October 15 Meeting Minutes

Introduction

All seven panel members were in attendance, and the minutes from the October 6th meeting were approved without comment. During this meeting, the Panel pursued two tasks. First, Panel members discussed their tentative recommendations that will be included in their final report. Second, the Panel listened to presentations from OACT and CBO staff who presented their differing projections of the costs associated with the new Medicare Advantage program.

During the meeting, the Panel started reviewing some of its tentative recommendations, then listened to the OACT and CBO Medicare Advantage (MA) presentations, and then concluded with a second session where the Panel continued discussing their recommendations. In the interests of concision and brevity, these minutes will begin with a brief review of the major points in the MA presentations, followed by the tentative recommendations and corresponding discussion.

Medicare Advantage (MA)

The MA program offers a new voluntary insurance option to Medicare beneficiaries. A new set of regional health insurance plans following a PPO model will be established in between 10 to 50 regions. OACT currently has a contract with RTI to recommend the number and location of these regions, but regions will be at least state-wide and in some instances likely will combine states. Each regional MA plan must:

- Accept all Medicare beneficiaries in the region;
- Provide full Part A and Part B coverage; and
- Provide Rx coverage to those electing Part D.

Regional PPO plans have the following incentives to participate:

- Symmetric risk corridors in 2006 and 2007;
- A stabilization fund (initially funded with $10 billion; additional funds will be provided by plans who bid below benchmark premiums) providing entry bonuses, national plan bonuses, and retention bonuses from 2007 to 2013; and
- Premium payments that are higher than Medicare FFS payments.

There are no limits on the number of plans that may participate in each region. Plans submit bids detailing their Part A and B and Part D premiums/costs, including their (prospective) expected administrative costs and profits. OACT will then negotiate with plans whose administrative and costs and profits appear to be high relative to their overall premium bids. A benchmark premium is then established in each region that is a blend of the weighted average of county MA rates for all counties in the region and the weighted average of plan bids in the region (the blend weights are equal to the share of beneficiaries enrolled nationally in FFS (85% now) and one minus this first weight).

If a plan's bid is below the benchmark, 25 percent of the difference reverts to the stabilization fund. The plan must then indicate how it will use the remaining 75 percent of the difference to either

provide supplemental benefits and/or reduce Part B and/or Part D premiums. Beneficiaries who select plans whose premiums exceed the benchmark must pay the entire difference (excess of premium above the benchmark). Plan payments are then equal to the lesser of the plan's bid and the benchmark, subject to beneficiary risk adjustment and adjustments for geographic variation among the local areas within a region.

While OACT and CBO agree on the basic provisions of the MA program, they differ widely in their expected costs. The primary reason for MA program costs is that premium payments are expected to exceed what FFS payments would have been for those beneficiaries who elect to enroll in the MA program. MA premium payments are higher because the county rates used in the blended benchmark premium calculations are equal to the greater of FFS costs in that county and a payment floor. One OACT simulation of the expected regions under the MA program indicated that MA premium payments would be 1 ½ to 13 percent higher than FFS payments in each region – and this difference would average 8 percent across the country. In addition to the high premium payments, the stabilization payments represent an additional program cost.

OACT assumes that there will be widespread participation in the MA program. In the current Medicare+Choices (M+C) system, plans must be HMOs, and a major inducement plans use to encourage enrollment is through providing Rx coverage. With the introduction of Part D, MA PPO plans and M+C HMOs will not face these costs (plans either will not provide Rx benefits to their enrollees or will provide Part D coverage but will receive the corresponding Part D payments to meet these costs). OACT believes plans will compete to offer more attractive, additional non-Rx benefits and/or reduce beneficiary premiums substantially to encourage beneficiaries to enroll. Finally, beneficiaries who have been reluctant to enroll in an HMO may find the looser restrictions of PPOs more attractive, and this effect could increase over time as individuals enrolled in PPO options prior to Medicare eligibility are willing to continue to select such options. OACT projects that enrollment will reach 32 to 33 percent of beneficiaries in the M+C and MA options, with enrollment being roughly split (16 percent in each option) by 2009. This leads to costs of $48 billion for the MA program through 2013.

In contrast, CBO predicts that very few Medicare beneficiaries will enroll in either the M+C HMO or MA PPO options. CBO relies on a "revealed preference" approach that reasons the MMA and MA does not provide insurers with new options that are not available under the current M+C program, with one exception. CBO believes that the higher premium payment amounts will stem the current declines in M+C enrollment (CBO project enrollment to fall from 12 to 8 percent), and that enrollment will stabilize at around 12 percent by 2013. This stabilization will occur primarily in counties where plans had been facing a lower "losers blend" premium and now will receive a higher premium floor. CBO concludes that the MA program will cost only $14 billion by 2013 -- $10 billion of which represents the stabilization fund.

John Bertko is inclined to favor the OACT approach more than the CBO approach. John believes that plans, particularly with the changes introduced by Part D, have very strong incentives to encourage enrollments and noted that enrollment is already rising above the 12 percent level. While he agrees that enrollment eventually could grow higher (through competition and the relative attractiveness of a PPO option), he did not indicate if he agrees with a 33 percent enrollment level, and he also believes it will take longer than 2009 for enrollment to stabilize (he noted that HMO enrollment percentages took at least 12 years to stabilize).

The Panel's other comments consisted of three main points:

- Potential reluctance to comment on MA – while the Panel has had little time to first review the assumptions underlying OACT projections and then come to recommendations in any aspect of Medicare, they have had the least time of all for the MA program. In addition, some Panelists are not sure how large an issue this is relative to some of the other topics under consideration;
- There appeared to be some minor agreement that a PPO option might be more attractive to some Medicare beneficiaries than an HMO model; and
- The key issue to consider is whether the MA program will affect any long run projections – particularly if higher MA participation might reduce the long term growth rate in Medicare expenditures (i.e., MA is not just a "level" effect).

Recommendations

When it was considering specific recommendations, the Panel struggled with both semantics and nuance. While Panel members repeatedly agreed that key OACT assumptions and projection techniques were "reasonable," in many cases , such "reasonable" assumptions were either one of wide range of reasonable assumptions and/or the data and evidence available on which to base assumptions and projection methods were so poor and incomplete that the associated level of uncertainty is very high. Thus, the form many of the Panel's recommendations have taken is to agree that the OACT assumption or projection is "reasonable," but then to suggest possible alternatives or to note the high degree of uncertainty. In addition, many of the Panel's recommendations are to wait until better data become available (especially for the Part D program), and then to use these data to revise the assumptions and projections as soon as possible.

GDP + 1

Overall, the Panel agreed that the current assumption that the long run growth rate in Medicare costs per capita will be 2.2 percent per year (GDP +1 if GDP per capita growth is 1.2 percent) is reasonable. The "but(s)" in this instance probably consist of some set of the following additional recommendations:

- A more general recommendation is that the long run per capita growth rate in Medicare costs be of the form a*GDP + b, where a and b are not necessarily equal to 1 (as they are now);
- Long run Medicare growth rates should be the outputs of structural/behavioral models that consider factors such as:
  - Income;
  - Relative prices; and
  - Technological change, and

  Where such structural/behavioral models may also be disaggregated by either type of service (e.g., Part A, Part, B, or Part D) or ideally by morbidity and even disease;
- OACT should continue to support current efforts to develop new approaches and models (e.g., CGE models); and

- The Department of Health and Human Services (HHS) should pursue an aggressive policy of supporting extramural research that explores the long run growth rates of health care costs.

Sustainability

The Panel supported some version of the following recommendations related to "sustainability:"

- "Sustainability" – i.e., whether the economy can support a given level of health care or Medicare costs is not an issue that should be dealt with in the Trustees Report;
- The Trustees Report instead should project Medicare costs under current law – whatever those costs could be; and
- Medicare care cost projections may depend on structural/behavioral factors (e.g., Medicare beneficiary cost sharing, reduced marginal propensity for health and thus for medical spending, etc.) that may retard long run spending growth.

Short Run Projections

The Panel had a spirited discussion regarding the following two issues:

- Should the Trustee projections be allowed to depart from current law "if and when the Trustees believe the continuation of current law is unlikely;"
- If so, should such departures be reported explicitly as alternative projections/scenarios or should the departures be part of either the low or high projections (relative to the intermediate projections); and
- Should the Panel make a specific recommendation for the SGR.

While not committing itself, the Panel appeared to be leaning towards making a recommendation supporting departures in unusual circumstances, that such departures should be reported explicitly as alternative projections to the current law projections, and that the only instance where they believe such circumstances now exist is for the SGR.

Part D's Impact and A and B

The Panel agrees with the Trustees current assumption that Part D spending will not affect Part A or Part B spending.

The "but" here is that the introduction of the Part D program represents a natural experiment that tests this assumption, and HHS should support research to determine whether Part A or B does respond to Part D.

Uncertainty

The Panel agrees on some version of the following recommendations:

- The Overview to the Trustees Report should include not only the intermediate but also the high and low Medicare cost projections;

- To better reflect uncertainty, the Trustee's Report low and high projections should reflect the combined effects of reasonable sets of assumptions, and these assumptions do not have to be symmetric; and
- The Trustees Report should explore the use of graphical techniques such as influence and phase diagrams in their representation of uncertainty.

Infinite Horizon

The Panel agrees that the Trustees Report current treatment of infinite horizon projections should not change.

Presentation

In general, the Panel supports reporting more information on combined Medicare (Part A, B, and D together) costs and government expenditures in the Trustees Report and in the Overview. Specific recommendations on what else to include in the Overview include the following:

- Representing Medicare government expenditures as a percentage of GDP (this information is now presented in Figures I.E.1 and I.E.2);
- Reporting beneficiary out-of-pocket expenditures as a percentage of income:
  - Beneficiary out-of-pocket expenditures should include all expenditures – Parts, A, B, and D (do not exclude Part A);
  - Beneficiary income should be total family income, not only Social Security benefits; and
  - Represent the ratio of beneficiary-out-pocket expenditures to total family income in two ways:
    - What percentage of beneficiaries have their out-pocket expenditures exceed some fraction of their two income (e.g., what fraction has out-of-pocket expenditures greater than 20 or 40 percent of their income) in each year; and
    - The ratio of beneficiary average out-of-pocket expenditures to mean total family income in each year.

Use of Social Security Economic and Demographic Assumptions

Ed Hustead potentially wanted to note the HI and SMI projections rely on OASDI economic and demographic assumptions, but that Chief Actuary will use his Statement of Actuarial Opinion to describe any differences he has with the OASDI assumptions. The rest of the Panel believed that because this issue was not considered in any depth by the entire Panel that its (the Panel's) report should not make any recommendation, but instead might want to encourage the next Panel to consider this topic.

MCBS as Baseline

The Panel agrees to some version of the following recommendations:

- The MCBS is a reasonable option for Projecting Medicare Part D spending per beneficiary;

- The MCBS has numerous limitations – small sample, underreporting, data are not current (1998 MCBS used for the 2004 projections) and a lot of assumptions needed to be made to estimate Medicare Part B spending per beneficiary in 2006;
- FEHBP data should be used as an external benchmark to test the validity of the projections based on the MCBS; and
- Part D data should be used as soon as possible for projecting Part D costs:
  - Premium data will be available by Summer, 2005 (can be used in the 2006 Report); and
  - Claims data for part of 2006 will be available to be used by the 2007 Report.

NHE Trend Projections

The Panel agrees to some version of the following recommendations:

- The use of the NHE to trend the MCBS projections forward to 2004 to 2013 is reasonable;
  - The process used to develop the NHE , including the choice and impact of the add factors and the methods used to predict the model's independent variables and add factors could be made more transparent;
- The FEHBP data should also be used to validate the NHE Rx growth projections; and
- Part D data should be used to project long term trends in Rx cost growth as soon as possible (but the Panel recognizes that it may be many years before enough such Part D data are available to make such projections and that many of the same problems faced by those now making the NHE Rx projections will remain even after such Part D data become available).

Prescription Drug Prices, Rebates, Discounts and Induction

The Panel agrees to some version of the following recommendations:

- OACT's current projections of the combined discounts PDPs will be able to secure (15 percent in 2006 rising to 25 percent by 2011 and beyond) are reasonable;
  - The Panel considered but decided not to recommend widening the assumptions in the high and low scenarios (savings +/- 5 percent from 2006 to 2013 to +/- 10 percent);
- OACT's administrative cost assumptions (12.6 percent in 2006 falling to 10.7 percent in 2013) are plausible;
- OACT's induction assumptions (averaging 12 percent in 2006) are reasonable but should not be increased; and
- OACT assumption that drug prices will not increase significantly after the Part D program is implemented is reasonable.

Beneficiary Participation

The Panel agrees to some version of the following recommendations:

- OACT and the Trustees should continue to assume that enrollment in fallback plans (i.e., plans that assume less than full risk) will be minimal and will not affect current Part D projections; and

- OACT should assume that beneficiary participation (i.e., the take-up rate) will be 10 percentage points lower than the current 99 percent assumption (excluding Medicare beneficiaries who are currently employed). Of the additional 10 percent of beneficiaries assumed not to participate in Part D:
  - None of the 10 percent should include the dual eligible (those also enrolled in state Medicaid programs) who will be automatically enrolled in Part D;
  - Half (5 percent) of the 10 percent not enrolling should have drug spending in the lowest spending quintile in 2006; and
  - Half (5 percent) of the 10 percent not enrolling are randomly distributed across all those eligible for Part D.

Employer Reactions

While the Panel did not specifically agree or disagree with OACT's current assumptions regarding employer reactions, the Panel probably will advise OACT and the Trustees to consider the following issues:

- OACT now assumes approximately 75% of those enrolled in employer plans will continue to be enrolled in those plans and that their employers will take the subsidies, and that 25% of employees will be enrolled in Part D (either if their employer becomes a PDP or through enrolling in alternative PDP). The Panel cautions that this 25% percent assumption may be too high;
- Instead, some employers may decide not to completely drop their plans or become PDPs but instead will offer wrap-around plans:
  - This make take some time until there are PDPs available to "wrap around;"
  - Those employers who decide to offer a wrap-around plan may subsequently decide to drop the wrap-around coverage; and
- Assuming that 75 percent of employees will be covered by their employers during the projection period (2006 to 2013) may be too high:
  - New employers are less likely to offer such coverage; and
  - Existing employer plans may not cover all future retirees.

Low-Income Subsidy

The Panel did not make specific recommendations on this issue except to note the following:

- OACT's take-up rate (65 percent for the intermediate projection, +/- 15 percent for the low and high projections) were still higher than the CBO projections (30 to 45 percent); and
- OACT and the Trustees will know more about this a few years after the Part D program is implemented.

Risk Corridors

The Panel agrees with OACT that Part D risk corridors should not be expected to increase or decrease Part D costs.

Data Recommendations

Many of the Panel's recommendations, especially for Part D, are to replace current assumptions and projection techniques with those based on Part D data when these data become available. The Panel is especially concerned that OACT have the resources available and systems in place to access the Part D premium, enrollment, and claims data as these data become available, and note that it may be easier and less expensive to provide OACT with such access when these data systems are just being specified and created than to do so later, when such a system might need to be "retro-fitted."