

Meeting Minutes: October 6th Meeting of the Technical Panel

1. Administrative Matters

For the record, all seven Panel members were in attendance at the meeting; Rick Foster of OACT was another prominent participant in the discussions, and various current or former staff members at OACT, CBO, or CMS (non-OACT) contributed to the discussion.

There was no public comment.

At the request of the panelists, this set of minutes has a different structure and format. The Panel in this meeting began discussing its tentative recommendations for its final report. In some cases, an issue was discussed but no decisions, even tentative recommendations, were reached. In such cases, Panel members have agreed to meet in subgroups to discuss such topics further and report back at the October 15th meeting were ideally tentative joint Panel decisions regarding these outstanding issues will be reached. In other instances, initial recommendations on particular topics were reached by the Panel in this meeting, and a Panel member was assigned to oversee drafting corresponding recommendations. To facilitate that process, this set of minutes is organized by topic and recommendation (where these exist), instead of attempting to be a summary of the entire meeting (the approach taken for earlier minutes).

2. Long-Run Projections

2.1. GDP + 1

The current long-run growth rate of all Medicare expenditures used in the Trustee's projections is the rate of growth of gross domestic product per capita (1.2%) + 1.0% -- or GDP + 1. This growth rate was selected by the 2000 Panel and then adopted by the Trustees.

The first issue is how the 2000 Panel adopted GDP + 1. In effect, the growth rate in health care costs per capita for a 40-year period (4.4% per year) was decomposed into elements that this Panel believes would and would not persist over time. Approximately ½ of the 4.4% growth rate, or 2.2% was expected to persist over time. This continued rate of growth (2.2%) was attributed to technological change, but might be better thought of technological change and other persistent factors (or even technological change plus the net result of offsetting other persistent factors).

The 2000 Panel then struggled with how to best interpret and present the 2.2% growth rate. A key issue was the relationship between changes in income and changes in the long run growth rate in health care costs. Put in other terms, what is the income elasticity of health care? Given the wide variation in the empirical literature on health care income elasticities, the 2000 Panel decided to deal with this issue by representing its 2.2% growth recommendation as GDP + 1 (the Trustees Report estimate of per capita GDP growth = 1.2% plus one percentage point).

The present Panel faces at least three related issues:

- Should the long run growth rate of health care be represented as a function of per capita GDP?
- If so, what is that function/behavioral identity (i.e., what is the income elasticity of health care)?
- What needs to change for this function/behavioral identity to change?

In its discussions, the Panel decided to table making recommendations on this topic until the next meeting on October 15th. In the interim, the long run subgroup (Ed Husted, Mark Pauly, and David Metzler) agreed to discuss these issues in more detail.

By recognizing that the 2000 Panel really recommended at 2.2% growth rate, the current Panel considers the GDP + 1 equation to be an accounting identity, not necessarily a behavioral identity, though it does imply a behavioral identity because cost growth is assumed to grow faster if income GDP growth rises. As such, more attention should be devoted to how the long run growth rate assumption should be adjusted for GDP growth. Options include:

- A simple growth rate e.g., 2.2%);
- A function of GDP (now GDP + 1); or
- Some other behavioral identity.

Next, the Panel considered what that function or behavioral identity should be. This is a choice of what income elasticity to use. Implicitly, if the current GDP + 1 assumption is taken to be a behavioral identity, it suggests that each 1 percentage point increase in per capita GDP growth is associated with a 1 percentage point increase in the health care growth rate. A more sophisticated approach would use an income elasticity and/or some other parameter to define the behavioral identity/functional form. Given the wide range of empirical estimates and differences between cross-sectional and time series findings, the Panel has not reached any recommendation yet, including even a request for more research in this area.

One final issue that was hinted at in today's discussion as well as in some earlier discussions is what needs to change for the current assumption (2.2%) to change. A behavioral identity would be one way to address this question. Alternatively, if the Panel (as the 2000 Panel) is still reluctant to specify a behavioral identity, it still could make sense to make recommendations regarding how to update the current assumption. Remember that the 2.2% number came from a decomposition of growth rates for a 40-year period (i.e., half of the growth rate was expected to persist). Options for updates could include that at some future point (perhaps five or ten years in the future), a similar analysis be conducted again with updated data. If a future analysis determined that the overall growth rate or the fraction of the growth rate assumed to persist through time changes, it could then be appropriate for OACT and the Trustees to use a new long run health care growth rate.

One final issue is whether the Panel wants to recommend some form of decomposition for long run growth rates. Options include:

- By type of service – A, B, and D; or
- By disease or morbidity.

There was no strong consensus for either approach. Some Panel members did not believe disaggregation was particularly valuable (it is possible that what is growing rapidly in one period may not be growing rapidly in another period), and all Panel members appeared to agree that it is not yet possible to track long run cost growth patterns yet by disease, condition, or morbidity.

2.2. Sustainability

Mark Pauly agreed to be responsible for this issue.

The 2000 Panel determined that by 2080, GDP + 1 would lead to health care representing 38% of total GDP. That Panel agreed that this level of spending was reasonable for two reasons:

- Under the GDP+1 assumption, non-health care spending continued to grow. Through 2080, under GDP + 2, non-health spending would need to decline after 2040 to accommodate health care spending; and
- Some panelists believed that spending of less than 40% appeared plausible.

Rick Foster reported that updated results for the CGE and LIFT models suggested that health care would represent between 42 and 44 percent of health care spending by the end of a 75 year projection period.

Panel discussion on this topic was wide-ranging, and Panel members expressed many different opinions and points. Some of the key points raised included the following:

- Sustainability itself may not be an issue – the previous Panel was more concerned whether GDP + 1 itself was plausible (sustainability is almost a by-product);
- Health spending and overall economic growth may be endogenous:
 - More health care spending could make people healthier (not measured in GDP) and/or more productive (which would increase GDP);
 - If the health care sector is less productive than non-health care sectors of the economy, as health represents a larger share of the economy, overall economic growth could slow; and
 - Increases in health care spending could retard overall technology growth and thus economic growth;
- Are there any “brakes” on health care spending growth:
 - Could some element of current law limit health care spending growth;
 - Are out-of-pocket expenses, especially for Medicare beneficiaries, a natural way to limit health care spending (by the end of the current 75 year projection period, average Medicare out-of-pocket costs will exceed average Social Security benefits);
 - Will diminishing marginal utility of health care consumption eventually limit growth; and
 - How much do price effects have to overcome income and quality effects to attain continued health care growth.

2.3. Short-Run Projections

Ed Husted agreed to take the lead on this issue.

The major topic of discussion was when and how the short-run projections should differ from current law. The primary example is the physician updates resulting from the sustainable growth rate (SGR) projections in the current report. The Trustees Report current projections of the physician update are negative factors of roughly five percent per year for seven years for a total reduction in physician payments of over 31 percent between 2006 and 2013 (see table III.B1 on page 126). The Panelists believe that this growth rate is implausible and noted that the Trustees Report came close to making the same point – i.e., the Trustees Report mentions that the assumption is “unrealistically low” and “very unlikely to occur before legislative changes intervene.”

While there was general agreement to this point, what should be done was harder to determine. The Panel and some of the audience engaged in an active debate regarding the Trustees Report, current law, and legislative versus executive branch privilege and prerogative. Major points include the following:

- What is the purpose of the Trustees Report – is it to represent current law, no matter how implausible, or use assumptions that are more reasonable (even if such assumptions, even if stated as being alternative assumptions, appear to violate current law);
- Should the Trustees Report ever include information that appears to require a change in current law:
 - Rick Foster could only remember one instance for the OASDI Report back in the early 70’s when benefits were double-indexed, and the Report included an optional set of projections where benefits were wage-adjusted; and
- Would making such recommendations represent an Executive Branch (as represented by the Trustees) infringement on the rights and prerogatives of the Congress?

In addition to some recommendation related to current physician payment projections (options include assuming that the physician payments cannot become negative or even has 1.5% minimum increase as in 2004 and 2005), the Panel also considered and may make additional recommendations for the high and low projections. In particular, instead of typically using fixed and symmetric assumptions (e.g., +/- 2%), high and low scenarios instead could combine the effects of a combined set of specific alternative assumptions.

The Panel may also want to provide context to any such recommendations by indicating that they will only recommend departures from current law “if and when they believe that continuation of current law is unlikely” (the latter language was sent to me by Ed Husted).

2.4. Part D’s Impact on A/B

David Metzler will take the lead on this issue.

Current OACT projections assume that Part D will have no effect on A and B spending. For the most part, Panelists agreed that this assumption was reasonable. Key issues that surfaced in the discussion included:

- Assuming no effect on A and B is reasonable because no one is even sure what the sign of any effect or effects would be (let alone magnitude);
- OACT's argument in one respect at least appears to be inconsistent:
 - On the one hand, OACT postulates that only about ¼ of the elderly lack Rx coverage and thus that Part D will not expand coverage that much; and
 - On the other hand, OACT's estimates generate an increase in drug use (induction) of 12 percent – could such an increase in drug use have spill-over effects for Parts A and B;
- There may be a short run and a long run story:
 - Short run effects could go either way, if Rx use substitutes for other use or if Rx use induces individuals to demand more health services (particularly Part B – physician);
 - Actuarial evidence finds little support that higher Rx spending is associated with changes in other health care spending;
 - The long run is also mixed:
 - Rx use could improve health status and reduce care costs for certain diseases/conditions; and
 - It is not clear if Rx use would extend life and if so would reduce or increase health care costs;
- A recent review of the literature found little evidence either way that Rx spending affects other health care spending;
- Doctors who do not know about their patient's health insurance coverage and exposure to health care costs may now assume everyone has Rx coverage and will begin prescribing more drugs, increasing Rx use (but not necessarily other health care use)
- The real story might be an intermediate, as opposed to a short or long run story;
- Rx spending increases for the over and under 65 populations appear to be similar; and
- Another part of the “real story” may require research into how Rx use increases or decreases other health care use for specific diseases.

2.5. Uncertainty

Mark Pauly and David Metzler agreed to collaborate on uncertainty.

At least three major issues were discussed:

- Should stochastic modeling be used (or its use expanded);
- How should OACT use its resources; and
- How should uncertainty be reported (or better reported) in the Trustees Report?

At present, OACT includes stochastic results for its ten-year Part B estimates, but does not have stochastic estimates for Part D or for A/B intermediate or long run projections. For the most part, OACT and the Trustees now represent uncertainty through the presentation of the low, intermediate, and high projections. The low and high projections use symmetric assumptions (e.g., +/- 2%) applied

to overall A or B intermediate growth rate to generate their projections. The resulting low and high projections tend to provide symmetric differences relative to the intermediate projections. For the short-range Part D projections, each of several key projection factors is modified in a higher-cost or lower-cost direction.

In contrast, stochastic models tend to treat parameters as variables with particular distributional properties, and then allow these parameters to vary randomly. Distributional assumptions are based on historical patterns of variation for these key model parameters. The results of stochastic modeling produce a distribution of different results with varying estimated probabilities of occurring (e.g., Medicare spending has a X% chance of being less than \$Y in Year t).

Preliminary OACT research appears to support the following for stochastic models:

- Projection estimates vary more for stochastic models in the near term, but after ten years, stochastic models appear to vary less than the current high/low scenario approach – this could mean that uncertainty is being overestimated over the intermediate and long run projections; and
- Projection estimates may not be as symmetric as the high and low approach.

OACT supports developing stochastic models for many reasons:

- OACT expects most of its projections will rely on stochastic methods within 20 years;
- Stochastic models appear to be more consistent theoretically;
- As the Trustees Report moves more away from actuarial balance calculations to year by year projections, a stochastic approach may be more useful;
- It may be a better way to represent risk – i.e., by stating that a good or bad result has a fixed probability of occurring, rather than presenting plausible upper and lower bounds for projection estimates (the current high/low scenario approach).

At the same time, stochastic model development faces serious challenges:

- Manpower – Social Security had six to nine staff working full-time on the problem; OACT has one person working part-time; and
- Theoretical – Social Security modeling is easier (the models are better known and the issue becomes estimating parameters), while it is harder for Medicare:
 - The appropriate model, let alone plausible parameter estimates, is not as well known; and
 - There is less relevant data to derive plausible point estimates and distributions for key parameters in a Medicare stochastic model.

Some Panel members believe that OACT has more important priorities, particularly with Part D and other aspects of MMA, to spend much time on stochastic modeling – i.e., Point Two – how should OACT use its resources. Possible Panel recommendations on stochastic modeling could include:

- Suggesting that an Expert Panel be convened to address the feasibility of stochastic modeling for various parts of Medicare; and

- For Part D, waiting for some period (perhaps three to five years) until enough data are available to support a stochastic model.

The Panel in general believes that even without stochastic modeling, the current treatment of uncertainty in the Trustees Report could be expanded:

- Including the low, high, and intermediate projections instead of just the intermediate projections in the Overview;
- Replacing symmetric assumptions for the low and high scenario with a combined set of reasonable assumptions about each key parameter – the low and the high scenarios would then reflect the net result of the combined effect of these sets of assumptions. These analyses could also include informed sensitivity analyses; and
- Better representations of information – for example, using techniques from the medical risk literature such as influence diagrams to represent uncertainty.

2.6. Infinite Horizon

Ed Husted agreed to take the lead here.

This topic received very little discussion. The Panel did not see any reason to expand the treatment of the infinite horizon in the current Trustees Report, where it receives some attention, but less than that paid to the 75 year projection. Currently the infinite horizon is reported separately for each segment of the program. The infinite horizon method was first added to the Social Security report and then extended to HI.

The Panel members thought that the infinite-horizon projections for Medicare offered relatively little value to the Trustees Report and should not be expanded or given greater emphasis. They noted that Medicare’s financial problems are already apparent within the 75-year projection period and that the uncertainties associated with Medicare projections are far greater than for Social Security.

A second possible recommendation would be to have some sort of transition from the GDP + 1 to GDP + 0 from year 75 to year 76. Possibilities include a “glide path” (similar to the shift from the short run to the long run projections), or the use of method for closing the model such as:

- Reducing the marginal propensity to consume health care (a similar approach was adopted in the CGE model); or
- Having health care spending growth be limited by requiring non-health care spending to attain some level (e.g., non-health care spending cannot decrease or must exceed some low, fixed growth rate – the Treasury approach).

2.7. Presentation

No one has been assigned specific responsibility for this topic.

The Panel had a number of different ideas but did not appear to reach a consensus on particular recommendations. Opinions raised from very specific ideas regarding how to change the Trustees Report (and most notably, its Overview) to concerns that the Panel should present options for

conducting different projections and let Trustees decide what to include in the Report or at least how to present the results.

Before discussing specific Panel member ideas, it is worth noting that the Trustees have been trying to streamline the Overview as much as possible to keep the attention of the reader who is not interested in all of the details of the program.

OACT believes Report readers fall into three groups:

- Those who read the one-page highlights;
- Those who read the overview; and
- Those who delve into the technical details of the entire report.

Panel members expressed the following ideas:

- The overview should include more results on all of Medicare;
- The overview should include a more comprehensive treatment of uncertainty:
 - Some panel members suggest including a comparison of past projections (or past projections net of current law changes) with what actually occurred, to provide a sense of the accuracy of the projections and correspondingly a measure of uncertainty (either, but especially the latter, would require a great deal of OACT staff time);
 - At a minimum, report results for the low, intermediate, and high scenarios;
 - Some Panelists were concerned that trying to net out current law may provide a sense that current law is more responsive to the financial health of the Medicare Trust Funds than is truly the case;
- Including more charts projecting government expenditures;
- Including the table comparing out-of-pocket expenses to Social Security benefits:
 - This was replaced with a chart in 2004 because it was considered to be misleading for two reasons. First, it did not reflect either the subsidization of lower income beneficiaries or the other income high income beneficiaries. Second there was a discontinuity in the out-of-pocket payments with the introduction of Part D in 2006; and
 - It may also make sense to indicate what percentage of beneficiaries have out-pocket expenses that now exceed their Social Security benefits.

Ed Husted sent me the following specific recommendations:

- A figure that will show the total government expenditures as a percentage of GDP. The numbers are included in Figure I.E2 but we believe it would be useful to add a new table that showed only the General revenue transfers and the HI deficit.
- Tables that would show the numbers that are incorporated in Figures I.E1 and I.E2 as well as the recommended new table.
- A figure similar to Figure II.C1 that includes the average HI out-of-pocket as compared to the average Social Security benefit and a table showing those numbers. We understand the possibility for misinterpretation of the dollars of out-of-pocket and premiums before and after introduction of Part D. That could be solved by either starting the chart in 2006 or including the estimated premium and out-of-pocket cost for Medicare beneficiaries for prescription drug costs before 2006.

2.8. Use of Social Security Economic and Demographic Assumptions

This topic was not discussed in the October 6th meeting, but Ed Husted sent me the following language:

The Medicare projections are necessarily based on the economic and demographic assumptions chosen by the Trustees for the OASDI projections. These assumptions drive all Medicare cost estimates so they are very important in projecting the financial status of Medicare.

We understand that the CMS Chief Actuary participates in the discussions of the Social Security assumptions and the Chief Actuary has stated that he will use his Statement of Actuarial Opinion to describe any differences he has with the reasonableness of the Social Security assumptions. We believe that this process is an appropriate safety net that prevents unreasonable economic and demographic assumptions from being used for Medicare.

3. Prescription Drug Projections

Bill Scanlon indicated that the Rx subgroup was thinking about recommendations in three broad categories:

- Part D;
- Uncertainty; and
- Steps to improve projections:
 - Collecting, making available, and analyzing administrative Part D data when it comes on-line; and
 - Research efforts.

The topics discussed below probably need to be cross-walked into this three-category framework, but I am not sure yet how to do this. For that reason, I will continue to present Panel recommendations and thinking topic-by-topic.

One more point – I do not think that Panelists have yet to be assigned primary responsibilities for the Prescription Drug sections.

3.1. MCBS as Baseline

Overall, most Panelists agree with some version of the following three recommendations:

- The use of the MCBS to project Medicare Part D spending per beneficiary is the best available alternative;
- New data – preferably Part D data when it becomes available – should replace the MCBS as soon as possible:

- One option might be to have transition period where some average of MCBS and new Part D data are used for the projections; and
- External data – most likely FEHBP data – should be used as an external benchmark for the MCBS (and perhaps NHE) projections.

Specific ideas included the following:

- Using the new fallback study to replace the Part/AB regression model (used to adjust Rx undercounting) in the MCBS appears to be a better approach;
- FEHBP data should be used:
 - Howard Eng should be contacted;
 - The actuary at OACT who was looking into this issue left unexpectedly so progress on this issue has lagged;
 - Most Panelists agree that the FEHBP could be used to look at how MCBS data were trended forward from 1998 (2005 projections are scheduled to use the 2001 MCBS):
 - FEHBP may provide more insights into differences in trend for the over and under age 65 populations;
 - It is not clear if FEHBP can be used to compare MCBS projections for 2003 or 2004 in level terms:
 - MCBS includes those with and without private health insurance coverage – FEHBP only includes those with coverage (though one in theory could compare the MCBS sample with coverage with FEHBP);
 - Even if one adjusted for coverage differences, the FEHBP sample may still be unrepresentative (e.g., higher levels of use), and it is not clear if these differences could be adjusted (e.g. with demographics or some sort of risk adjustment); and
 - Even if results could not be adjusted, it would be interesting if the FEHBP Rx cost number in 2003 or 2004 was lower than the OACT MCBS projection;
 - Improvements are planned for the institutional sample from the MCBS:
 - The PACE demonstration is now used to adjust their Rx use; and
 - Drug use, but not cost, is available, and U MD is now pricing this utilization in an ASPE contract.

3.2. NHE Trend Assumptions

Panelists appear to be in broad agreement on the following tentative recommendations:

- NHE projections (used to trend MCBS data for the 2004-2013 period in the Part D projections) – appear to be reasonable given current sources of data;
- The projections could also be informed by FEHBP data – especially with regards to health expenditure trends and differences between the over and under 65 populations; and
- NHE projections should not be used once Part D data are available and are used in the projections (as Part A and B data are used now):
 - One aside – OACT indicated that it has not yet planned how it will use these Part D data when they become available.

While the Panel could not offer particular recommendations for better approaches, there are two areas of concern they have with the NHE projections. First, some Panelists are concerned with the model approach itself. In particular, the current model is an econometric time series model that uses a few explanatory variables (per capita income, relative drug price inflation, new drug introductions, DTC advertising) with various lag structures and two time dummies (to reflect managed care and PBM effects). The problem some Panelists see with this approach is that it may be very difficult to predict the independent variables (the “X’s”) over the ten-year projection period.

An alternative approach would be to include only variables where solid projections exist (e.g., GDP or personal income) and time trends. In theory, these X’s would be easier to predict (they are known for the time trends), reducing one type of model uncertainty. OACT was concerned that such a parsimonious model would not be able to account for the large shifts in drug costs over the past few years. This remains an open question.

The second issue raised by Panelists are the add factors. OACT faces a dilemma when modeling. In part because of the lack of data available (38 observations currently, perhaps 20 to 25 if their new approach of eliminating data before 1980 is adopted), very few independent variables can be included in the model. OACT is convinced, however, that adjusting for these other factors (e.g., blockbuster drugs, tiering, etc.) is crucial for model projections to be accurate.

Panelists are concerned that the add factor process is a black box. OACT now contacts a broad cross-section of experts (from government, industry, and academia) to collect their views on what add factors are important and what these add factors likely will be during the forecast period. Panelists were not aware the process was this broad-based, but Panel members may still want to make one or both of the following recommendations:

- Continue to collect add factor data but make this process more transparent, even if information continues to be collected informally; and
- Make the use of add factors in the NHE projections more explicit to the public.

3.3. Prescription Drug Prices, Rebates, Discounts, and Induction

Currently, OACT assumes that PDPs will be able to secure Rx price discounts that average 15% in 2006, and that this will grow by two percentage points per year until it reaches 25 percent (CBO assumptions were similar). The low and high projections assume symmetric 5 percentage point differences (2006 – 10 versus 20 percent, rising ultimately to 20 to 30 percent). These factors combine the effects of discounts and rebates, generic substitution and formularies, and plan administration.

The Panel agrees that 15 to 25 percent assumption is reasonable, and notes that PBMs and other large purchasers are already attaining this level of savings. One Panel member advocated that the high/low ranges be expanded, so that savings ranged from 5 percent (low) to 25 percent (high) in 2006 and increased to 15 percent (low) to 35 percent (high) within five years. The reasons for this recommendation included:

- It is not clear how many drug categories plans will be required to cover – with more categories, the ability of plans to use formularies and generic substitution will lessen (the converse is true if plans are only required to cover fewer categories); and
- The outcome of bargaining between Rx companies and plans, especially large national PDPs – is not clear. Savings may be less if Rx companies with new blockbuster drugs are reluctant to offer discounts – this would reduce savings. Alternatively, the most commonly used drugs are not blockbusters and many have generic equivalents, so PDP bargaining power could lead to larger discounts.

The Panel agreed that the OACT plan administration costs (12.6% in 2006 falling to 10.7% by 2013) were plausible and superior to the lower administrative cost estimates proposed by CBO.

There was an active debate on induction. Put simply, as Part D provides coverage to the uninsured or improves or worsens coverage of those already with insurance, beneficiaries will be “induced” to consume more or less drugs. OACT assumed dollar for dollar induction up to \$3,000, and no induction beyond that point but the effect was smoothed without affecting the overall mean prescription drug cost. This resulted in an overall induction rate of 12 percent. In contrast, CBO used an arc elasticity of -0.3 that resulted in an induction rate of 9 percent. The difference in 2006 between the two estimates is slightly less than \$100 (3 percent on a base of approximately \$3,000 per beneficiary).

Economists on the Panel at first thought induction was too high, because the dollar for dollar induction appeared to correspond to an elasticity of as much as -1.0 depending on the level of drug expenditures, while actuaries on the panel believed induction levels were reasonable. Hearing that CBO’s -0.3 elasticity translated into 9 percent induction lessened these concerns. The economists, however, believe that plausible elasticity ranges vary from -0.1 to -0.4 , and center near -0.25 . This suggests that OACT’s assumption may be plausible/reasonable, but is at the high end of this range. OACT has agreed to translate its induction into elasticities for the simulated MCBS sample, and report ranges and measures of central tendency.

The Trustees assume no price increases associated with the new Medicare benefits and CBO assumes a 3.5 percent price increase.

3.4. Beneficiary Participation

OACT started with 43.1 million eligible beneficiaries in 2006. From this total, 2 million active workers with employer primary coverage were subtracted, leaving 41.1 million eligibles. OACT then assumed that 0.4 million would not adopt Part D – leaving 40.7 million in Part D – 94.4% of the 43.1 million and 99.0% of the 40.7 million (net of workers).

OACT offers the following reasons for its high take-up rates:

- The Part D benefit is subsidized by at least 74.5 percent;
- A considerable number (6.4 million) of dual eligibles will automatically enroll and an additional 8.5 million are assumed to remain in subsidized employer plans (OACT counts these as Part D participants); and

- Premium penalties (1% per month) for late enrollees will encourage those eligible to enroll as soon as possible.

The Panel expressed concerns that take-up rates are implausibly high, and offered the following reasons:

- Unlike Part B, enrollment is not automatic (people must elect not to enroll in Part B, while under Part D, eligibles must decide to enroll);
- Part B participation is not universal – between 4 and 5% of those eligible elect not to enroll in Part B;
- This is not a free benefit – the EITC (spell out) offers a free benefit to those eligible and not all elect to enroll; Part D beneficiaries must pay a premium (now calculated to be \$35 per month):
 - The EITC eligible population is admittedly a special one and may behave quite differently on average from those eligible for Part D; and
- Part D may not be financially advantageous for low users of Rx – particularly for those in the bottom quintile of use.

At the previous meeting, the Panel asked OACT to simulate what would happen if some low users (those in the bottom two quintiles of use) elected not to participate. In response, OACT simulated the following four scenarios (and assuming premiums are calculated at a relative risk of 1.0):

- ¼ of the bottom quintile does not participate – 0.1% fall in total spending, 1.4% increase in federal spending;
- ½ of bottom quintile does not participate – 0.8% fall in total spending, 2.8% increase in federal spending;
- 85% of bottom quintile does not participate - 1.5% fall in total spending, 4.7% increase in federal spending; and
- 75% of bottom 35% does not participate – 4.8% fall in total spending, and 1.8% increase in federal spending.

These simulation results suggest that reductions in benefit expenditure due to lower participation are nearly offset by higher per-beneficiary costs due to adverse selection. Further, depending on the treatment of beneficiary premiums with a select enrollment, the loss of premium revenues could be greater than the reduction in benefit outlays, thereby increasing overall costs to Medicare.

The Panel finally appeared to recommend that in 2006, take-up rates fall by 10% -- one half in the bottom quintile and one half distributed randomly across the population, and that this percentage decline over five (5?) years to 5% (same 50-50 split between bottom quintile and random distribution).

The Panel agreed with OACT that enrollment in fall back plans (those with less than full risk) will be quite low and does not need to be explicitly modeled.

3.5. Employer Reactions

This was an area of considerable debate, and it did not appear that the Panel reached any recommendations or agreements. This suggests this is one area that would benefit from additional work.

Currently, employers can adopt one of four options:

- Drop their Rx coverage (individuals could enroll in Part D, perhaps with employers paying some of the premium)
- Becoming a PDP (this could be limited to just the employer's workers and retirees; employers could also seek national or regional waivers);
- Retaining their plans and receiving a 28% subsidy for drug costs only incurred from \$250 to \$5,000; or

Dropping their primary drug coverage and offering wrap-around coverage to supplement the Part D benefit.

Panel member opinions on what might occur varied widely and included the following:

- Dropping coverage – some Panel members believe that a significant number of employers may drop coverage; but others believed:
 - Employers would do better to offer wrap-around coverage; or
 - Employers may be precluded from dropping coverage, at least for some retiree cohorts, because the case law will not allow employers to eliminate their retiree benefits unless the employer reserved the right to do so (there was an extensive range of opinions as to how many retirees are protected by these rulings and how long such protections would matter); and
 - Some State and local governments in cases are not allowed by law to eliminate retiree benefits for current employees and retirees;
- Wrap-around plans:
 - OACT and CBO believe these will be unlikely, because such benefits will drive up the TROOP catastrophic cost limits;
 - Some Panelists believe that wrap-around coverage offers large employers significant financial advantages, but differ as to whether employers will offer wrap-around coverage immediately or will wait until PDP plans become available (to wrap-around) and until more is known about premiums and other key parameters; and
 - Non-profits and other employers who would not benefit from the tax advantages of the subsidies might be more likely to offer wrap-around plans.

There was general agreement of the need for a comparison table that lays out OACT assumptions regarding the costs to employers and to the Trust Fund of the various employer options.

3.6. The Low Income Subsidy

Currently, there is a three-tiered system of subsidies to low-income populations (defined by both income and assets tests). The dual eligible and those passing a more stringent means test are eligible for a higher subsidy level, while those meeting a less restrictive means test receive slightly lower subsidies. These subsidies include assistance with both beneficiary premiums and copayments. At

somewhat higher income levels, the assistance with Part D cost sharing is less generous, and the premium waiver phases out. OACT expects the combined benefit amounts to be approximately \$4,000 per beneficiary per year in 2006.

OACT estimates of low subsidy costs are higher than those of CBO, for two reasons. First, OACT estimates that the subsidy amounts are higher. Second, and the topic addressed by the Panel, OACT assumed higher take-up rates. Some eligibles (6.4 million) – the dual eligibles, are automatically enrolled.

For those who were not automatically enrolled, OACT assumed take-up rates of 65% in 2006 and later. The Panel noted that CBO assumed a take-up rate of 30% -- OACT indicated that the take-up rate was 45% (I think the difference could be that CBO assumed a transition from a lower to a higher take-up rate over the projection period). OACT based its assumption on the experience of full dual Medicare/Medicaid beneficiaries, QMBs, and SLMBs:

- Roughly 70% of full dual beneficiaries enrolled – and the benefit is worth about \$12,000 (this is skewed by nursing home residents whose benefit is worth at least \$40,000); and
- Significantly lower percentages of QMBs and SLMBs enrolled and these benefits were worth approximately \$2,300 and \$1,000, respectively.

OACT believes that a 65% take-up rate for \$4,000 benefit is reasonable, especially if some SLMBs (and QMBs) enroll by being induced by the new Part D subsidies (the woodwork effect). Outreach efforts may also succeed, and unlike the QMB/SLMB options, those eligible for Part D do not have to apply through public assistance agencies.

Panel members were not sure if OACT's assumptions were too high, and they did not make an alternative recommendation.

One aside – in the discussion of eligibility levels, someone noted that SLMB eligibility was available to those up to 135% of poverty. I (Kevin) indicated that this amount was approximately \$16,000 for a two-person household. I looked up the actual figures that are as follows (2004):

- One-person households – 135% of poverty is \$951 per month, or \$11,412 per year; and
- Two-person households – 135% of poverty is \$1,269 per month, or \$17,112 per year (close to my \$16,000 estimate).

3.7. Data Collection and Research Ideas

The Panel wants to make sure that OACT has the resources – the staff, the hardware and software, the time, the data (Part D and other data – e.g., IMS and PBM data) it will need to start modeling Part D and making future projections. OACT staff members indicated that they have been involved in discussions with CMS and other related entities and believe they will have access to a 100% file of claims fairly rapidly. Because these claims will be adjudicated at a pharmacy, OACT also believes that most if not all of the claims files will be clean.

The Panel offered to work with OACT to make recommendations in this area to make sure OACT has the resources it needs for this work. Some more work specifying specific needs and recommendations appears to be warranted.