

CBO TESTIMONY

**Statement of
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Director**

Prescription Drugs and Medicare Financing

**before the
Committee on Finance
United States Senate**

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**CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
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Mr. Chairman and Members of the Committee, I am pleased to be here today to describe the Congressional Budget Office's (CBO's) latest projections of Medicare spending and their implications for the program in the long run. I will also raise several issues to be considered in designing an outpatient prescription drug benefit for Medicare beneficiaries. Those two topics are related: while the financial pressure faced by Medicare in the next decade and beyond has intensified interest in restructuring the program, that same pressure complicates efforts to expand Medicare to add a new benefit that could be very costly.

PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

The growth of Medicare spending has been much slower in the past few years than it has been historically. In fiscal years 1998 through 2001, CBO estimates that benefit payments will have grown at an average annual rate of 3.4 percent, compared with 10.0 percent per year over the previous decade. That lower rate of growth can be attributed to several factors, including the Balanced Budget Act of 1997 (BBA), strong efforts to reduce fraud and abuse by increasing compliance with payment rules, and slower inflation, both economywide and in the health care sector.

Partly in response to the slowdown in Medicare spending, the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA) increased payments to providers and plans above the levels that would otherwise have resulted. Those increases will continue to be felt in future years.

CBO estimates that Medicare will spend \$237 billion on benefits for 40 million elderly and disabled people in fiscal year 2001. Despite the recent slowdown in spending growth, that amount is almost 25 percent more than Medicare spent five years ago. Medicare now accounts for about 12 percent of estimated total federal spending, or 2.3 percent of gross domestic product (GDP).

Moreover, CBO is projecting faster Medicare growth over the next decade. We estimate that Medicare spending will more than double—reaching \$491 billion—by fiscal year 2011, reflecting an average increase of 7.7 percent per year (see Figure 1). At that rate, Medicare spending in 2011 will constitute 19 percent of the federal budget, assuming no change occurs in current tax and spending policies. In fact, the program will account for 36 percent of the projected increase in federal spending by the end of the decade.

CBO expects the growth in Medicare spending to accelerate for several reasons. The bulk of the savings from the compliance efforts that were begun in the late 1990s have

now been realized. In addition, provider payment rates for most services (including hospital care and services furnished by physicians, skilled nursing facilities, and home health agencies) are automatically increased to reflect changes in input prices. CBO estimates that those updates will raise Medicare spending by 3.1 percent annually over the next decade, as a result of recent legislation boosting some rates and the expiration of previous legislation restricting others. Roughly 43 percent of the projected increase in Medicare spending in fiscal years 2002 through 2011 comes from automatic updates and other changes in payment rates.

Increases in the utilization of health services resulting from a larger and older Medicare population make up an additional 26 percent of the projected increase in program spending. The number of Medicare beneficiaries will rise over the next 10 years—and the average age of Medicare beneficiaries will increase as people live longer. As a result, Medicare beneficiaries will use more services. The remaining 31 percent of the projected spending increase is attributable to other factors, such as changes in medical technology and practice patterns as well as changes required by the BBA, BBRA, and BIPA (for example, expansions in covered benefits).

As with all CBO projections, these figures are not intended to predict the future. As baseline estimates, they explicitly assume no legislative changes during the period to which they apply. Nevertheless, they illustrate the mounting financial pressure facing the Medicare program under current and expected future conditions.

LONG-TERM PROJECTIONS

Medicare spending occurs under two separate programs, the Hospital Insurance (HI) program, or Part A, and the Supplementary Medical Insurance (SMI) program, or Part B. HI spending will total an estimated \$137 billion in fiscal year 2001, paying for inpatient hospital care, some stays in skilled nursing facilities, some home health care, and hospice services. SMI spending in that year is projected to reach almost \$100 billion, paying for services from physicians and outpatient care facilities, as well as medical supplies and home health benefits.

The HI program is financed by the Medicare payroll tax and the portion of income taxes on Social Security benefits that is earmarked for the HI trust fund. The SMI program is financed primarily from general revenues that cover about 75 percent of SMI costs, with the rest covered by monthly premiums paid by enrollees. It should be noted that 87 percent of total Medicare revenues in 2001 come from taxes paid by

current workers; current Medicare beneficiaries pay the other 13 percent through SMI premiums and income taxes on Social Security benefits.

The annual report released earlier this week by the Medicare Board of Trustees indicates that estimated total income to the HI trust fund will exceed estimated outlays by \$29.8 billion in fiscal year 2001. But \$12.6 billion of that amount comes from interest on the trust fund's assets and from other miscellaneous sources. If just the tax revenues dedicated to the HI trust fund were counted against the fund's outlays, its estimated surplus this year would be only \$17.2 billion.

The Medicare trustees also report that under their intermediate assumptions, the HI trust fund will exhaust its assets in 2029—four years later than they projected in last year's report. But the trust fund's expenses will exceed its dedicated revenues beginning in 2016—a full 13 years earlier. By 2029, the revenues dedicated to the HI trust fund would equal only 68 percent of costs; by 2075, that ratio would be only 32 percent.

Those data do not take into account Medicare's SMI program, which is growing more rapidly than the HI program. As recently as fiscal year 1997, HI benefit payments constituted 66 percent of total Medicare benefit payments. As of 2001, that proportion had declined to 58 percent, and CBO projects that it will have declined to 53 percent by fiscal year 2011. Some of that change is due to the movement of home health care from HI to SMI according to the provisions of the BBA, which increases the estimated balance in the HI trust fund in fiscal year 2011 by about \$240 billion. That shift further blurs an already hazy distinction between the two programs.

The Medicare trustees' report projects that total Medicare spending will increase from 2.2 percent of GDP in 2000 to 3.9 percent in 2025 and 8.5 percent in 2075. Those numbers reflect a change in the trustees' assumptions from last year, following the recommendation of their panel of experts that they raise their projection of long-term growth in Medicare spending per beneficiary.¹

The mounting financial pressure on the Medicare program is highlighted by the large and growing difference between projected total Medicare spending and the total amount of federal revenues specifically dedicated to the program, including the Medicare payroll tax, the portion of the income taxes on Social Security benefits that

1. That change is consistent with the one that CBO applied in its most recent report (October 2000) on *The Long-Term Budget Outlook*.

are paid to the HI trust fund, and premiums paid by enrollees for SMI. That difference is the minimum amount of federal general revenues required to fund total Medicare expenditures.

According to the Medicare trustees, the discrepancy between total Medicare expenditures and dedicated revenues will be \$64.0 billion in 2001, or 0.6 percent of GDP (see Figure 2). By 2011, that gap is projected to rise to \$138.6 billion, or 0.8 percent of GDP. That amount would represent 30 percent of Medicare's gross outlays, up from 26 percent in 2001. By 2075, that gap is projected to grow to 6.0 percent of GDP.

Beyond the next decade, utilization of Medicare-covered services is expected to accelerate. As I stated earlier, Medicare enrollment, which has increased at a rate of about 1 percent a year over the past 10 years and is expected to grow somewhat faster over the next decade, will rise even more rapidly as the baby-boom generation begins to retire in 2011. According to the Medicare trustees, there will be 77 million beneficiaries in 2030—an increase of 95 percent over this year's enrollment. In addition, as technology advances, more services will be available for use by more patients, and those services will be more costly.

At the same time, the number of workers whose payroll taxes provide the bulk of Medicare's dedicated revenues will not keep up with the growing number of beneficiaries. While the number of beneficiaries in 2030 will be 95 percent greater than it is now, the number of workers paying into Medicare will be only about 15 percent greater. As a result, the ratio of covered workers to Medicare beneficiaries is expected to fall from 4.0 to 2.3. Correspondingly, Medicare HI spending as a percentage of taxable payroll is expected to rise, from 2.7 percent in 2000 to 4.9 percent in 2030 and 10.7 percent by 2075 (see Figure 3).

These financial pressures have focused policymakers' attention on restructuring the Medicare program. There are two basic issues. First, Medicare lacks a mechanism for using market forces to encourage efficiency in running the program and providing health care to its beneficiaries. Although the Medicare+Choice program was intended to expand the availability of different types of private plans to Medicare beneficiaries and increase the use of private-sector approaches for organizing and delivering health care, price competition among such plans is limited to the premium they charge for

additional benefits and the amount of cost sharing faced by their enrollees.² Moreover, plan participation has declined, resulting in reduced enrollment, and attempts to develop competitive-bidding demonstration projects in selected areas have not been successful.

Second, Medicare does not provide modern insurance protection to its beneficiaries. Its benefits are still modeled largely on those provided by the private insurance industry of the 1960s. And unlike typical private coverage today, it does not cover outpatient prescription drugs. In addition, some Medicare benefits are subject to coverage limits, and the program has no stop-loss provision to protect beneficiaries against the consequences of very costly episodes of illness that may exceed those limits. As a result, many elderly people have purchased additional coverage through medigap policies, and others rely on employer-sponsored coverage to reduce their financial risk.

PROVIDING COVERAGE FOR PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

Beneficiaries' Current Spending on Prescription Drugs

In recent years, growth in prescription drug spending has far outpaced growth in spending for other types of health care. The impact of those rising expenditures on Medicare beneficiaries, on employers who offer retiree health coverage, and on state governments has, in turn, put proposals for a prescription drug benefit through Medicare near the top of the policy agenda.

Between 1990 and 2000, annual spending on prescription drugs in the United States grew at nearly twice the rate as that for total national health expenditures, and it has maintained a double-digit pace since the mid-1990s. For the U.S. population as a whole, three factors explain most of that growth: the introduction of new and costlier drug treatments, broader use of prescription drugs by a larger number of people, and lower cost-sharing requirements by private health plans. Within some therapeutic classes, new brand-name drugs tend to be much costlier than older drug therapies, which has also contributed to growth in spending. Use of prescription drugs has broadened as well, because many new drugs provide better treatment or have fewer side effects than older alternatives and more people are aware of new drug therapies

2. Beginning in 2003, plans can offer their enrollees rebates on a portion of the SMI premium.

through the "direct to consumer" advertising campaigns of pharmaceutical manufacturers.

Even without a Medicare drug benefit, CBO expects prescription drug costs for Medicare enrollees to grow at a rapid pace over the next decade (see Table 1). At an average annual rate of 10.3 percent per beneficiary, drug costs would rise at nearly twice the pace of combined costs for Medicare's HI and SMI programs, and much faster than growth in the nation's economy. (CBO's estimates of rising drug spending are based on the latest projections for prescription drug costs within the national health accounts.)

Existing Coverage

Third-party coverage for prescription drugs has become more generous for the population as a whole, but that trend is less clear for Medicare beneficiaries. In 1997, nearly one-third of the Medicare population had no prescription drug coverage. On average, Medicare beneficiaries paid about 45 percent of their drug expenditures out of pocket (see Figure 4). By comparison, all people in the United States paid an average of 39 percent of the cost of their prescriptions. Because Medicare beneficiaries are elderly or disabled, they are also more likely to have chronic health conditions and use more prescription drugs: nearly 89 percent filled at least one prescription in 1997. Medicare beneficiaries made up 14 percent of the population that year, yet they accounted for about 40 percent of the \$75 billion spent on prescription drugs in the United States.

Those factors suggest that growth in drug spending has a larger financial impact on the Medicare population than on other population groups. However, aggregate statistics mask a wide variety of personal circumstances. Nearly 70 percent of beneficiaries obtain drug coverage as part of a plan that supplements Medicare's benefits, but those supplemental plans vary significantly in their generosity.

Traditionally, retiree health plans have provided prescription drug coverage to more seniors than any other source, and their benefits have been relatively generous. In 1997, about one-third of Medicare beneficiaries had supplemental coverage through a current or former employer, and most of those plans provided drug coverage (see Table 2). Although specific benefits vary, it is common to find relatively low deductibles and copayments in employer-sponsored drug plans.

However, prescription drug spending by elderly retirees has become a significant cost to employers, and many have begun to restructure their benefits. For example, a 1997 Hewitt Associates' study for the Kaiser Family Foundation found that among large employers, drug spending for people age 65 or older made up 40 percent to 60 percent of the total cost of their retiree health plans. Average utilization of prescription drugs among elderly retirees was more than double that for active workers. Although relatively few employers in the Hewitt survey have dropped retiree coverage altogether, most have taken steps to control costs, such as tightening eligibility standards, requiring retirees to contribute more toward premiums, placing caps on the amount of benefits that plans will cover, and encouraging elderly beneficiaries to enroll in managed care plans.

In some parts of the country, Medicare+Choice (M+C) plans are another means by which the elderly and disabled have obtained prescription drug coverage. In 2000, for example, 64 percent of Medicare beneficiaries had access to M+C plans that offered some drug coverage. However, many M+C plans have scaled back their drug benefits in response to rising costs and slower growth in Medicare's payment rates. Nearly all such plans have annual caps on drug benefits for enrollees—many at a level of only \$500 per year—and a growing share of plans charge a premium for supplemental benefits.

While 26 percent of the Medicare population relied on individually purchased (often medigap) plans as their sole form of supplemental coverage in 1997, less than half of that group had policies that covered prescription drugs. Medigap plans with drug coverage tend to be much less generous than retiree health plans; medigap plans have a deductible of \$250, 50 percent coinsurance, and annual benefit limits of either \$1,250 or \$3,000. Premiums for plans that include drug coverage also tend to be much higher than premiums for other medigap plans, due in part to their tendency to attract enrollees who have higher-than-average health expenses.

Certain low-income Medicare beneficiaries may be eligible for Medicaid coverage, which generally includes a prescription drug benefit. All state Medicaid programs offer prescription drug coverage (usually involving little or no cost sharing) to people whose income and assets fall below certain thresholds. In addition, as of January 2001, 26 states had authorized (but had not necessarily yet implemented) some type of pharmaceutical assistance program, most of which would provide direct aid for purchases to low-income seniors who did not meet the Medicaid requirements. About 64 percent of the Medicare population lives in those states.

Thus, middle- and higher-income seniors can usually obtain coverage through retiree or M+C plans, while seniors with the lowest income generally have access to state-based drug benefit programs. However, beneficiaries with incomes between one and two times the poverty level are more likely to be caught in the middle, with income or asset levels that are too high to qualify for state programs and less access than higher-income enrollees to drug coverage through former employers.

Design Choices for a Medicare Drug Benefit

Rapid growth in prescription drug costs, together with erosion of private insurance coverage for retirees, suggests that there will be continued political pressure for relief to seniors and the disabled through the Medicare program. Depending on the structure of the proposed benefit, though, those same forces could also rapidly expand the cost of a new Medicare drug program because individuals tend to consume more or costlier prescription drugs when they obtain insurance coverage. Further, implementing only a drug benefit now might complicate more extensive reform of the Medicare program in the future.

A Medicare drug benefit might address a number of objectives. The most fundamental would be to ensure that all beneficiaries had access to reasonable coverage for outpatient prescription drug costs—but there is room for considerable debate about what that would mean. The various objectives that might be thought desirable in the abstract are often mutually incompatible, so that difficult choices must be made. For example, it is not possible to provide a generous drug benefit to all Medicare beneficiaries at low cost—either enrollees' premiums or the government's subsidy costs would be high. If most of the costs were paid by enrollees' premiums to keep federal costs low, some Medicare beneficiaries would be unwilling or unable to participate in the program. If costs were limited by covering only catastrophic expenses, few enrollees would benefit in any given year, possibly reducing support for the program. If, instead, costs were limited by capping the annual benefits paid to each enrollee, the program would fail to protect participants from the impact of catastrophic expenses.

In designing a drug benefit, policymakers must make four fundamental decisions:

- Who may participate?
- How will program costs be financed?

- How comprehensive will coverage be?
- Who will administer the benefit and under what conditions?

Participation. Although most Medicare enrollees use some prescription drugs, the bulk of such spending is concentrated among a much smaller group. In 1997, about 13 percent of enrollees had expenditures of \$2,000 or more, accounting for 45 percent of total drug spending by the Medicare population. Forty-six percent had expenditures of \$500 or less, making up about 8 percent of total spending. Most spending is associated with treatment of chronic conditions—such as hypertension, cardiovascular disease, and diabetes. The skewed distribution of spending and the need for people with chronic conditions to stay on drug therapies over the long term makes stand-alone drug coverage particularly susceptible to adverse selection, where enrollment is concentrated among those who expect to receive more in benefits than they would pay in premiums.

Because of the likelihood of adverse selection, a premium-financed drug benefit offered as a voluntary option for Medicare enrollees must restrict participation in some way. If Medicare beneficiaries were free to enroll in or leave the program at will, only those who expected to gain from the benefit would participate each year. That would drive premiums up, which would further reduce enrollment as those enrollees with below-average drug costs dropped out.

Most of the drug benefit proposals developed in 2000 would have provided a voluntary drug option, but they attempted to mitigate the potential for adverse selection by one of two approaches: either they gave enrollees only one opportunity to choose the drug benefit, at the time they first became eligible, or they imposed an actuarially fair premium surcharge on those who delayed enrollment. Another approach that would avoid the problem of adverse selection would be to couple the drug benefit with Part B of Medicare, so that enrollees could choose either Part B plus a drug benefit or no Part B and no drug benefit. In that case, even if the drug portion of the benefit was not heavily subsidized, the current 75 percent subsidy of Part B benefits would ensure nearly universal participation in the coupled benefit.

Financing. Program costs could be entirely financed by enrollees' premiums, or some or all of the costs could be paid by the federal government. Given a one-time-only enrollment option, participation rates would be reasonably high, even if the program was largely financed by enrollees' premiums. If enrollees lived long enough, virtually all of them would benefit from drug coverage, and the erosion now occurring in the

comprehensive coverage provided by private plans would also spur participation. Further, employer-sponsored health plans would probably require that retirees eligible for a new Medicare benefit participate in it, just as they now effectively require that retirees participate in Part B. And state Medicaid agencies, even if not required to do so, would choose to enroll dual eligibles (people eligible for both Medicare and Medicaid) in a new Medicare drug benefit if their costs under the new program were less than the cost of the drug benefits now provided under Medicaid. However, if a generous drug benefit was fully financed by enrollees, premiums would be high, making the benefit difficult to afford for lower-income beneficiaries ineligible for Medicaid. The drug proposals developed last year all provided full subsidies to low-income people for both cost-sharing and premium expenses, in addition to partially subsidizing premium costs for all other enrollees.

Coverage. A Medicare drug benefit could be designed to look like the benefit typically provided by employer-sponsored plans. If so, it would be integrated with the rest of the Medicare benefit. Further, it would have low cost-sharing requirements (ranging from 20 percent to 25 percent coinsurance or a copayment per prescription of \$10 to \$25) and stop-loss protection—a dollar limit above which no cost sharing would be required. Such comprehensive coverage would provide good protection for enrollees, but it would be very costly. Not only would it transfer most of the costs of drugs currently used by enrollees to the Medicare program, but it would also increase utilization among those with less generous coverage now.

One way to constrain costs and utilization is by limiting coverage—covering only catastrophic costs, for example, or imposing a cap on benefits paid per enrollee each year. If Medicare provided coverage only for catastrophic costs, most enrollees would receive no benefit payments in any given year. Nevertheless, it would be inaccurate to say that those enrollees would receive no benefit, since they would be protected against the possibility of catastrophic expenses—the main function of insurance. Public support for a drug benefit might be stronger, though, if most enrollees could reasonably expect to receive some benefit payments each year.

Alternatively, policymakers could take the other approach to limiting costs: covering a portion of all drug costs but only up to a benefit cap. But because that approach would not protect those enrollees who are most in need, most of last year’s proposals included stop-loss protection. The end result was a benefit unlike anything available in the private sector—a hybrid that had a capped benefit, then a “hole” with no drug coverage, and finally a stop-loss provision, beyond which the program would pay all drug costs (see Figure 5). The larger the range of spending encompassed by the hole,

the less costly the program would be—but also the less coverage the benefit would provide.

An approach to limiting costs within the context of a more traditional benefit would be to have a higher initial deductible amount, relatively high cost-sharing requirements, and a high stop-loss value. Or the program could provide a more generous benefit similar to those provided by employer-sponsored plans, with federal costs limited by having most of the costs financed by enrollees' premiums.

Administration. The way in which a drug benefit is administered can also have a significant effect on how costly it is. All recent proposals have envisioned adopting the now common private-sector approach of using pharmacy benefit managers (PBMs) in each region. Proposals have differed, however, in whether only one or several PBMs would serve a region, in whether the responsible entities would assume any insurance risk, and in what kind of restrictions would be placed on them.

Private health plans use PBMs to process claims and to negotiate price discounts with drug manufacturers and dispensing pharmacies. PBMs also try to steer beneficiaries toward lower-cost drugs, such as generic, preferred formulary, or mail-order drugs. In addition, because of their centralized records for each enrollee's prescriptions, they can help to prevent adverse drug interactions. The likelihood that PBMs could effectively constrain costs depends on their having both the authority and the incentive to aggressively use the various cost-control mechanisms at their disposal. In the private sector, PBMs often have considerable leeway in the tools they can use, but they do not assume any insurance risk for the drug benefit. At most, they may be subject to a bonus or a penalty added to their administrative fee, based on how well they meet prespecified goals for their performance.

Some of the proposals developed last year (such as the one developed by the Clinton Administration) adopted the typical private-sector model, with a single PBM selected periodically to serve each region and with all insurance risk borne by Medicare, not the PBM. Two main concerns about that model are that it might prove politically difficult to allow the designated PBMs to use cost-control tools aggressively if enrollees have no choice of provider in each region, and that non-risk-bearing PBMs might have too little incentive to use strong tools, even if they were permitted.

Other proposals (such as the Breaux-Frist bills and the House-passed drug bill) adopted a different model, more akin to the risk-based competitive model characteristic of Medicare+Choice plans. Those proposals envision multiple risk-bearing entities

(such as PBM/insurer partners) that would compete to serve enrollees in each region. Enrollees would have some choice among providers, so that beneficiaries who were willing to accept more-restrictive rules (such as a closed formulary) in return for lower premium costs could do so, while others could select a more expensive provider with fewer restrictions. If the entities bore all of the insurance risk for the drug benefit, they would have strong incentives to use whatever cost-control tools were permitted. However, they would also have strong incentives to try to achieve favorable selection by avoiding enrollees most in need of coverage.

One concern about this model was that no entities might be willing to participate if they had to assume the full insurance risk for a stand-alone drug benefit. To mitigate that concern, the proposals included federally provided reinsurance for high-cost enrollees. (Reinsurance means that the federal government would share part or all of the costs of high-cost enrollees.) However, reinsurance would tend to weaken the plans' incentives to control costs. Another concern was that differences among plans in benefit structures or strategies for cost control could result in some plans attracting low-cost enrollees and others attracting sicker and more costly enrollees. The risk of that kind of selection would lead plans to raise the cost of the benefit. Moreover, to avoid such risks, plans would, over time, come to offer very similar plan designs.

The Cost of Covering Prescription Drugs for Medicare Enrollees

CBO is in the process of updating its estimates for several of the proposals developed in the last session of the 106th Congress. Some sense of the potential costs of a Medicare drug benefit can be gained, however, by adding up the amounts that Medicare enrollees are expected to spend on prescription drugs under current law (see Table 3). Over the period from 2002 through 2011, CBO estimates that about \$1.5 trillion will be spent on prescription drugs for Medicare enrollees under current law. Thus, a drug benefit that covered 50 percent of enrollees' spending would cost about \$728 billion through 2011. If, instead, the benefit covered all costs above \$1,000 per enrollee per year, costs through 2011 would be about \$1.1 trillion. If only costs above \$5,000 a year were covered, costs through 2011 would be about \$365 billion. Those figures, however, are only meant to give a sense of the magnitude. The costs of a drug benefit would also depend on utilization responses by enrollees, the kinds of cost-management tools that would be used, and how much of the gross costs of the benefit would be financed through enrollees' premiums.

CONCLUSIONS

Despite the recent slowdown, spending for Medicare is expected to grow at an annual rate of 7.7 percent over the next decade. After that, growth is likely to be more rapid as the leading edge of the baby-boom population becomes eligible for benefits. Although the latest report by the Medicare trustees shows improvement in the HI trust fund's balances, that fund does not give a complete picture of Medicare's financial condition—in particular, it ignores the excess of costs over premium revenues for the SMI program. Because Medicare's projected spending outstrips expected growth in dedicated revenues, the program will increasingly depend on general revenues to cover its costs.

While policymakers are well aware of Medicare's long-run financial problems, they also know that its benefit package has deficiencies relative to the benefits typically provided by private-sector insurance plans. One such deficiency is that the program provides only very limited coverage for outpatient prescription drugs—an increasingly important component of modern medical care. But adding a drug benefit would significantly increase Medicare's costs, and unless it was fully financed by enrollees' premiums, it would exacerbate the imbalance between the program's projected spending and its dedicated revenues.

TABLE 1. CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2002-2011

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2002-2011
	2002	2011	
Drug Spending ^a	1,989	4,818	10.3
Medicare Benefits ^b	6,512	10,538	5.5
Memorandum:			
Gross Domestic Product per Capita	39,275	56,569	4.1

SOURCE: Congressional Budget Office.

- a. Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer.
- b. Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs.

TABLE 2. PRESCRIPTION DRUG COVERAGE AMONG MEDICARE ENROLLEES BY TYPE OF SUPPLEMENTAL COVERAGE, 1997

	Number of Medicare Enrollees (Thousands)			Percentage of All Enrollees		
	No Drug Coverage	Drug Coverage	Total	No Drug Coverage	Drug Coverage	Total
No Supplemental Coverage	2,941	0	2,941	7.4	0	7.4
Any Medicaid Coverage ^a	1,448	5,449	6,897	3.6	13.7	17.4
Employer-Sponsored Plans	1,671	11,163	12,834	4.2	28.1	32.3
Individually Purchased Policies	5,753	4,532	10,286	14.5	11.4	25.9
Other Public Coverage ^b	0	1,396	1,396	0	3.5	3.5
HMOs Not Elsewhere Classified ^c	<u>678</u>	<u>4,696</u>	<u>5,374</u>	<u>1.7</u>	<u>11.8</u>	<u>13.5</u>
Total	12,491	27,236	39,728	31.4	68.6	100.0

SOURCE: Congressional Budget Office based on data from the 1997 Medicare Current Beneficiary Survey.

NOTES: Some beneficiaries hold several types of coverage at once. The categories in this table are mutually exclusive, and CBO assigned people to groups in the order shown above. The numbers in the table may not add up to totals because of rounding.

HMO = health maintenance organization.

- a. Comprises beneficiaries who received any Medicaid benefits during the year, including those eligible for a state's full package of benefits as well as others who received assistance for Medicare premiums or cost sharing through the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual programs.
- b. Beneficiaries who received aid for their drug spending through state-sponsored pharmacy assistance programs for low-income elderly make up 60 percent of this category. The remainder received prescription drug benefits through the Veterans Administration.
- c. Primarily HMOs under Medicare+Choice risk contracts.

TABLE 3. PROJECTED SPENDING ON PRESCRIPTION DRUGS
BY MEDICARE ENROLLEES (In billions of dollars)

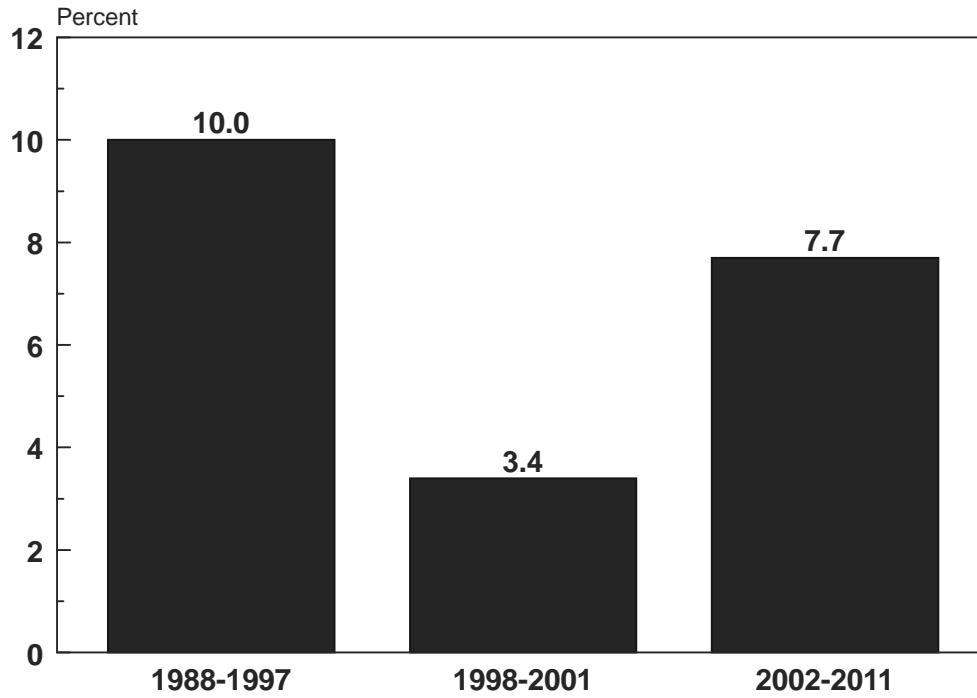
Year	All Spending per Enrollee Above					
	\$0	\$1,000	\$2,000	\$3,000	\$4,000	\$5,000
2002	81	49	29	18	11	8
2003	92	59	38	24	16	11
2004	104	70	47	32	22	15
2005	117	81	57	40	28	20
2006	131	95	68	50	36	27
2007	148	110	82	61	46	35
2008	165	126	97	74	57	44
2009	185	145	113	89	70	55
2010	205	164	131	105	84	68
2011	<u>228</u>	<u>185</u>	<u>151</u>	<u>123</u>	<u>101</u>	<u>82</u>
Total, 2002-2011	1,456	1,084	814	616	472	365

SOURCE: Congressional Budget Office (using its January 2001 baseline).

NOTES: Drugs currently covered by Medicare are not included in these figures.

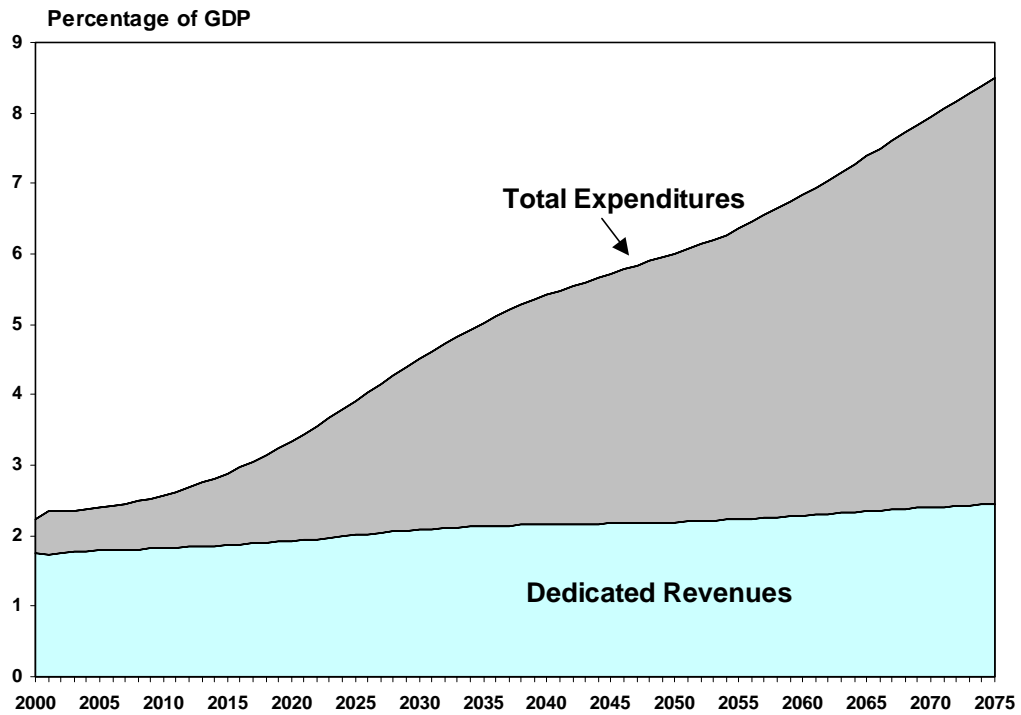
The numbers in the table may not add up to totals because of rounding.

FIGURE 1. ANNUAL AVERAGE MEDICARE SPENDING GROWTH FOR VARIOUS PERIODS



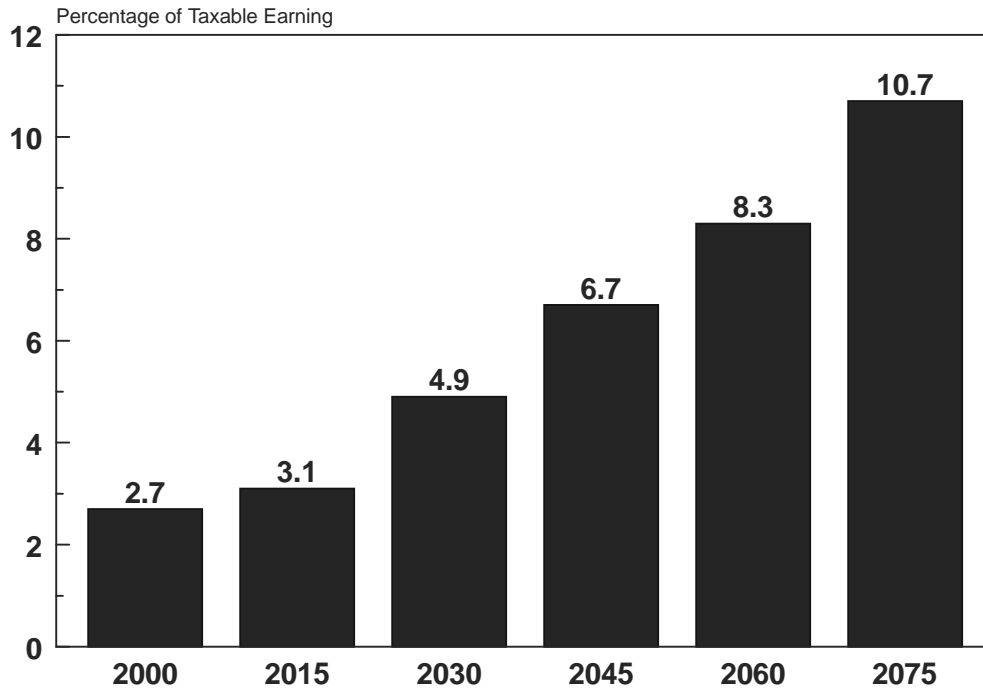
SOURCE: Historical data from the Health Care Financing Administration and Projections by the Congressional Budget Office.

FIGURE 2. PROJECTED MEDICARE OUTLAYS AND DEDICATED REVENUES
AS A PERCENTAGE OF GDP, CALENDAR YEARS 2000-2075



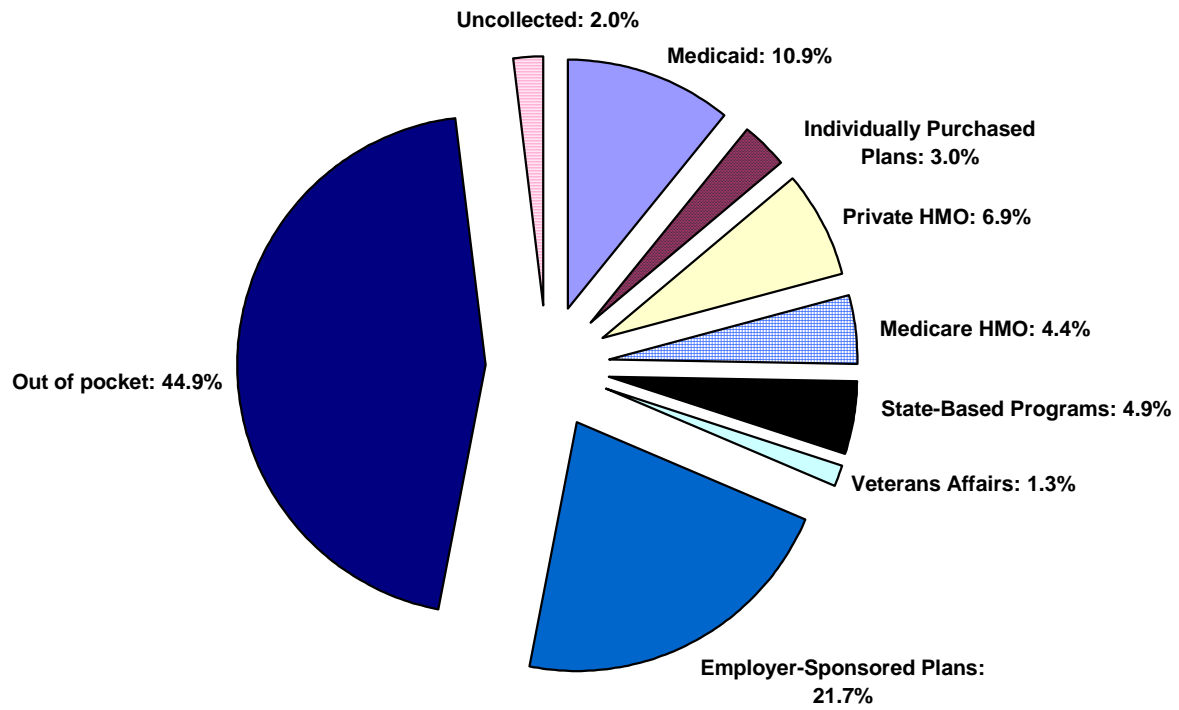
SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

FIGURE 3. MEDICARE HI COSTS AS A PERCENTAGE OF TAXABLE EARNINGS, 2000-2075



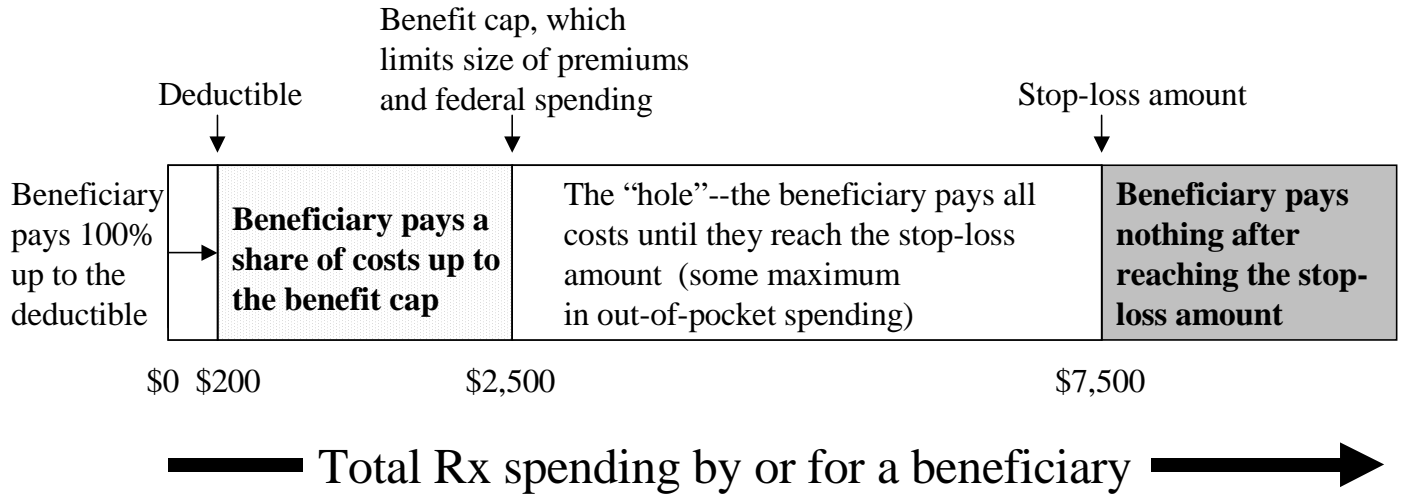
SOURCE: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

FIGURE 4. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE ENROLLEES,
BY PAYER, 1997



SOURCE: Congressional Budget Office tabulations from the 1997 Medicare Current Beneficiary Survey.
Drugs currently covered by Medicare are not included here.

FIGURE 5. POSSIBLE FEATURES OF A PRESCRIPTION DRUG INSURANCE BENEFIT



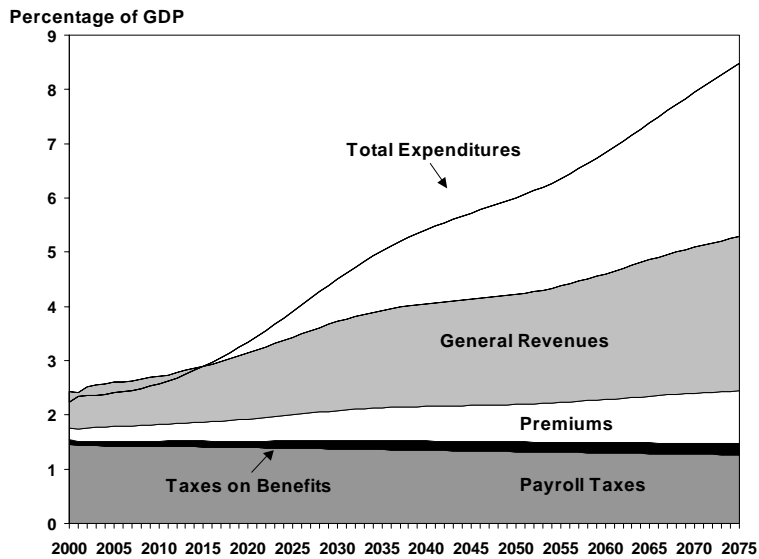
Plan premiums would be based on the expected average cost of benefits plus administrative fees and profit (load) minus any government subsidies.

SOURCE: Congressional Budget Office.

CHARTS PRESENTED AT THE HEARING



Medicare Expenditures and Noninterest Income as a Percentage of GDP, Calendar Years 2000-2075



Source: Board of Trustees, Federal Hospital Insurance Trust Fund (2001).

Medicare-3/22



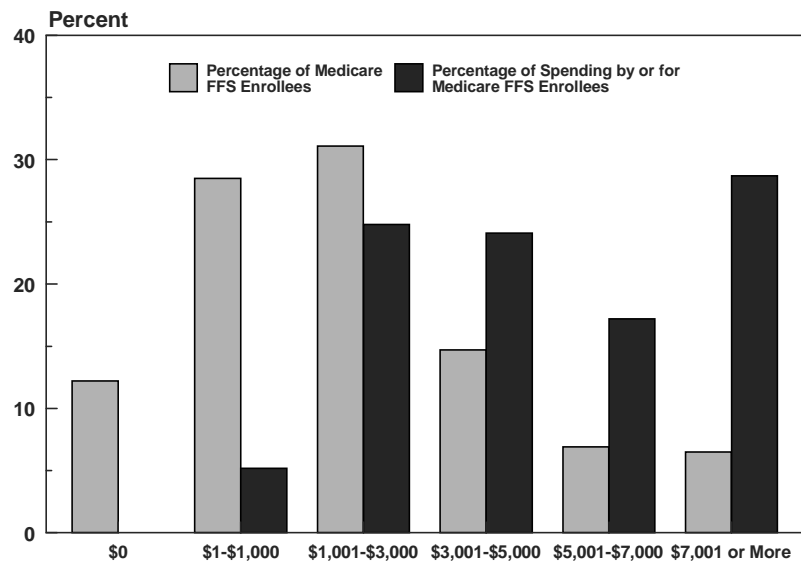
CBO's Baseline Projections of Drug Spending and Medicare Benefits per Enrollee

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2002-2011
	2002	2011	
Drug Spending	1,989	4,818	10.3
Medicare Spending	6,512	10,538	5.5

Medicare-3/22



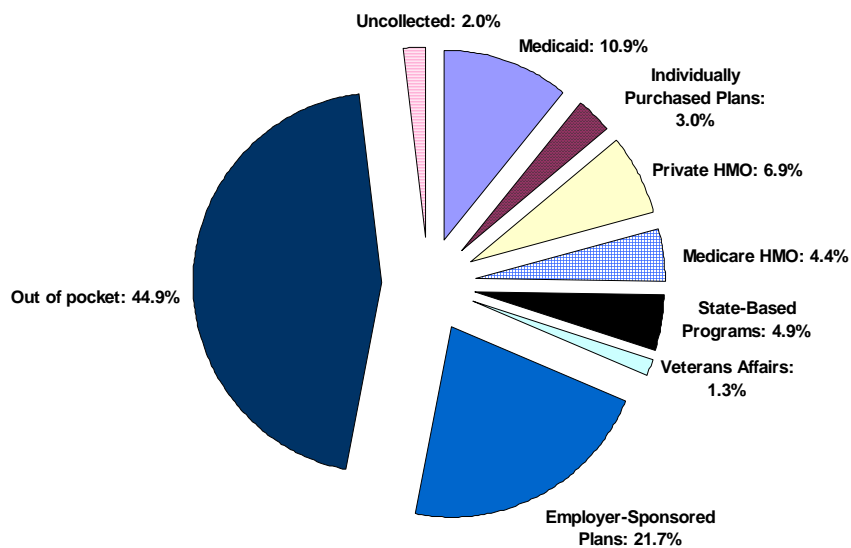
Enrollees' Outpatient Prescription Drug Spending in 2004



Medicare-3/22



Distribution of Drug Spending for Medicare Enrollees, by Payer, 1997



Medicare-3/22

