2016 TECHNICAL REVIEW PANEL
ON THE MEDICARE TRUSTEES REPORT
Minutes
August 30, 2016

The Technical Review Panel met at 9:00 a.m. on August 30, 2016 in Room 738G of the Hubert Humphrey Building in Washington, D.C. 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 (Chair, Department of Health Policy at Vanderbilt University School of Medicine)
- Austin Frakt (Associate Professor, Boston University School of Medicine)
- 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)

Call to Order—Don Oellerich, ASPE
Don Oellerich welcomed the panel members with opening remarks. The last time this panel was convened was five years ago and that panel submitted a report. At that time the panel was faced with challenging questions related to the effect of the Affordable Care Act on the Medicare program. The goal of the current panel is to provide extensive review of the methods and assumptions that help with long-term and short-term projections and measures. As an independent panel, members are also free to bring up other issues and considerations. The advice from the panel will help the trustees better inform Congress and the public on the status of the trust funds. The contributions of the panel help to assure the public and Congress that the projections in the Trustees report are reasonable given the enormous uncertainty of projecting Medicare for the next 75 years.

Background and Expectations—Paul Spitalnic, Chief Actuary
Paul Spitalnic introduced himself as the chief actuary and welcomed the panel. Mr. Spitalnic noted that the work of the panel is critical to ensuring that the advice and ultimately the evaluation of the programs is done as independently, objectively, and expertly as possible.

The board of trustees consists of four ex officio members of the executive branch. The Secretary of the Treasury is the head of the board. The Secretary of the Health and Human Service, Secretary of Labor, and the Commissioner of Social Security are also part of the board. In addition, there are also two public trustees. Unfortunately, at this point, as at the time of the last report, the public trustees positions are vacant.

The role of the trustees is to manage the trust fund, mostly out of the treasury. One of the key functions is to report annually to Congress and to the public at large on the operation and status

of the trust fund including a statement of the actuarial status of the trust fund. The report is generated through the Trustees Working Group and is an evaluation of the trust fund. The report does not include policy recommendations though the report does identifies areas for policymaker consideration and attention. As chief actuary, Mr. Spitalnic issues as opinion at the end of the report certifying that the analyses presented are based on techniques and methodologies that are generally accepted within the actuarial profession and, essentially, that the assumptions and results are reasonable.

Areas that the Trustees Working group spends a lot of time on as part of their work on the report and areas that the panel is asked to consider priority include 1.) Sustainability of certain elements of current law, 2.) Transitioning from short-term to long-term projections, 3.) Shifting of services between Medicare Part A/B and D and across sectors, and 4.) Reflecting uncertainty through various alternative scenarios. While the panel can certainly identify other areas for discussion and consideration, addressing the four issues outlined here will provide critical benefit to the trustees and the process. Panelists were encouraged to request additional information as necessary to inform their discussions. Actionable recommendations as a result of the panel discussions will help inform the process and may be adopted by the Trustees and included in future reports. Ideally all recommendations from the panel will be unanimous.

Opening Remarks—Ellen Meara, Mike Thompson

Dr. Meara and Mr. Thompson welcomed the panel. As panel chairs, they proposed the goal of setting the path for moving ahead after the first two-day meeting. They also encouraged the panel to consider what additional information they will need to make decisions and particularly to address the priorities outlined by Mr. Spitalnic.

Presentation and Discussion of the Current Long Range Method—Factors Contributing Growth Model

Steve Heffler, Director of the National Health Statistics Group in the Office of the Actuary

Steve Heffler welcomed the group and noted that he encourages any questions as he walks through the approach to the long-run health spending projections.

The factors model is the method upon which the long-range Medicare spending projections are built. The model is built on aggregate long-range (years 25-75) health spending projections that are based on the economic projections that underlie the Trustees' report. The model is at the overall health sector level. It is not a Medicare-specific model.

The factors model ties the trend in health spending to key macroeconomic factors that are specific to the health sector to help derive long-range projections. These factors include demographics (age and gender), change in insurance coverage, change in relative medical price inflation, change in real per capita income, and a residual (primarily attributable to the development and diffusion of new medical technologies). Note that change in insurance coverage is measured based on proportion of benefits that are covered—it is not covered versus non-covered. The model is a demand-side view. Some of the supply factors are in theory captured in the residual. The model focuses on long-run historical experience because the model is designed to be used for the latter half of the projection period. For this reason the model does

not focus on short-term variations. By having a demand model where price is one of the pieces of the model, it is possible to break apart the price piece from the non-price piece.

In constructing the model, OACT tries not to make standard assumptions or keep things constant over the long-run historical period and the long-run future period. If these types of assumptions are made then the projections lead to very large shares of GDP. Historical experience is used as a guide, but judgement and assumptions are important. OACT assumes that the demand for care is going to change over time. The reason for the change is not something that the model addresses specifically.

One of the keys to the factors model is that one can take projections of economic variables that are used throughout the Trustees' Report and build them into the model. The factors model brings in the concept of some kind of behavioral response to these various factors in the form of elasticities where we can use the change in those variables over time and our expectation about the behavior and how that might change over time to put those together to generate a projection of health spending. The elasticities represent a pure behavior effect of the particular concept holding all other factors constant. The technology concept comes into play with the income concept through an endogenized income/technology elasticity inclusive of both of those effects. By doing this, the technology effect enters into the income concept. The effect is that the elasticity on that variable ends up being something well above one, historically, it has been one and a half or more. Income ends up being a very key factor in this model in the sense that every percentage point growth we are getting in income, we are getting more than that growth in health spending.

Underlying growth in volume and intensity for the overall health sector is generated from the factors model. This growth is applied to different components of the Medicare program. The major take-away from the use of the factors model is that the assumption of the growth rate of Part A and Part B services, the volume and intensity growth rate, is the same as it is for the overall health sector for years 25 to 75. Note that fee-for-service projections go directly into the Medicare Advantage projections. OACT assumes that that over the long run that physician prices grow at a slower rate than the overall health sector prices because hospital prices grow at a faster rate than overall health sector prices and that the volume and intensity of physician services is growing faster than for hospitals or skilled nursing facilities or home health. But in aggregate the growth rate is similar. Note that the data used in the factors model is 1970 through 2013 so issues regarding Medicaid expansion, for example do not yet have an effect on model results.

The results show that projected growth rate of real GDP is pretty flat, around 1.7%, and the growth of health care spending (V&I) is expected to slow over time. Historically, real per capita NHE spending has grown on average from 1990 to 2014 about four times faster than real GDP has grown. In the projection period, the growth in health care spending (V&I) is lower than the growth rate of real GDP. This comes from the factors model and is in response to health care prices that are anticipated to rise faster than overall prices over the projection period. As the price of care becomes more expensive, people will consume less. The second factor is that as health consumes a larger portion of income, people are likely to consume less healthcare. This plays out through the income technology elasticity which falls over time in the projection.

Presentation and Discussion of Medicare Long-Run Current-Law Sustainability Issues
Steve Heffler, Director of the National Health Statistics Group in the Office of the Actuary
Steve Heffler opened his presentation noting that it will address the long run current loss sustainability issues that have been discussed in the Trustees Report.

The ACA requires that all part A and most part B payment updates be reduced by the annual growth in economy-wide multifactor productivity. The concern here is that if payments under Medicare don't keep up with the costs of providing care, the availability and quality of care for Medicare beneficiaries could fall below that received by individuals with private insurance. The last panel recommended that the trustees continue to present a set of alternative projections in which average Medicare spending per beneficiary rises faster than under the current law baseline.

Now current law with MACRA specifies long-run physician payment rate updates of 0.75 for physicians in alternative payment models with expiration of the 5 percent bonus in 2025 and 0.25 for those in the merit-based incentive payment system with expiration of the add-on in 2025. The concern here is that if payments do not vary based on economic conditions and do not keep pace with the average rate of physician cost increase then access to Medicare-participating physicians could become a significant issue in the long run.

Participants discussed the assumptions of no-change in the private market and that this might not be an accurate assumption.

At the request of the Trustees, OACT at CMS has prepared a set of illustrative Medicare projections under hypothetical modification to current law. The alternatives do not reflect endorsement of the policies represented by the alternatives. Differences between the illustrative alternative and the current-law projections demonstrate that long-range costs could be higher.

The ACA specifies that beginning in 2020 and then transitioning through 2034, that payment updates are transitioned from a market basket minus economy-wide MFP (1.1) concept to a market basket minus .4 where 0.4 is what OACT has estimated is the overall health sector productivity. When the 0.7 percent gap is projected infinitely it seems harder to achieve this in the long run. Prior to ACA the update was the market basket. Note that the market basket labor versus non-labor share have not varied much over time.

The panelist discussed the issue of substitution. Is it possible to substitute less costly forms of care and still achieve the same quality?

The illustrative alternative phases out payment update reductions from 2020 through 2034 from market basket minus economy-wide MFP (1.1) to health sector MFP (0.4) and eliminates the cost-reducing actions of the Independent Payment Advisory Board (IPAB). It also transitions physician payment updates from 0 percent specified in current law in 2025 to the Medicare Economic Index (2.2 percent) in 2040 and later. It also eliminates the expiration of 5 percent bonus for physicians in alternative payment models and $500 million for physicians in MIPS.

Steve Heffler presented the illustrative alternative compared to the current law. Under current law Medicare expenditures are about 6% of GDP in the long run compared to 9.1% of GDP under the illustrative alternative. The projections were also shown breaking out HI and SMI

separately. The actuarial deficit under current law is 0.73. Under the illustrative alternative it is 1.85. Differences between the alternatives are greatest in the long run.

OACT presented analyses of sustainability measures including hospital productivity estimates, a comparison of Medicare and private prices, and margin simulation. Hospital productivity, based on 10-year moving average of growth rates, has tended to be below economy-wide productivity (0.4 versus 1.1). Over the period 1990–2013, economy-wide growth is about 1. The long-run assumption to be consistent with the trustee's expectations about labor productivity and real GDP growth is 1.1. Note that the analyses only examine productivity and do not address outcomes.

As part of the analysis, OACT looked to see what would happen if Medicare payments grew by market basket minus 1.1 because the law requires it, and private payments grew market basket minus .4 because we think that is achievable. What ends up happening is by 2090 we end up with Medicare paying about 40 percent of what private insurance is paying. Similar analyses was presented for physician prices.

The panel discussed whether changes due to value-based purchasing and alternative payment models are incorporated into the model. What are the incentives regarding future prices?

OACT also presented margin data showing the proportion of facilities with negative margins. The data show an increasing percent of facilities with negative Medicare margins. MedPAC has noted that we might expect increasing negative Medicare margins with increasing commercial rates due to lack of cost pressure and control on the private side.

Presentation and Discussion on the Sustainability of Current Law, and the Alternative Law Projections
Randy Mariger, Office of Economic Policy, U.S. Treasury
Randy Mariger and Tara Watson welcomed the group and introduced the presentation as the view of the U.S. Treasury on the description of sustainability in the trustee's report.

Since the ACA, the trustee's report has warned that the law is likely to be unsustainable and that the costs are likely to be higher than current-law projections. Alternative projections illustrate the degree to which costs might be higher than the current-law projection.

Rather than showing alternative projections to the ACA, another approach is to show the bad things that might occur if the ACA stayed in place. The report could explain the concerns that lawmakers may have to face including falling profit margins, decreased access to care, and lower quality. The trustees report could discuss these potential issues more completely.

The argument against presenting alternative projections for the ACA is that there is no additional information provided that cannot be imparted with the discussion of the problems that could arise under the ACA if it were to remain in place over the entire 75 year period.

The purpose of a projection is to make lawmakers decide what to do with the program and it can only be helpful if premised on current law. Projections are made without judgement about the likelihood that the law will remain in place. In the past, the consequences of inaction related to

Medicare sustainability has been that the program would run out of funding. In the current example, the consequence is lower quality care.

The proposal presented included making the challenges ahead more concrete. An example is to show the efficiency gains that Medicare providers must achieve relative to past trends in order for profit margins not to decline relative to 2015. Dr. Mariger shared a prototype of a chart that could be included in the trustees report showing projected Medicare expenditures compared to reimbursement necessary to maintain 2015 provider profit margins if health care productivity growth and quality growth remain at historical levels.

The panel discussed the assumption of continued current profit margins and questioned basis for that assumption. The panelists also discussed the value of simplicity in presentation of assumptions and information and discussed what it is that policymakers really need to know. The blue line of projected Medicare expenditures looks good from a fiscal point of view, but is there a measures of quality, access, or spending per beneficiary that can be shown as well? The blue line is not what has been achieved historically, is there a way to show that?

Public Comments

There were no public comments.

The Panel adjourned at 4:30 p.m.

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The Technical Review Panel met for the second day at 9:00 a.m. on August 31, 2016, in Room 738G of the Hubert Humphrey Building in Washington, D.C. Present were all of the Panel's members:

- Ellen Meara (Professor, The Dartmouth Institute for Health Policy and Clinical Practice), co-chair
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Presentations

The Panel heard and discussed presentations by the following staff

- John Shatto, CMS/OACT
- Paul Spitalnic, CMS/OACT
- Clare McFarland, CMS/OACT
- Randy Mariger, Treasury

John Shatto (Transitioning from Short Term to Long Term Projections)
John Shatto (CMS/OACT) discussed the 15-year transition period used to bridge the gap between the short-run and long-run projections and where the Panel can help. He summarized the current method used during the transition period as well as prior technical panel findings. For instance, Part D doesn't separate price and volume & intensity (V&I) in years 1–10, and Part A service splits are maintained for 25 years. He also discussed possible alternatives such as a shorter, a longer, or no transition period. Finally, although we have all kinds of Medicare demonstrations (BPCI, CJR, etc.) going on, these payment reforms are not built into the projections since they are not yet rolled out nationwide. The Panel can help by (1) reviewing current projection methods and assumptions, (2) considering alternative transition methods, and (3) considering the appropriate way to handle incongruities between years 10 and 11 and between reports.

In the discussion afterwards, it was reiterated that a number of different approaches can be used. Panel members proposed other alternatives such as doing a 1–25 year model and a 10–75 year model and then blending the two models for the transition time period. They also offered

suggestions including doing sensitivity analyses for the transition period model and a separate transition model for Medicare Part A.

Paul Spitalnic (Shifting of Medicare Services—Parts A, B and D)
Paul Spitalnic (CMS/OACT) discussed how we should incorporate the shifting of Medicare service types into the long-run projections. In the past 30 years, Medicare spending has seen a dramatic shift from inpatient services to managed care and Part D services. In 2012, a meta-analysis of literature suggested that legislative changes in Part D should result in an offset in other health spending. However, it is difficult to know long-run implications. For example, Hepatitis C drug spending has skyrocketed from years 2013 to 2015, but there is no specific medical effect reflected in the current projections, other than the aggregate technology factor in the long-run model. The Panel can help by (1) reviewing current projection methods and assumptions, (2) considering whether service-shifting should be projected in the long run, and (3) considering the appropriate way to incorporate significant new developments (such as prescription drugs) in long-run projections.

Panel members asked a number of technical questions about the presentation and offered some of their own observations about the factors and issues that were discussed. For example, in the personal health care spending by category pie charts, the share from hospital currently includes outpatient services. It would be nice to separate that out from the inpatient services. Panel members also commented that technologies such as mobile health and telehealth will pull services away from hospitals, which affects the split and the shift of Medicare services.

Clare McFarland (Reflecting Uncertainty—High, Low, and the Alternative Scenarios)
Clare McFarland (CMS/OACT) discussed alternative projections that use different assumptions to model current law. Alternative projections differ from the illustrative alternative in that the alternative projections are based on current law while the illustrative alternative reflects the intermediate projection but with assumed changes to current law. The current approach to conduct alternative projections for Medicare Part A costs is to assume that Part A services will grow 2 percentage points less rapidly and 2 percentage points more rapidly under the low-cost and high-cost alternatives, respectively, than the results under the intermediate assumptions. The 2-percentage-point variation implicitly includes the variation in demographics, economic factors, and health care spending by age as mortality improves or worsens. Taxable payroll and income from tax on social security benefits are explicitly calculated using the Trustees' low-cost and high-cost assumptions. For Medicare Parts B and D, benefits increase, relative to the Gross Domestic Product (GDP), 2 percent less rapidly and 2 percent more rapidly, respectively, than the results under the intermediate assumptions. She talked about the Trustees Working Group proposal for Alternative projections and solicited feedback.

The Panel discussion afterwards focused on how the 2% was selected and the role of the high versus low projections. They also talked about alternatives to the high/low projections such as a stochastic model.

Randy Mariger (Reflecting Uncertainty—High, Low, and the Alternative Scenarios)
Randy Mariger (Treasury) mentioned that the purpose of alternative projections is to give policymakers a range (rather than just a point estimate) for the size of reforms necessary to make

a program solvent or sustainable. He also pointed out that while the Social Security (OASDI) Trustees Report describes its alternative projections as "low-cost" and "high-cost", those are misnomers and cause lots of confusion. The low-cost and high-cost OASDI projections are actually low-net-cost and high-net-cost projections. Treasury's recommendation is to pattern the Medicare alternative projections after the OASDI alternative projections and aim to yield a range for the 75-year actuarial balance (AB75). Since the numerator of AB75 is the trust fund balance less the present value of net costs over 75 years (and less the PV of year 76 costs), and net costs are gross costs less non-interest income, each low-net-cost assumption should raise (improve) AB75, and each high-net cost assumption should lower (worsen) AB75. He also discussed potential objections to the revised projection methods and what CMS can do about them.

Panel members asked a number of technical questions about the presentation and offered some of their own observations about the projection methods, such as using an 80% confidence interval instead of the high/low model.

Panel Discussion and Development of Next Steps

The final session of the meeting included roundtable discussion of the following topics:

1. What data do the panelists need to inform future discussions?
2. What areas do the panelists think the group should focus on in future discussions?
3. Should the panel consider forming subgroups to address particular topics?

Panel Co-chairs: Michael Thompson, Ellen Meara

Panel Members: Greger Vigen, Melinda Buntin, Austin Frakt, Mark Pauly, Geoff Sandler, Dale Yamamoto, Kate Bundorf

Geoffrey Sandler:

1. Geoff Sandler noted that it would be helpful to have more information on costs in the last few years of life since there may be changes with use of hospice and palliative care services. Knowing more about how big an issue Part B drugs (specialty drugs) are would also be helpful.
2. Geoff Sandler also noted that focusing on the proportion of expenditures in Part A vs. Part B vs. Part D and by difference types of services would be valuable.
3. See #2.

Melinda Buntin:

1. Melinda Buntin indicated that knowing more from those that use the projections would be helpful in guiding areas for the group to focus on. She suggested that it might be valuable to speak with people from CBO and MedPAC to hear their thoughts.
2. A potential area for future discussion is the implicit effects of all long-run assumptions that are made. Can data be used to further consider if the assumptions are realistic?
3. Subgroups on HI; SMI; and Part D may be helpful since the documents themselves are organized that way.

Mark Pauly:

1. It would be helpful to have alternative versions of the pie charts showing total expenditures, particularly breaking out Medicare Advantage versus fee-for-service.
2. Suggestions for future topics area discussions include continued discussion of assumptions around access versus costs. What would projections like under varying access assumptions? What would assumptions look like if we maintain current costs? What is the tradeoff between access and cost? How high do costs need to be before spending approaches zero?

Dale Yamamoto:

1. Dale Yamamoto indicated that utilization data and more information on assumptions regarding inpatient and post-acute care for the short to long-term transition would be useful.
2. Discussion on Part D program would be beneficial.
3. See #1 and #2

Kate Bundorf:

1. Kate Bundorf suggested that more information on the short-run model is needed to think about the transition issues. Additionally, more information of how alternative payment models are being considered would be valuable.
2. Future discussion of long-run trends by sector and on conveying uncertainties would be valuable.

Austin Frakt:

1. Additional discussion and presentation from other stakeholders would be beneficial.
2. Austin Frakt noted that the panel was asked to focus on four areas, and he wants to bring it back to those areas after all these presentations.

Greger Vigen:

1. Greger Vigen noted that it will be important to know more about the interaction between Medicare Advantage and fee-for-service and the connection to the long-term projections.
2. Future discussions related to productivity and the employer contract will be important.

Ellen Meara:

1. Ellen Meara indicated that having the CBO's input on how they use the parameters and how they see the goals will be important. More information on shifting of expenditures across sectors will be helpful in understanding impacts on Medicare projections.
2. Ellen Meara suggested the value of further discussion of panel goals and the contributions that will be most valuable.
3. Subgroup discussion of Part A, B, and D may be helpful in the longer term.

Michael Thompson:

1. Michael Thompson posed a question on if there is information on the lagged effects of main events (such as DRG) based on historical events? What are the expected transitions Parts A, B, and D?

2. Michael Thompson suggested discussions around the probabilities of different scenarios. Currently the different scenarios get the same attention from the audience without any probabilities assigned; how do we communicate reality as effectively as possible?

Don Oellerich said that the next meeting would be scheduled for a full day on September 30th and it could be a virtual meeting. He will send out future meeting dates soon.

Public Comments

There were no public comments.

The Panel adjourned at 3:30 p.m.