Meeting Minutes: Technical Panel on Medicare Trustee Reports (September 24, 2004)

Opening Comments

Ed Hustead asked that two items be changed in the September 15th minutes – the first referring to an Andy Cosgrove comment on the Panel's charge, and the second related to the Panel's decision to defer having a presentation from RAND on its model. These changes will be made to the September 15th minutes.

General Discussion on Part D

The seven Panel members divided into two groups:

- Part D – John Bertko, Alice Rosenblatt, William Scanlon, and Mike Chernew; and
- Long Run – Ed Hustead, David Meltzer, and Mark Pauly

Each sub-group will confer and report back with recommendations for the entire group to consider for the next meeting (October 6). At the October 15th meeting, recommendations should be made and writing assignments will be handed out for chapters of the report. Panel members will then prepare bullets for each chapter and send them to Abt, who will flesh the bullets out into sentences and paragraphs and develop a final report draft. The draft will then be reviewed with suggested changes and revisions at the final meeting on November 15th.

Ed Hustead then headed a discussion on OACT's Part D assumptions. The first assumption was on the number of Part D enrollees:

- 43.1 million (2006) eligible for Part D
- 2.0 million eliminated because they are working
- 0.4 million are expected to decline coverage
- This leaves 40.7 million enrolled in Part D in 2006

John Bertko found this assumption (40.7 million enrollees) highly problematic for the following reasons:

- Part D enrollment is not by default – unlike Part B, where Medicare beneficiaries are automatically enrolled and must choose not to enroll, Medicare beneficiaries must choose to enroll in Part D.
- The experience with both Medicare Drug cards and with the current $600 subsidy has been that enrollment is much lower than anticipated.
- Beneficiaries often know their prescription drug (Rx) expenses, and those in the bottom quintile will determine Part D is a bad deal for them. These individuals might not enroll.

Mark Pauly agreed, and Mike Chernew added that Medicare beneficiaries would have to pay a premium for Part D (the benefit is not free). This may induce more not to select coverage. David

Meltzer questioned how big the problem might be – an error of 10% here actually would not be that large.

The discussion then shifted to risk. John Bertko contended that there would be adverse selection if the bottom quintile acts as he believes (i.e., that some will elect not to enroll). Rick Foster agreed that this could be a problem, and indicated while there will be some auto enrollment (for dual eligibles), Medicare beneficiaries already do not sign up for all the benefits they can receive (not all those eligible for Medicaid coverage apply). OACT now assumes that a large number of those eligible for low-income subsidies under Part D will not apply for them. Rick also added that CMS did not expect so many organizations (75 or 76) to offer a drug card during the transition.

Ed Hustead raised another problem – to the extent the press reports negatively about the Part D program, enrollment could be further discouraged. Rick Foster agrees, indicating that some commentators believe the program is a "right wing conspiracy." He added that a public education campaign that includes an explanation of late enrollment penalties would be crucial.

John Bertko proposed that OACT simulate an alternative with a lower take up rate:

- 70 percent take up rate
- Adverse selection – 1.2 to 1.3 as opposed to 1.3
- It is not clear how much of the lower take up rate is do to disproportionately lower enrollment in the lowest cost quintile (which causes adverse selection) and how much is randomly distributed across cost quintiles. Later, John asked that ¼ of the lowest quintile be assumed to not enroll in Part D.
- Five year transition when take up rates rise to levels now proposed by OACT

At this point, the discussion shifted yet again. Mike Chernew indicated that no matter what the premium subsidy was in percentage terms, beneficiaries might still be reluctant to pay their share of the premium, which could induce them not to enroll. This point developed into a discussion of how plans will price their premiums. John Bertko believes that plans will act strategically and if they expect adverse selection, they will set their premiums accordingly higher. OACT and CBO representatives countered that plans will be required to bid assuming neutral risk selection (1.0). There was considerable disagreement on this issue, including whether if plans bid assuming higher risk if they will have their premiums adjusted twice by OACT/CMS.

The Panel then considered CBO's take up assumptions. CBO started with Part B enrollment (94 percent of Medicare) and assumed that since the premium subsidy was about the same (75%), a similar number of Medicare beneficiaries would elect Part D. From this, CBO subtracted government retirees (their Part D participation would be an intra-government transfer) and employed persons, leading to a take up rate of 87 percent.

Mark Pauly returned to his concern that Part D coverage may induce more costs in Part B. This discussion morphed into one concerning Medicare Advantage (MA) plans. The Panel expressed concerns that MA plans might act strategically and try to shift some of its combined premium from A/B to D. John Bertko pointed out that different parts of OACT will be reviewing the A/B and D bids and that A/B givebacks would further reduce plan incentives to act strategically.

There was some discussion of how Rx companies would react. John thought that insurance companies would be largely indifferent to Part D – what they may lose in price they would gain back in quantity. David wondered if retail Rx prices for those without coverage would increase – Mike responded by indicating that depends on the elasticity of demand by those lacking insurance. Alice asked how many Medicare eligibles have bought their own Rx coverage. John thought that about 25 percent bought plans and 10 percent of those covered Rx.

The next topic was employers. OACT estimates employers provide coverage to 11.3 million now, but that this will drop and 2.8 million will shift to Part D (many employers may pick up some or all of the Part D premium). Rick Foster then discussed some of the OACT assumptions:

- Employer subsidy of 28% would average $611
- Those in Part D cost Medicare an average of $1250 -- $350 of that is for reinsurance (Medicare pays 80% above threshold, plan pays 15%, beneficiaries pay approximately 5%)
- Benefit to employers of $611 may rise to $900 (subsidy is tax free)

Rick then pointed out that the Panel should focus on what happens to the trust fund; CBO has considered other impacts – some of $611 would bid up wages that would be taxed as general revenues. CBO also estimated over 10 years that payroll taxes on these higher wages would be approximately $7 billion. David Meltzer contended that broader budgetary issues, not just trust fund issues, should matter. Rick also indicated that with the catastrophic threshold and reinsurance, very few employers would decide to offer wrap-around coverage.

The topic then moved to the cost side. Ed reviewed some OACT calculations:

- MCBS (raw) -- $898 per beneficiary (1998)
- MCBS with adjustment for underreporting -- $1,082
- MCBS with adjustment for institutional population -- $1,147
- MCBS adjusted to 2006 -- $3,034
- MCBS under MMA
  - Full retail -- $3,189 (this is what MCBS would be in the absence of discounts)
  - Pre-Induction -- $2,710 (this is MCBS after the 15% reduction assumed that PDPs and other plans can achieve in the first year)
  - Post-Induction -- $3,030 (this is the MCBS after people are induced by Part D coverage to consume more drugs)

John Bertko questioned if Rx cost growth rates differ for those over and under 65 (OACT used National Health Expenditure (NHE) projections to inflate MCBS data to 2006). Mark Pauly wondered if any under 65 data should be used to model drug expenditures for Medicare beneficiaries. Rick Foster responded by stating that OACT's talks with PBMs suggest that there is little difference in cost growth rates for drugs for those under and over 65, and noted that 65% of drugs are used by both groups. He also indicated that CBO had a 2-3% price increase adjustment for the effect of the MMA under Part D.

The Panel then considered the issue of drug prices under Part B. Mike wondered how much incentives plans would have to contain cost growth given reinsurance. John responded by indicating

that price negotiations often cover all drugs, not just expensive "blockbuster drugs." Mark Pauly thought that if an Rx manufacturer has monopoly power for a drug it would find a way to use that power to increase prices. Rick Foster noted that out-of-pocket costs are already declining and that there will be less of a role for Part D to affect prices.

Mark Pauly raised two concerns – but he noted he himself have doubts whether prices will really be affected. First, with more insurance coverage, there may not be enough uninsured left to "anchor" prices and avoid price increases. Second, in a point he attributed to Joseph Newhouse, he indicated that Part D's reinsurance may greatly reduce constraints on drug companies to offer new blockbuster drugs at even higher prices.

John Bertko and Mike Chernew discussed distributional issues. John asked about how the NHE models works, and whether under Part D the Rx cost distribution across Medicare beneficiaries may be extended – more wind up below the donut hole or above the catastrophic threshold. Mike noted that recent trends suggest healthier people's health care costs are increasing relatively more rapidly.

Alice raised her concern that OACT's is using old (1998) data and asked if FEP or CHAMPUS data might be used to look at cost trends. John cautioned that these data are biased to higher health care users, but was not clear if this bias would affect cost growth over time. Rick said OACT would consider looking at these other data to look at trends over time. Mike indicated that a cohort analysis might find cost shifts but that underlying trends would remain relatively constant.

Bill Scanlon asked Rick Foster how OACT/CBO assumptions regarding Medicare Advantage (MA) differed. Rick thought the Panel might not have time to consider MMA's effects on MA but would welcome their interest. This may be a topic for a future meeting – there is some treatment of this in the CBO appendix.

Bill Scanlon returned to the Part D discussion and raised his concern regarding how the Trustee Report will deal with the issue of uncertainty. Alice expressed more concerns about old data, and asked what was being done now to insure that data for the post Part D period become available for analysis as soon as possible – she also asked if a database to handle these data is currently being built. OACT staff replied that they consider it very important that as much data as possible, perhaps all data, be collected, but indicated that progress towards building a dedicated data system has been slow.

Non-Adopted Recommendations from the 2000 Panel

Clare McFarland presented on this topic. The following recommendations are being explored but have not yet been implemented:

- I-4 – Each services' spending components (price and quantity) be explicitly modeled in the short term – preliminary work suggests this does not improve forecasts – John Bertko raised the issue of the impact of changes in imaging
- I-8 – Spending distinctions by age/gender cells for survivors and decedents be made – this is close to being done and should be part of the 2005 report
- I-11 – Managed care enrollment projections be based on a cohort analysis (age, gender, and geographic cells) – this will probably not be completed for the 2005 report
-

- IV-4 – SMI cost projection decomposition analysis be similar to HI actuarial balance analyses – this could be done with GDP as a denominator
- IV-6 – SMI stochastic model be further enhanced and develop an HI stochastic model – this is being worked on but progress slow given demands of MMA
- IV-7 – Difference in health care cost trends between high or low assumptions and intermediate assumptions be greater in the short term and that the long run differences are always greater than zero
    - Current differences +/- 2 percent for 25 years – then intermediate ranges for next 50 years

OACT does not intend to implement the following recommendations:

- I-9 – Develop and incorporate specific health status models in the projections – this is a good idea, but the RAND project did not produce usable results, and an ARC project by Trapnell cites feasibility issues
- II-4 – Forecasts of trend growth rates and shift effects that are different from their long-term values be partially offset by changes in the opposite direction before the ultimate value is reached – OACT fears the projection oscillations that will result will be misinterpreted (false precision), and Rick Foster noted that projecting average trends, let alone oscillations, is hard enough
- IV-2 – To the extent possible, Trustees regularly evaluate and report on the accuracy of past HI and SMI projections over various periods (e.g., 1, 5, and 10 years)
    - OACT does this for 1 year projections but believes netting out legislative effects over longer periods would be much harder
    - David Meltzer still thinks that comparing what happened to the projections is still important
- IV-8 – Develop new set of health care projection uncertainty predictors with respect to underlying factors (e.g., managed care) that can affect both HI and SMI projections under various scenarios – not done because of lack of time and resources

Overview of NHE-Rx Projections

Three OACT/CMS staff – Steve Heffler, Sheila Smith, and Sean Keegan, discussed the NHE model and its Rx projections.

Key model assumptions include the following:

- Economic and demographic assumptions and Medicare/Medicaid projection are exogenous and taken from the Medicare Trustees' Report
- Top down model – output from all sectors except Rx constrained to aggregate output
    - Adjustments are small
    - Model predicts both real per capita and prices
- Model now suffers from circularity for Part D
- Model estimates Rx sales at retail (no hospital or physician office)

- Model includes external adjustment (add factors) that are drawn from multiple sources – other forecasts, outside consultants, research following trends in new drugs and drugs coming off patent
  - Mike asked if these adjustments are line items that are applied to final outputs or are built more into the model – answer is a bit of both
- Rx spending growth model
  - Real per capita income (2 year moving average (MA) -- positive), relative drug price inflation (negative), new drug introductions (3 year MA – positive), and direct to consumer (DTC) advertising (5 year MA – positive)
- Rx price inflation
  - Input price inflation (1 yr lag, positive) drug research spending (polynomial distributed lag (PDL), positive), managed care/PBM effect (1993 and forward dummy, negative)

Model results were then presented indicating that relative price inflation (post 2002) is 20% of Rx spending growth – rest (80%) due to utilization and intensity.

A general discussion of the model then ensued. The dummy in the Rx price inflation model replaced measures of managed care share – OACT felt that this measure was increasingly subject to measurement error (managed care now is less restrictive than managed care from earlier periods). John Bertko suggested using PBM enrollment instead. Mark wondered if some measure of the relative generosity of insurance could be built in, but recognized it would be endogenous. David Meltzer suggested that interaction effects might drive down the prices of older drugs. Mark Pauly proposed that drug research spending with a lag might be better than a PDL.

John was surprised that relative price inflation had such a small (20%) share of recent and projected future Rx drug spending growth – he thought it would be closer to 50%. Sheila Smith replied that this was largely a by-product of medical price indices. Mike thought more recent data might shift the relative price share higher and noted that it was rising slightly towards the end of the projection period. John stated that all prices are higher and that generic prices are increasing most rapidly.

Sheila indicated that a problem she faced was fitting the data without the 1993 and beyond dummy – there just appeared to be a structural shift. John thought this might be a Hilary Clinton health care reform effect. David asked with growth rates instead of absolute levels were modeled.

After looking at the graph of actual versus unadjusted regression projections of private real per capita spending growth and relative price inflation, Mike was surprised how well the model fit and asked if the models included a time trend – they did not. Sheila also indicated that OACT faced a balancing act – the model appeared to over-predict spending growth for the projection period, and how much of an add factor should be used is open to question. Without an add factor, Rx spending would exceed MD spending by 2013 – and this was considered unreasonable by OACT.

Sheila made some other model points:

- R square for spending growth model about 70%
- Highly sensitive to specification (model has 5 variables and data only from 1965 – very few degrees of freedom)

- Much of fit due to the inclusion of a 1999 dummy (spike in costs) – Celebrex and Vioxx, flu, and Y2K drug stockpiling – but model still fits fairly well without the 1999 dummy

Model lag structures were discussed next. Sheila indicated lag structures depended not only on model fit but what appeared to reasonable given what is known about key factors (e.g. DTC). Mike is worried that no matter how well the model fits, what really matters is how well the "X's" (independent variables can be predicted). There also is not enough data to estimate lag structures (e.g., as Mark Pauly suggested – using part of the sample to estimate a lag structure and apply that to the rest of the time series).

Sheila then discussed planned model changes that include:

- Rx spending from all sources – not just private (responds to Medicare circularity) – not a big issue practically because private is such a large share now but critical conceptually
- Adjust to keep demographics constant
- Restrict interval to 1984 and beyond – 1970's very hard to fit
- Impact of changes in consumer effective prices of average out-of-pocket share changes controlled with price elasticity assumptions (model does not fit low cost growth in early 90's followed by rapid up tick in late 90's)

Sheila concluded with some discussion issues:

- Tiered copayments
- Blockbuster drugs
- Projecting DTC, new molecular entities, drug industry research spending
- How do PBMs affect spending and how will this persist (or not)

The Panel returned to "how to predict the X's." Mike believes that a model with a time trend might be easier to use for predictions. Sheila countered by saying that a time trend does not preclude issues including what period to use for the model and whether and how many time dummies should be included (and how the model assumes these dummy effects to persist or dissipate). Another issue was PBMs – if their effect is important, the big expansion that will occur in 2006 may have important implications for the NHE Rx model.

One woman in the audience thought that generic entry and drugs going off patent should be modeled more explicitly. OACT staff countered by indicating that this is done through the model add factors. Mark Pauly thought another option would be to include a variable measuring average drug vintage – this would get at both new and old drugs.

Alice asked about how recent the model is. Current data used is through 2002 – 2003 data are now being used for comparison. The model appeared to over-predict cost inflation from 2002 to 2003 – model is at 12.3 percent, and the actual is around 10 percent.

Long Run Projections

John asked (and OACT responded) about how much above GDP A, B, and D are projected to be from now to 2013

- A – GDP + 0.6%
- B – GDP + 1.9%
- D – GDP + 4.4%

Mark made the point that nothing in current law guarantees we will move from this short run to a long run of GDP + 1.0% (we may be driving towards a cliff and know we have to steer the car but the car has no steering wheel). Bill added that changes may be so wrenching as to be unacceptable to the U.S. – we are already resisting changes adopted internationally. Bill also believes the Trustee Report should educate the public – not just project what will happen. David is concerned that data used to make projections already includes key structural changes.

Rick Foster responded by noting that Social Security has it much easier – it just needs to project real economic growth and demographics. The Medicare report has always focused on the short run and uses the long run more as an illustration. Mike asked that the current law discussion be made much more explicit in the report, and David returned to Mark's analogy – when do we have to change the car's direction and by how much to avoid the wall.

Department of the Treasury Presentation

Mark Warshawsky was the presenter. He indicated that the Trustee Report historically used an infinite horizon (Perpetuity) as its long run measure. The horizon was restricted to 75 years in the 1960s as Congress repeatedly adjusted benefits (there was no automatic inflation adjuster). Even after benefits were indexed, the 75-year forecast continued. The 1999 Social Security Technical Panel expressed interest in an infinite horizon.

He continued by noting that since the last major Social Security reform (1983) that was designed to achieve long-term actuarial balance, the 75-year picture is worsening each year. There is now a 2% payroll deficit – this due mostly (2/3) to the passage of time, not to changing assumptions or conditions. The problem is the out years are much worse and as time passes, more and more bad years are included in the 75-year projections.

Mark Warshawsky advocates including an infinite horizon for several reasons:

- Makes shift of burden across generations clearer
- Public Trustees of Social Security heavily involved and are interested
- Broad interest on both sides of the aisle in Congress (testimony of Social Security actuary Steve Goss well received)
- Problem is not the concept – but how to implement, especially for Medicare

The Panel raised several concerns. David Meltzer wants to retain the 75-year projections (Mark W. responded that both are in the report). Mark W. also believes dropping the infinite horizon now would be awkward. Ed Hustead asked what value-added an infinite horizon has for Medicare – the

real issue to Ed is when the Medicare program will go broke (now projected to do so in 2019). Mark W. countered that keeping both Trustee Reports (Medicare and Social Security) similar has value in itself, and that the infinite horizon provides more of a sense of how much must change to correct programs.

Mike Chernew is o.k. with a Social Security infinite horizon, but points out for Medicare that reasonable assumptions will generate unreasonable results (e.g., too large a share of total economy consumed by Medicare). Bill Scanlon added that if one starts with reasonable outcomes, the assumptions needed to get to these outcomes might be unreasonable. Mark W. responded by stating that Steve Goss believes the infinite horizon is a good way to test the projection's logic.

Alice Rosenblatt believes that with so much uncertainty in health care, infinite horizon projections may be so misleading that the cause more harm than benefit. Instead, infinite horizon numbers may be more footnote material.

Ed started a discussion of the Medicare infinite horizon deficit (now 5.3% of payroll taxes). He asked how to interpret this. Mark W. responded the infinite horizon provides some sense of the relative deficits of the two programs – Medicare and Social Security. Michael O'Grady thought the infinite horizon makes the need to act clearer and more immediate. Mike Chernew considers that what is promised by Medicare is less clear that what is promised by Social Security. Mark Pauly believes you could bump up the tax rates to cover the deficit (ignoring the effect on the macro economy) but does not know if the capacity will be there to provide corresponding amount of service, and considers having the Trustee Report deliver bad news is a good thing.

Mike asked if the 5.3% deficit includes a slowdown to cost growth equaling GDP growth (it does). Rick Foster would like to see the Trustees Report move away from summary measures like the actuarial deficit that may obscure what is going on and instead rely more on year-to-year results. Rick also indicated that no one believes payroll taxes will increase by anywhere near 5.3%. He says the only purpose in his mind for the summary measures is for the balance test – David asked what this is and Rick responded:

- Compare program cost and program income in present value terms over 75 years
- Year by year differences cannot be too large
- Balance between program cost and program income must be within 5% of program costs
- Not even close to balance currently

Mark Warshawsky mentioned that CBO uses a 100-year horizon so that all people alive right now will be modeled until death. Mike and Rick had a brief discussion of discount rates and how they affect infinite horizon calculations. Bill Scanlon believes what matters more given the MMA is the intermediate and short-run – in his view, current 75-year projections are bad enough. David asked if anyone looks at not only what has to be done but when it has to be done for long run actuarial balance – Rick indicated that Trustee Report now indicates what payroll taxes would need to be if taxes were not changed until one year before the fund is project to go broke.

General Panel Discussion on the Long Run

Ed asked what should be done about GDP+1 – should there be a panel vote? John asked if this applies to A or A and B, and if the projections indicating that Medicare spending will exceed total GDP at the end of projection periods is for HI only or for A, B, and D. The 2000 Panel predicted medical care at 38% of GDP in 75 years under GDP+1.

Mike pointed out that most models need a measure of "reasonableness." The 2000 Panel's measure was that spending other than health care must continue to increase – this occurs through 2075 under GDP+1 but other spending will start to fall in 2040 under GDP+2. Rick Foster indicated the CMS Greg Won CGE model indicates that out-of-pocket premiums will exceed Social Security benefits on average within 75 years. Mark Pauly added that cost-sharing provisions themselves may define "what is reasonable" and Michael O'Grady and Rick Foster stated the CGE projections are illustrative – incomes vary and most elderly have more than just Social Security income.

Alice and Mark both wonder if Part B cost sharing will help close model – cost sharing will be so high that beneficiaries can no longer afford more health care. John Bertko asked when GDP+1 is phased out, and Mark Freeland indicated that most models including the CMS CGE model have natural, long run S-shaped curves for medical projections. Mike Chernew said the Panel had reviewed another model with a similar assumption on using non-medical spending as the way to close the model. Kevin Coleman responded by saying this was the treasury model and it assumes that non-medical spending must growth at some positive rate (0.75 to1.5 percent).

Mark Pauly indicated that the private sector is not constrained by current law and speculates that there could be some spillover into Medicare, slowing its costs. Rick Foster added that Medicare spending growth might not be sustainable if Medicare insurance becomes much better than its private counterpart. Mike returned to his point that Medicare costs can be contained to some degree by deciding what services will be covered.

Alice raised a new point – current law already is not sustainable, and cited repeated changes to the SGR as evidence. Mark returned to his former concern that Part D coverage may increase other Medicare spending – especially Part B (office visits). Rick agrees that current law, particularly SGR, is not tenable, and Mike went on to point out SGR is not included in GDP+1 and that there are no separate long-run growth rates by service type – and that ultimately, growth cannot exceed GDP. Rick stated that if the Panel wants to use the CGE model, Panel members could call him, Greg Won, Sheila Smith, or Mark Freeland.

Ed asked if the baseline Social Security projections are reasonable. Rick thinks they are reasonable but not optimal. Mark raised the issue of whether health care costs affect GDP growth (Baumol argument – medical care is less productive, and shifting resources to less productive sectors reduces growth). Ed thought this raises a natural question – should GDP+1 hold for any level of GDP?

This question sparked a debate over productivity and income elasticity. First, panelists disagreed on medical productivity – David believes much of the new spending growth will be for Rx and that Rx companies are not less productive – John disagreed, citing inefficiencies associated with off-label drug use. Mark believes medical productivity has never been measured accurately given the problem

of adjusting for quality. Mike added that some of health care's benefits (longer life, reduced morbidity) are not counted in GDP.

On the elasticity issue, Mike said the 2000 recommendation was really 2.2% -- not GDP+1. If so, David thought that rapid enough growth could mean we can grow out of the problem. Mike stated that this depends on income elasticity. Mark and Mike indicated that this is not well measured but that most estimates are positive, but it is not clear if they are greater than 1.0. Rick mentioned that GDP+1 implicitly allows for faster growth (the +1) if GDP rises. Mike stated the 2000 Panel selected the +1 format for convenience and because the implied income elasticity (1.0) appeared to be reasonable. Mark returned to the issue – if GDP is not 1.2%, then what is the recommendation – i.e., GDP + what?

The Panel went on to consider how to measure elasticity. It measurement depends on health status and technology, both of which are endogenous (Bill Scanlon), and these are not measured well at all (John). Incorporating health status is a good goal (Mike) and there is some progress on technology measurement (Mark), and income elasticity can also be measured in the NHE estimates, and there is work on making this progress into a book (Rick). Greg Won was asked by Steve Heffler what the CGE model is finding, and Greg responded by stating income elasticity appears to be greater than 1.0, but declining (falling from 1.5 to 1.6 to 1.1 to 1.2). Long-run income elasticity cannot exceed 1.0.

Looking Forward to Next Meetings

The current plan is to discuss recommendations at the October 6th meeting and reach them at the 15th meeting. The draft report will then be prepared (by Abt based on panelist bullets for each chapter), and the report will be reviewed at the November 15th meeting. Bill Scanlon indicated that it was his understanding that subgroups could come to tentative recommendations, but these recommendations must be reviewed and decided upon by the entire Panel in open meetings.

Return to Part D Discussions

Given the remaining time in the meeting, Ed asked the Panel to return to its review of Part D assumptions. He asked Greg Savord of OACT to explain a table measuring the impact of the Rx benefit on state and Federal Medicaid payments. Greg made the following points:

- Top of the table is impact on states, bottom on Feds – both now split Medicaid costs
- Only thing that matters is "claw back" – states must return share (that declines over time) of their Rx savings to Medicare (this is income to Trust Fund). Ed asked if these calculations were "mechanical," and Greg thought they were and detailed the following:
  - Estimate number of dual eligibles by state
  - Apply claw back shares
  - Apply state shares of Medicaid expenses
  - Inflate over time using Part D per capita growth

Alice asked why CBO and OACT projections of Rx cost increases differ. Rick is fairly sure this is due to CBO using 2002, not 2003, projections. Alice also asked why OACT cost projections increase so rapidly in the out years. Rick replied this is due to OACT assumptions on PBM savings (starts at

15 percent and increases 2 percent per year until it reaches 25 percent) – once 25% is reached, the drag of an increasing PBM savings factor no longer slows cost growth.

Alice also asked about administrative costs. Rick replied there some small CMS admin costs, but that plan admin costs are not paid by the 80% cost sharing above the catastrophic threshold – only drug costs are subject to reinsurance.

Ed asked how risk corridors were modeled – Greg Savord replied that OACT assumed plans bid perfectly and that there would be no risk corridor costs or savings. Risk corridor flows will not begin until 2007 (there needs to be a 2006 cost settlement process).

The next topic was the employer subsidy – this did not result in much discussion. The low-income subsidy sparked more interest. OACT believes that Part D will encourage some individuals to apply for Medicaid to qualify for the low-income subsidy. Of 14.5 million eligible for a subsidy, OACT expects 4 million will not receive a subsidy in 2006. There is a small amount of drug card savings in 2006 because of prescriptions carried over from 2005 and because of differences between fiscal and calendar years.

Rick pointed out that OACT's cost estimate ($539 billion) includes the savings in Medicaid and other areas. OACT believes the impact on Medicare costs will be $761 billion over 10 years.

Alice asked several questions about what projections and data were fiscal versus calendar year. She also wanted to know more about specific differences between OACT and CBO, including:

- Mean drug expenditures – is it $3,096 for CBO and $3,030 for OACT?
- How do use effects compare – 9% for CBO and 12% for OACT
- Rick added that OACT assumes more induction
- Growth rate differences – the issue of 2002 (CBO) versus 2003 (OACT) from the NHE

Public Comment

There was no public comment at the conclusion of this meeting.