Chapter II (Short-range)

Recommendation	Description	Notes
Finding II-1	Trustees' short-range assumptions are reasonable	—
Rec. II-2	More frequent reviews of the continuing relevance of assumptions/recommendations	Not taken; most previous review panel in 2011 The panel report stated that panels were not convened every 4 years due to OACT workloads. At this point, we would not necessarily agree with that. Other factors have delayed this panel. Also, all assumptions are reviewed each year by outside auditors (actuaries and economists) who are reviewing the projections for the SOSI. Also, when we were evaluating changes to the factors model for the 2015 report, we consulted several outside experts.
Rec. II-3	Assumptions made for one part of Medicare, made for all other parts	Hard to gauge based on Trustees report; not explicitly mentioned We have made some improvements with regard to consistency among the parts. Age-sex factors have been added Part D.
Rec. II-4	Consider explicit projection assumptions regarding % of beneficiaries with Medigap coverage	Hard to gauge based on Trustees report; not explicitly mentioned We do not make explicit assumptions.
Rec. II-5	Impact on inpatient hospital expenditures from legislative factors and case mix should be presented separately, not part of "other factors" in table IV.A1 of Report	Partially taken; as of 2016, Case Mix is presented separately, but Legislative Factors still part of Other Factors. It is not possible to breakout the impact of legislation versus unrelated reasons for the change in historical data.

Recommendation	Description	Notes
Rec. II-6	Projecting trends in aggregated measures in addition to individual components may assist in any smoothing needed on the more volatile components	Hard to gauge based on Trustees report; not explicitly mentioned Since the time the last panel concluded, we have gotten access to much more timely data and created tools that allow us to look at trends by type of service in much more detail than previously. We analyze this data quarterly and take results into consideration in the projections.
Rec. II-7	Comparing historical trends in hospital compensation increases economy-wide data in the Employment Cost Index	Hard to gauge based on Trustees report; not explicitly mentioned We have been keeping track of the latest historical trends (both OACT internal analysis and by our forecasting contractor, IHS Global Insight, in June 2016) that informs the market basket forecasts used in the Trustees Report.
Finding II-8	Current assumptions for inpatient hospital case-mix growth may be too high and those for SNFs and home health care may be too low	- See II-9
Rec. II-9	Study historical case-mix growth trends for hospitals, SNFs, and home health care to obtain clearer picture of underlying growth trends	Yes, taken; Inpatient hospitals changed from 1% to 0.5%; SNFs changed from 1% to 1.5%; home health care changed from 1% to 1.5%
Rec. II-10	Reconsideration of ultimate growth rate of SNF per capita utilization	Yes, taken; Changed from 0% to 1% per year
Rec. II-11	Reconsideration of ultimate growth rate of per capita home health utilization	Yes, taken; Changed from 0% to 1% per year
Finding II-12	Trustees' assumption of no material direct impact on utilization is reasonable despite the rebasing and re-pricing of unit prices for episodes of home health care in 2014	—

Recommendation	Description	Notes
Rec. II-13	Continue to monitor the home health % shares of Part A and Part B expenditures and adjust future shares as necessary, as program-integrity efforts expand and cap on outlier payments affects expenditures	Assumed that yes, taken Yes, we monitor this and change as necessary.
Rec. II-14	Part A hospice services should be analyzed separately by site of service (i.e., home, SNF, physician office, etc.)	Not really taken, but monitored more We do track hospice spending by site of service but since 90 percent of the payment is for routine home care, we do not project the spending separately.
Finding II-15	Assumptions used for the behavioral offset for physician services based on study more than 10 years old and date over 20 years old	- (**About SGR)
Rec. II-16	New study to estimate behavioral offset for physician services	**About SGR
Rec. II-17	Establish single alternative scenario for physician payment rate updates	**About SGR; but Yes, taken Prior to 2015 when MACRA was passed, eliminating the SGR, we had an alternative scenario that changed only the physician payments from current law.
Rec. II-18	Continue to use current methods to estimate the effects of increased enforcement to diminish fraud and abuse	Hard to gauge based on Trustees report, but it seems like Yes, it was taken We do not have anything explicitly built into the baseline for impacts of fraud and abuse efforts but historical trends are part of the base.
Rec. II-19	Trustees' approach with regard to ACOs is reasonable; Trustees should monitor share of beneficiaries that are part of ACOs on annual basis	Yes, taken We closely monitor ACO participation and performance. In 2012, the penetration rate of assignable beneficiaries was 6%, quickly growing to 29% in 2016 and with an expectation of a rate of 31% in 2017.

Recommendation	Description	Notes
Finding II-20	Current assumptions for competitive bidding on DME are reasonable and should be maintained	—
Finding II-21	Trustees' assumptions related to MA plan quality (Quality Measures) and the "star" system are reasonable	—
Rec. II-22	Trustees' assumption related to trends in MA bids is reasonable. Future work should continue.	Assumed that yes, taken After the 2010-2011 panel concluded, we updated the bid growth assumption to be the mid-point between FFS spending growth and the MA benchmark growth rate for each year between 2012-2017. In general, the MA benchmark growth has been less than FFS spending growth due to the ACA transition to the FFS based benchmarks. Now that the transition is over (starting with the 2017 MA rate book), we have reverted back to the bid growth rate = FFS spending. During the transition, the bid growth rate played out very close to as expected.
Rec. II-23	Improve modeling by using longitudinal analysis, incorporating trends in the non-MA market (implicitly or explicitly), and adopting MA enrollment trend assumption	Unclear if taken, based on methodology for projecting enrollment: not taken (pg. 154 of Report) We studied and tested serveral alternative projection models, especially those using longitudinal analysis. In the end, we determined that the model using cohorts based on county characteristics and longitudinal penetrations analysis is superior.
Finding II-24	Approach of using a macro forecast of NHE drug estimates is reasonable	—
Finding II-25	Assumed Part D "induction factor" is reasonable	—

Recommendation	Description	Notes
Finding II-26	Trustees' approach regarding expected changes in participation in RDS program is reasonable	—
Rec. II-27	Identify sources of discrepancy between recent forecasts of Rx spending growth and subsequent actual experience	Yes, taken; sources of discrepancy identified on pg. 103 of report (sub-section C: actual experience vs. prior estimates)
Rec. II-28	Explore potential for bottom-up models of NHE drug component and Part D to improve short-range forecasts (using detailed data available on various drug classes or on specific drugs that could influence SR)	Yes, taken; model used provides the 2016-2018 drug-specific and therapeutic-class-specific growth rate projections
Rec. II-29	Explore ways to build Part D experience into SR projections for year 4 and beyond	Yes, taken; a transition factor applied to 2019 and 2020 to converge NHE projected growth rates in 2021
Rec. II-30	Continue to monitor impact of changes in employer actions on retiree participation in Part D plans	Yes, taken

Chapter III (Long-range)

Recommendation	Description	Notes
Rec. III-1	For national expenditures, consider results of "GDP + X" model and "factors contributing to growth" model	Yes, taken; uses both models in LR projections We are currently using the factors model to project overall health spending for the last 50 years of the projection. The assumed growth rate is GDP + 0.9 in 2040, gradually declining to GPD + 0.5 in 2090.
Finding III-2	Trustees' assumption that the quantity of services per beneficiary under Medicare rises at same rate as for per capita non-Medicare is reasonable	—
Rec. III-3	Incorporate assumption that ACA will have small, negative impact on LR growth rate of volume and intensity of services per beneficiary	Yes, taken; "growth in Medicare payment rates will reduce the volume and intensity growth of services by 0.1% per year"
Rec. III-4	Per capita Medicare expenditures rise at average rate equivalent to per capita GDP + 0.2% after incorporation of ACA impacts	Yes, taken (used in 2013 Trustees report, but not currently used) The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of services. When Parts A, B, and D are combined, the weighted average growth rate is 3.8 percent over the last 50 year period, or GDP minus 0.1 percent. (This is based on the factors model.)

Chapter IV (Uncertainty under current Medicare law)

Recommendation	Description	Notes
Finding IV-1	Current law about Medicare payment updates for hospitals and other non-physician providers	—
Finding IV-2	**About SGR reduction on payment rates	— No longer applicable since the SGR has been eliminated but physicians now fall in the category with those providers impacted by the productivity cuts.
Rec. IV-3	Continue to present alternative projections in which average Medicare spending per beneficiary rises faster than current-law baseline	Yes, taken
Rec. IV-4	Inclusion of alternative projections within Report in the form of a chart	Yes, taken