employer, low-income grouping, and retiree drug subsidy plans. PDP plans are most common followed by MAPD then RDS plans. In regards to Part D Trend, OACT built a Part D micro model for the short run that uses drug-specific and therapeutic class-specific utilization/price data, projects growth trend for each drug, considers the dynamics between brand-name and generic drug competition, and other market information. Short-run trend is transitioned to National Health Expenditure (NHE) data projections from years 4 to 6 and final trend assumptions may change due to enrollment mix change and legislation. PDP and MAPDP have different spending profiles and the micro model projects their trends separately.

Mark Pauly asked how CMS/OACT accounts for the fact that growth in prescription drug spending can lead to cost offsets elsewhere, particularly in regards to inpatient and outpatient spending. The response was that these effects are built into emerging trends on the Part A and B side, and that they slightly lower the trend for these components of Medicare. Another question raised concerned whether the growth of MA had a financial impact on Part D and MAPD plans. This trend does affect the ultimate cost projections to the extent that there is a growing share of Part D beneficiaries in MAPDs, which shifts costs from Part D to MA. The panel also raised a question on whether a higher future rebate level should be considered.

Ellen Meara—Panel Criteria for Success/Priorities Given Charge

Ellen Meara reminded the panel members of their objectives and scope of their task. Their mission is to advise the Secretary of Health and Human Services regarding trust funds with issues pertaining to sustainability, utilization, changes in shares over time, transition from short to long-term projections, and uncertainty, including high and low cost options. The panel is charged with developing a set of actionable recommendations. Paul Spitalnic noted that coming to the right recommendations is preferable even if doing so means delaying those recommendations. The panel should not rush to conclusions or be pressured by timelines. Recommendations may be incorporated into the 2017 report or into later reports depending on timing.

Ellen Meara then asked how the panel will know whether it is achieving its goals. How should the panel prioritize its activities? She requested that panelists respond to a poll on these questions. The poll asked: what is the measure of success for the panel?

- A) Recommendations incorporated
- B) Trustees' Report used by broader group
- C) Trustees' Report informs decisions around trust fund sustainability
- D) Trustees' Report improves trust fund sustainability
- E) Trustees' Report improves welfare of Medicare beneficiaries
- F) All of the above

The answers that received the most votes were C) and D) concerning sustainability. Austin Frakt disagreed and said the panel's main goal should be increasing the accuracy and precision of the forecast. Michael Thompson disputed the wording of C) and D) since Part B is funded by general revenue and does not have the same sustainability issues as Part A. Also, the panel does not make policy recommendations but rather informs them. Geoff Sandler said the panel visibly informs because there is not a clear understanding of what is behind the curtain developing actuarial projections. Ellen Meara agreed, saying the panel informs decisions. Mark Pauly stated the purpose of the Trustees' Report is to provide information for citizens to judge how much of a guarantee that benefits will continue to flow. Melinda Buntin hopes the report informs people who are in a position to make policy changes and adjustments. The panel should get the right recommendation instead of an expedient one as well as consensus around the recommendations where possible.

Overall, the role of the report is to accurately forecast costs and describe implications of current law, coupled with authoritative analysis. Finances are central to the report but so is access to care and tax levels needed to sustain Medicare.

Ellen Meara said that the panel should think of its job in several phases. First, provide a baseline level of knowledge incorporating relevant identifiable data needed for making recommendations. Second, get to preliminary recommendations; third, refine the recommendations; and fourth, insert the recommendations into the report. With respect to this process, the panel should discuss whether they are ready to formulate recommendations and the gaps that may prevent them from doing so. The panel should divide and conquer to make progress and have a set of preliminary recommendations ready by the next meeting.

Michael Thompson—Impact of Policy Adjustment versus Market Adjustments on Long-Term Spending

Michael Thompson asked whether the rate of spending is more of a result of secular trends or legislative actions; that is, changes in law and policy versus longer-term factors. In response, Melinda Buntin pointed to a graph showing annual growth in Part A/B Medicare spending per beneficiary over time, which averages to nearly 0 indicating that there are secular trends independent of legislation that were contributing to the slow-down in growth. She mentioned the impact of certain developments on Medicare projections, including external events, economic downturns, regulatory changes, price growth, productivity cuts, and prescription drug spending, including with new hepatitis C drugs. Kate Bundorf referred Melinda Buntin's points back to the factors model. This model uses long-term projections with a historical estimate and a residual, which bundles together technology and changes in policy and is an estimate of the rate of growth going forward.

Mark Pauly stated that the panel is searching for a measure of impact of health care spending in terms of the burden on the economy and taxpayers. The previous panel suggested the amount left over after health care spending goes down in addition to the growth rate in overall income. However, this measure isn't Medicare-specific. The economist's favorite measure is the excess burden of taxation and inefficiencies in growth. Rising health care spending also leads to declining employer support for health care and places a burden on other discretionary spending.

Kate Bundorf mentioned the effect of the shift to DRGs in the 1980's, which plays out in the factors model and noted that this may be moving us toward a particular assumption of growth. DRGs significantly changed inpatient hospital spending. This development bears semblance to the current shift toward value-based models as well as other factors, such as changes in technology. Don Oellerich added that other factors to consider are the rise in private sector high deductible health plans, which may have spillover effects on Medicare, lower readmissions rates, and the rise of coordinated care. Therefore, there are a multitude of specific instances where changes in law have large effects on Medicare. Otherwise, however, there has been a secular slowdown in spending per beneficiary over time.

Mark Pauly—Access-Cost Tradeoffs in Long-Term Projections

Mark Pauly stated that when he was on Medicare Payment Advisory Commission (MedPAC) his group received a report on the percentage of doctors who would take new Medicare patients. The figure was quite high at the time. If the panel is going to concern itself with trends on Medicare payments versus payment in the private sector, a time series analysis on measures of access would be useful to have. There should be some attempt to relate difference in payments to difference in access for Medicare beneficiaries. The access issue relates to a number of factors: the level of doctors by specialty; salaries for doctors in the United States versus those in other countries; salaries for doctors versus salaries for other professionals; the lack of primary care physicians; supply of physicians by specialty; percentage of doctors taking new Medicare patients; and spillover effects from the rise of deductibles for private sector plans. Mark Pauly recommended that MedPAC engage the panel regarding these topics. Ellen Meara agreed, suggesting that Mark Miller in particular should discuss these issues at his presentation on November 1st.

Kate Bundorf—Alternative Payment Models and Experiments

Kate Bundorf asked panel members how they should consider new payment models such as Accountable Care Organizations (ACOs), episode-based payments, and APMs/MIPS in terms of formulating long-range projections. A question to consider is whether or not they are precisely defined in terms of their impact on spending. ACOs seem reasonably defined, APMs/MIPS are still in rulemaking, and other new payment models are being introduced over time. What is the impact of these models on long-term spending, what do they look like, and is there tangible evidence on their effect on care delivery? One suggestion is that policy and payment changes of this nature could potentially be incorporated into projections as part of a general sensitivity analysis.

In response to Kate Bundorf's questions, Melinda Buntin posited that the most likely value of savings from these new models is not zero. For example, ACOs can generate savings of 1-2% per year after 3 years but going forward they may have difficulty beating their last year's benchmark and generating continued savings. As a result, ACOs may have less of an impact in the long term. Greger Vigen added that these models may shift the hospital business plan of performing more services for greater revenue. This change in incentives could have a significant bearing on projections going forward.

Austin Frakt, Greger Vigen—Spillover Effect of Medicare Advantage

Austin Frakt noted that there may be a spillover effect between MA and Medicare FFS and shared five studies that have explicitly looked at this issue. The best way to examine this effect is using an instrumental variable approach. However, the panel does not have good estimates of the impact of spillover since earlier results may no longer apply today and the instrumental variable approach is no longer viable since Medicare Advantage payments are tied to FFS spending. The practice pattern changes that Medicare Advantage incentivizes may already have been made though the extent of spillovers may vary by Medicare Advantage penetration. Potentially the panel could take

an average of prior levels and conduct a meta-analysis of past studies. Kate Baker and Michael Chernew have published on this issue topic.

There are several effects to consider in regards to MA spillover. First is the spillover from Medicare into private insurance and vice versa on price and use effects. Second is the effect of cost-sharing provisions of Medicare on beneficiary behavior. The third, as Greger Vigen suggested, is the management effect, which gives hospitals a strong business reason to align practices, spend in smarter ways, and manage resources more efficiently, particularly with the rise of APMs and MIPS. Austin Frakt added that there is a book on changing hospital practice for efficiency by James Robinson.

Geoff Sandler—End of Life Care

Geoff Sandler posed the question as to whether the use of alternative care settings for end of life care should be specifically reflected in projections. Melinda Buntin responded by noting that a Health Affairs article by Joan Teno from two years ago reported a seemingly contradictory phenomenon: while the proportion of people dying outside the hospital increased the proportion dying in an intensive care unit (ICU) also increased, resulting in no net changes in overall resource intensity. Mark Pauly added that the percent of Medicare spending on care for the last year of life has been relatively stable over time. However, different age distribution, which reflects changes in mortality, can influence end of life spending. Melinda Buntin then pointed out that there has been a shift in the point of maximum Medicare end-of-life spending per beneficiary. This development is due in part to increased Medicare spending on SNF/hospice benefits.

Melinda Buntin—Transition & Share Changes Over Time

Melinda Buntin referred to Figure 2D1 of the 2016 Trustees' Report, which depicts Medicare spending as a share of GDP. The figure dates back to 2000 the proportion of GDP Medicare constitutes with a breakdown by each of its four parts. Part B as a share of GDP has grown more rapidly since 2000 than hospital insurance. Melinda suggested it would be helpful to have a further breakout of shares and service categories on a per capita basis, including MA versus FFS and a denominator of Part A or Part A plus B excluding MA. On this point, Dale Yamamoto said there is greater use of observation stays in hospitals under Part B, which may over time be dampened by the two midnight rule. Also, there is substitution in inpatient in favor of outpatient, which then may be substituted by services provided in the physician's office. This migration is occurring in part because of more favorable reimbursement for services provided in outpatient settings.

Dale Yamamoto—Changes in Part D over Time

Dale Yamamoto noted that the increase in prescription drug prices affects other services and are embedded in the historical experience of Medicare. Hepatitis C drugs and pent up demand can further affect spending. The 2000 panel used GDP plus 1% in the projection. However, there was not enough data on drug spending at the time and Part D now features a greater component for potential technological advances. A relevant question concerns whether technology will always add costs especially given the advent

of bundled payments, ACOs, as well as a larger role for MA. Melinda Buntin also noted that drug expenditures may offset other types of costs including for physicians and hospitals.

Ellen Meara—Uncertainty

Ellen Meara asked the panel how to consider uncertainty in its assumptions. Ellen noted that the panel heard from presentations on alternatives to high and low-cost estimates relative to intermediate ones. In her view, the alternatives described in the presentations may inadequately incorporate shifts in relative spending by sex and age as well as changes in mortality rates. Dale Yamamoto suggested plus or minus 2% to account for these issues but Ellen Meara questioned whether to further refine that figure. Kate Bundorf said that simplicity is appealing and that further analysis may not be helpful. She also asked whether the 75 year period is worth keeping due to the huge range of uncertainty of projecting that far outwards. However, the panel is mandated to use that time frame.

Ellen Meara, Mike Thompson—Discussion of Next Steps

Ellen Meara asked the panel what goals they want to pursue going forward. Suggestions that were discussed included:

- Highlighting issues pertaining to sustainability and consulting MedPAC to see what they have researched in the past on the subject.
- Prioritizing access to care for Medicare beneficiaries as a topic for discussion and analysis.
- Further analysis of prescription drug spending for Part D, including high and low cost options.
- A focus on current versus alternative high and low cost estimates.
- Advantages and disadvantages of proposed panel changes

Ellen Meara and Michael Thompson said they will send a follow-up e-mail between September 30th and the next meeting to be held in person.

Public Comments

There were no public comments.

The Technical Review Panel adjourned at 4:40 PM on September 30th, 2016. The next meeting will take place in-person and be held from October 31st, 2016 to November 1st, 2016.