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MEDICARE

Observations on Program Sustainability and Strategies to Control Spending on Any Proposed Drug Benefit

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

April 9, 2003

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Highlights

Highlights of GAO-03-650T, a testimony before the Committee on Ways and Means, House of Representatives

The House Committee on Ways and Means is holding a hearing on modernizing Medicare and integrating prescription drugs into the program.

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.

At the same time, Medicare already faces a huge projected financial imbalance that has worsened significantly in the past year.

This statement discusses the challenges of adding a drug benefit to Medicare in the context of the program's current and projected financial condition. It also examines program design issues to be considered with respect to administering any proposed drug benefit. Specifically, it discusses how private sector health plans have used entities called pharmacy benefit managers (PBM) to control drug benefit expenditures.

www.gao.gov/cgi-bin/getrpt?GAO-03-650T.

To view the full statement, click on the link above. For more information, contact William J. Scanlon at 202 512-7114.

The recent publication of the 2003 Medicare Trustees' annual report reminds us that Medicare in its current condition—without a prescription drug benefit—is not sustainable. At the same time there are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, that may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs.

The Hospital Insurance (HI) portion of Medicare faces a huge projected financial imbalance that has worsened significantly in the past year. Under the Trustees' 2003 intermediate estimates, the present value of HI's actuarial deficit is $6.2 trillion—a 20 percent increase over the prior year. Beginning in 2013, HI's program outlays are expected to begin to exceed program tax revenues, putting increased pressure on the federal budget to raise the resources necessary to meet program costs. In addition, Supplementary Medical Insurance is projected to place an increasing burden on taxpayers and beneficiaries.

GAO's long-term budget simulations show that, absent meaningful entitlement reforms, demographic trends and rising health care spending will drive escalating federal deficits and debt. Neither slowing the growth of discretionary spending nor allowing the 2001 tax reductions to sunset will eliminate the imbalance. While additional economic growth will help ease our burden, the potential fiscal gap is too great to grow our way out of the problem.

The application of basic health insurance principles to any proposed benefit could help moderate the cost for both beneficiaries and taxpayers. These include beneficiary protections against the risk of catastrophic medical expenses and premium contributions and cost-sharing arrangements that encourage beneficiaries to be cost conscious.

The private sector's use of PBMs to control drug expenditures may be instructive for Medicare, but the program's unique role and nature may moderate how such entities would be used and the potential efficiency gains afforded in attempting to transfer PBM-like strategies to Medicare.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss issues related to an outpatient prescription drug benefit for Medicare beneficiaries. 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, about 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 recent publication of the 2003 Trustees' annual report reminds us that Medicare in its current condition—with no prescription drug benefit—already faces a huge projected financial imbalance that has worsened significantly in the past year. Furthermore, as the Medicare Trustees made clear over 10 years ago, the current Medicare program is not fiscally sustainable in its present form.

In 10 years, Hospital Insurance (HI) Trust Fund outlays will begin to exceed tax receipts, and by 2026 the HI trust fund will be exhausted. However, trust fund insolvency does not mean the program will cease to exist; program tax revenues will continue to cover a portion of projected annual expenditures.[1]

The huge fiscal pressures created by the retirement of the baby boom generation and rising health care costs are on our 10-year budget horizon. Between now and 2035, the number of people age 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 fewer workers to support them in retirement.

We must also remember that Medicare has grown substantially as a percent of the federal budget since its enactment in 1965. In addition, it is

[1]Under the Trustees 2003 intermediate assumptions, revenues from the HI payroll tax and the taxation of certain Social Security benefits are initially projected to cover about three-fourths of projected expenditures once the trust fund is exhausted. This ratio, however, is projected to decline rapidly.

expected to represent an increasing percentage of the federal budget in the years ahead. After a brief slowdown in the late 1990s, Medicare spending growth has recently accelerated. In fiscal year 2001, growth in program spending reached nearly 9 percent, with spending on certain services increasing much more rapidly. For example, spending for home health services grew about 30 percent and spending for skilled nursing facility care grew slightly over 20 percent. For the first 5 months of fiscal year 2003, Medicare spending has been growing at 7.6 percent.[2]

A significant problem that hobbles Medicare's ability to achieve a desirable degree of efficiency is that the program too often pays overly generous rates for certain services and products. For example, for certain services, our recent work has shown substantially higher Medicare payments relative to providers' costs—as much as 35 percent higher for home health care and 19 percent higher for skilled nursing facility care.[3] Similarly, Medicare has overpaid for various medical products. In 2001, we reported that Medicare paid over $1 billion more than other purchasers in 2000 for certain outpatient drugs that the program covers. Excessive payments hurt not only the taxpayers but also the program's beneficiaries or their supplemental insurers, as beneficiaries are generally liable for copayments equal to 20 percent of Medicare's approved fee. For certain outpatient drugs, Medicare's payments to providers were so high that the beneficiaries' copayments exceeded the price at which providers could buy the drugs. The Centers for Medicare & Medicaid Services (CMS) has not acted on our recommendation that Medicare establish payment levels for drugs more closely related to actual market transaction costs, using information available to other public programs that pay at lower rates.[4]

In the face of these short-term and long-term cost pressures, I continue to maintain that 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

[2]Congressional Budget Office, *Monthly Budget Review* (Washington, D.C.: Mar. 10, 2003).

[3]See U.S. General Accounting Office, *Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher than Costs*, GAO-02-663 (Washington, D.C: May 6, 2002) and *Skilled Nursing Facilities: Medicare Payments Exceed Costs for Most but Not All Facilities*, GAO-03-183 (Washington, D.C: Dec. 31, 2002).

[4]U.S. General Accounting Office, *Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Costs*, GAO-01-1118 (Washington, D.C.: Sept. 21, 2001).

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. Stated differently, it will be prudent to adopt a modified Hippocratic oath for Medicare reform—namely, any such reform proposals should "do no further harm" to Medicare's already serious long-range financial imbalance.

As you deliberate on ways to modernize Medicare's benefit package while striving for program sustainability, I would like to highlight several key considerations:

- The traditional measure of HI Trust Fund solvency is a misleading gauge of Medicare's financial health. Long before the HI Trust Fund is projected to be insolvent, pressures on the rest of the federal budget will grow as HI's projected cash flow turns negative and the gap between program tax revenues and expenditures escalates. Moreover, a focus on the financial status of HI ignores the increasing burden Supplemental Medical Insurance (SMI)—Medicare part B—will place on taxpayers and beneficiaries.

- GAO's most recent long-term budget simulations continue to show that, absent meaningful entitlement reforms, demographic trends and rising health care spending will drive escalating federal deficits and debt. To obtain budget balance, massive spending cuts, tax increases, or some combination of the two would be necessary. Neither slowing the growth of discretionary spending nor allowing the 2001 tax reductions to sunset will eliminate the imbalance. In addition, while additional economic growth will help ease our burden, the potential fiscal gap is too great to grow our way out of the problem.

- Under the huge budgetary pressures that we are sure to face in the coming years, we must 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 through their premium contributions and cost-sharing arrangements. Given our already huge Medicare financial imbalance, it is also important that benefit expansion proposals include targeting mechanisms to ensure that federal support is directed at the beneficiaries with the greatest financial risk.

- The private sector's use of entities called pharmacy benefit managers for controlling drug expenditures may be instructive for Medicare, but the program's unique role and nature may moderate how these strategies will be used and the potential efficiency gains afforded in attempting to transfer these strategies to Medicare.

Outlook Worsening for Medicare's Long-Term Sustainability

Today the Medicare program faces a long-range and fundamental financing problem driven by known demographic trends and projected escalation of health care spending beyond general inflation. The lack of an immediate crisis in Medicare financing affects the nature of the challenge, but it does not eliminate the need for change. Within the next 10 years, the first baby boomers will begin to retire, putting increasing pressure on the federal budget. From the perspectives of the program, the federal budget, and the economy, Medicare in its present form is not sustainable. Acting sooner rather than later would allow changes to be phased in so that the individuals who are most likely to be affected, namely younger and future workers, will have time to adjust their retirement planning while helping to avoid related "expectation gaps." Since there is considerable confusion about Medicare's current financing arrangements, I would like to begin by describing the nature, timing, and extent of the financing problem.

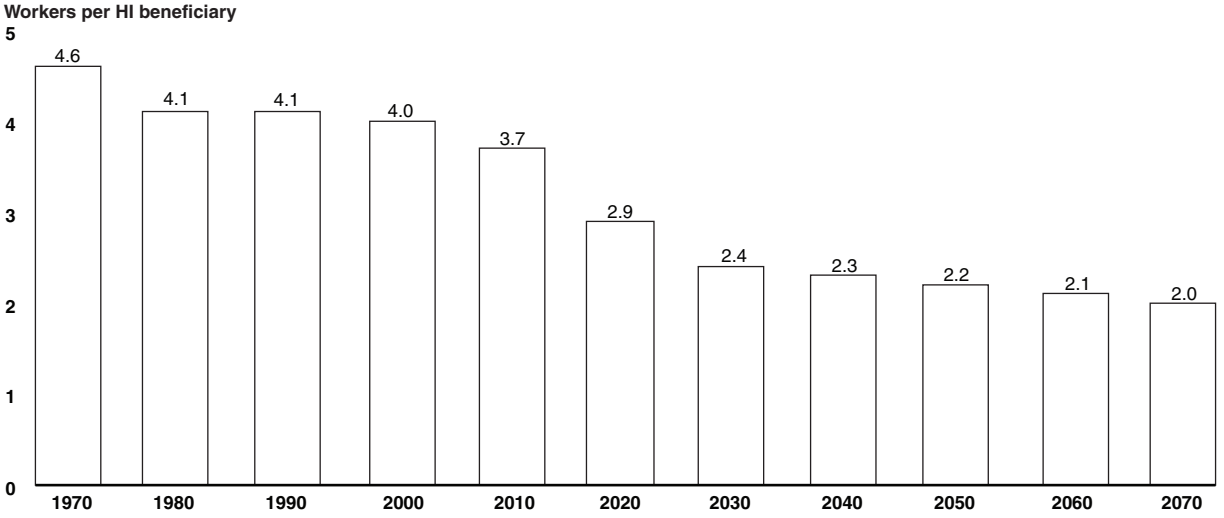
Demographic Trends and Expected Rise in Health Care Costs Drive Medicare's Long-Term Financing Problem

As you know, Medicare consists of two parts—HI and SMI. HI, which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services, is financed by a payroll tax. Like Social Security, HI has always been largely a pay-as-you-go system. SMI, which pays for physician and outpatient hospital services, diagnostic tests, and certain other medical services, is financed by a combination of general revenues and beneficiary premiums. Beneficiary premiums pay for about one-fourth of SMI benefits, with the remainder financed by general revenues. These complex financing arrangements mean that current workers' taxes

primarily pay for current retirees' benefits except for those financed by SMI premiums.[5]

As a result, the relative numbers of workers and beneficiaries have a major impact on Medicare's financing. The ratio, however, is changing. In the future, relatively fewer workers will be available to shoulder Medicare's financial burden. In 2002 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. For the HI portion of Medicare, in 2002 there were nearly 4 covered workers per HI beneficiary. Under their intermediate 2003 estimates, the Medicare Trustees project that by 2030 there will be only 2.4 covered workers per HI beneficiary. (See fig. 1.)

Figure 1: Ratio of HI-Covered Workers to Beneficiaries



Source: CMS, Office of the Actuary.

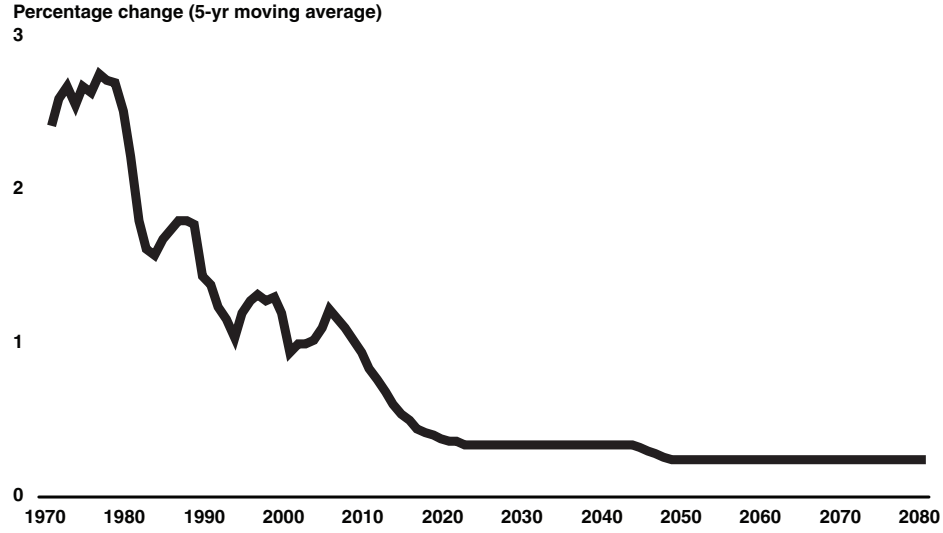
Note: Projections based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

[5]Another small source of funding derives from the tax treatment of Social Security benefits. Under certain circumstances, up to 85 percent of an individual's or couple's Social Security benefits are subject to income taxes. Under present law, the Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds are credited with the income taxes attributable to the taxation of the first 50 percent of OASDI benefit payments. The remainder of the income taxes attributable to the taxation of up to 85 percent of OASDI benefit payments is credited to the HI Trust Fund. Any other income taxes paid by retirees would also help finance the general revenue contribution to SMI.

The demographic challenge facing the system has several causes. People are retiring early and living longer. As the baby boom generation ages, the share of the population age 65 and over will escalate rapidly. A falling fertility rate is the other principal factor underlying the growth in the elderly's share of the population. In the 1960s, the fertility rate was an average of 3 children per woman. Today it is a little over 2, and by 2030 it is expected to fall to 1.95—a rate that is below replacement. The combination of the aging of the baby boom generation, increased longevity, and a lower fertility rate will drive the elderly as a share of total population from today's 12 percent to almost 20 percent in 2030.

Taken together, these trends threaten both the financial solvency and fiscal sustainability of this important program. Labor force growth will continue to decline and by 2025 is expected to be less than a third of what it is today. (See fig. 2.) Relatively fewer workers will be available to produce the goods and services that all will consume. Without a major increase in productivity, low labor force growth will lead to slower growth in the economy and slower growth of federal revenues. This in turn will only accentuate the overall pressure on the federal budget. This slowing labor force growth is not always recognized as part of the Medicare debate, but it is expected to affect the ability of the federal budget and the economy to sustain Medicare's projected spending in the coming years.

Figure 2: Labor Force Growth



Source: Social Security Administration, Office of the Chief Actuary, and GAO.

Note: GAO analysis based on the intermediate assumptions of *The 2003 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and the Federal Disability Insurance Trust Funds*. Percentage change is calculated as a centered 5-year moving average.

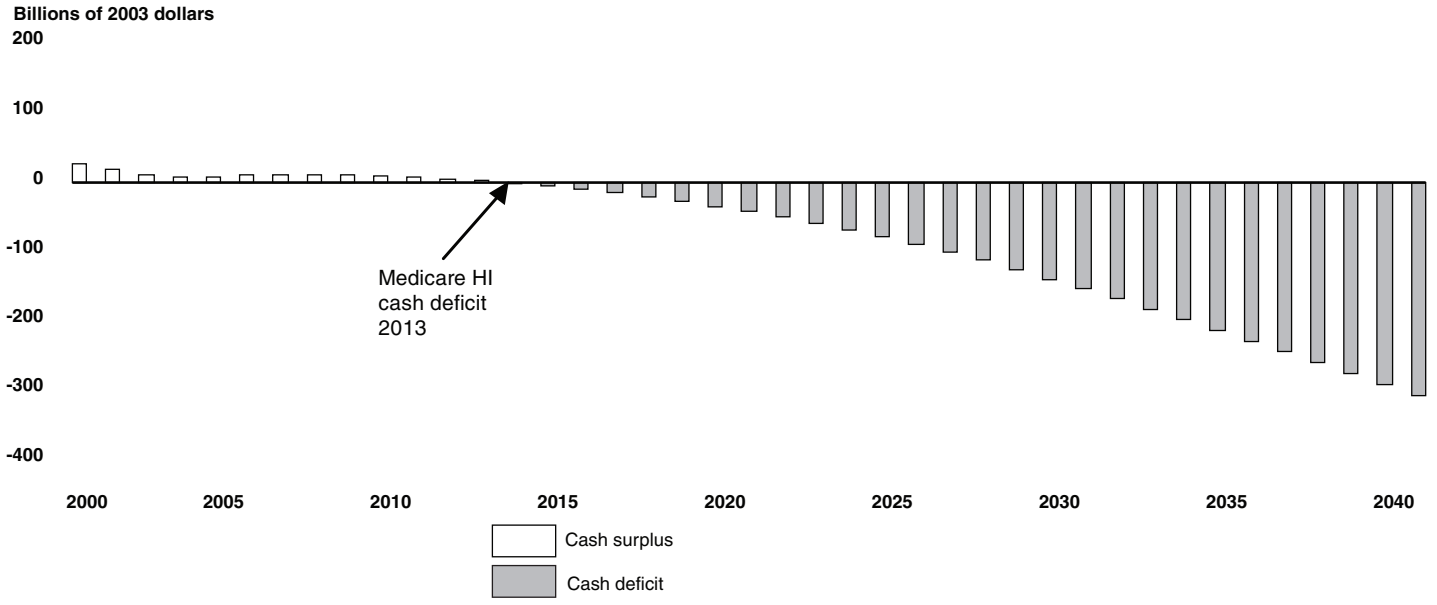
The demographic trends I have described will affect both Medicare and Social Security, but Medicare presents a much greater, more complex, and more urgent challenge. Unlike Social Security, Medicare spending growth rates reflect not only a burgeoning beneficiary population, but also the escalation of health care costs at rates well exceeding general rates of inflation. The growth of medical technology has contributed to increases in the number and quality of health care services. Moreover, the actual costs of health care consumption are not transparent. Third-party payers largely insulate covered consumers from the cost of health care decisions. These factors and others contribute to making Medicare a greater and more complex fiscal challenge than Social Security.

HI's Trust Fund Faces Cash Flow Problems Long before the HI Trust Fund Is Projected to Be Insolvent

Current projections of future HI income and outlays illustrate the timing and severity of Medicare's fiscal challenge. Today, the HI Trust Fund takes in more in taxes than it spends. Largely because of the known demographic trends I have described, this situation will change. Under the Trustees' 2003 intermediate assumptions, program outlays are expected to begin to exceed program tax revenues in 2013. (See fig. 3.) To finance these cash deficits, HI will need to draw on the special-issue Treasury securities acquired during the years of cash surpluses. For HI to "redeem"

its securities, the government will need to obtain cash through some combination of increased taxes, spending cuts, and/or increased borrowing from the public (or, if the unified budget is in surplus, less debt reduction than would otherwise have been the case). Neither the decline in the cash surpluses nor the cash deficits will affect the payment of benefits, but the negative cash flow will place increased pressure on the federal budget to raise the resources necessary to meet the program's ongoing costs. This pressure will only increase when Social Security also experiences negative cash flow and joins HI as a net claimant on the rest of the budget.[6]

Figure 3: Medicare's HI Trust Fund Faces Cash Deficits as Baby Boomers Retire



Source: CMS, Office of the Actuary, and GAO.

Note: GAO analysis based on the intermediate assumptions of *The 2003 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

The gap between HI income and costs shows the severity of HI's financing problem over the longer term. This gap can also be expressed relative to taxable payroll (the HI Trust Fund's funding base) over a 75-year period.

[6]Under the Trustees' intermediate 2003 projections, this will occur for Social Security (OASDI) in 2018.

This year, under the Trustees' 2003 intermediate estimates, the 75-year actuarial deficit is projected to be 2.40 percent of taxable payroll—a significant increase from last year's projected deficit of 2.02 percent. This means that to bring the HI Trust Fund into balance over the 75-year period, either program outlays would have to be immediately reduced by 42 percent or program income immediately increased by 71 percent, or some combination of the two. These estimates of what it would take to achieve 75-year trust fund solvency understate the extent of the problem because the program's financial imbalance gets worse in the 76th and subsequent years. As each year passes, we drop a positive year and add a much bigger deficit year.

The projected exhaustion date of the HI Trust Fund is a commonly used indicator of HI's financial condition. Under the Trustees' 2003 intermediate estimates, the HI Trust Fund is projected to exhaust its assets in 2026. This solvency indicator provides information about HI's financial condition, but it is not an adequate measure of Medicare's sustainability for several reasons. In fact, the solvency measure can be misleading and can serve to give a false sense of security as to Medicare's true financial condition. Specifically, HI Trust Fund balances do not provide meaningful information on the government's fiscal capacity to pay benefits when program cash inflows fall below program outlays. As I have described, the government would need to come up with cash from other sources to pay for benefits once outlays exceeded program tax income.

In addition, the HI Trust Fund measure provides no information on SMI. SMI's expenditures, which currently account for about 43 percent of total Medicare spending, are projected to grow even faster than those of HI in the near future. Moreover, Medicare's complex structure and financing arrangements mean that a shift of expenditures from HI to SMI can extend the solvency of the HI Trust Fund, creating the appearance of an improvement in the program's financial condition. For example, the Balanced Budget Act of 1997 modified the home health benefit, which resulted in shifting a portion of home health spending from the HI Trust Fund to SMI. Although this shift extended HI Trust Fund solvency, it increased the draw on general revenues and beneficiary SMI premiums while generating little net savings.

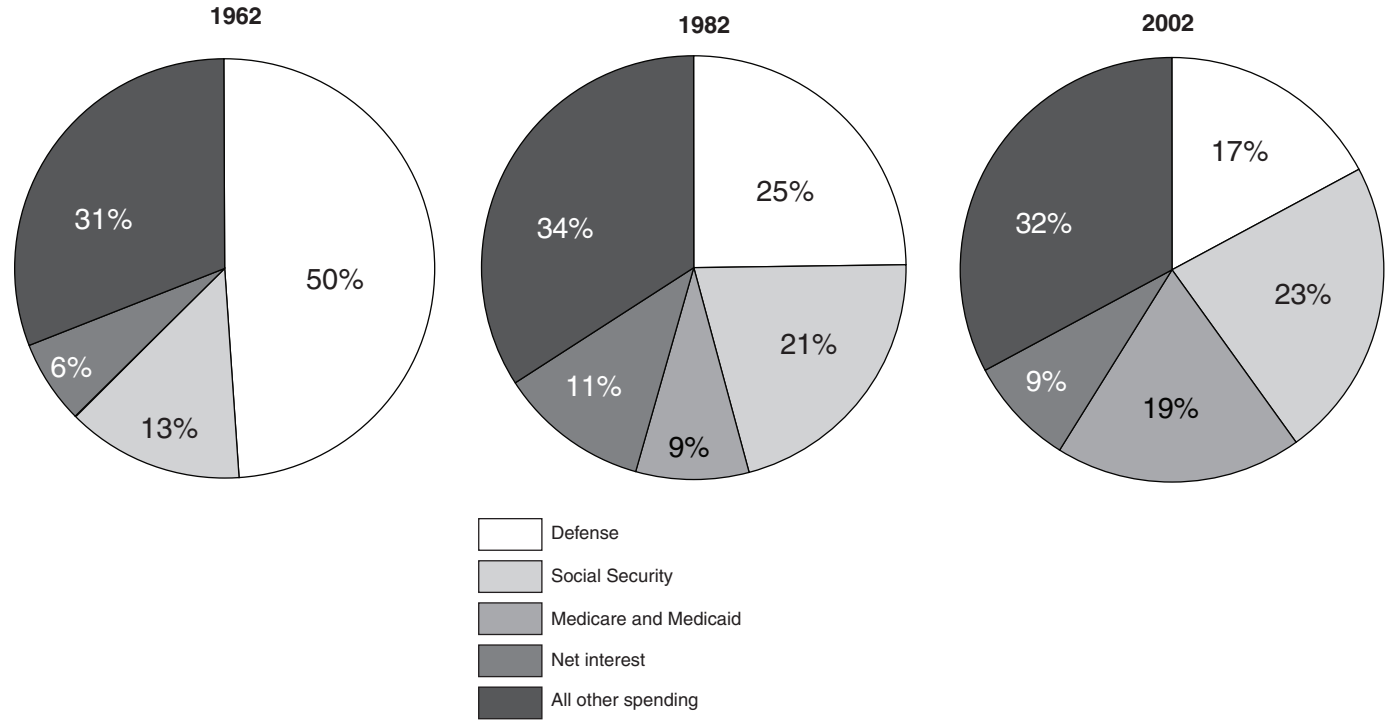
Ultimately, the critical question is not how much a trust fund has in assets, but whether the government as a whole and the economy can afford the promised benefits now and in the future and at what cost to other claims on available resources. To better monitor and communicate changes in future total program spending, new measures of Medicare's sustainability

are needed. As program changes are made, a continued need will exist for measures of program sustainability that can signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product (GDP) devoted to Medicare, or program spending per enrollee. As such measures are developed, questions would need to be asked about actions to be taken if projections showed that program expenditures would exceed the chosen level.

Absent Reform of Medicare and Other Entitlements for the Elderly, Budgetary Flexibility Will Disappear

Taken together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 12 percent of federal revenues in 2002 to more than one-quarter by midcentury. The budgetary challenge posed by the growth in Medicare becomes even more significant in combination with the expected growth in Medicaid and Social Security spending. As shown in figure 4, Medicare, Medicaid, and Social Security have already grown from 13 percent of federal spending in 1962 before Medicare and Medicaid were created to 42 percent in 2002.

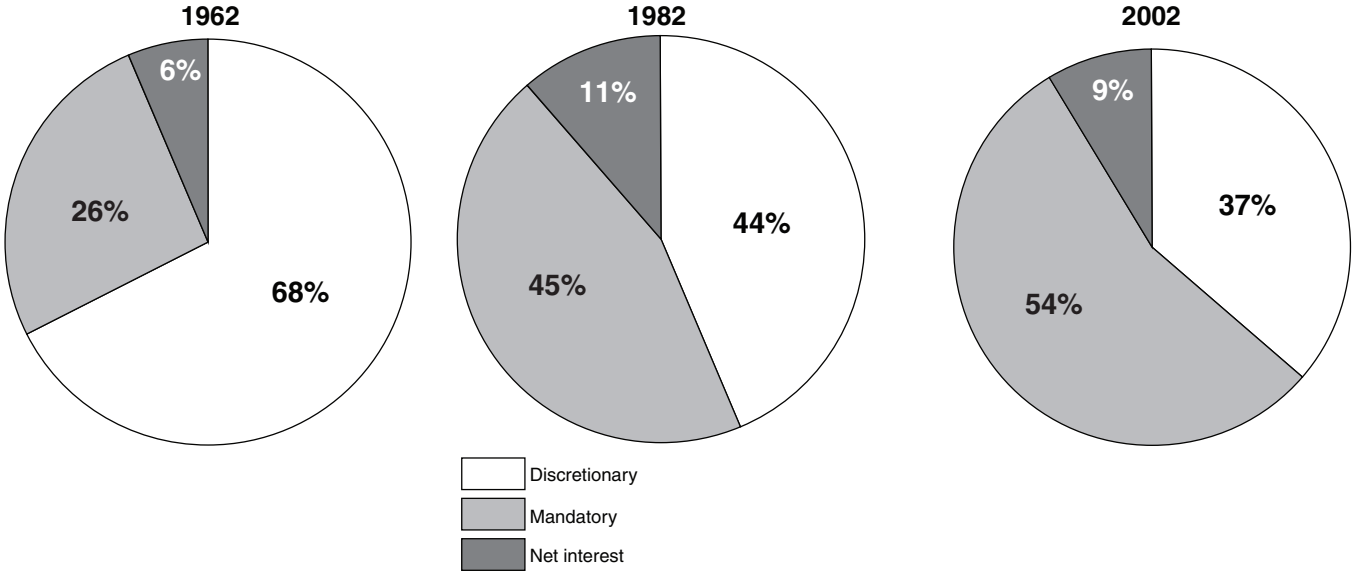
Figure 4: Composition of Federal Spending by Budget Function, 1962, 1982, and 2002



Source: Budget of the United States Government, FY 2004, Office of Management and Budget.

This growth in spending on federal entitlements for retirees will become increasingly unsustainable over the longer term, compounding an ongoing decline in budgetary flexibility. Over the past few decades, spending on mandatory programs has consumed an ever-increasing share of the federal budget.[7] In 1962, prior to the creation of the Medicare and Medicaid programs, spending for mandatory programs plus net interest accounted for about 32 percent of total federal spending. By 2002, this share had almost doubled to approximately 63 percent of the budget. (See fig. 5.)

Figure 5: Federal Spending for Mandatory and Discretionary Programs, Fiscal Years 1962, 1982, and 2002



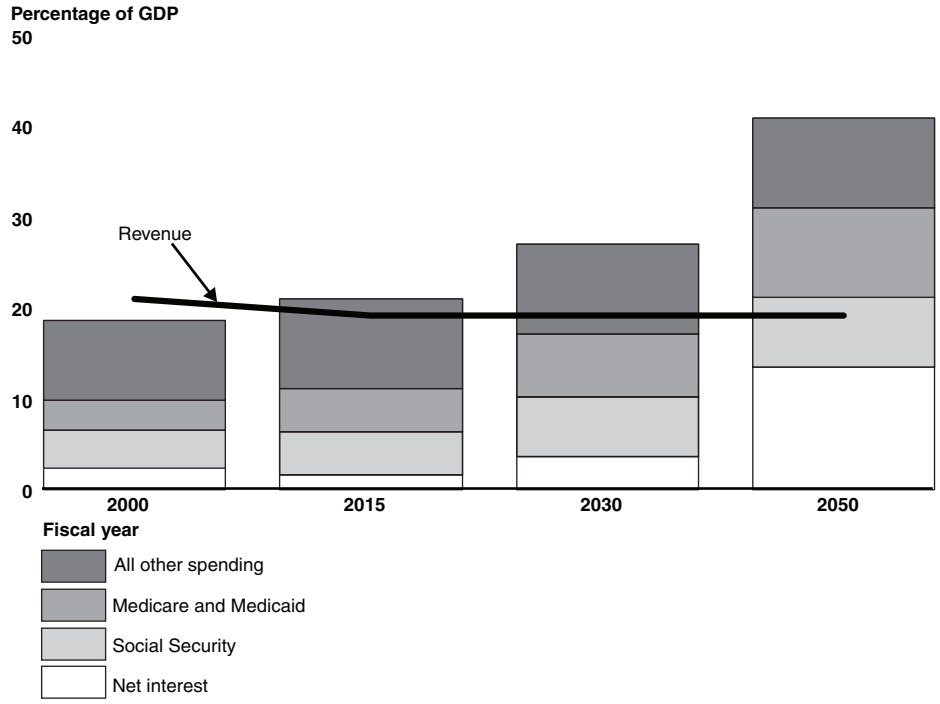
Source: *Budget of the United States Government: Fiscal Year 2004, Office of Management and Budget.*

In much of the past decade, reductions in defense spending helped accommodate the growth in these entitlement programs. However, even before the terrorist attacks of September 11, 2001, this ceased to be a viable option. Indeed, spending on defense and homeland security will grow as we seek to combat new threats to our nation's security.

[7]"Mandatory spending" refers to outlays for entitlement programs such as food stamps, Medicare, and veterans' pensions; payment of interest on the public debt; and outlays for certain nonentitlement programs such as payments to states from Forest Service receipts. In 2002 Social Security, Medicare, and Medicaid accounted for over 71 percent of mandatory spending.

GAO prepares long-term budget simulations that seek to illustrate the likely fiscal consequences of the coming demographic tidal wave and rising health care costs. These simulations continue to show that to move into the future with no changes in federal retirement and health programs is to envision a very different role for the federal government. Assuming, for example, that the tax reductions enacted in 2001 do not sunset and discretionary spending keeps pace with the economy, by midcentury federal revenues may not even be adequate to pay Social Security and interest on the federal debt. Spending for the current Medicare program—without any additional new benefits—is projected to account for more than one-quarter of all federal revenues. To obtain budget balance, massive spending cuts, tax increases, or some combination of the two would be necessary. (See fig. 6.) Neither slowing the growth of discretionary spending nor allowing the tax reductions to sunset eliminates the imbalance. In addition, while additional economic growth would help ease our burden, the projected fiscal gap is too great for us to grow our way out of the problem.

Figure 6: Composition of Spending as a Share of GDP Assuming Discretionary Spending Grows with GDP after 2003 and the 2001 Tax Cuts Do Not Sunset



Source: GAO's March 2003 analysis.

Note: Assumes currently scheduled Social Security benefits are paid in full throughout the simulation period. Social Security and Medicare projections are based on the Trustees' 2003 intermediate assumptions.

Indeed, long-term budgetary flexibility is about more than Social Security and Medicare. While these programs dominate the long-term outlook, they are not the only federal programs or activities that bind the future. The federal government undertakes a wide range of programs, responsibilities, and activities that obligate it to future spending or create an expectation for spending. A recent GAO report describes the range and measurement of such fiscal exposures—from explicit liabilities such as environmental cleanup requirements to the more implicit obligations presented by life-cycle costs of capital acquisition or disaster assistance.[8] Making government fit the challenges of the future will require not only dealing

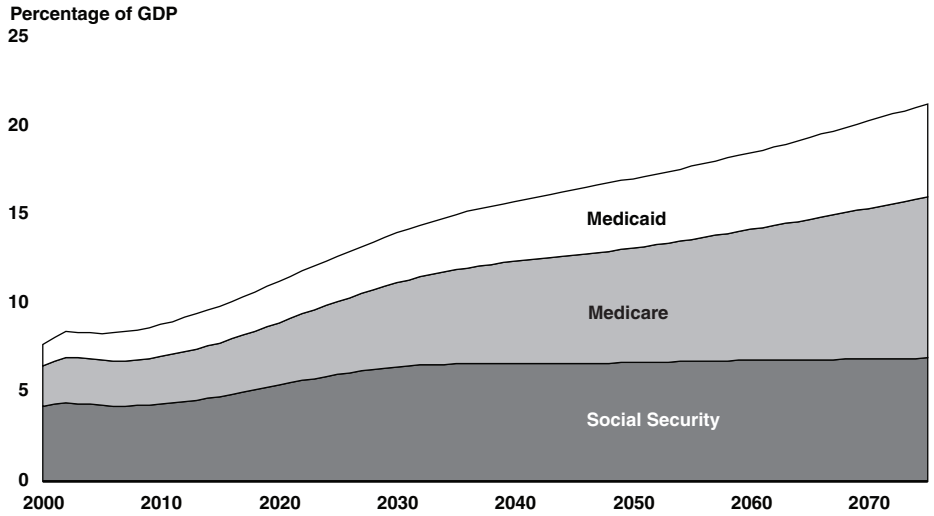
[8]U.S. General Accounting Office, *Fiscal Exposures: Improving the Budgetary Focus on Long-Term Costs and Uncertainties*, GAO-03-213 (Washington, D.C.: Jan. 24, 2003).

with the drivers—such as entitlements for the elderly—but also looking at the range of other federal activities. A fundamental review of what the federal government does and how it does it will be needed. This involves looking at the base of all major spending and tax policies to assess their appropriateness, priority, affordability, and sustainability in the years ahead.

Medicare Is Projected to Absorb Ever-Increasing Shares of the Economy

At the same time, it is important to look beyond the federal budget to the economy as a whole. Figure 7 shows the total future draw on the economy represented by Medicare, Medicaid, and Social Security. Under the 2003 Trustees' intermediate estimates and the Congressional Budget Office's (CBO) most recent long-term Medicaid estimates, spending for these entitlement programs combined will grow to 14 percent of GDP in 2030 from today's 8.4 percent. Taken together, Social Security, Medicare, and Medicaid represent an unsustainable burden on future generations.

Figure 7: Social Security, Medicare, and Medicaid Spending as a Percentage of GDP



Source: CMS, Office of the Actuary, SSA, Office of the Actuary, CBO and GAO.

Note: Projections based on the intermediate assumptions of the 2003 Trustees' Reports, CBO's March 2003 short-term Medicaid estimates, and CBO's June 2002 Medicaid long-term projections under midrange assumptions.

Although real incomes are projected to continue to rise, they are expected to grow more slowly than has historically been the case. At the same time, the demographic trends and projected rates of growth in health care spending I have described will mean rapid growth in entitlement spending.

Taken together, these projections raise serious questions about the capacity of the relatively smaller number of future workers to absorb the rapidly escalating costs of these programs.

As HI trust fund assets are redeemed to pay Medicare benefits and SMI expenditures continue to grow, the program will constitute a claim on real resources in the future. As a result, taking action now to increase the future pool of resources is important. To echo Federal Reserve Chairman Alan Greenspan, the crucial issue of saving in our economy relates to our ability to build an adequate capital stock to produce enough goods and services in the future to accommodate both retirees and workers in the future.[9] The most direct way the federal government can raise national saving is by increasing government saving; that is, as the economy returns to a higher growth path, a balanced fiscal policy that recognizes our long-term challenges can help provide a strong foundation for economic growth and can enhance our future budgetary flexibility. It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Putting Medicare on a sustainable path for the future would help fulfill this generation's stewardship responsibility to succeeding generations. It would also help to preserve some capacity for future generations to make their own choices for what role they want the federal government to play.

As with Social Security, both sustainability and solvency considerations drive us to address Medicare's fiscal challenges sooner rather than later. HI Trust Fund exhaustion may be more than 20 years away, but the squeeze on the federal budget will begin as the baby boom generation begins to retire. This will begin as early as 2008, when the leading edge of the baby boom generation becomes eligible for early retirement.[10] CBO's current 10-year budget and economic outlook reflects this. CBO projects that economic growth will slow from an average of 3.2 percent a year from 2005 through 2008 to 2.7 percent from 2009 through 2013, reflecting slower labor force growth. At the same time, annual rates of growth in entitlement spending will begin to rise. Annual growth in Social Security outlays is projected to accelerate from 5.2 percent in 2007 to 6.6 percent in 2013. Annual growth in Medicare enrollees is expected to accelerate from 1.1

[9]Testimony before the Senate Committee on Banking, Housing, and Urban Affairs, July 24, 2001.

[10]In 2008, the first baby boomers will reach age 62 and become eligible for Social Security benefits; in 2011, they will reach age 65 and become eligible for Medicare benefits.

percent today to 2.9 percent in 2013. Acting sooner rather than later is essential to ease future fiscal pressures and also provide a more reasonable planning horizon for future retirees. We are now at a critical juncture. In less than a decade, the profound demographic shift that is a certainty will have begun.

As Bleak Fiscal Future Looms, Efforts to Address Medicare Coverage Gaps Are Being Considered

Despite a common awareness of Medicare's current and future fiscal plight, pressure has been building to address recognized gaps in Medicare coverage, especially the lack of a prescription drug benefit and protection against financially devastating medical costs. Filling these gaps could add significant expenses to an already fiscally overburdened program. Under the Trustees' 2003 intermediate assumptions, the present value of HI's actuarial deficit is $6.2 trillion, a 20-percent increase from the prior year.[11] This difficult situation argues for tackling the greatest needs first and for making any benefit additions part of a larger structural reform effort.

The Medicare benefit package, largely designed in 1965, provides virtually no outpatient drug coverage. Beneficiaries may fill this coverage gap in various ways. According to the Medicare Current Beneficiary Survey, nearly two-thirds of Medicare beneficiaries had some form of drug coverage from a supplemental insurance policy, health plan, or public program at some point during 1999. All beneficiaries have the option to purchase 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 private health plans that contract to serve Medicare beneficiaries. In recent years, coverage through these sources has become more expensive and less widely available. Beneficiaries whose incomes fall below certain thresholds may qualify for Medicaid or other public programs. More than one-third may lack drug coverage altogether.

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 15.9 percent per year from 1996 to 2001, more

[11]This estimate represents the present value of HI's future expenditures less future tax income, taking into account the amount of HI trust fund assets at hand at the beginning of the projection period and adjusting for the ending target trust fund balance. Excluding the ending target trust fund balance, HI's unfunded obligation is estimated to be $5.9 trillion over the 75-year period under the Trustees' 2003 intermediate assumptions.

than double the 6.5 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 6.5 percent in 1996 to 9.9 percent in 2001. By 2012, 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, 1996 to 2001

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)
2001	$140.6	15.4	8.7
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
Average annual growth from 1996 through 2001		15.9	6.5

Source: CMS, Office of the Actuary.

In 2002, CBO projected that the average Medicare beneficiary would use $2,440 worth of prescription drugs in 2003. This is a substantial amount considering that some beneficiaries lack any drug coverage and others may have less coverage than in previous years. Moreover, significant numbers of beneficiaries have drug expenses much higher than those of the average beneficiary. CBO also estimated that, in 2005, 12 percent of Medicare beneficiaries would have expenditures above $6,000.

In focusing on the need for prescription drug coverage, we should not forget that Medicare does not provide complete protection from catastrophic losses. Under Medicare, beneficiaries have no limit on their out-of-pocket costs attributable to cost sharing. The average beneficiary who obtained services had a total liability for Medicare-covered services of $1,700, consisting of $1,154 in Medicare copayments and deductibles in addition to the $546 in annual part B premiums in 1999, the most recent year for which data are available on the distribution of these costs. For beneficiaries with extensive health care needs, the burden can be much higher. In 1999, about 1 million beneficiaries were liable for more than $5,000, and about 260,000 were liable for more than $10,000 for covered services. In contrast, employer-sponsored health plans for active workers

typically limited maximum annual out-of-pocket costs for covered services to less than $2,000 per year for single coverage.[12]

Recently, several proposals have been made to add a prescription drug benefit to the Medicare program. While different in scope and detail, the proposals have certain features in common—including use of a third-party entity to administer the new drug benefit. The remainder of my remarks will focus on the lessons learned from our work regarding the private sector's use of such an entity to manage the drug benefits of insurers' policyholders and health plans' enrollees.

Private Sector Strategies for Controlling Drug Expenditures May Be Instructive for Medicare

Some proposals to add a Medicare outpatient prescription drug benefit look to private sector strategies as a means to administer a drug benefit and control costs. Most employer-sponsored health plans contract with private entities, known as pharmacy benefit managers (PBM), to administer their prescription drug benefits, and those that do not contract with PBMs may have units in their organizations that serve the same administrative purpose. Typically, on behalf of the health plans, PBMs negotiate drug prices with pharmacies, negotiate rebates with drug manufacturers, process drug claims, operate mail-order pharmacies, and employ various cost-control techniques, such as formulary management and drug utilization reviews. In 2001, nearly 200 million Americans had their prescription drug benefits administered through PBMs. This year, we reported on the use of PBMs by health plans in the Federal Employees' Health Benefits Program (FEHBP).[13] In considering the application of these findings to Medicare, we are reminded that Medicare's unique role and nature may temper how the strategies and potential efficiency gains afforded by private sector PBMs may be transferred to benefit the program.

[12]The Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits: 2000 Annual Survey* (Menlo Park, Calif. and Chicago: 2000).

[13]U.S. General Accounting Office, *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies*, GAO-03-196 (Washington, D.C.: Jan. 10, 2003). FEHBP covered about 8.3 million federal employees, retirees, and their dependents as of July 2002, and the three FEHBP plans we reviewed accounted for about 55 percent of FEHBP enrollment. The FEHBP plans and PBMs we reviewed were Blue Cross and Blue Shield, which contracted with AdvancePCS for retail pharmacy services and Medco Health Solutions for mail-order services; Government Employees Hospital Association, which contracted with Medco Health Solutions; and PacifiCare of California, which contracted with Prescription Solutions, another subsidiary of PacifiCare Health Systems.

Private Sector Uses PBMs to Leverage Price Negotiations through Volume Purchasing

PBMs use purchasing volume to leverage their negotiations with pharmacies and drug manufacturers in seeking favorable prices in the form of discounts, rebates, or other advantages. Through negotiations, PBMs create networks of participating retail pharmacies, promising the pharmacies a greater volume of customers in exchange for discounted prices. PBMs may be able to secure larger discounts by limiting the number of network pharmacies. However, smaller networks provide beneficiaries fewer choices of retailers, thereby limiting convenient access. These are trade-offs health plans must consider in deciding how extensive a pharmacy network they want their PBMs to offer beneficiaries. The health plans we reviewed in our FEHBP study generally provided broad retail pharmacy networks. The average discounted prices PBMs obtained for drugs from retail pharmacies were about 18 percent below the average prices cash-paying customers without drug coverage would have paid for 14 selected widely used brand-name drugs. For 4 selected generic drugs, the PBM-negotiated retail pharmacy prices were 47 percent below the price paid by cash-paying customers.

PBMs also use their leverage to negotiate with drug manufacturers for rebates. Rebates generally depend on the volume of a manufacturer's products purchased. Health plans and PBMs can add to that volume by concentrating beneficiaries' purchases for particular types of drugs with certain manufacturers. Health plans can steer their beneficiaries' purchases to specific drugs through the use of a formulary—that is, a list of prescription drugs that health plans encourage physicians to prescribe and beneficiaries to use. Determining whether a drug should be on the formulary involves clinical evaluations based on a drug's safety and effectiveness, and decisions on whether several drugs are therapeutically equivalent.[14] Restricting the formulary to fewer drugs within a therapeutic class can provide the PBMs with greater leverage in negotiating higher rebates because they can help increase the manufacturer's market share for certain drugs. However, a restricted formulary provides beneficiaries with fewer preferred drug alternatives and makes the policies governing

[14]A pharmacy and therapeutics committee within the health plan or a PBM typically makes decisions about whether to include particular brand-name or generic drugs on the plan's formulary.

coverage of nonformulary drugs or the cost sharing for them critical to beneficiaries.[15]

The FEHBP plans and PBMs we reviewed provided enrollees with generally nonrestrictive drug formularies across a broad range of drugs and therapeutic categories.[16] The manufacturer rebates that the PBMs passed through to the FEHBP plans effectively reduced plans' annual spending on prescription drugs by a range of 3 percent to 9 percent. The share of rebates PBMs passed through to the FEHBP plans varied subject to contractual agreements negotiated between the plans and the PBMs.

PBMs also assisted the FEHBP plans by providing a less expensive mail-order drug option. Mail-order prices for the FEHBP plans we reviewed averaged about 27 percent lower than cash-paying customers would pay for the same quantity at retail pharmacies for 14 brand-name drugs and 53 percent lower for 4 generic drugs. The FEHBP plans generally had lower cost-sharing requirements for drugs purchased through mail order, particularly for more expensive brand-name drugs or maintenance medications for chronic conditions.

The claims and information processing capabilities PBMs offered also helped the FEHBP plans to manage drug costs and monitor quality of care. PBMs maintain a centralized database on each enrollee's drug history that can be used to review for potential adverse drug interactions or potentially less expensive alternative medications. They also use claims data to monitor patterns of patient use, physician prescribing practices, and pharmacy dispensing practices. Their systems provide "real-time" claims adjudication capabilities that allow a customer's claim for a drug purchase to be approved or denied at the time the pharmacist begins the process of filling a prescription. Two plans in our FEHBP study reported savings ranging from 6 to 9 percent of the plan's annual drug spending; the savings

[15]Plans generally encourage the use of formulary drugs by having lower cost sharing or requiring special approval of a nonformulary drug. For example, health plans have increasingly adopted three-tiered cost-sharing strategies whereby enrollees incur the lowest out-of-pocket costs for using generic drugs, higher costs for brand-name drugs on the formulary, and the highest costs for brand-name drugs not included on the formulary.

[16]Our report compared the FEHBP plans' formularies to the Department of Veterans Affairs (VA) National Formulary, considered by the Institute of Medicine to be not overly restrictive. Each FEHBP plan we reviewed included over 90 percent of the drugs listed on the VA formulary or therapeutically equivalent alternatives, and included at least one drug in 93 percent to 98 percent of the therapeutic classes covered by VA.

were associated primarily with real-time claims denials preventing early drug refills and safety advisories cautioning pharmacists about potential adverse interactions or therapy duplications.

Use of Private-Sector Strategies in Medicare Would Represent Departure from Traditional Policies and Practices

While Medicare's sheer size would provide it with significant leverage in negotiating with pharmacies and drug manufacturers, doing so would represent a departure from traditional Medicare. Medicare beneficiaries represent less than 15 percent of the population but a disproportionately higher share—about 40 percent—of prescription drug spending. However, because of Medicare's design and obligations as a public program, its current purchasing strategies vary considerably from those of the private sector.

- *Any willing provider.* In contrast with private payers' reliance on selective contracting with providers and suppliers, the traditional Medicare program has generally allowed any hospital, physician, or other provider willing to accept Medicare's reimbursements and requirements to participate in the program. With respect to drug purchasing in particular, private plans determine the extent of their enrollees' access by the choices they make about the size of their participating pharmacy network and breadth of their drug formulary. Allowing any pharmacy willing to meet Medicare's terms to participate or allowing all therapeutically equivalent drugs equal coverage on a formulary would restrict the program's ability to secure advantageous prices. Moreover, health plans and PBMs currently make formulary determinations privately. In contrast, Medicare's policies have historically been open to public comment.

- *Administrative rate-setting.* Whereas private health plans typically rely on price negotiations to establish payment rates, Medicare generally establishes payment rates administratively. As discussed earlier, Medicare's rates often exceed market prices and this is the case for some of the few outpatient prescription drugs covered by Medicare.[17] The program's method of paying for these drugs is prescribed in statute: In essence, Medicare pays 95 percent of a drug's "average wholesale price" (AWP). Despite its name, however, AWP is not necessarily a price that wholesalers charge and is not based on the price of any actual sale of drugs by a manufacturer. AWPs are published by manufacturers in drug price compendia, and Medicare bases providers' payments on these published AWPs. Other public and private purchasers typically use the

[17] GAO-01-1118.

leverage of volume and competition to secure better prices. By statute, Medicaid, the nation's health insurance program for certain low-income Americans, is guaranteed manufacturers' rebates based on prices charged other purchasers.[18] Certain other public payers can pay at rates set in the federal supply schedule, which uses verifiable confidential information on the prices drug manufacturers charge their "most favored" private customers. Manufacturers agree to these prices, in part, in exchange for the right to sell drugs to the more than 40 million Medicaid beneficiaries.

- *Low-budget program administration*. Duplicating the type of controls PBMs have exercised over private-sector drug benefits would likely involve devoting a larger share of total expenditures to administration than is spent by Medicare currently. Medicare's administrative costs historically have been extremely low, averaging about 2 percent of the cost of the services themselves.[19] This level of expenditure may not be consistent with the level needed to review the volumes of claims data associated with prescription drugs for the elderly or acquire and maintain the on-line systems and databases PBMs use to employ such utilization controls as real-time claims adjudication. The number of prescriptions for Medicare beneficiaries could easily exceed the current number of claims for all other services combined, or over 1 billion annually.

Decisions about the Extent of Latitude and Competition Allowed Are Critical to Administering a Medicare Drug Benefit

Medicare would undoubtedly need assistance from external entities to administer a drug benefit, just as it has used insurers to process claims in the traditional program and Medicare+Choice plans to go further by also managing services and assuming risk. Decisions about the roles assigned an entity or entities and the latitude allowed them in carrying out those roles would be critical. These decisions would undoubtedly affect the benefit's value to beneficiaries and the efficiencies and savings secured for both beneficiaries and taxpayers. Some of these decisions parallel those made by FEHBP plans that I discussed—trade-offs about beneficiaries' interests in broad pharmacy networks and formularies versus potential savings. Others stem from the uniqueness of Medicare, its likely

[18]Since the enactment of the Omnibus Budget Reconciliation Act of 1990, drug manufacturers are required to provide rebates to state Medicaid programs on outpatient drugs based on the "lowest" or "best" prices they charged other purchasers or a minimum of 15.1 percent of the average manufacturers' price (AMP) for brand-name drugs. Rebates must be at least 11 percent of AMP for generic drugs.

[19]U.S. General Accounting Office, *Medicare: HCFA Faces Challenges to Control Improper Payments*, GAO/T-HEHS-00-74, (Washington, D.C.: Mar. 9, 2000).

disproportionate share of the drug market, and its position as a public program requiring transparency and fairness.

Insurers and PBMs have been successful in securing some savings on drug purchases by leveraging their volume to move market share from one product to another. Medicare's leverage, given that purchases by the elderly constitute about 40 percent of the drug market, could be considerable. Yet the large market share may also be likely to attract considerable attention. The administration of a Medicare drug benefit could then be subject to the same intensity of external pressures from interested parties regarding program prices and rules that can often inhibit the program from operating efficiently today. The potential for micromanagement could compromise trying to use the very flexibility PBMs have employed in negotiating prices and selecting preferred providers in order to generate savings. An alternative would be to sacrifice some of the program's leverage and grant flexibility to multiple PBMs or similar entities so that any one entity would be responsible for administering only a share of the market.

Contracting with multiple PBMs or similar entities, however, would pose other challenges. If each had exclusive responsibility for a geographic area, beneficiaries who wanted certain drugs could be advantaged or disadvantaged merely because they lived in a particular area. To minimize inequities, Medicare could, like some private sector purchasers, specify core benefit characteristics or maintain clinical control over formulary decisions instead of delegating those decisions to its contractors.

If multiple PBMs or similar entities operated in a designated area, beneficiaries could choose among them to administer their drug benefits. These organizations would compete for consumers directly on the basis of differences in their drug benefit offerings and administration. This contrasts with the private sector where drug benefits are typically part of an overall insurance plan, and PBMs typically compete for contracts with insurers or other purchasers. Competition could be favorable to beneficiaries if they were adequately informed about differences among competing entities offering drug benefits and shared in the savings. However, adequate oversight would need to be in place to ensure that fair and effective competition was maintained. For example, a means to ensure that beneficiaries received comprehensive user-friendly information about policy and benefit differences among competing entities would be necessary. Monitoring marketing and customer recruitment strategies and holding entities accountable for complying with federal requirements would require adequate investment. The contracting entities could need

protections as well. Some mechanism would be needed to risk adjust payments for differences in beneficiaries' health status so that those entities enrolling a disproportionate share of high-use beneficiaries would not be disadvantaged.

Concluding Observations

Medicare's financial challenge is very real and growing. The 21st century has arrived and our demographic tidal wave is on the horizon. Within 5 years, individuals in the vanguard of the baby boom generation will be eligible for Social Security and 3 years after that they will be eligible for Medicare. The future costs of serving the baby boomers are already becoming a factor in CBO's short-term cost projections.

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 just the next 10 years. For this reason, I cannot overstate the importance of adopting meaningful reforms to ensure that Medicare remains viable for future generations. Adding a drug benefit to Medicare requires serious consideration of how that benefit will affect overall program spending. If competing private entities are to be used to administer a drug benefit, it is important to understand how these entities can be used in the Medicare context to provide a benefit that balances beneficiary needs and cost containment.

Medicare reform would be done best with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. Given the size of Medicare's financial challenge, it is only realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. We should begin this now, when retirees are still a far smaller proportion of the population than they will be in the future. The sooner we get started, the less difficult the task will be.

We must also be mindful that health care costs compete with other legitimate priorities in the federal budget, and their projected growth threatens to crowd out future generations' flexibility to decide which competing priorities will be met. In making important fiscal decisions for our nation, policymakers need to consider the fundamental differences among wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations

within a broader context of providing for other important national needs and economic growth.

The public sector can play an important role in educating the nation about the limits of public support. Currently, there is a wide gap between what patients and providers expect and what public programs are able to deliver. Moreover, there is insufficient understanding about the terms and conditions under which health care coverage is actually provided by the nation's public and private payers. In this regard, GAO is preparing a health care framework that includes a set of principles to help policymakers in their efforts to assess various health financing reform options. This framework will examine health care issues systemwide and identify the interconnections between public programs that finance health care and the private insurance market. The framework can serve as a tool for defining policy goals and ensuring the use of consistent criteria for evaluating changes. By facilitating debate, the framework can encourage acceptance of changes necessary to put us on a path to fiscal sustainability. I fear that if we do not make such changes and adopt meaningful reforms, future generations will enjoy little flexibility to fund discretionary programs or make other valuable policy choices.

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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