Meeting Minutes: Technical Panel on Medicare Trustee Reports (September 15, 2004)

Opening Comments

Andy Cosgrove welcomed the Panel (all seven members were in attendance) and indicated he would miss the next scheduled meeting (on Friday, September 24th). In his stead, a designee, Daniel Durham, will be the official government representative.

The minutes from the August 27th meeting were accepted with a request from Edwin Hustead that the next set of minutes be "more terse."

OACT's Medicare Prescription Drug Model

Four CMS staff members – Paul Spitalnek, John Poisal, Greg Savord, and Sally Burner were the main presenters of this material. Richard Foster and others provided additional comments.

Paul began with a discussion of the Part D benefit. Key points include the following:

- Program starts on January 1, 2006
- Anyone entitled to Medicare Part A or enrolled in Medicare Part B can participate
- Plans will include Medicare Advantage (MA), Prescription Drug Plans (PDPs) and Fallback plans
- There must be at least two plans (and one PDP) in each region designated by CMS (there may be 10 to 50 regions – not decided yet)
- If fewer plans participate in a region, CMS will seek Fallback plans to supplement choice
- Standard plan provisions
  - $250 deductible
  - 25% coinsurance to limit of $2,250
  - Donut hole with out-of-pocket expenditures continuing to $3,600
  - Catastrophic coverage above out-of-pocket threshold (beneficiaries only liable for $2/5 or 5% copays)
  - All amounts in 2006 – indexed at per-capita Part D expenditure growth

At this point, there was a general discussion on the provisions, including:

- Out-of-pocket limit for expenses of beneficiaries only – not what others pay on their behalf (Ed Hustead)
- Doubts about how such limits would be administered (Alice Rosenblatt)
- Not clear what counts against the out-of-pocket limits (e.g., flexible spending accounts and other health accounts, etc. (John Bertko and Mark Pauly)

Paul then started leading the discussion again by indicating that catastrophic provisions would be triggered at $5,100 if beneficiaries paid all their own prescription drug costs, but that this amount is not in the law, and can't be because the limit is triggered by True Out-of-Pocket Expenses (TROOP).

He then led a discussion of benefit design. The benefit provisions above are standard. Plans must bid on a standard plan design (these bids set beneficiary premiums and plan payments), but plans may also offer:

- Actuarially equivalent benefits – assumed by OACT (out for public comment) that this means 25% cost sharing
- Alternative coverage – can have various copays and coinsurance provided expected beneficiary payments average 25% cost sharing on a population basis
- Enhanced coverage – can offer lower cost sharing or cover more drugs, but costs in excess of standard option are borne dollar for dollar by higher beneficiary premiums.

Alice and John then lead a discussion of actuarial equivalence. In effect, each plan must have an actuary use generally acceptable principles (not rigidly defined) to estimate plan costs (and thus ultimately, plan premiums). Actuaries are subject to codes of professional conduct and are audited. CMS must then approve these calculations – ideally, these calculations will be reviewed by CMS actuaries, not by auditors.

Paul and John then discussed some other issues. These include that plans are provided risk corridors (symmetric, +/- 2.5% to start, and +/- 5%) to guard against errors in cost estimates. All plan cost calculations are also prospective.

Paul then discussed several other Part D provisions:

- Low income subsidies – Dually eligible and other low-income (under 150% of poverty line) beneficiaries meeting asset tests qualify for two-tiers of subsidies – both lower premiums and reduced cost sharing (cost sharing subsidies count against TROOP)
- TROOP discussed again
- Premiums – based on plan bids and will average 25.5%
- Employers
    - Can receive a subsidy (28% of drug expenses – plan and retiree, tax free) to offer actuarially equivalent plan
    - Can become a Part D plan
    - Can offer wrap-around coverage
    - Can reimburse Part D premiums on behalf of retirees/workers
    - Can drop coverage (those formerly covered now fully in Part D)

There was a general discussion about uncertainties surrounding employer options. It is not clear what actuarial equivalence means (benefit comparability, costs, or what population (standard, employer, some mix) should be used). Mark Pauly speculated about how employer-funded spending accounts would count against TROOP (if dollars revert to employees, probably do count against TROOP).

There is also a lot of uncertainty what employers will do. Paul indicated wrap-around coverage unlikely (just pushes out TROOP catastrophic threshold). Some panelists thought employers may drop coverage, but John Bertko noted:

- Case law may prevent some firms from dropping plans

- Subsidy will encourage some to continue offering plans.

John Poisal then began a discussion of the Medicare Current Beneficiary Survey (MCBS), the main data source used by the OACT model. The MCBS:

- Uses a complex sample design (e.g., oversampling disabled and oldest old) to best represent Medicare population
- Includes about 13,000 beneficiaries with prescription drug data
- Respondents provided calendars to record all medical events and asked to save Rx bottles/tubes
- There is a complex imputation methodology (not part of public use file) to estimate Rx expenditures
    - First DataBank's Bluebook to Medicaid Statistical Information System MSIS) merge to generate average wholesale price (event price)
    - Bluebook data merged to MCBS individual data at 11-digit NDC level (drug name, form, strength, etc.)
    - Event prices adjusted for discounts, dispensing fees, and rebates by payer (Medicaid, ESI, Retail, HMO, etc.)
    - Resulting calculations used to verify reported data
    - 2001 file now exists, 2002 being constructed

Sally Burner then took over and discussed how OACT is using MCBS data in its model:

- 1998 file now in use (will be updating hopefully by next Trustee's Report to 2001)
- File aged forward by population, MA enrollment, and expenditures
    - Expenditures trended using National Health Expenditures (provide estimates to 2013)
- Imputation for underreporting
    - Run regression on respondents who report all physician encounters: Rx events as function of Medicaid status, health status, inpatient stays, home health and physician visits
    - Apply regression estimates to rest of sample to inflate Rx events (max of imputed value and what was actually reported on MCBS)
    - Underreporting (on average 83 of 100 reported) – Mark Pauly noted rate for those who did under-report would be much higher
    - Better method based on 1999 Pharmacy File-Back Study available for next set of estimates
- Institutional population
    - Estimate non-Medicare covered days
    - Get per-day spending in community
    - Institutional costs – institutional days * community-per-day costs * PACE factor (3.67) – PA Medicare Demo project

Greg Savord then discussed the OACT micro-model:

- Person-based (Rx costs for each person)
- Only models PDP benefit and FFS

- MCBS file adjusted back to event prices and then a price adjustment used to capture discounts, rebates, management, and generic substitution used (15%)

This sparked a Panel discussion. Mike Chernew raised the issue that Rx manufacturers may raise their prices and that what matters is the net result (price increases from manufacturers versus rebates and other cost reductions secured by plans) of these actions. John Bertko thought plans would compete aggressively on price and will be aided by requirement that two drugs must be included in 146 therapeutic categories (competition within category).

Rick Foster then indicated that there was a five-year transition (savings growing from 15 to 25%), and that researchers have not found any difference in drug price increases between drugs focused on the over and under-age 65 markets. The 25% figure was based on what large employers and PBMs are now achieving.

Mark Pauly asked about what happens to new drugs – he believes these will have much more rapid price increases under Part D. The issue of two drugs in each class was raised once more, and John Bertko noted that 65% of drugs serve all age groups (under age 65 will be a source of price competition).

Greg returned to his model discussion. The model runs twice. There is a pre-induction step, where initial drug costs estimated above are subject to plan provisions. There is then an induction step, where coverage changes are allowed to affect drug demand and cost (induction). Induction is assumed to be:

- Dollar for dollar on coverage changes – if Part D lowers (or raises) out-of-pocket costs, there is a dollar for dollar increase (or decrease) in drug costs
- No induction above $3,000 or for dual eligibles
- Model then applies plan provisions and estimates who pays what (beneficiaries, plans, Medicare).

After induction, plan models employer subsidies assuming a standard benefits package.

There was a general discussion of induction. John thought the assumptions were reasonable. David Metzler wondered how much information patients have and who actually would be making such decisions about buying more or less Rx.

Paul then returned to some other issues:

- TROOP – only modeled for wrap-around coverage, and model assumes those with Medigap Rx will drop it (raises threshold, have to pay premium)
- MA enrollment assumed to rise to 33% (Sally)
- Extra MA dollars can still buy more benefits (Paul)
- Take up – model assumes everyone on Part B (94 percent) will adopt) – premium subsidy, late enrollment penalties (1% of premium per month or actuarial equivalent) will encourage immediate enrollment with no selection problems
- Add 12.5% admin load in 2006 – lower each year

John Bertko started a discussion of take up rates. He believes that Medicare beneficiaries are good at predicting their drug costs, and according to his rough calculations, Part D is a winner only for the two top Rx cost quintiles – not clear for the middle quintile, and a loser for the bottom two quintiles. If so, people in the bottom two quintiles may not enroll – leading to adverse selection and higher premiums for those enrolled (but not higher overall projection costs). Others not so sure – David Metzler does not believe the elderly operate this way. There was a question raised about the appropriate time horizon – i.e., elderly may only look out for five years. Paul S. believes elderly are risk adverse, is not sure if the benefit is a loser for that many people (even if they can predict their drug costs) and does not see a selection problem. David M raised the possibility that some elderly would spend down and join the benefit after they are Medicaid eligible (and thus would receive the low income subsidy).

Paul S. returned to other assumptions – including:

- Low income subsidy – all dual eligibles would apply and there would be a woodwork effect (more eligible for Medicaid might enroll for low income subsidy). Numbers based on CPS/SIPP
- States must pay back Medicaid drug dollars (clawback) – based on MSIS data
- Employers split into federal, state and local, private union, and private non-union – estimate perhaps ¼ would drop coverage (most likely for private non-union)
    - Subsidy take up for each category

Rick Foster believes employer wrap-around coverage will be rare, but John pointed out this is what MA plans do now. If contributions to retiree health benefits were frozen – hard to say what would happen to wrap-around. Ed asked for spreadsheets with all the assumptions (take up rates, induction, costs, etc.) listed out for the Panel to review. Mike mentioned that the Panel might want to split up various parts of Part D projections and have different groups work on each.

David mentioned the value of some sensitivity analysis. He advocates using extreme values for each assumption, to determine what parameters drive the model. He then believes attention should be paid most to the model drivers. Rick mentioned that there are three sets of projections already and offered OACT help if the Panel wants more projections and variations. He also noted that relatively small differences have resulted in big gaps between the OACT and CBO projections.

Paul S mentioned the five aspects of the projections most subject to uncertainty:

1. MCBS under-reporting – and will better methodology based on fall-back improve things
2. Induction impact on drug use
3. What will plans offer and will MA plans offer supplemental coverage
4. Take rates and will there be adverse selection
5. Employer options – who will take the subsidy (estimated at $611), who will offer wrap-around coverage, and who will drop coverage

Bill Scanlon emphasized uncertainty and advocated that the Panel speak to this in its report. Mike noted that some of the uncertainty would be eliminated by 2007. Mark asked whether the projections assume Rx use affects other Part A or B spending (Mark believes it may induce more Part B). Rick Foster indicated that the "a previous administration" gathered documents on drug use impact studies,

but that the cover memo with the materials noted that only studies finding that Rx use reduced other spending were included. OACT did not find much useful evidence of savings.

CBO's Medicare Prescription Drug Projections

Tom Bradley introduced this discussion, led by Phil Ellis, on CBO's estimates for Medicare Part D.

Phil noted the large difference ($130 billion, $100 billion for drugs) for 2006 to 2013 between the two estimates (OACT is higher). $32 billion of the $100 billion related to the basic benefit and employer subsidies. Much of the CBO detailed assumptions are in the paper CBO distributed, but key points included:

- CBO used its own micro model based on the MCBS
- Instead of individual imputation for underreporting (OACT), CBO used an overall factor of 17.5%
- Phil was not sure on CBO's institutional population imputations
- Data from 1999 MCBS
- Enrollment in Part D high and representative (no adverse selection)
- Plans would spring up to serve beneficiaries
- CBO employer subsidy ($766) higher than OACT ($611) – Rick Foster indicated that with tax break, the $611 comparable to $900 Part D cost per beneficiary (net of reinsurance of $350)
- Roughly 20% of employers would drop coverage – almost no employers would offer wrap-around coverage
- Rx spending does not alter Part A or B
- Enrollment at 87% -- 94% (Part B) less 7% -- active workers and federal retirees
- Demand elasticity of 0.3 for Rx use
- Spending reductions would be 20-25% (net result of generic substitution, management, and price discounts, exemption from Medicaid best price)
- Launch prices for new drugs would be higher due to Part D
- Low income subsidies lower than OACT ($50 to $60 billion)
    - 45% participate (versus 67% OACT)
    - Three transition as beneficiaries learn about subsidy (OACT – immediate)
    - Lower because of lack of knowledge, stigma, not sure if they are poor enough to qualify, and language
    - Subsidy separate from plan enrollment process – must apply at Medicaid offices for subsidy
    - QMBY/SLMBY also have many eligible not participating

Panel comments included the following:

- PDP savings assumptions – where do they come from – both CBO and OACT based on PBM/large employer experience and interviews (PDPs may be more aggressive than employers because PDPs only care about price, not about workers/retirees as well)
- Alice Rosenblatt wanted more details on all assumptions – ideally a side-by-side starting from the MCBS and continuing through all model simulation steps (CBO and OACT)

- The Panel is not sure how punitive current Part D delayed enrollment penalties really are
- Ed asked about reinsurance – this occurs when Medicare pays 80% of expenses above TROOP catastrophic threshold
- John asked about generic drugs versus new biotech – how are they accounted for in the National Health Expenditures (NHE)
- Panel stressed importance of cost increases – Mike noted how large total drug costs may be more important than small variations in share borne by Medicare
- John believes that plans will have strong incentives to conduct outreach on low income subsidy – may increase number receiving subsidy

Department of the Treasury: Long Run Projections

Jason Brown presented this material. Treasury started with the 2000 Panel GDP+1 proposal, and noted that is not sustainable over an infinite horizon. There are four sets of projections:

- Calibrated to 1940 to 1990 (2.2% real spending growth)
- 1966-2002 (2.5% real spending growth)
- 1940-2002 (2.7% real spending growth)
- 1983-2002 (2.0% real spending growth
- All four projections started with actual medical spending growth and netted out factors not expected to continue over long run (basically everything but technology; dispute whether relative medical price inflation should be netted out (David Metzler))

Basic assumption is as medical spending crowds out non-medical spending, people demand less health care, and medical spending drops. The Panel not sure when this will happen (David) or if this will happen (Mark). The budget constraint used to close the model does allow public medical spending to grow unabated (can lead to medical costs in total (private and public) exceeding GDP).

Basic finding is depending on how much one expects non-health spending to grow (Jason suggested 1.5% real), long run projections of medical spending are reasonable – large share of GDP, but not all GDP.

Panel responses included:

- Mike not sure if non-medical spending has to grow that much – 1.5% sounds too high to him
- David believes what is more valuable is considering how much behavior and the economy has to adjust and how much this depends on when adjustments are made (e.g., when do we start taxing ourselves more or spending less on health care)
- Alice wanted to know why the interest in an infinite horizon – Rick Foster believes it is due to Treasury's interest in privatizing Social Security – need an infinite horizon so that transition costs (when some are paying off old beneficiaries and contributing to their own accounts) are offset in the future by lower taxes once benefits are privatized
- Mark raises the issue of time discount – how much does the infinite horizon matter under any reasonable rate of time discount
    - Rick Foster determined 75 year Part A deficit is 3.12 percent versus 5.30 percent for an infinite horizon

Long Run Health Costs – OACT

Mark Freeland opened the discussion that was lead by Greg Won, before Margaret McCarthy of the University of Maryland contributed with a discussion of model results.

Greg indicated the OACT CGE model is attempting to be a flexible model allowing simulation of many different options (including Trustee GDP+1). It really is a model of the demand for medical technology – that in turn becomes medical costs. Ed Hustead asked when GDP+1 takes over – projections based on NHE through 10 years, then a transition period to 25 years, where GDP+1 is in effect. Depending on preferences for technology and the degree to which technology is cost increasing, model yields high but plausible shares (medical costs as fraction of GDP).

The Panel's discussion focused on current law. In particular, do any of these models really apply current law. For example (Mark Pauly), current law requires Medicare to adopt medical technologies if they are effective (and perhaps cost effective). Mark also questioned whether under current law taxes must adjust to expenditures or expenditures to taxes.

Margaret then presented some LIFT findings. LIFT was calibrated to GDP+1, the CGE model (based on 1977-2003), or the CGE model (based on 1992-2003). Unlike GDP+1, the other two paths show eventual leveling in Medical costs in the economy – this includes having personal health expenditures equal non-health expenditures by the end of the simulation period.

Panel Deliberations

The Panel had a general discussion regarding its role and next steps. This included a debate whether the Panel should split up into groups responsible for different issues (aspects of Part D or the long run) that would report back to the group. Others believed there was not enough time to follow this sort of process, and that the Panel should review issues and makes recommendations as a group.

Alice raised the issue of how to best use the Panel's time. She does not believe the Panel should investigate the infinite horizon any more and that 70 to 80 percent of the attention should be on Part D (with the remainder on the long run for 75 years).

David asked the Panel understand why we (the Panel) are doing this and why. Bill Scanlon asked if the Panel should make the decisions themselves or look to working outside the meetings.

Mike asked that the Panel consider reviewing each topic (e.g., low income subsidies), and decide if the assumptions are reasonable, and if not, how they should be changed (at least methodologically). These would be chapters of the report, with a final chapter for issues that were not addressed or need more study.

Andy Cosgrove reminded the Panel that its charge was to discus and address the long run, Part D, and infinite horizon, but that it does not need to make specific recommendations.

Rick Foster asked the Panel to review the projections and determine if they are reasonable or at least that OACT made a good faith effort to do things fairly, and that because Part D projections are new to 2004, vetting them in some way is very important.

David wanted the Panel to recognize that it cannot guarantee the validity of any of the projections, but that recognizing inherent uncertainties is important.

John thought a recommendation might be to have a follow-up Panel in two or three years when more is known (especially about Part D).

Rick Foster believes this Panel can still provide a lot of help to OACT and the Trustees by considering the Part D projections carefully.

Ed asked about the RAND model discussed at the last meeting. RAND was not available to attend this meeting, and Andy Cosgrove indicated that RAND sent a 200 page document on their model and disability work. He was not sure how valuable this document would be to the panel. Rick Foster echoed this, indicating that RAND's work is promising, but does not yet address how health status affects long run health spending.

Next Steps

Ed Hustead asked the Panel to send him and Bill Scanlon their ideas on what questions/subtopics the Panel should address by the 21st – they would get these back out by the 22nd.

There was a general request for CBO and OACT to provide more details on their specific Part D projections.

At the next meeting, there will be a presentation on the NHE Rx projections. The rest of the meeting will be to consider the Panel questions/topics assembled by Ed and Bill.

Rick Foster offered to send papers on OACT's work looking at health care cost trends for decedents and survivors (a crude way to see how health status may affect long run health care costs), if the Panel is interested.

Public Comment

The only public comment was "good luck."