2016 TECHNICAL REVIEW PANEL
ON THE MEDICARE TRUSTEES REPORT
Minutes of the Meeting Day December 19th, 2016

The Technical Review Panel met on December 19th at 9:30 a.m. in Room 738G of the Hubert Humphrey Building in Washington, D.C. 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 Department of Veteran Affairs and Boston University)
- 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))
- Liming Cai (CMS, OACT)
- Sheila Smith (CMS, OACT)
- John Shatto (CMS, OACT)
- Clare McFarland (CMS, OACT)
- Stephen Heffler (CMS, OACT)
- Michael Chernew (Health Economist at Harvard Medical School)

Review Meeting Minutes & Goals for the Meeting- Ellen Meara

Ellen Meara began the meeting by noting that panel members had a few editorial comments on last meeting's minutes and had suggested that the minutes be shorter. Don Oellerich added that he would like to get the minutes to the panel sooner.

Ellen Meara then asked Paul Spitalnic to comment on the uncertainty in the policy environment and implications for the report. Paul Spitalnic responded that the report is always prepared on a current law basis. In the event that major legislative action occurs during the process of developing the report, the Trustees will evaluate on a case by case basis to see if there are significant effects on the financial projections. This responsibility may require delaying the report, but this will depend on the timing and magnitude of potential changes.

Ellen Meara then briefly reminded the panel of the issues that are in front of them. These include: the long term rate of growth; sustainability of key Medicare cost growth factors; future

changes in utilization of care; transition from short to long-range projections; current/alternate projection methodologies including high/low cost options; and recommendations for areas of future research.

In past meetings, panel members were asked slightly more specific questions from the Office of the Actuary (OACT). These topics and questions include:

- Long-term rate of growth—Are the assumptions appropriate?
- Sustainability—What additional analyses can be considered? Does the language reflect the issues at hand? Is there value in producing an alternative projection and what are the appropriate assumptions?
- Utilization of care—should changes in site of care be projected in the long range?
- Prescription drug spending—should prescription drug spending grow at different rates than medical spending indefinitely in projections? How should significant new developments be reflected in projections when the effects are more likely to be experienced in the mid to long range?
- Transition from short to long range—Is a linear transition appropriate?
- Uncertainty—how does the panel think about it, do assumptions around it used by Trustees make sense? Should the Trustees return to 10-year stochastic modeling for Part B?
- How should impact of health care spending on mortality be incorporated into low/high cost projections?

The agenda for the meeting included a presentation by Michael Chernew, a presentation from CMS/OACT on age/mortality, and discussion of sustainability as well as changes in utilization/drug spending with a presentation from Murray Aitken. Ellen Meara noted that the goal of the meeting is to stimulate conversation and get more specific about what information would justify continuing and shaping recommendations versus tabling them.

Long Term Spending Medical Growth and Sustainability Issues—Michael Chernew

Ellen Meara introduced Michael Chernew, who is an economist at Harvard Medical School, past member of the panel, and a member of the Medicare Payment Advisory Commission (MedPAC). His presentation focused on factors that determine general health care spending, the demand for health care services, as well as sustainability and productivity issues in health care.

Michael Chernew recalled that one of the main issues the 2000 Medicare Technical Panel confronted concerned long-range health care spending. The discussion focused on demand-side factors that could slow down spending growth; that is, whether or not people pay more out of pocket and share in higher costs. Beneficiaries either pay out-of-pocket or they buy supplemental coverage. People without supplemental coverage—such as Medigap insurance—have lower spending and slower spending growth according to research Michael Chernew has conducted with Ezra Goldenstein. These effects are dependent upon the price elasticity of demand, which can be divided into two components—the compensated price elasticity and the share of income spent on health multiplied by income elasticity. What this equation means is that the more an individual spends on health (and the higher the share of total income) the more sensitive they are

to price changes. This suggests that the elasticity of demand might rise over time. Such factors are heterogeneous in nature and can vary significantly across the population depending upon their health and income.

There are several issues to consider pertaining to the demand side of health care spending. Over 90 percent of beneficiaries have supplemental coverage and some of this has been covered by employers. However, the value of employer coverage offerings is decreasing. This affects Medicare beneficiaries who have employer-sponsored benefits to fill in gaps in Medicare coverage. In addition, high Medicare Advantage (MA) rates relative to fee-for-service (FFS) have resulted in coverage for additional benefits for beneficiaries. Generous employer coverage and generous benefits in Medicare Advantage have protected beneficiaries from cost-sharing under current law. Lower MA rates combined with less generous employer coverage place more cost-sharing on Medicare beneficiaries, who then turn to Medigap, which is still highly subsidized. The ultimate question that arises from these issues is to what extent do existing cost-sharing requirements in Medicare law slow spending growth?

To answer this question, Michael Chernew collaborated with Melissa Favreault, a senior fellow at the Urban Institute, and worked with the dynamic simulation of income model, DYNASIM. Michael Chernew and Melissa Favreault placed a health/Medicare model on top of DYNASIM that factors in health status, mortality, as well as insurance choice/coverage.

The theoretical framework that Michael Chernew described was as follows: spending increases, causing premiums to rise, leading beneficiaries to drop or shift to less generous coverage due to their budget constraint, which in turn causes spending and spending growth to decrease. With this framework in mind, Michael Chernew used the model to forecast Medicare program and personal out of pocket spending using demand-side factors (income effects, moral hazard, adverse selection), supply-side factors (technology, payment reform), and individual characteristics (health status, income, disability). Spending is contingent on supplemental coverage, the income/wealth of consumers, as well insurance coverage/choices. Coverage can be supplemental, employer-sponsored, self, public, or traditional Medicare, with subcategories for each such as health maintenance organization (HMO) and FFS.

The main result is that aggregate spending does not slow that much due to demand-side factors in part due to subsidies and supplemental coverage. The results showed that by 2040, spending was 5 percent lower than it would have been if there was no income elasticity at all. However, there are certain distributional effects. For example, out-of-pocket spending grows much faster for low-income people with high levels of spending who lack generous supplemental coverage. These individuals, particularly the sickest among them, are most hurt by decreases in coverage. As the panel discussed, the model does have some limitations. For example, it does not fully consider how household or family wealth—which incorporates extended social supports — may affect income and the budget constraint for individuals. The panel discussed the potential effect of the model on the supply-side in terms of technology development or capital investment and noted that this may be limited.

Michael Chernew next turned to the topic of productivity and sustainability in health care. He suggested that the sustainable growth rate (SGR) was not sustainable and that its replacement, MACRA, avoided draconian cuts to physician payments though the fee trajectory

for physicians is very low. Is the trajectory of fees so low that the system is unsustainable? Where unstainable means that payment that is below the cost of producing adequate quality. Productivity refers to the ability to reduce the resources or cost needed to produce a given quality over time. The more productive an organization is the more likely it can sustain lower payment. Productivity gains arise from human capital improvement (e.g., experience/training), reorganization of care (e.g., retail clinics), and new technologies, such as home monitoring, telemedicine, and more effective treatments/drugs. Productivity suggests that you are getting more quality per dollar.

Michael Chernew shared a hypothesis raised by economist Louise Sheiner: payment rates are equal to the input price growth minus productivity. That is, if health sector productivity growth is the same as overall productivity growth then providers can continue providing a constant quality of care. As a result, if wages grew more rapidly than fees productivity would make up the difference and quality would remain the same.

The question that comes from this hypothesis is whether or not one can translate better quality with higher cost into same quality with lower cost due to productivity increases. However, quality gains are normally cost increasing, and desired outcomes may not be sustainable if reimbursement is not above input costs. A new technique that generates more quality—in a more efficient manner might not be replicable with a lower production function. Productivity gains are not necessarily even across services. It is not clear that productivity gains that are quality enhancing can be transitioned to gains that are cost saving.

One potential solution is to transition away from FFS toward other payment models such as bundles. Under FFS, price is paid for a service, substitution between services is not rewarded, and sustainability requires that every service be reimbursed above its cost. If the fees under the fee schedule for a service are too low, they cannot be compensated by areas where there is more productivity. Under FFS, a health system may not be flexible enough to move money away from specialists toward primary care physicians. In contrast, under a bundle, a health care system has incentive to move money across providers in a way that makes the system more sustainable. Savings in one area can be allocated to other areas, substitutability across services is encouraged, outputs in a FFS system (such as office/hospital visits) are converted to inputs, and volume reductions can be converted to effective price increases. In response to a panel question regarding current law, Michael Chernew noted that he thinks that there is enough flexibility under current law to allow organizations to shift money across providers in a way that is sustainable.

Michael Chernew then said that cost is not necessarily correlated with quality and that more health spending may even lead to worse quality. Cost reductions can be sustained while maintaining quality, particularly if savings come in the form of reducing waste. As the Institute of Medicine (IOM) reports, waste consists of unnecessary services, inefficiently delivered services/operational inefficiencies, excessive administrative costs and prices, missed prevention opportunities, and fraud. IOM considers waste to be 33% of all spending though Michael Chernew noted that this may be high. Michael Chernew also mentioned Choosing Wisely, which is an American Board of Internal Medicine initiative to reduce waste by challenging specialty societies to change practices.

For the final part of his presentation, Michael Chernew discussed payment reform options. Payment reform can take the form of reduced payments, which may not be sustainable, movements away from FFS via episode bundles, or population based payments. For episode payments such as the Bundled Payment for Care Improvement initiative (BPCI), there is some evidence of savings, particularly in the areas of post-acute care. However, savings may be offset by increased episode volume.

Michael Chernew also referenced the results for Accountable Care Organization (ACO) initiatives. Pioneer ACOs decreased savings by 1.2%, which was primarily derived from reductions in acute inpatient, post-acute, and hospital outpatient department spending. In regards to the MSSP, Michael Chernew noted that MSSP had a similar savings profile to Pioneer despite the absence of downside risk.

Michael Chernew noted that the system is flexible and that Center for Medicare & Medicaid Innovation (CMMI) can make adjustments to current models. The shift away from FFS may raise other issues if FFS is the reference point for fee updates, for MA benchmarks, and CMMI innovations.

Age and Time to Death Adjustment on Spending—CMS Office of the Actuary (OACT)

Ellen Meara introduced the session as a follow-up of discussion at earlier meetings regarding the question of whether changes in mortality and survival can influence changes in patterns of spending by age. Liming Cai provided an overview of the topics to be covered including historical demographic data by age and time to death (TTD), a discussion of the historical contribution of demographic change to growth in Medicare spending per enrollee using the age-sex method and age-sex-TTD method, projections of the contribution of demographic change based on current and alternative methods, and a description of how OACT evaluates the assumption of constant TTD spending distribution.

In regards to historical demographic data by age and TTD, spending for men rises more quickly than women relative to the mean and it increases with age for both sexes. These demographic effects on spending are driven by the distribution of Medicare enrollment by age and sex as well as spending by age and sex. Beneficiaries ages 85+ have higher spending than other age cohorts. Overall, changes in the distribution of enrollment by age and sex are larger than changes in spending by age and sex. The current projection method assumes that the spending distribution by age and sex is constant over time.

Liming Cai then noted that Medicare spending also varies by TTD. Spending for FFS enrollees in their last year of life averages 5.7 times the mean. TTD can better explain cross-sectional variation in spending PMPM than age or sex.

Liming Cai then turned the presentation to Stephen Heffler who discussed the historical contribution of demographic change to growth in Medicare spending per enrollee. Demographics has referred to the changing enrollment distribution over time by age and sex, but has not taken changes in relative spending by age into account. It assumes that time to death is not changing. OACT performed a test looking at incorporating time to death to see that impact it may have by looking at changing distributions of time to death and spending by age, by sex, and by time to death category. Since mortality is improving, enrollees are on average farther from death and

more people are living longer so the cumulative increase in spending due to demographic change is less.

The Social Security Administration (SSA) predicts that over time, probability of survival will increase for an average 65-year-old from 2010-2085. Also, as a percentage of the total, enrollment decreases for 65 to 69-year-olds and increases for 85+-year-olds from 2008 to 2085. From 1992-2008, the age/sex distribution of Medicare enrollees contributed 0.16% to spending growth but when TTD is factored in, this figure decreased to −0.30%. Therefore, demographic contributions to real Medicare FFS spending PMPM was small in relative terms from 1992-2008.

Sheila Smith continued the discussion regarding the incorporating TTD into the projections. She noted that the contribution of age, sex, and TTD is lower than the contribution of age and sex alone. The average reduction in the annual contribution to growth is three tenths of a percentage point over 75 years which does add up over time. This finding indicates that contribution of demographic change over time is smaller than under the current methodology but the overall effect is small.

Paul Spitalnic asked the panel about further analysis on this topic. He asked whether it is reasonable to use simulations to improve time to death projections and whether it is reasonable for the time to death assumptions to remain constant over time.

Ellen Meara noted that it seems that the effect is either in demographics or in the residual. A panel member questioned whether the added complexity is worth the relatively small benefit to understanding the ultimate goal. Ellen Meara asked the panel whether there is additional information here that may help them in making recommendations. A panelist noted that the fundamental question for the panel to consider is how much impact does this analysis have on the assumptions the panel makes. Do the results presented warrant complicating the work? This is worth monitoring but perhaps it is premature to include in the report? A panel member proposed that the panel go beyond recommending monitoring and indicate in the report itself that monitoring is occurring. Another panel member suggested including some discussion surrounding the findings and why this is important to monitor. Ellen Meara concluded by putting placeholders on the agenda regarding transition issues and blending from short to long-run projections.

Panel Discussion of Sustainability—Assumptions and Presentation

Ellen Meara reiterated several questions for the panel on sustainability. What additional analyses should support sustainability in the Trustees Report? Does the language and overview adequately describe the future uncertainty for Medicare around sustainability? Is there value in producing an alternative to current law and what are the appropriate assumptions? A panelist followed up on these questions and raised the issue of total compensation versus a fee-only impact. The panel could look at the impact on physician compensation, which incorporates utilization increases, coding, and other factors. The panelist also brought up the question of the magnitude of the alternative versus basic scenario. Another issue is financial productivity; that is, how many efficiency reductions can be taken out of the system right now, which ties into access issues.

Ellen Meara followed up on these points and explained that there are materials in the write-ups, including from Kate Bundorf, Austin Frakt, and Greger Vigen on the illustrative alternative, Kate Bundorf on presentational issues, Ellen Meara on productivity, and Mark Pauly on access/excess burden. She asked the panel whether, starting on her piece on productivity, the heath care sector can be as productive as the overall economy, a question that is relevant for productivity updates and MACRA payment updates. How does productivity influence sustainability assumptions and should it be measured differently? Has quality changed over time and how should it be accounted for in the illustrative alternative? Ellen Meara also raised the issue of sustainability of payment updates and flexibility to maintain productivity improvements under current law. She stated her desire to make the illustrative alternative more digestible and informative. She also returned to the question of CMMI's flexibility under current law and the effect that it may have on the illustrative alternative.

Paul Spitalnic responded by noting that CMMI has a great deal of flexibility with regards to its 76 active models. A pertinent question concerns the ultimate outcomes that these models are producing. Are they significantly reducing costs while maintaining quality? Have they proven successful? OACT can make available colleagues from CMMI to gain insight into the models they test, what the agency looks for in terms of evaluation, and how their models could affect uncertainty and alternate projections. He added that CMMI's timetable is very short but their work could have other mid or long-range implications and OACT has been involved in looking at these implications.

A panel member asked, based on this discussion, whether there is a need for an alternative projection, and suggested that the answer is yes due to the question of sustainability under the current scenario. However, the wording may not adequately describe the rich discussion on sustainability.

Another panel noted the uncertainty of current law where CMMI has so much discretion and when there is uncertainty over the outcomes of its activities. This is further complicated by Congress' control over CMMI. However, the group is coming to an agreement that this is an important issue.

A panel member noted that there are three mechanisms in the Trustees Report to convey uncertainty: (1) the illustrative alternative, (2) adjustment in rate of growth for long-term projection, and (3) items in the body of report that convey uncertainty on hospital and physician payment updates. Another panel member asked whether potential results of CMMI experiments are built into the figures featured in the report noting that it would be interesting to have two alternatives—one with CMMI experimentation and expected successes and one without. A panel member said there is no explicit effect of CMMI in the projections. Paul Spitalnic said that CMMI's effect is limited by FFS payment update constraints and limitations on cost-sharing increases. The only way that current law projections would be achievable is if CMMI was successful. If a CMMI demonstration is performing poorly, then it is terminated or modified in future rounds. If CMMI wants to expand a program the Secretary must approve and the program must achieve certification.

The panel then turned to Kate Bundorf's remarks on the illustrative alternative. Kate Bundorf's paper describes how the alternative projection has changed since the time of the SGR

and that the effects of payment reductions are uncertain. For the first recommendation, she suggested that the Trustees should continue to present one or more illustrative alternatives forecasting Medicare spending assuming less than full implementation of provider payment reductions. The alternative projection could also break apart the effects of physician and non-physician payment reductions as well as the Independent Payment Advisory Board (IPAB). Kate Bundorf also noted that there is a tradeoff between the value of continuity and changing underlying assumptions.

A panel member added that the panel should do due diligence on existing assumptions, including accurately describing start dates for impacts, total compensation versus other, as well as discrepancies between hospitals and non-hospitals on spending and update factors. There is a wide gap between the physician update factors and the market basket that is used. There is also a gap on the hospital side pertaining to the productivity factor. A panelist suggested that the report to break down the difference between the illustrative alternative and current law by physician versus hospital.

A panel member noted the 2025 payment cliff under MACRA. The five percent APM bonus and the additional pool that goes into the merit-based incentive payment system (MIPS) disappears in 2025, at which time there is a cliff. The cliff is bigger than any cliff that occurred under the SGR. The Trustees Report has tried to quantify the magnitude of the differences between the productivity provider cuts and physician payments. These differences result in a gap of 0.7 between economy-wide (1.1) and health care achievable (0.4) productivity on the non-physician side, which stands in contrast to the 2.2 or 2.3 percent physician productivity update.

A panel member added that the phase out of the productivity updates starts in 2019, at which time the 0.7 gap narrows noting that it is appropriate to reevaluate the 2019 date since the magnitude of cuts have been far less than anticipated given that economy-wide productivity is relatively low. Also, the 2025 date on the physician side is an appropriate place for the override, at which time updates start at 0 or 0.75%. If cuts do not occur on either side, the IPAB has a greater weight. A panel member then suggested that the impact of the start dates does not start at 2025 but requires a build-up period before the cumulative impact needs to be built into assumptions.

A panel member discussed how the physician payment rates falling after 2025 raises concern about the level of access for Medicare beneficiaries for physician services. The panel member raised the idea of developing a chart for the report that illustrates the relationship between access and physician payment rates. The chart may compare Medicare payments with an estimate of private payments. There would be an absolute price decline line relative to the line that is assumed for private sector payments. Though when Medicare or Medicaid cut payments, physicians may reduce prices to attract private sector patients.

Stephen Heffler noted that the long-range assumption of the Medicare Economic Index (MEI) incorporates economy-wide wage growth with physicians achieving economy-wide productivity. A panel member added that physician supply may be a factor to consider, particularly for primary care physicians who have lower payments compared to specialists. Another panel member suggested that the panel may want to consider total compensation, which includes not just fees but also supplements and bonus payments, for different specialties of

physician. Ellen Meara suggested that the panel start from Kate Bundorf and Mark Pauly's potential recommendations on these issues.

Mark Pauly also raised the issue of excess burden. If the tax burden to sustain Medicare becomes too high, then it may create distortions in the economy. The Trustees Report currently includes data on Medicare spending relative to Gross Domestic Product (GDP). Instead, it may be informative to present the future of Medicare as a whole or by part in relation to the marginal tax rate. The report could include a chart illustrating the surcharge on everyone's income tax above current levels that would be needed to sustain Medicare. Such a chart would convey to citizens what future Medicare cost growth would mean to them and everyone who pays taxes.

Ellen Meara then turned back to the topic of the illustrative alternative. She noted that the panel members agreed that there was value in having an illustrative alternative to current law in the Trustees Report. However, the panel believes that the language provided in the report may not adequately describe future uncertainty. It is not transparent to a casual reader what the illustrative alternative conveys. Furthermore, there is ambiguity regarding current law, particularly as it relates to CMMI. A panel member said that the Trustees Report should reflect that current law, which is very dynamic, is not equivalent to the status quo. Paul Spitalnic noted that if Medicare cost growth rates exceed certain level, then IPAB, or the Secretary of HHS acting in place of IPAB, can propose policies to constrain Medicare spending. If Congress takes no action, then the policies will be implemented. However, IPAB currently has no appointed members.

Following up on these topics, the panel discussed potential speakers for the next meeting in February. Ellen Meara noted the potential of bringing in officials from CMMI. A panel member suggested having a representative from the Council of Economic Advisors, which had recently released a report on the performance of the ACA. Another panel member proposed that the panel could learn from a representative from a health care system about issues such as waste reduction and hospital efficiency gains and productivity and volunteered to write a summary of the sustainability assumptions regarding the illustrative alternative. The panel adjourned for the day at 4:30 p.m.