

# Meeting Minutes: Technical Panel on Medicare Trustee Reports (August 27, 2004)

## ***Introduction and Call to Order: Michael O'Grady, ASPE***

All seven committee members -- Edwin Hustead (HayGroup), William Scanlon (Independent Consultant), Alice Rosenblatt (WellPoint Health Networks, Inc.), John Bertko (Humana, Inc.), David Meltzer (University of Chicago), Mark Pauly (University of Pennsylvania), and Michael Chernew (University of Michigan) were in attendance. The Panel's purpose is to provide an external, independent, and objective review of the Medicare Trustee Report.

Dr. Michael O'Grady, HHS Assistant Secretary for Planning and Evaluation (ASPE), opened the meeting. He made the following points:

- HHS is one of the six Medicare Trustees, and it includes the Office of the Actuary, responsible for generating the Trustee Report forecasts, and ASPE, the chief economic advisor to the Secretary;
- HHS and the Trustees have found the input of Technical Panels to be extremely valuable, and convening the best independent minds on the subject is always important;
- The new Medicare bill with its provisions for prescription drugs (Rx) is an important change to the program;
- He announced Edward Hustead, an actuary, and William Scanlon, an economist, as co-chairs of the Technical panel;
- He stressed the importance of having a balance both of views and approaches (actuarial and economic) on the Technical Panel; and
- He alluded to the requirements of the Federal Advisory Committee Act (FACA), which requires deliberations of this type to be open to the public. This could restrict the ability of the Technical Panel to reach decisions and recommendations except in its open meetings.

## ***Welcome and Introduction: Richard Foster, CMS Office of the Actuary***

Dr. O'Grady then introduced Richard Foster, Chief Actuary of the CMS Office of the Actuary, who made the following comments via telephone:

- *While there he does not want any rush to judgment by the Technical Panel, he did note that the goal is to include the panel's recommendations into the next Trustee Report;*
- He welcomed the panel to HHS and said he was honored to have the panel review the Office of the Actuary's (OACT's) work;
- He stressed the unique nature of the Trustee Reports:
  - Fair assessment of the Medicare program; and
  - Remarkably free of bias and politics;

- He believes the Trustee Reports have benefited from external review by Panels and indicated the following combination of factors helps assure the reports' integrity:
  - Assure reasonableness of methods;
  - Make sure the methods used are up-to-date; and
  - Methods and assumptions are fair and objective;
- The Technical Panel was convened on behalf of the Board of Trustees:
  - The board has no funding for such external reviews and needed HHS dollars;
  - Panel members were recommended, nominated and selected by the public trustees;
  - Panel members were selected both for their abilities and for their objectivity and lack of bias;
  - Alice Rosenblatt and Michael Chernew served on the most recent 2000 panel and provide continuity; and
  - Few direct rewards but an important public service;
- Mr. Foster cited a few examples of past panel member success;
  - One panel member later became a public trustee; and
  - Another panel member became Secretary of the Treasury and later President of Harvard University;
- This panel differs from previous panels in several important ways;
  - Previous panels usually reviewed all Trustee report projections and methodologies;
  - The current Panel has much less time and must follow an abbreviated process; and
- Mr. Foster stated the following about what is of most interest to OACT and the Trustees but noted that the Panel must reach its own decisions;
  - Long range growth rate of Medicare costs/spending;
  - Part D Rx benefit;
  - If possible – the utility of using an infinite horizon instead of a 75-year period for the long range projections; and
  - Less interested in Part A and Part B review – extensively reviewed by the 2000 Panel;
- Mr. Foster again noted the long range growth rate is the most important assumption in the Trustee Report;
- He offered the Panel the OACT's assistance;
- He indicated the OACT is not wedded to any assumptions;
- Mr. Foster noted the 2004 Report was the first to include any assumptions related to the Part D program and while the CBO and others have made Rx drug cost projections, there has been no internal review;
- Mr. Foster offered the following advice to the Panel;
  - He considers reaching a broad consensus is very important – while the Panel may want to assign responsibilities to investigate certain issues to sub-teams (divide and conquer approach) – it should reach its decisions and recommendations as one group;
  - He offered a bad and good example of past practice:

- One panel relied on key experts (often one) in key areas and the resulting recommendations often were neither internally consistent or consistent with mainstream thought; and
- He praised the 2000 Panel because it reached unanimous agreement and its recommendations were universally accepted – by both the Clinton and Bush trustees (a rare achievement).

After Mr. Foster concluded his comments, Dr. O’Grady made some additional comments. He indicated that OACT and ASPE were both available to the Panel, and he said the reason why the Panel received a projection report from the Department of the Treasury was that the Secretary of the Treasury is now the managing trustee of the Board of Trustees.

William Scanlon responded to Dr. O’Grady’s and Mr. Foster’s comments. While he agreed with them, he suggested that Part B might be put back of the table (i.e., be considered by the Panel), because the Medicare Modernization Act (MMA) places such a strong emphasis on short-term projections. If the Panel reviews Part B, this could help the Trustees more.

Mark Pauly indicated the Part D program has two parts: (1) its own direct costs; and (2) interaction effects with Part A and B (e.g., does Rx use reduce other medical costs).

Edwin Husted asked how the Panel can be expected to work so quickly and wanted to know who provided the guidance on the two suggested topics (long range projections and Part D). Dr. O’Grady and Mr. Foster indicated there was a broad consensus that these were the two top issues and that not dealing with them would be problematic.

Dr. O’Grady indicated the Panel could work offline. However, Andrew Cosgrove, the HHS Official directly responsible to the Panel, stressed that FACA means that offline discussions can only be related to technical concerns and issues of fact. Decision-making must be in open committee.

### ***Establishing the Panel***

Several HHS officials were then introduced to help with administrative matters. Panel members were asked to complete ethical disclosure and temporary government employment forms, and they were formally sworn in to serve on the panel.

A question was raised on timing. Andrew Cosgrove and Michael O’Grady indicated the meeting schedule (the next four meetings are September 15, September 24, October 6, and October 15), and that the final report of the panel would be most useful if it were completed by mid- to late fall.

## ***CGE Models: Mark Freeland and Gregory Won, CMS Office of the Actuary***

The first presentation of the meeting then began. Presenters included Mark Freeland and Gregory Won of the CMS Office of the Actuary (OACT) – Mr. Won was the main speaker. Thomas Rutherford of the University of Colorado and Joseph Anderson, two consultants to CMS, were also available (Dr. Rutherford by phone and Dr. Anderson in the meeting).

CMS is now funding two projects to develop medical cost projection models:

- An extension of the Dale Jorgensen macroeconomic computational general equilibrium (CGE) model that will extend the model's ability to model the medical sector of the economy – results are due in 2005 (Anderson); and
- A simpler, more aggregated CGE model specially developed for CMS and available now (Rutherford) – the topic of today's discussion (CMS model).

Mr. Won indicated the CMS model has four features:

- Model agents include consumers who maximize their utility and producers who maximize profits;
- Agents interact in markets through prices – but prices are not directly determined by either side;
- Markets clear (through price adjustments); and
- Any good or service produced must be funded – e.g., if an individual buys and consumes medical care, that individual must have enough income to pay for that care.

Next, Mr. Won indicated that medical spending in the CMS model depends on technology, price and demographics, and leads to an equilibrium level of care. He indicated the model is simple and stylized, but can be run to measure how sensitive results (medical spending) are to changes in economic and demographic assumptions. CMS model results can also be entered in the University of Maryland “LIFT” model for additional validation.

David Meltzer asked two questions – does everyone in the model receive the same standard of care, and what would happen if government were not in the model. Michael Chernew asked how disaggregated was health care in the model – in particular, was Rx separate from other health care, and if technology was a residual in the model.

Mr. Freeland indicated the CMS model was short term and more simple, and that the Jorgensen/Anderson model might be better able address more detailed questions.

John Bertko asked if the CMS model can model special events (e.g., changes in law) – Mr. Won indicated that it could not, and that the study period was important – e.g., using data from the 1990's implicitly models a world where managed care reduces medical costs.

Michael Chernew asked how the model measures medical care productivity – is productivity more health care (e.g., more hospital stays), or is productivity and output how much individual health is produced. Michael Chernew also returned to the technology as “residual” issue. Mr. Won responded that the model measures medical output as the amount of medical services being produced and that there is a separate model component for health (a function of medical spending/services).<sup>1</sup>

Mr. Won indicated the CMS model has two distinct types of technology:

- Process innovative – the same amount of capital and labor produces more medical care – i.e., the residual; and
- Product innovative – the introduction of a new treatment.

The former – is cost decreasing, while the latter could be cost-increasing or decreasing – a product innovation may substitute for an older, more expensive treatment (and save costs), or could offer care in a new area where care formerly did not exist (cost increasing). A product innovation could also do both – substitute for previous care and offer a new source of care (e.g., angioplasty).

Michael Chernew noted this is not strictly true. If the demand for medical care is sufficiently elastic, any technological innovation could increase costs – if the amount of service demanded increases more (in percentage terms) than the decrease in unit cost. He also speculated if the CMS model could be used to model changes in clinical practice indirectly through model parameters.<sup>2</sup>

John Bertko asked about consumer preferences, and mentioned that direct-to-consumer advertising is a new aspect of the health care market. Mr. Won responded by saying the model has a consumer utility function, but that this function is highly abstracted.

David Meltzer asked about technological diffusion. Mr. Won responded that it appears that people will buy more health care if it is available (e.g., through new technologies), but this is slowing over time.

Alice Rosenblatt mentioned the overall productivity of medical care (technology).

William Scanlon asked a general question about whether the CMS model can measure individual details (e.g., specific medical conditions or diseases).

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<sup>1</sup> Traditional economic growth theory posits that output is a function of labor and capital – e.g., output increases as the amount of labor and capital used in production increases. Over time, however, output has grown more rapidly than the combined growth in capital and labor – this extra, or “residual” growth – is technology.

<sup>2</sup> “Elasticity” refers to the relationship between changes in demand and either price (price elasticity) or income (income elasticity). If the percentage change in demand is greater than the percentage change in price or income, the relationship is deemed elastic. If the percentage change in demand is less than the percentage change in price or income, the relationship is deemed inelastic. If a good or service (like medical care) is elastically demanded, if its price falls, the total expenditure on that service would increase.

Mr. Won responded by stating that the period selected for model calibration has a big effect on the long-term growth rate in medical care.

John Bertko raised the issue of public health changes – smoking cessation and obesity.

Mr. Won responded by stating the model is abstracted to the point where a single index is assumed to measure health. Mr. Freeland added that the model is highly aggregated, and that perhaps an actuarial approach to indicating how these various factors affect model parameters could be highly informative.

Mr. Freeland then asked Dr. Rutherford to speak, who made the following comments:

- The model is most concerned with what factors drive medical growth – projecting what happens to detailed aspects of the medical care over a long time horizon would be very difficult;
- Goal is to produce a range of values, not a point estimate;
- Model allows for non-health goals to affect the demand for and production of medical care – these other non-health goals may reduce medical care spending;
- David Meltzer interjected by asking about tax-payer and government – what if tax-payers do not want to pay the taxes necessary to fund public health care spending; and
- Dr. Rutherford concluded that how the model is closed to reflect a government budget constraint in equilibrium is critical and sensitive, but that willingness to pay taxes is not a specific model parameter.

Michael Chernew indicated that the 2000 Panel wrestled with these issues and what is meant by “current law.” If agents do not pay for their health care and get it for free, the amount of health care demanded blows up (Chernew language). He indicated that the previous panel was in his view deliberately and productively fuzzy (Chernew language) with regards to what constitutes current law. Michael Chernew asked if consumers pay the price for the medical care in the model, and Mr. Won responded that they do.<sup>3</sup>

Mr. Won indicated that the CMS model is calibrated to a reference period for the nature and form of technological change. He and Mark Pauly speculated that a model could have technology endogenously determined, perhaps in response to overall medical spending and the resources devoted to R&D. Mark Pauly believes this would be extremely difficult.

Dr. Rutherford stated that the model is in a steady state where the level of medical technology must clear its market.

William Scanlon indicated that it appears the CMS model may assume that current law does change.

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<sup>3</sup> The Medicare Trustees are required by law to project Medicare spending assuming that the provisions of current law are in effect indefinitely; they cannot assume that current law changes in response to changes in Medicare spending in their projections and forecasts.

Mr. Won then presented some model results – calibration periods included 1987 to 2003, 1977 to 2003, and 1992 to 2003. If the model is calibrated to 1987 to 2003 or 1977 to 2003, the medical share of GDP by 2100 is nearly 30 percent; if calibrated to 1992 to 2003, the share is just over 15 percent by 2003. CMS model estimates were then input into the LIFT Model to determine how health care spending affects the rest of the economy.

Michael Chernew indicated the past panel used the LIFT model and that by the end of the 75-year projection period, medical care consumed 38 percent of GDP. He stressed, however, that measuring stuff by shares is deceptive – while medical care’s share of the economy did increase, spending on non-medical care also increased – just at a slower rate. Productivity – how fast the pie is growing – is a key.

David Meltzer raised doubts concerning whether such a world is realistic – would everyone be working in health care?

Mark Pauly replied that some of the medical sector would be transfers and quasi-rents – not all employment.

Michael Chernew indicated that again productivity would be key, and David Meltzer responded that technology would have to become more important.<sup>4</sup>

Dr. Rutherford indicated one of the most important results of building models is to convey the level of uncertainty related to key model parameters – often through sensitivity analyses and probability clouds.

John Bertko raised the issue of technology and waste – Mr. Won indicated the model does not measure that.

Alice Rosenblatt indicated that calibrating the model to a period of high managed care use could be a proxy for reducing medical waste.

Mr. Won indicated the CMS model is a tool, and not an answer, and further indicated CMS is not wedded to a particular model.

Mr. Freeland asked Dr. Rutherford for his comments.

John Bertko said that maybe the Panel should not get bogged down in detail and instead should focus on a few big things that perhaps could be simulated in model runs.

A CMS staff indicated that the LIFT model is highly flexible, includes tax rates as an endogenous parameter, and that altering health care productivity is easy to do in the model.

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<sup>4</sup> **An aside** – having a single sector of the economy represent a large fraction of total production is not unprecedented. For example, just over 100 years ago, as much as half of the workforce was employed directly in agriculture – and the second most common form of employment was domestic service.

Mr. Freeland asked Dr. Anderson to comment on the other model (extension of Jorgensen), and Dr. Anderson made the following comments:

- Also a CGE model;
- Uses more data;
- Builds on intra-industry sector approach – nine (9) health care sectors including hospitals and Rx, and 22 non-health sectors – from the National Income and Product Accounts – aggregated data back to 1948;
- Health Interview surveys – Medical Expenditure Panel Survey (pooled, 1996-2000) and BLS Consumer Expenditure Survey (pooled, 1980-2000);
- Includes measures of consumer out-of-pocket costs;
- Calibrated to National Health Expenditures and consistent with OACT projections; and
- Models health care purchasing in more detail and endogenously.

Michael Chernew asked if model assumes that supply creates its own demand – Dr. Anderson said he may have misspoke, and that supply and demand are always equal and determined in markets in CGE models.

Dr. Rutherford welcomed the comments, indicated that other outside information can inform models, and was particularly interested in the direct-to-consumer advertising issue. He cautioned the Panel by stating he was a CGE, not a health, expert. Finally, Dr. Rutherford agrees that R&D can determine future innovation, but that is was not explicitly included in the CMS model.

### ***Summary of 2000 Medicare Technical Panel's Long Run Growth Rate Assumption: Michael Chernew, University of Michigan***

Dr. Chernew (Michael Chernew) was then asked to review the 2000 Panel deliberations. He made the following comments:

- Medicare projections always has been and always will be an interesting topic;
- The past Panel would not have been successful without the support of OACT and ASPE staff;
- The 2000 Panel took its mission to be reasonable – not right;
- The former long-term projection was GDP+0 – i.e., in the long run, medical spending was assumed to grow at the same rate as the overall economy in real terms;
- None of the panel believed this – the question became what should the “+” be;
- To answer this question, the panel looked back at 10 year periods;
- Once the core rate of medical care spending for a ten year period was determined (by averages or medians) – how much of this would persist:
  - Assumed persistent source of growth is technology – which is about half of all medical cost growth;
  - Overall medical growth rate = 4.4% -- half of this is 2.2% -- net out GDP growth (1.2%) – 2.2% - 1.2% = 1.0%; and
  - Long term growth = GDP + 1.0% (GDP+1).
- Why use “GDP+” language:



- Consistent with Trustee Reports;
- By having GDP in – nets out overall effect of income growth;
- This is also net of demographic growth – population aging will also increase medical and Medicare spending growth;
- Also used LIFT model to determine if GDP+1 sustainable for 75 years:
  - Results appeared sustainable;
  - Cannot view current law too literally;
  - Productivity and financing and spillover to rest of economy is critical.

The Panel then had a general discussion of health care spending – level (one-time changes in spending) versus slope (rate of growth through time).

Michael Chernew indicated some work he has done suggests that movement in morbidity may mean shift (level change) to more expensive conditions (obesity), but that cost increases over time for these more expensive conditions (slope) is lower than the overall growth of medical spending. There might also be a transition (level change) to lower costs through managed care.

Michael Chernew indicated Rand has a partial equilibrium model estimating health care costs that allow for such transitions. This model ignores the rest of the economy, but has been used a lot to model the effects of disability and age. It is being supported by the National Institute for Aging (NIA).

Michael Chernew thought the previous panel did a poor job of integrating the supply side into its considerations, which in his opinion were demand-driven. He stressed this was his and only his personal opinion.

John Bertko wondered if Rx is a level and/or a slope issue, and persisted by raising the issue of off-label drug use, which could be a slope effect.

Mark Pauly indicated it depends if off-label and/or inappropriate use occurs all at once (level) or varies through time (slope).

Mark Pauly also asked about what is in the other half besides technology – this must include demography, but this is small.

Michael Chernew responded by stating that the previous panel looked at both technology as a residual as well as specific new technologies.

Mark Pauly speculated if it is appropriate to assume the “other half” is fixed and frozen over time.

Alice Rosenblatt contributed her comments on the previous panel. She mentioned that no one liked or believed GDP+0 (no historic evidence for it), and that GDP + something had to be an improvement.

Michael Chernew – the panel was more interested in how technology is used rather than any effects on individual medical prices.

## ***Panel Discussion***

There was then a break for lunch, followed by a general Panel discussion.

Edwin Husted asked the Panel to consider its schedule and scope. He asked about the first panel. Michael Chernew responded that it had more time (six months) and had more and longer (1 ½ day) meetings). It first reviewed everything, then split up issues and assigned them to committees composed of both economists and actuaries, who developed recommendations that were shared and vetted by the entire panel.

William Scanlon initiated a discussion of current law, raising the issue of how Congress has continued to change Medicare's sustainable growth rate (SGR).

Dr. O'Grady questioned what is reasonable – and what is meant by current law.

David Meltzer wondered if the Panel should consider going back in time and taking out major changes in the law to identify the long run growth rate. He speculated that the long run growth rate might be negative if medical care is adjusted for quality, and believes spending would be much lower if Medicare had not been enacted.

William Scanlon and Edwin Husted returned to the Panel's charge by stating the need for considering the two major issues, but that it might be necessary to bring in "other factors."

Mark Pauly mentioned the GDP+1 is like the top of a funnel with many other things in it.

Michael Chernew was asked what the last panel did. Michael Chernew stated the 2000 Panel took its time to learn about Trustee Report assumptions, and that this is best done through staff presentations – reading written materials is not enough.

Alice Rosenblatt stated that she believes the current panel has only time to consider two major things, and that in another four years people will be interested in what was done about Part D.

William Scanlon mentioned that it would be reasonable for the Panel to suggest what data are needed to do a better job of on-going monitoring of the Medicare program.

Mark Pauly indicated that while total Rx spending may not increase much under Part D, Medicare spending would increase a lot.

John Bertko indicated that Rx has grown from 10 to 15 to 20% of private expenditures, and is a larger share of elderly health care spending.

Michael Chernew stated that it might be more important for the Panel to consider how the projections are made than to debate what the actual projections should be. Methodology is

more important than the number itself, and the last Panel thought a range of different values could have been reasonable. There is noise in every period, and it is important to ignore noise and special events like Medicare when thinking about long term projections.

David Meltzer stated that laws (like Medicare) are not just noise and how well the panel nets out the effects of laws will be very important.

Mark Pauly – for long-term growth, “It’s technology, stupid.”

Alice Rosenblatt raised the issue of specific diseases and how these might affect projections. Her specific example was Alzheimers. She wondered if taking a few diseases that affect baby boomers (cardiovascular, Alzheimers) and determining their impacts might be a way of testing the reality of long-term projections.

Michael Chernew indicated the Rand modeling suggests that many expensive conditions have slow rates of cost growth.

William Scanlon raised the issue of the appropriate level of aggregation and believes the Panel cannot hope to capture everything. He also stated that GDP+1 is the highest possible level of aggregation.

Mark Pauly mentioned that international, cross-country studies have not found expected relationships between age and spending. This may be due to morbidity compression. He also made the point that he does not believe the medical economy is supply-constrained (beds and professionals will become available given sufficient demand), but does concede that there may be over-supply problems, particularly for some medical technologies.

Edwin Husted attempted to return to the Panel’s charge by indicating that maybe the Panel should focus on the two major issues but go into other topics when necessary.

Michael Chernew reiterated that drugs and GDP+1 are both key issues.

John Bertko asked how the last Panel organized itself. Michael Chernew responded by stating that sub-teams held conference calls to make tentative decisions. One person in each subteam was the lead author of each chapter of the 2000 Panel’s report, supported by one main secondary author. Each subteam was a mixture of economists and actuaries.

William Scanlon asked that he thought the current Panel was not responsible for writing the report. Andy Cosgrove stated that ASPE has contractors to prepare the draft of the report and asked Kevin Coleman of Abt (the contractors) to speak. Mr. Coleman indicated that Abt is responsible for preparing the report, but that the report will be the Panel’s report -- not Abt’s. Mr. Coleman also indicated Abt could be flexible if the Panel wanted more of a role in authoring the final report.

Mark Pauly asked if it would be more productive to think about building upon past work rather than starting from scratch.

Michael Chernew mentioned that the current discussion had yet to consider the 75-year versus infinite horizon issue. GDP+1 (or GDP + anything) cannot work over an infinite horizon. Something has to force leveling off – such as maintaining non-health sector spending or growth. Most CGE models have diminishing marginal utility of health care, which leads to less health care spending.<sup>5</sup>

Alice Rosenblatt stated she had been keeping notes and three ideas occurred to her: (1) how to use the Rand model; (2) obesity – could something be learned from smoking or lung cancer; and (3) voluntary spending – the medical economy is changing because more consumers are directly (voluntarily) purchasing medical care (e.g., Lasik surgery). From an actuarial standpoint, a key issue for Rx projections is what is the baseline – with no Medicare Rx coverage in the past, other sources must be used to confirm the baseline.

John Bertko mentioned using the MCBS. Dr. O’Grady stated there could be several relevant data sources – MCBS, MEPS, and written materials from organizations such as the National Center for Health Statistics. He also indicated that CBO has its own Medicare Part D projections – but believes these are only for 10 years.

Michael Chernew – knowing what measures or parameters should be included in projections may be as important as actual projection numbers.

David Meltzer – returned to the GDP+1 issue, and wondered if the Cutler (95)<sup>6</sup> paper had considered how individual insurance and other secondary spillover effects may have affected how technology was measured. Michael Chernew stated this would be hard to do.<sup>7</sup>

Edwin Husted and William Scanlon asked the Panel to start putting together a list of topics for the next meeting that could include:

- GDP+1
- Part D
- Long-term modeling
  - Revisiting numbers

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<sup>5</sup> **An aside** – economic theory postulates that individuals maximize utility. To maximize utility, the marginal utility for each good or service – or the incremental utility provided from consuming the last unit of a good or service – must be equal for all goods or services. Further, economic theory suggests marginal utility declines – as consumption of a good or service increases, the incremental utility from consuming one more unit of that good or service declines. If so, at some point all consumers would rather consume another good or service than continue to consume additional medical care.

<sup>6</sup> Cutler, David M.: *Technology, Health Costs, and the NIH*. Harvard University and the National Bureau of Economic Research. Paper prepared for the National Institutes of Health Economics Roundtable on Biomedical Research. Cambridge, MA. September 1995.

<sup>7</sup> **An aside** – the Cutler paper was one of the main sources of the 2000 Panel’s assumption that half of long-term medical spending growth is due to technology.

- Revisiting methods
- Sustainability and the infinite horizon
- Michael Chernew added a topic and thought it might be valuable for the Panel to learn how OACT differentiates between short, intermediate, and long-term projections.

Mark Pauly asked if maybe the best way to do long-term projections is to determine what is medical care's reasonable ultimate share of economic output and then to adjust projections to hit that target. This would make necessary technological change more explicit.

David Meltzer speculated that short-term changes could affect long-run costs.

Michael Chernew agreed that Mark Pauly's idea was a possible approach, and stated that models can both verify a set of assumptions and well as change projection methods themselves.

William Scanlon wondered if there is some way to build health status into OACT projections. OACT staff members responded that they have been looking at this issue for some time and there was not way to do this productively back in 2000-2001.

Michael Chernew offered to coordinate with RAND so the panel can learn more about the RAND model's capabilities.

Mark Pauly suggested more attention be paid to relative input prices for health care. For example, if medical care's share of the economy increases, how much will wages have to increase to attract workers to the medical workforce. In addition, how much are wages in health care determined by wages and other prices in non-health care sectors.

Alice Rosenblatt indicated that not only wages but mortality is important, and that mortality assumptions are detailed in the Social Security Trustee report which is available on-line. This stimulated a discussion of valuable resources. Dr. O'Grady mentioned CMS, CBO, and the NIA research agenda as possibilities. William Scanlon added RAND and the Treasury report and its treatment of the infinite horizon. David Meltzer added international context as another resource/viewpoint.

Edwin Husted asked if Panel members could be assigned to topics. There was a general agreement that this is premature.

Some OACT and CMS staff offered to put something together on the Cutler paper and netting out non-technology effects, and also indicated that seeing some actual numbers will be helpful and promised to provide some model runs.

Michael Chernew indicated that three issues discussed during the meeting – CGE, GDP+1 and the Treasury infinite horizon, and specific disease impacts – need an organizing structure.

David Meltzer returned to the issue of a political model that included taxpayer willingness to pay taxes.

Michael Chernew mentioned that one way current law can be fuzzy is through coverage policy – Medicare costs can be contained if new services are not covered.

Mark Pauly mentioned the current Trustee Reports include high, intermediate, and low program cost projections that are flexible, and suggested lawmakers should design laws with similar flexibility.

The Panel then considered what needs to be looked at for Part D. Edwin Husted mentioned CBO and CMS projections and spillover into Part A and B. Others mentioned how full managed care will affect Rx demand, and getting an Rx database from CMS.

William Scanlon asked if the Treasury paper is enough for the infinite horizon or if more is needed.

John Bertko asked that if written materials are provided that key materials be designated as part of a “syllabus.”

Michael Chernew asked how RAND should be brought in, and Dr. O’Grady broadened that into who should be brought in.

Michael Chernew stated that short-term projections are much more detailed and complex than the long-term projections. He asked Alice Rosenblatt about her experiences because this was one of her major responsibilities on the last Panel. Alice Rosenblatt responded that she was drowning in the assumptions and advised the current panel to at best focus on one or two short-term projection topics. William Scanlon mentioned maybe those should be the SGR and currency of data.

David Meltzer asked about price versus income and greater degrees of aggregation.

Michael Chernew mentioned cross-state and national studies.

Alice Rosenblatt mentioned a big short-term issue for the last panel was Medicare+ Choice; William Scanlon suggested the MMA boosts recent attention to this issue.

Michael Chernew indicated the last Panel looked at Medicare+Choice in several ways – how many beneficiaries joined plans, was there a sample selection effect, and did Medicare+Choice have spillover effects for fee-for-service. These were all problematic issues.

Mr. Cosgrove summarized the topics to be discussed at the next meeting and the organizations ASPE will invite to participate:

- Medicare Part D: CMS Office of the Actuary and Congressional Budget Office; and
- Long-Term Modeling: CMS OACT, Treasury, and NIA

Edwin Hustead asked panelists to think about a date between October 30<sup>th</sup> and November 15<sup>th</sup> to serve as an alternate date for one of the meetings. This would give the panel more chance to consider the final report. November 15<sup>th</sup> (Monday) was selected.

### ***Public Comment***

There was no public comment.