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MEDICARE

Financial Outlook Poses Challenges for Sustaining Program and Adding Drug Coverage

Statement of David M. Walker
Comptroller General of the United States

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss options for increasing Medicare beneficiaries' access to prescription drugs. There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs. Recent estimates suggest that, at any point in time, over a third of Medicare beneficiaries lack prescription drug coverage. The rest have at least some drug coverage through various sources—most commonly employer-sponsored health plans—although recent evidence indicates that this coverage is beginning to erode.

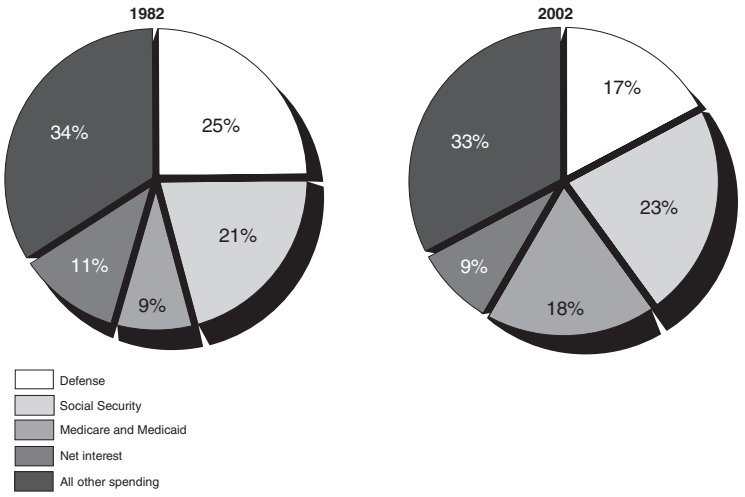
At the same time, however, the short-term and long-term cost pressures facing the existing Medicare program are considerable. After a brief slowdown in the late 1990s, Medicare spending growth has recently accelerated. In the last fiscal year, growth in program spending reached nearly 9 percent, with spending on certain services increasing much more rapidly. For example, spending for home health grew about 30 percent and spending for skilled nursing facility care grew slightly over 20 percent.

As I have noted previously, substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. These fundamental reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, any proposals to help seniors with the costs of prescription drugs would need to be carefully crafted to avoid further erosion of the projected financial condition of the Medicare program, which is already unsustainable in its present form.

We must also remain mindful that the fiscal pressures created by the retirement of the baby boom generation and rising health care costs are just over the horizon. Between now and 2035, the number of people who are 65 and older will double. Federal health and retirement spending are expected to surge as people live longer and spend more time in retirement. In addition, advances in medical technology are likely to keep pushing up the cost of providing health care. Moreover, the baby boomers will have left behind fewer workers to support them in retirement. Absent substantive reform of the entitlement programs, a rapid escalation of federal spending for Social Security, Medicare, and Medicaid beginning less than 10 years from now is virtually certain to overwhelm the rest of the federal budget.

As figure 1 shows, fiscal flexibility has already decreased as spending for Social Security, Medicare, and Medicaid have absorbed an increasingly large share of the federal budget. Reductions in defense spending have helped accommodate the growth in these entitlement programs. However, reductions in defense spending can no longer be used as a means to help fund other claims on the budget; indeed, spending on defense and homeland security will grow as we seek to combat threats to our nation.

Figure 1: Composition of Federal Spending by Budget Function.



Note: 2002 data based on OMB current services estimate.

Source: Budget of the United States Government, Fiscal Year 2003, Office of Management and Budget.

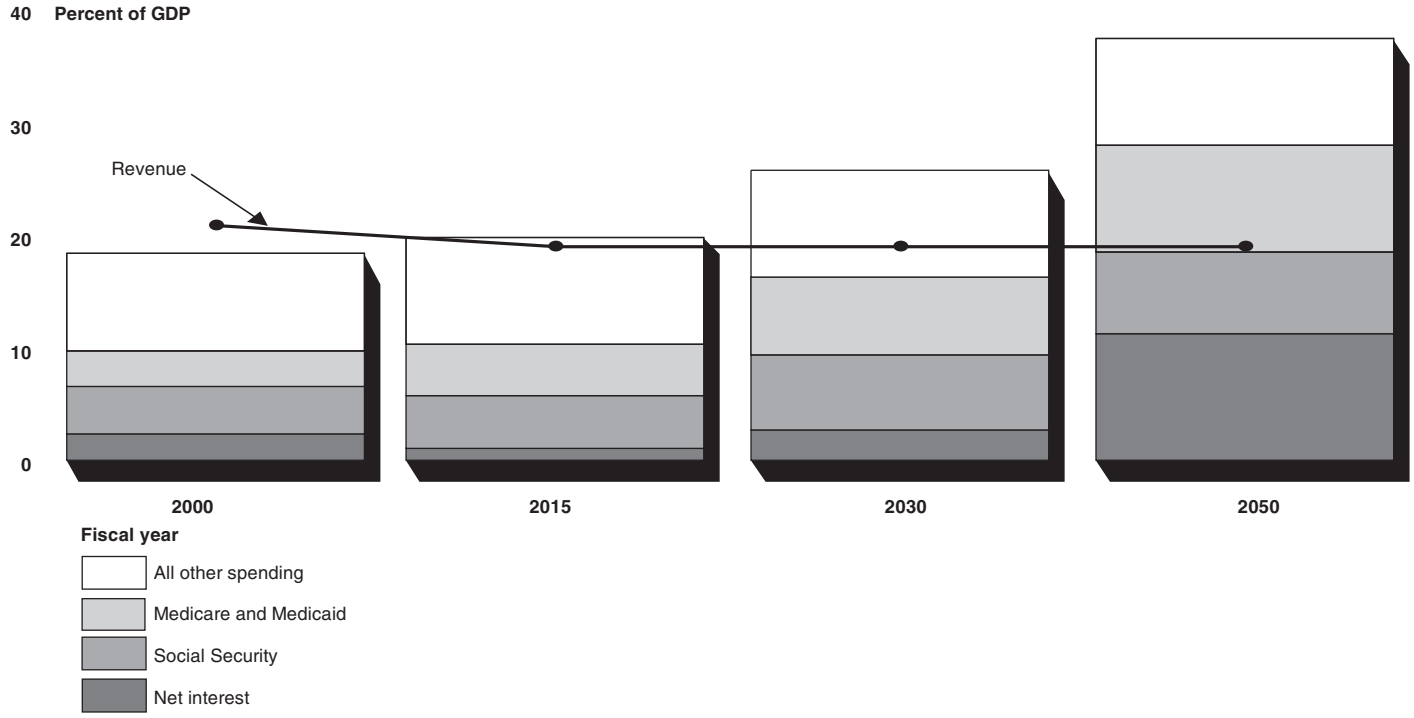
Today my remarks will focus on (1) the access and affordability issues that underlie the interest in a Medicare prescription drug benefit, (2) the financial challenges Medicare faces to meet its current obligations, and (3) key considerations in light of the tension between benefit expansions and budgetary pressures.

In summary, intentions to add prescription drug coverage to Medicare's benefits come during a period of rapid growth in national spending for pharmaceuticals. Between 1995 and 2000, spending for prescription drugs rose more than 2 1/2 times faster than spending for health care overall, and this dramatic growth is expected to continue in the coming years. In the absence of a drug benefit in the Medicare program, many beneficiaries obtain coverage from other sources, including health plans, public

programs, and the Medigap insurance market. But the price, availability, and level of such coverage vary widely, leaving substantial gaps and exposure to high out-of-pocket costs for hundreds of thousands of beneficiaries.

Despite the various pressures to adopt a prescription drug benefit, the rapidly escalating cost of meeting current obligations for present and future beneficiaries argues for careful deliberation and extreme caution in crafting any benefit expansion. Medicare's trustees have indicated in recent years that the Medicare program is already unsustainable in its present form. GAO's long-term budget simulations show that the aging of the baby boom generation and rising per capita health care spending will, absent meaningful reform, lead to massive fiscal challenges in future years. Assuming, for example, that last year's tax reductions are made permanent and discretionary spending keeps pace with the economy, by mid-century, spending for the current Medicare program—without the addition of a drug benefit—is projected to account for more than one-quarter of all federal revenues. In fact, federal revenues may only be adequate to pay Social Security and interest on the federal debt. As a result, massive spending, tax increases, or some combination of the two would be necessary to obtain balance. (See fig. 2.)

Figure 2: Composition of Spending as a Share of Gross Domestic Product (GDP) Assuming Discretionary Spending Grows with GDP and the Tax Cuts Do Not Sunset.



Source: GAO's March 2002 analysis.

The huge budgetary pressures that we are sure to face in the coming years require that we set priorities so that any benefit expansions are in line with available resources. In this regard, the application of basic health insurance principles to any proposed benefit could help moderate the cost for both beneficiaries and taxpayers. Under these principles, beneficiaries receive protections against the risk of catastrophic medical expenses while remaining conscious of the cost of care. At the same time, it is important that benefit expansion proposals include targeting mechanisms to ensure that federal support is directed at the beneficiaries with the greatest financial risk. Nevertheless, as I have stated previously, no matter how well designed a new benefit may be, adding benefits without fundamentally reforming the existing program will merely hasten the exhaustion of Medicare's Hospital Insurance (HI) trust fund and the draining of general revenues. Any benefit expansion will also serve to make our long-range fiscal challenge even greater. Ideally, Medicare

reforms should be designed to improve our long-range fiscal situation. At a minimum, they should be designed so as not to make our long-range fiscal challenge worse.

Rising Drug Spending Elevates Beneficiary Access Concerns

Extensive research and development have led to new and improved prescription drug therapies that, in some instances, have replaced other health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription drugs as part of health care has grown. However, not all new drug therapies serve to reduce the need for more invasive and expensive medical procedures. Some new drug therapies are substitutes for already existing, less expensive, ones and may not appreciably improve efficacy or reduce side effects. Others may be used more for making lifestyle enhancements than for extending life or treating a serious medical condition. Spending on the new drug therapies, along with the mass media advertising of prescription drugs, serves to significantly increase total drug spending as a component of health care costs.

The Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage. Beneficiaries may fill this coverage gap in various ways. All beneficiaries have access to individually purchased supplemental policies—Medigap—when they first become eligible for Medicare at age 65. Those policies that include drug coverage tend to be expensive and provide only limited benefits. Some beneficiaries have access to coverage through employer-sponsored policies or Medicare health maintenance organizations (HMO). In recent years, coverage through these sources has become more expensive and less widely available. Beneficiaries whose income falls below certain thresholds may qualify for Medicaid or other public programs.

Prescription Drug Costs Continue to Rise Rapidly

In recent years, prescription drug expenditures have grown substantially, both in total and as a share of all heath care outlays. Prescription drug spending grew an average of almost 15 percent per year from 1995 to 2000, well more than double the 5.6 percent average growth rate for health care expenditures overall. (See table 1.) As a result, prescription drugs account for a growing share of health care spending rising from 6.1 percent in 1995 to 9.4 percent in 2000. By 2011, prescription drug expenditures are expected to account for almost 15 percent of total health expenditures.

Table 1: National Expenditures for Prescription Drugs and Health Care, 1995-2000.

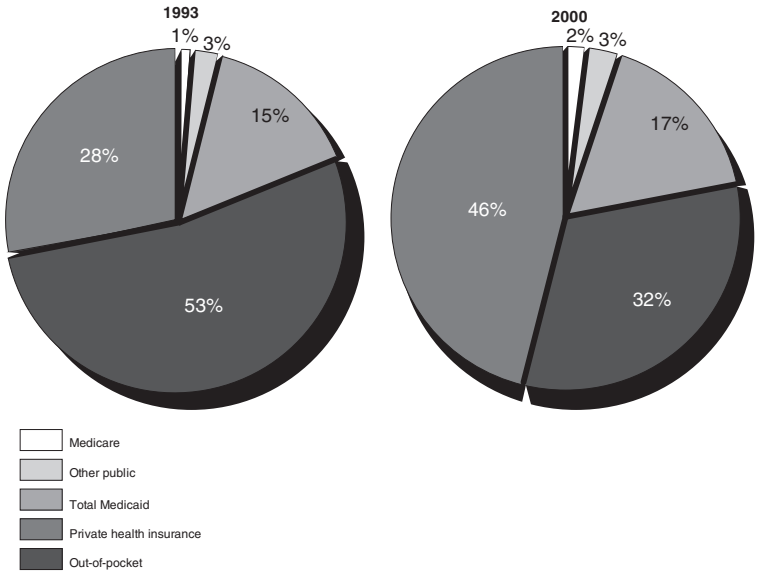
Year	Prescription drug expenditures (in billions)	Annual growth in prescription drug expenditures from previous year (percent)	Annual growth in health care expenditures from previous year (percent)
2000	$121.8	17.3%	6.9%
1999	103.9	19.2	5.7
1998	87.2	15.1	5.4
1997	75.7	12.8	4.9
1996	67.2	10.5	5.0
1995	60.8	11.2	5.7
Average annual growth between 1995 and 2000		14.9	5.6

Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

Total drug expenditures have been driven up by several factors. Drug coverage by private insurance has likely contributed to the rise in spending, because insured consumers are partially insulated from the costs. In the years from 1993 to 2000, the share of prescription drug expenditures paid by private health insurers rose from more than a fourth to almost a half. (See fig. 3.) The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the growth in drug spending by boosting the volume of drugs used as well as the average price for drugs used. Similarly, biotechnology advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. Advertising pitched to consumers has also served to increase the demand for prescription drugs. A recent study found that, in 2000, the 50 drugs most heavily advertised directly to consumers were responsible for nearly half of the roughly $21-billion increase in retail spending on prescription drugs from 1999 to 2000.[1]

[1]The National Institute for Health Care Management Research and Educational Foundation, *Prescription Drugs and Mass Media Advertising, 2000* (Washington, D.C.: Nov. 2001).

Figure 3: Shares of National Outpatient Drug Expenditures by Payer Type, 1993 and 2000.



Note: Out-of-pocket expenditures include direct spending by consumers for prescription drugs, such as coinsurance, deductibles, and any amounts not covered by insurance. Out-of-pocket premiums paid by individuals are not counted here.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Drug Coverage for Medicare Beneficiaries Is Becoming More Expensive and Less Available

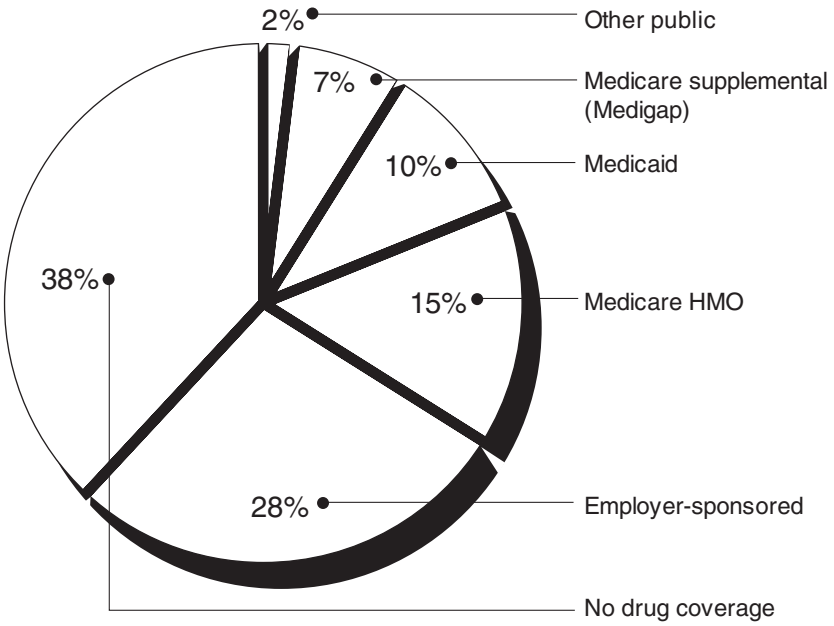
In 2001, CBO estimated that the average Medicare beneficiary would use $1,756 worth of prescription drugs. This is a substantial amount considering that some beneficiaries lack any drug coverage and others with coverage may have less than in previous years. Moreover, significant numbers of beneficiaries have drug expenses much higher than those of the average beneficiary. CBO also estimated that some 10 percent of Medicare beneficiaries would have expenditures of $4,000 or more.[2]

According to a recent survey, in the fall of 1999, nearly two-thirds of Medicare beneficiaries had some form of drug coverage from a

[2]CBO estimates reported in Michael E. Gluck and Kristina W. Hanson, *Medicare Chart Book* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, fall 2001).

supplemental insurance policy, health plan, or public program. More than one-third reported that they lacked drug coverage altogether.[3] (See fig. 4.)

Figure 4: Source of Drug Coverage for Medicare Beneficiaries, Fall 1999.



Source: Barents Group analysis of 1996 through 1999 Medicare Current Beneficiary Survey Access to Care Data.

Employer-sponsored health plans provide drug coverage to the largest segment of the Medicare population with coverage. However, there are signs that this coverage is eroding. Fewer employers are offering health benefits to retirees eligible for Medicare, and those that continue to offer coverage are requiring retirees to pay a larger share of costs. The proportion of large employers offering health coverage to retirees eligible for Medicare declined from 31 percent in 1997 to 23 percent in 2001. At the same time, the proportion of large employers requiring Medicare-eligible

[3]Mary A. Laschober and others, "Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996 to 1999," *Health Affairs*, www.healthaffairs.org (Feb. 27, 2002).

retirees to pay the full cost of their health coverage increased from 27 percent to 31 percent.[4]

In March 2001, 10 percent of Medicare beneficiaries obtained prescription drug coverage through a Medicare HMO, down from about 15 percent in 1999. Medicare HMOs have found drug coverage to be an attractive benefit that beneficiaries consider when choosing to enroll. However, owing to rising drug expenditures and their effect on plan costs, fewer Medicare HMOs are offering a drug benefit. In 2002, 50 percent of Medicare beneficiaries have access to a Medicare HMO with drug coverage, down from 65 percent in 1999. The drug benefits the plans do offer have become less generous, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

About 7 percent of beneficiaries purchase Medigap policies that provide drug coverage. These policies have shortcomings: they tend to be expensive, involve significant cost-sharing, and do not provide protection against catastrophic out-of-pocket expenses. In 1999, average premiums for standard Medigap policies that included drug coverage ranged from about $1,400 per year to $1,700 per year.[5] Beneficiaries remained responsible for a $250 deductible for drugs and 50-percent coinsurance. The drug benefit was capped at an annual limit of $1,250 or $3,000. Furthermore, Medigap premiums have been increasing in recent years. One recent study reported that, from 1999 to 2000, premiums for the Medigap plans offering prescription drug coverage rose the most—by 17 to 34 percent—compared to 4 to 10 percent increases for Medigap plans without prescription drug coverage.[6]

All Medicare beneficiaries who qualify for full Medicaid benefits receive drug coverage that may include some limits, such as restrictions on the number of prescriptions that can be filled per month, depending on the state's Medicaid plan. Individuals with low incomes who are not eligible

[4]William M. Mercer, Incorporated, *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 1997* (New York, N.Y.: 1998) and *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 2001* (New York, N.Y.: 2002).

[5]U.S. General Accounting Office, *Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives*, GAO-02-533T (Washington, DC: Mar. 14, 2002).

[6]Weiss Ratings Inc., "Prescription Drug Costs Boost Medigap Premiums Dramatically," http://www.weissratings.com/NewsReleases/Ins_Medigap/20010326Medigap.htm (Palm Beach Gardens, Fla.: Mar. 26, 2001).

for full Medicaid benefits may have access to some drug coverage through a state pharmacy assistance program. As of April 2002, 26 states and the District of Columbia had such a program in operation.

Access barriers to prescription drugs may be particularly acute for Medicare beneficiaries who lack drug coverage and have substantial health care needs. In 1998, among beneficiaries in poor health, those without drug coverage had drug expenditures that were $910 lower than those with drug coverage and they filled 14.5 fewer prescriptions. The difference in expenditures and use between the two groups suggests that the lack of drug coverage may impose barriers to health care.[7]

Expanding Benefits Needs to Be Considered in Light of Larger Medicare Fiscal Concerns

The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. Although the need to modernize Medicare's benefit package is compelling, the program is already fiscally unsustainable in its present form, and the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years.

As Currently Structured, Medicare Is Fiscally Unsustainable

On March 26, 2002, the trustees of the Medicare trust funds reported on the current and projected financial status of the program over the next 75 years. The report stated that, while the near-term financial condition has improved slightly since last year's report, Medicare continues to face substantial financial challenges in the not-too-distant future that need to be addressed soon.

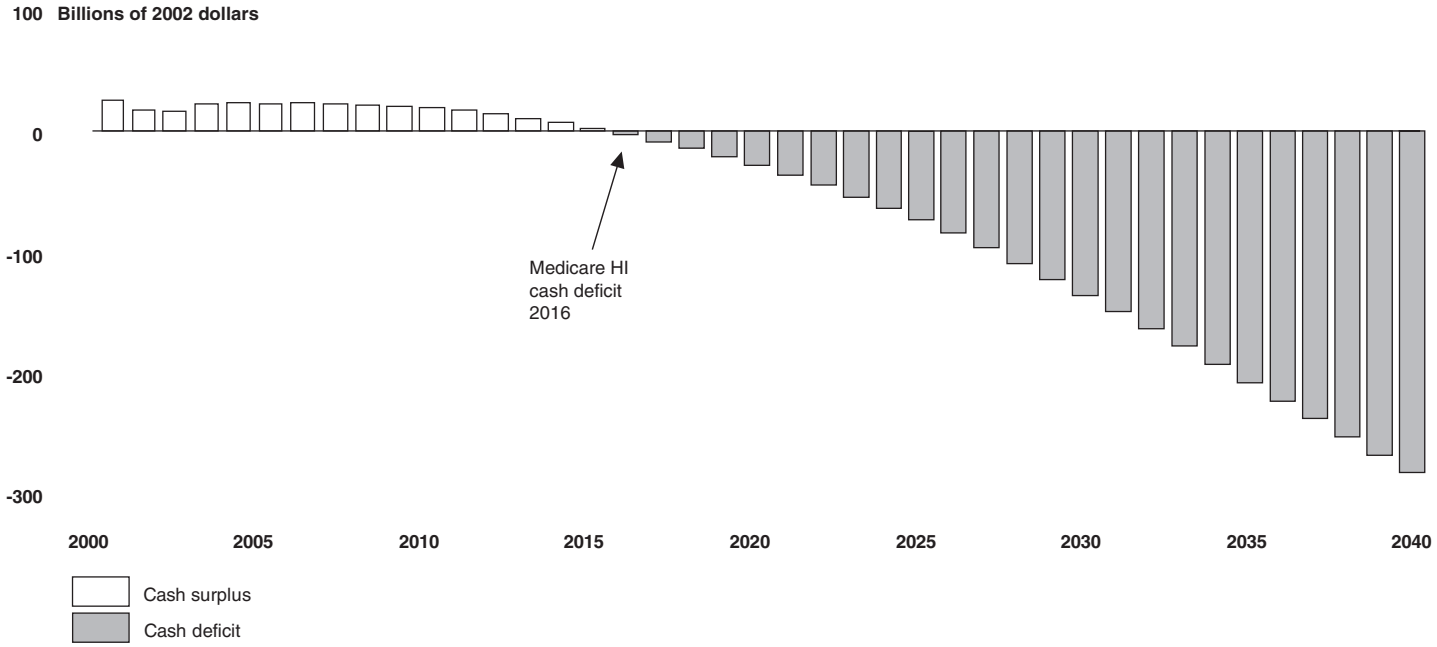
Medicare's fiscal health is often gauged by the projected solvency of the HI trust fund, which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services and is financed by payroll taxes. The gap between income and costs can best be expressed relative to taxable payroll (the HI trust fund's funding base). This year, under the trustees' 2002 intermediate estimates, the 75-year actuarial deficit is projected to be 2.02 percent of taxable payroll—an increase from last year's projected deficit of 1.97 percent. This means that to bring the HI

[7]John A. Poisal and Lauren Murray, "Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage," *Health Affairs* vol. 20, no. 2 (March/April 2001).

trust fund into balance over the 75-year period, either program outlays would have to be immediately reduced by 38 percent or payroll tax income immediately increased by almost 70 percent, or some combination of the two.

The trustees' report also projected that the trust fund for Medicare's HI component would remain solvent until 2030. However, the projection that the HI trust fund is not facing imminent insolvency does not mean that we can or should wait until 2030 to take action. Although HI revenues currently exceed HI outlays, the March 2002 trustees' report projects that cash deficits will reemerge in 2016 and grow larger with each passing year. (See fig. 5.) Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare HI trust fund is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. While the U.S. Treasury securities in the HI trust fund are backed by the full faith and credit of the U.S. government, they essentially represent an unfunded promise to pay, which will require tough fiscal choices in future years.

Figure 5: Net Cash Flow of the Medicare Hospital Insurance Trust Fund, 2000-2040.



Source: GAO analysis based on the intermediate assumptions of the *2002 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

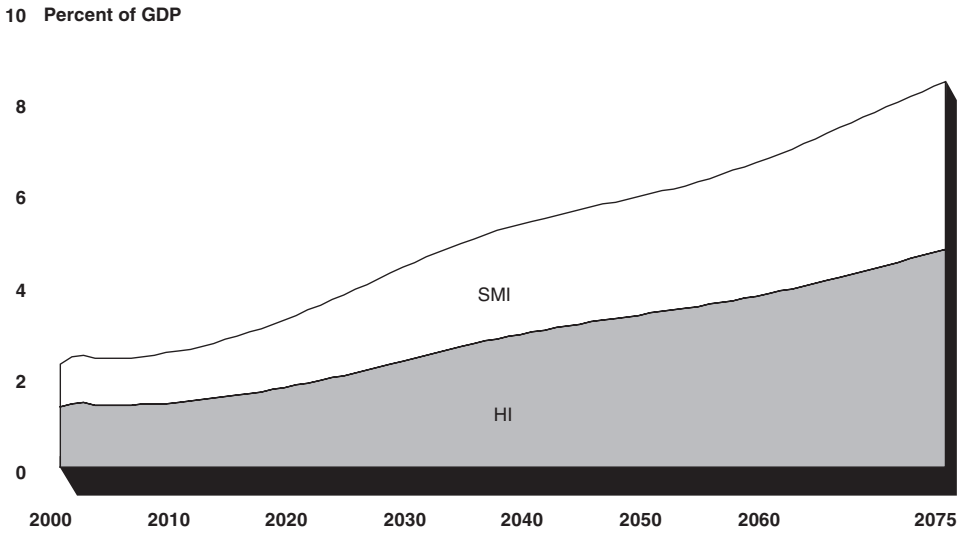
To finance its cash deficits, the HI trust fund will need to draw on the special- issue Treasury securities acquired during the years when the program generated cash surpluses. The negative cash flow will place increased pressure on the federal budget. In essence, for HI to "redeem" its securities, the government will need to obtain cash through some combination of increased taxes, spending cuts, increased borrowing from the public (or correspondingly less debt reduction than would have been the case had cash flow remained positive).

A focus on HI solvency alone, however, does not provide a complete picture of the Medicare program 's expected future fiscal claims. The Supplementary Medical Insurance (SMI) portion of Medicare, which covers physician and outpatient hospital services, diagnostic tests, and certain other medical services, is not reflected in the HI solvency measure. SMI is largely funded through general revenues and its outlays are projected to grow even faster than HI outlays in the near future.

Bleak Outlook for Medicare's Long-Term Sustainability Increases Urgency for Program Reform

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 11 percent of federal revenues in 2001 to more than one-quarter by mid-century. Over the same time frame, Medicare's expenditures are expected to more than double as a share of the nation's economy, from 2.4 to 6.0 percent, as shown in figure 6. Moreover, relatively fewer potential workers will be available to shoulder Medicare's financial burden. In 2000 there were 4.9 working-age persons (18 to 64 years) per elderly person, but by 2030, this ratio is projected to decline to 2.8.[8]

Figure 6: Medicare Spending as a Percentage of GDP, 2000-2075



Note: Projections based on intermediate assumptions of the 2002 HI and SMI trustees' report.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary.

The progressive absorption of a greater share of the nation's resources for health care is in part a reflection of the rising share of the population that is elderly. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up

[8]For the HI portion of Medicare, in 2001 there were 4 covered workers per HI beneficiary. Under their intermediate 2002 estimates, the trustees project that by 2030 there will be only 2.4 covered workers per HI beneficiary.

about 12 percent of the total population; by 2030, they will comprise 20 percent. Medicare growth rates, however, reflect not only a rapidly increasing beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future with no changes in federal health and retirement programs is to envision a very different role for the federal government. Assuming, for example, that last year's tax reductions are made permanent and discretionary spending keeps pace with the economy, spending for net interest, Social Security, Medicare, and Medicaid consumes nearly 50 percent of federal revenue by 2015 and more than three-quarters of federal revenue by 2030, leaving little room for other federal priorities including defense and education. (See fig. 2.) By 2050, total federal revenue is insufficient to fund entitlement spending and interest payments, resulting in deficits that are escalating out of control.

Our long-term simulations illustrate the magnitude of the fiscal challenges associated with an aging society and the significance of the related challenges the government will be called upon to address. As I have stated previously, early action to reform Medicare and other programs would yield the highest fiscal dividends for the federal budget and would provide a longer period for prospective beneficiaries to make adjustments in their own planning.[9] Waiting to build economic resources and reform future claims entails significant risks. First, we lose an important window during which today's relatively large workforce can increase savings and enhance productivity, two elements critical to growing the future economy. Second, we lose the opportunity to reduce the interest burden on the federal budget, thereby creating a legacy of higher debt. Third and most critically, we risk losing the opportunity to phase in changes gradually so that all affected parties can make the adjustments needed to adequately plan for the future.

Unfortunately, our long-range challenge has become more difficult, and the window of opportunity to address the entitlement challenge is

[9]U.S. General Accounting Office, *Budget Issues: Long-Term Fiscal Challenges*, GAO-02-467T (Washington, D.C.: Feb. 27, 2002) and *Medicare: New Spending Estimates Underscore Need for Reform*, GAO-01-1010T (July 25, 2001).

narrowing. It remains more important than ever to return to these issues over the next several years. Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole can afford the promised benefits now and in the future and at what cost to other claims on scarce resources.

Private Health Insurance Principles Should Guide Reform Efforts

Given the current federal fiscal environment, we cannot afford to ignore the difficult policy choices that must be made to keep the Medicare program on a sustainable footing. Adding prescription drug coverage to the Medicare benefit package would require balancing competing concerns about program sustainability, federal obligations, and the hardship faced by some beneficiaries. The addition of a benefit that has the potential to be massively expensive should be focused on meeting the needs deemed to be of the highest priority. This focus would entail targeting financial help to beneficiaries most in need and, to the extent possible, avoiding the substitution of public for private coverage. I continue to maintain, that, optimally, benefit expansions should be made in the context of overall program reforms that are designed to make the program more sustainable over the long term.

Several basic principles of health insurance provide a framework for keeping any new prescription drug benefit more affordable for both beneficiaries and the taxpayers. First, as health insurance is intended to protect individuals against large, or catastrophic, expenses, a well-designed benefit should limit beneficiaries' liability for out-of-pocket expenses. Second, a benefit should be designed to include reasonable cost-sharing to encourage the appropriate use of services. Third, the benefit should include features to avoid adverse selection, that is, avoid covering only beneficiaries who will use the benefit. Including the individuals who may not currently need the benefit—but may need it in the future—can spread the risk and help keep the cost down for everyone.

Leading proposals to integrate prescription drug coverage into the Medicare program, to varying degrees, incorporate these principles. For example, the proposals commonly limit a beneficiary's financial liability for prescription drug costs. They seek to restrain inappropriate spending, in part by requiring cost-sharing in the form of a deductible and coinsurance. To make drug coverage attractive to a broader spectrum of beneficiaries, the proposals subsidize the beneficiary premium. To further encourage beneficiaries to sign up for prescription drug coverage when they are healthy, the proposals include provisions that discourage delayed enrollment. Finally, because even modest cost-sharing amounts might

prove too burdensome for some individuals, the proposals include targeting mechanisms to help prevent low income from becoming a barrier to obtaining prescription drug coverage.

Although the leading prescription drug coverage proposals share certain key design features, they differ in important details, such as the amount of required cost sharing and the limit on beneficiary out-of-pocket costs. These differences reflect trade-offs in cost-control mechanisms, benefit generosity, and protections for beneficiaries with high needs. Careful debate about the different trade-offs is important, because both the overall design of a new benefit and the associated details determine the likely impact on both beneficiaries and taxpayers. Frankly, we know that incorporating a prescription drug benefit into the existing Medicare program will add hundreds of billions of dollars to program spending over the next 10 years. For this reason, I cannot overstate the importance of adopting meaningful financial reforms to ensure that Medicare remains viable for future generations.

Concluding Observations

Updating the Medicare benefit package may be an important step in addressing an aging society's legitimate expectations for health care. Expanding access to prescription drugs could ease the significant financial burden some Medicare beneficiaries face because of outpatient drug costs. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long-range financial integrity and sustainability. Care must be taken to ensure that any potential expansion of the program be balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances. The program needs to include adequate fiscal incentives to control costs and should be carefully targeted to meet genuine needs while remaining affordable.

This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Changes need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. Balancing these competing concerns may require the best from government-run programs and private sector efforts to modernize Medicare for the future. Medicare reform and modernization are best done with considerable lead-time to phase in changes and take action before the changes that are needed become dramatic and disruptive.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other committee members may have.

Contacts and Acknowledgments

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