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PRESCRIPTION DRUGS

Increasing Medicare Beneficiary Access and Related Implications

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Prescription Drugs: Increasing Medicare Beneficiary Access and Related Implications

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss options for increasing Medicare beneficiaries' access to prescription drugs. There are growing concerns about gaps in the Medicare program, most notably the lack of outpatient prescription drug coverage, which may leave Medicare's most vulnerable beneficiaries with high out-of-pocket costs that they may not be able to afford. In 1996, almost a third of Medicare beneficiaries lacked prescription drug coverage. The remaining two-thirds had at least some drug coverage through other sources—most commonly employer-sponsored health plans. Although the proportion of beneficiaries who had drug coverage rose between 1995 and 1996, recent evidence indicates that this trend of expanding drug coverage is unlikely to continue. Moreover, the burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or those who have substantial health care needs. In 1999, an estimated 20 percent of Medicare beneficiaries had drug costs of $1,500 or more–a substantial sum for those lacking some form of insurance to subsidize the purchase.

At the same time, however, long-term cost pressures facing the Medicare program are considerable. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. These fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, proposals to help seniors with the costs of prescription drugs should be carefully crafted to avoid further erosion of the projected financial condition of the Medicare program, which, according to its trustees, is already unsustainable in its present form.

On the one hand, you must grapple with the hard choices involved in making the Medicare program sustainable for future generations. On the other, you are faced with the plight of many seniors who cannot afford the medical miracles that may be achieved through access to pharmaceutical advances. Expanding Medicare's benefit package could address the latter. However, a recent study suggests that such an expansion could add between 7.2 and 10 percent annually to Medicare's costs.[1] Increased spending of that magnitude would only exacerbate the tough choices that will be required to put Medicare on sustainable footing for the future.

[1] M.E. Gluck, *National Academy of Social Insurance Medicare Brief: A Medicare Prescription Drug Benefit* (April 1999); p. 8. http//www.nasi.org/Medicare.medbr1.htm (4/22/99).

You are considering these issues at a historic crossroad. After nearly 30 years of deficits, the combination of hard choices and remarkable economic growth has led to a budget surplus. We appear—at least for the near future—to have slain the deficit dragon. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. While this is good news and even superior to the projections made last year, it does not mean that hard choices are a thing of the past. First, it is important to recognize that by their very nature projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Current projected surpluses could well prove to be fleeting, and thus appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and possible solutions more painful.

As the foregoing suggests, the stakes associated with Medicare reform are high for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

My remarks today will focus on Medicare beneficiaries' access to prescription drugs and the environment in which you consider increasing that access. Two proposals before you, one offered in the President's budget and the other contained in the Breaux-Frist bill,[2] would incorporate

[2] S. 1895, Medicare Preservation and Improvement Act of 1999.

Medicare prescription drug coverage in the context of larger Medicare reform. Other proposals that focus only on increasing access to affordable prescription drugs are also being considered. These proposals would either subsidize prescription drug coverage or lower prices faced by beneficiaries without coverage. To put these proposals in context, I will discuss the factors contributing to the growth in prescription drug spending and efforts to control that growth. I will also discuss design and implementation issues to be considered regarding proposals to improve seniors' access to affordable prescription drugs. I then will repeat my message about the Medicare program's current financial condition and its long term sustainability.

But before I turn to the specifics, let me reiterate that although people want unfettered access to health care, and some have needs that are not being met, 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 of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between 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 also providing for other important national needs and economic growth. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large.

Rising Drug Spending Elevates Beneficiary Access Concerns and the Importance of Cost-Control Efforts

Extensive research and development over the past 10 years have led to new prescription drug therapies and improvements over existing therapies that, in some instances, have replaced other health care interventions. For example, new medications for the treatment of ulcers have virtually eliminated the need for some surgical treatments. As a result of these innovations, the importance of prescription drugs as part of health care has grown. However, the new drug therapies have also contributed to a significant increase in drug spending as a component of health care costs. The Medicare benefit package, largely designed in 1965, provides virtually

no coverage. In 1996, almost one third of beneficiaries had employer-sponsored health coverage, as retirees, that included drug benefits. More than 10 percent of beneficiaries received coverage through Medicaid or other public programs. To protect against drug costs, the remainder of Medicare beneficiaries can choose to enroll in a Medicare+Choice plan with drug coverage if one is available in their area or purchase a Medigap policy.[3] The availability, breadth, and price of such coverage is changing as the costs of expanded prescription drug use drives employers, insurers, and managed care plans to adopt new approaches to control the expenditures for this benefit. These approaches, in turn, are reshaping the drug market.

Rise in Prescription Drug Spending

Over the past 5 years, prescription drug expenditures have grown substantially, both in total and as a share of all health care outlays. Prescription drug spending grew an average of 12.4 percent per year from 1993 to 1998, compared with a 5 percent average annual growth rate for health care expenditures overall. (See table 1.) As a result, prescription drugs account for a larger share of total health care spending—rising from 5.6 percent to 7.9 percent in 1998.

[3] As an alternative to traditional Medicare fee-for-service, beneficiaries in Medicare+Choice plans (formerly Medicare risk health maintenance organizations) obtain all their services through a managed care organization and Medicare makes a monthly capitation payment to the plan on their behalf.

Table 1: National Expenditures for Prescription Drugs, 1993-98

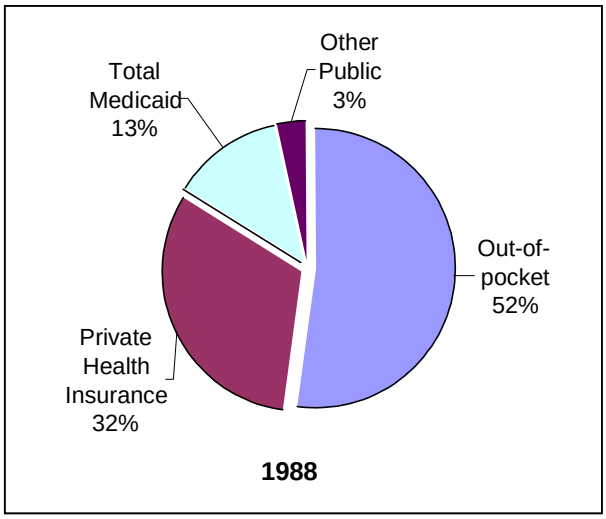
Year	Prescription drug expenditures (in billions)	Annual growth in prescription drug expenditures (percent)	Annual growth in all health care expenditures (percent)
1998	$90.6	15.4	5.6
1997	$78.5	14.0	4.7
1996	$68.9	12.9	4.6
1995	$61.0	10.6	4.8
1994	$55.2	9.0	5.5
1993	$50.6	8.7	7.4
Average annual growth between 1993 and 1998.		12.4	5.0

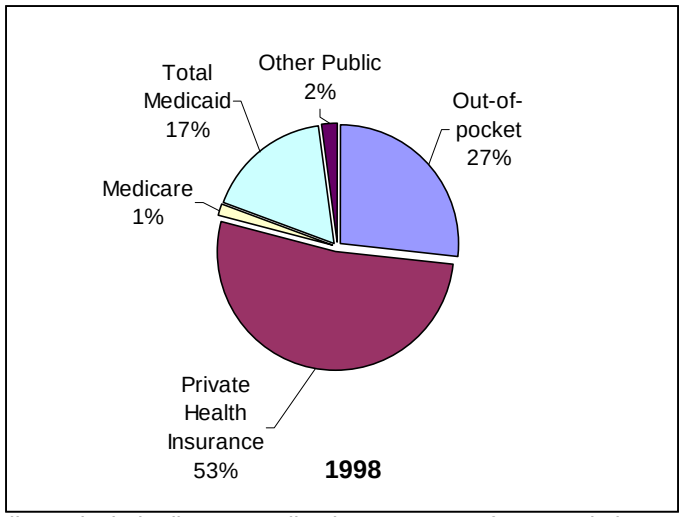
Source: Health Care Financing Administration (HCFA), Office of the Actuary.

Total drug expenditures have been driven up by both greater utilization of drugs and the substitution of higher-priced new drugs for lower-priced existing drugs. Private insurance coverage for prescription drugs has likely contributed to the rise in spending, because insured consumers are shielded from the direct costs of prescription drugs. In the decade between 1988 and 1998, the share of prescription drug expenditures paid by private health insurers rose from almost a third to more than half. (See fig. 1.) The development of new, more expensive drug therapies—including new drugs that replace old drugs and new drugs that treat disease more effectively—also contributed to the drug spending growth by boosting the volume of drugs used as well as the average price for drugs used. The average number of new drugs entering the market each year rose from 24 at the beginning of the 1990s to 33 now. Similarly, biotechnology advances and a growing knowledge of the human immune system are significantly shaping the discovery, design, and production of drugs. Advertising pitched to consumers has also likely upped the use of prescription drugs. A recent study found that the 10 drugs most heavily advertised directly to consumers in 1998 accounted for about 22 percent of the total increase in drug spending between 1993 and 1998.[4] Between March 1998 and March 1999, industry spending on advertising grew 16 percent to $1.5 billion. All of these factors suggest the need for effective cost control mechanisms to be in place under any option to increase access to prescription drugs.

[4] Barents Group LLC for the National Institute for Health Care Management Research and Educational Foundation, *Factors Affecting the Growth of Prescription Drug Expenditures* (July 9, 1999); p. iii.

Figure 1: Comparison of National Outpatient Drug Expenditures, 1988 and 1998





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

Source: HCFA, Office of the Actuary.

Current Medicare Beneficiary Drug Coverage

Prescription drugs are an important component of medical care for the elderly because of the prevalence of chronic and other health conditions associated with aging. In 1995, Medicare beneficiaries had an average of more than 18 prescriptions filled.[5] This varies substantially across beneficiaries, however, reflecting the range of their needs and also financial considerations such as third-party prescription drug coverage. In 1995, an elderly person's total average annual drug costs were $600[6] compared with a little more than $140 for a non-elderly persons.[7] For some, prescription drug spending was considerably higher–6 percent of Medicare beneficiaries spent $2,000 or more.[8] A recent report had

[5]M. Davis and others, "Prescription Drug Coverage, Utilization, and Spending Among Medicare Beneficiaries," *Health Affairs*, Vol. 18, No. 1 (Jan./Feb. 1999); p. 237.

[6]M. Davis, p. 239.

[7]Agency for Health Care Policy and Research Center for Cost and Financing Studies, National Medical Expenditure Survey data, *Trends in Personal Health Care Expenditures, Health Insurance, and Payment Sources, Community-Based Population, 1987-1995*, (March 1997); p. 10. http://www.meps.ahcpr.gov/nmes/papers/trends/intnet4d.pdf (6/10/99).

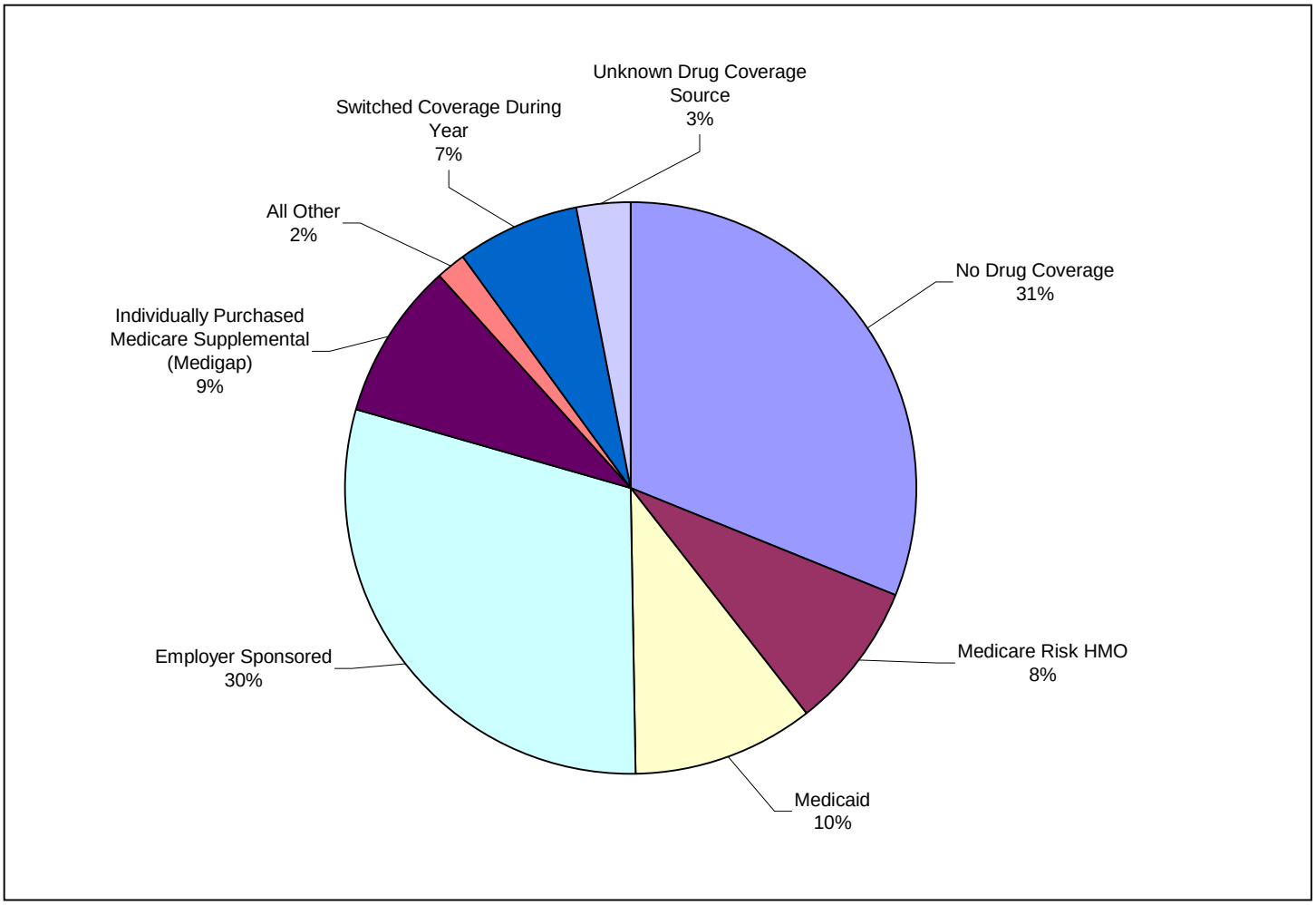
[8] J.A. Poisal and others, "Prescription Drug Coverage and Spending for Medicare Beneficiaries," *Health Care Financing Review*, Vol. 20, No. 3 (Spring 1999); p. 20.

projected that by 1999 an estimated 20 percent of Medicare beneficiaries would have total drug costs of $1,500 or more—a substantial sum for people lacking some form of insurance to subsidize their purchases or for those facing coverage limits.[9]

In 1996, almost a third of Medicare beneficiaries lacked drug coverage altogether. (See fig. 2.) The remaining two-thirds had at least some drug coverage—most commonly through employer-sponsored health plans. The proportion of beneficiaries who had drug coverage rose between 1995 and 1996, owing to increases in those with Medicare HMOs, individually purchased supplemental coverage, and employer-sponsored coverage. However, recent evidence indicates that this trend of expanding drug coverage is unlikely to continue.

[9] M.E. Gluck, p. 2.

Figure 2: Sources of Drug Coverage for Medicare Beneficiaries, 1996



Note: "All Other" includes coverage under non-risk Medicare HMOs, state-based plans, the Department of Defense, and the Department of Veteran's Affairs.

Source: HCFA, based on the 1996 Medicare Current Beneficiary Survey.

Although employer-sponsored health plans provide drug coverage to the largest segment of the Medicare population with coverage, there are signs that this could be eroding. Fewer employers are offering health benefits to retirees eligible for Medicare and those that continue to offer coverage are asking retirees to pay a larger share of costs. The proportion of employers offering health coverage to retirees eligible for Medicare declined from 40 percent in 1993 to 28 percent in 1999. This decline is at least in part due to the rise in the cost of providing this coverage, which grew about 21

percent from 1993 to 1999. At the same time, the proportion of employers asking retirees to pay the full cost of their health coverage increased from 36 percent to 40 percent.

In 1999, 13 percent of Medicare beneficiaries obtained prescription drug coverage through a Medicare+Choice plan, up from 8 percent in 1996. Medicare+Choice plans have found drug coverage to be an attractive benefit that beneficiaries seek out when choosing to enroll in managed care organizations. However, owing to rising drug expenditures and their effect on plan costs, the drug benefits the plans offer are becoming less generous. Many plans restructured drug benefits in 2000, increasing enrollees' out-of-pocket costs and limiting their total drug coverage.

Beneficiaries may purchase Medigap policies that provide drug coverage, although this tends to be expensive, involves significant cost-sharing, and includes annual limits. Standard Medigap drug policies include a $250 deductible, a 50 percent coinsurance requirement, and a $1,250 or $3,000 annual limit. Furthermore, Medigap premiums have been increasing in recent years. In 1999, the annual premium for one type of Medigap policy with a $1,250 annual limit on drug coverage, ranged from approximately $1,000 to $6,000.

All beneficiaries who have full Medicaid benefits[10] receive drug coverage that is subject to few limits and low cost-sharing requirements. For beneficiaries whose incomes are slightly higher than Medicaid standards, 14 states currently offer pharmacy assistance programs that provided drug coverage to approximately 750,000 beneficiaries in 1997. The three largest state programs accounted for 77 percent of all state pharmacy assistance program beneficiaries.[11] Most state pharmacy assistance programs, like Medicaid, have few coverage limitations.

The burden of prescription drug costs falls most heavily on the Medicare beneficiaries who lack drug coverage or who have substantial health care needs. Drug coverage is less prevalent among beneficiaries with lower incomes. In 1995, 38 percent of beneficiaries with income below $20,000 were without drug coverage, compared to 30 percent of beneficiaries with higher incomes. Additionally, the 1995 data show that drug coverage is slightly higher among those with poorer self-reported health status. At the same time, however, beneficiaries without drug coverage and in poor health had drug expenditures that were $400 lower than the expenditures

[10]Certain low-income Medicare beneficiaries are dually eligible for Medicare and Medicaid.

[11]These programs are operated in New Jersey, New York, and Pennsylvania.

of beneficiaries with drug coverage and in poor health. This might indicate access problems for this segment of the population.

Even for beneficiaries who have drug coverage, the extent of the protection it affords varies. The value of a beneficiary's drug benefit is affected by the benefit design, including cost-sharing requirements and benefit limitations. Evidence suggests that premiums are on the rise for employer-sponsored benefits, Medigap policies, and most recently, Medicare+Choice plans. Although reasonable cost sharing serves to make the consumer a more prudent purchaser, copayments, deductibles, and annual coverage limits can reduce the value of drug coverage to the beneficiary. Harder to measure is the effect on beneficiaries of drug benefit restrictions brought about through formularies designed to limit or influence the choice of drugs.

Cost-Control Approaches Are Reshaping the Pharmaceutical Market

During this period of rising prescription drug expenditures, third-party payers have pursued various approaches to control spending. These efforts have initiated a transformation of the pharmaceutical market. Whereas insured individuals formerly purchased drugs at retail prices at pharmacies and then sought reimbursement, now third-party payers influence which drug is purchased, how much is paid for it, and where it is purchased.

A common technique to manage pharmacy care and control costs is to use a formulary. A formulary is a list of prescription drugs, grouped by therapeutic class, that a health plan or insurer prefers and may encourage doctors to prescribe. Decisions about which drugs to include in a formulary are based on the drugs' medical value and price. The inclusion of a drug in a formulary and its cost can affect how frequently it is prescribed and purchased and, therefore, can affect its market share.

Formularies can be open, incentive-based, or closed. Open formularies are often referred to as "voluntary" because enrollees are not penalized if their physicians prescribe nonformulary drugs. Incentive-based formularies generally offer enrollees lower copayments for the preferred formulary or generic drugs. Incentive-based or managed formularies are becoming more popular because they combine flexibility and greater cost-control features than open formularies. A closed formulary limits insurance coverage to the formulary drugs and requires enrollees to pay the full cost of nonformulary drugs prescribed by their physicians.

Another way in which the market has been transformed is through the use of pharmacy benefit managers (PBM) by health plans and insurers to administer and manage prescription drug benefits. PBMs offer a range of

services, including prescription claims processing, mail-service pharmacy, formulary development and management, pharmacy network development, generic substitution incentives, and drug utilization review. PBMs also negotiate discounts and rebates on prescription drugs with manufacturers.

Expanding Access to Prescription Drugs Involves Difficult Design Decisions

Expanding access to more affordable prescription drugs could involve either subsidizing prescription drug coverage or allowing beneficiaries access to discounted pharmaceutical prices. The design of a drug coverage option, that is, the scope of the benefit, the covered population, and the mechanisms used to contain costs, as well as its implementation will determine the effect of the option on beneficiaries, Medicare or federal spending, and the pharmaceutical market. A new benefit would need to be crafted to balance competing concerns about the sustainability of Medicare, federal obligations, and the hardship faced by some beneficiaries. Similarly, the effect of granting some beneficiaries access to discounted prices will hinge on details such as the price of the drugs after the discount, how discounts are determined and secured, and which beneficiaries are eligible.

The relative merits of any approach should be carefully assessed. We suggest that the following five criteria be considered in evaluating any option. (1) Affordability: an option should be evaluated in terms of its effect on public outlays for the long term. (2) Equity: an option should provide equitable access across groups of beneficiaries and be fair to affected providers. (3) Adequacy: an option should provide appropriate beneficiary incentives for prudent utilization, support standard treatment options for beneficiaries, and not impede effective and clinically meaningful innovations. (4) Feasibility: an option should incorporate such administrative essentials as implementation and cost and quality monitoring techniques. (5) Acceptance: an option should account for the need to educate the beneficiary and provider communities about its costs and the realities of trade-offs required by significant policy changes.

Adding a Medicare Benefit

Expanding Medicare coverage to include prescription drugs would entail numerous benefit design decisions that would affect the cost of this expansion as well as its acceptability. A basic design decision concerns whether financial assistance provided for the benefit would be targeted to those with the greatest need—owing to a lack of existing drug coverage, high drug expenditures, or poverty—or whether the public financial subsidies would be available to all beneficiaries. The President's proposal extends coverage to all beneficiaries, with greater government subsidies

for the poor. The Breaux-Frist Medicare reform proposal incorporates optional drug coverage, which is subsidized fully for the poor and partially for others. The generosity of the benefit—the extent of beneficiary copayments, coverage limits, and catastrophic protections—will also be a major factor in assessing the impact of this benefit on the Medicare program. The President's benefit design incorporates 50 percent beneficiary copayments; an annual benefit limit; and a cap on catastrophic drug costs, which is yet to be designed. Under the Breaux-Frist approach, competing health plans could design their own copayment structure, with requirements on the benefit's actuarial value but no provision to limit beneficiary catastrophic drug costs.

Benefit cost-control provisions for the traditional Medicare program may present some of the thorniest drug benefit design decisions. Recent experience provides two general approaches. One would involve the Medicare program obtaining price discounts from manufacturers. Such an arrangement could be modeled after Medicaid's drug rebate program. While the discounts in aggregate would likely be substantial, this approach lacks the flexibility to achieve the greatest control over spending. It could not effectively influence or steer utilization because it does not include incentives that would encourage beneficiaries to make cost-conscious decisions. The second approach would draw from private sector experience in negotiating price discounts from manufacturers in exchange for shifting market share. Some plans and insurers employ PBMs to manage their drug benefits, including claims processing, negotiating with manufacturers, establishing lists of drug products that are preferred because of efficacy or price, and developing beneficiary incentive approaches to control spending and use. Applying these techniques to the entire Medicare program, however, would be difficult because of its size, the need for transparency in its actions, and the imperative for equity for its beneficiaries.

Medicaid Programs Rely on Rebates and Have Limited Utilization Controls

As the largest government payer for prescription drugs, Medicaid drug expenditures account for about 17 percent of the domestic pharmaceutical market. Before the enactment of the Medicaid drug rebate program under the Omnibus Budget Reconciliation Act of 1990 (OBRA), state Medicaid programs paid close to retail prices for outpatient drugs. Other large purchasers, such as HMOs and hospitals, negotiated discounts with manufacturers and paid considerably less.

The rebate program required drug manufacturers to rebate to state Medicaid programs a percentage off of the average price wholesalers pay manufacturers. The rebates were based on a percentage reduction that reflects the lowest or "best" prices the manufacturer charged other

purchasers and the volume of purchases by Medicaid recipients. In return for the rebates, state Medicaid programs must cover all drugs manufactured by pharmaceutical companies that entered into rebate agreements with HCFA.[12]

After the rebate program's enactment, a number of market changes affected other purchasers of prescription drugs and the amount of the rebates that Medicaid programs received. Drug manufacturers substantially reduced the price discounts they offered to many large private purchasers, such as HMOs. Therefore, the market quickly adjusted by increasing drug prices to compensate for rebates obtained by the Medicaid program.

Although the states have received billions of dollars in rebates from drug manufacturers since OBRA's enactment, state Medicaid directors have expressed concerns about the rebate program. The principal concern involves OBRA's requirement to provide access to all the drugs of every manufacturer that offers rebates, which limits the utilization controls Medicaid programs can use at a time when prescription drug expenditures are rapidly increasing. Although the programs can require recipients to obtain prior authorization for particular drugs and can impose monthly limits on the number of covered prescriptions, they cannot take advantage of other techniques, such as incentive-based formularies, to steer recipients to less expensive drugs. The few cost-control strategies available to state Medicaid programs can add to the administrative burden on state Medicaid programs.

Other Payers Employ Various Techniques to Control Expenditures

Other payers, such as private and federal employer health plans and Medicare+Choice plans, have taken a different approach to managing their prescription drug benefits. They typically use beneficiary copayments to control prescription drug use, and they use formularies to both control use and obtain better prices by concentrating purchases on selected drugs. In many cases, these plans and insurers retain a PBM's services to manage their pharmacy benefit and control spending.

Beneficiary cost-sharing plays a central role in attempting to influence drug utilization. Copayments are frequently structured to influence both the choice of drugs and the purchasing arrangements. While formulary restrictions can channel purchases to preferred drugs, closed formularies, which provide reimbursement only for preferred drugs, have generated substantial dissatisfaction among consumers. As a result, many plans link their cost-sharing requirements and formulary lists. The fastest growing

[12] OBRA 1990 allowed the states to exclude certain classes of drugs.

trend today is the use of a formulary that covers all drugs but that includes beneficiary cost-sharing that varies for different drugs—typically a smaller copayment for generic drugs, a larger one for preferred drugs, and an even larger one for all other drugs. Reduced copayments have also been used to encourage enrollees using maintenance drugs for chronic conditions to obtain them from particular suppliers, like a mail-order pharmacy.

Plans and insurers have turned to PBMs for assistance in establishing formularies, negotiating prices with manufacturers and pharmacies, processing beneficiaries' claims, and reviewing drug utilization. Because PBMs manage drug benefits for multiple purchasers, they often may have more leverage than individual plans in negotiating prices through their greater purchasing power.

Traditional fee-for-service Medicare has generally established reimbursement rates for services like those provided by physicians and hospitals and then processed and paid claims with few utilization controls. Adopting some of the techniques used by private plans and insurers might help better control costs. However, how to adapt those techniques to the characteristics and size of the Medicare program raises questions.

Negotiated or competitively determined prices would be superior to administered prices only if Medicare could employ some of the utilization controls that come from having a formulary and differential beneficiary cost-sharing. In this manner, Medicare would be able to negotiate significantly discounted prices by promising to deliver a larger market share for a manufacturer's product. Manufacturers would have no incentive to offer a deep discount if all drugs in a therapeutic class were covered on the same terms. Without a promised share of the Medicare market, these manufacturers might reap greater returns from charging higher prices and by concentrating marketing efforts on physicians and consumers to influence prescribing patterns.

Implementing a formulary and other utilization controls could prove difficult for Medicare. Developing a formulary involves determining which drugs are therapeutically equivalent so that several from each class can be included. Plans and PBMs currently make those determinations privately—something that would not be possible for Medicare, which must have transparent policies that are determined openly. Given the stakes involved in selecting drugs, one can imagine the intensive efforts to offer input to and scrutinize the selection process.

Medicare may also find it impossible to delegate this task to one or multiple PBMs. A single PBM contractor would likely be subject to the same level of scrutiny as the program. Such scrutiny could compromise

the flexibility PBMs have used to generate savings. An alternative would be to grant flexibility to multiple PBMs that are each responsible only for a share of the market. Contracting with multiple PBMs, though, raises other issues. If each PBM has exclusive responsibility for a geographic area, beneficiaries who need certain drugs could be advantaged or disadvantaged merely because of where they live. If multiple PBMs operated in each area, beneficiaries could choose one to administer their drug benefit. This raises questions about how to inform beneficiaries of the differences in each PBM's policies and whether and how to risk-adjust payments to PBMs for differences in the health status of the beneficiaries using them.

Extending Federal Price Discounts to Beneficiaries

Another option before the Congress would allow Medicare beneficiaries to purchase prescription drugs at the lowest price paid by the federal government. Because of their large purchasing power, federal agencies, such as, the Departments of Veterans Affairs (VA) and Defense (DOD), have access to prescription drug prices that often are considerably lower than retail prices. Extending these discounts to Medicare beneficiaries, or some groups of beneficiaries, could have a measurable effect on lowering their out-of-pocket spending, although whether this would adequately increase access or raise prices paid by other purchasers that negotiate drug discounts is unknown.

Typically, federal agencies obtain prescription drugs at prices listed in the federal supply schedule (FSS) for pharmaceuticals.[13] FSS prices represent a significant discount off the prices drug manufacturers charge wholesalers.[14] Under the Veterans Health Care Act of 1992, drug manufacturers must make their brand-named drugs available to federal agencies at the FSS price in order to participate in the Medicaid program.[15] The act requires that the FSS price for VA, DOD, the Public Health Service,

[13]The FSS for pharmaceuticals is a price catalog currently containing over 17,000 pharmaceutical products available to federal agencies.

[14]FSS prices are set through negotiations between VA, on behalf of the government, and drug manufacturers and are based on the prices that manufacturers offer their most favored nonfederal customers.

[15]The act covers single-source drugs, innovator multiple-source drugs, insulin, and biological products such as vaccines and antitoxins. The act does not cover noninnovator multiple-source or generic drugs.

and the Coast Guard be at least 24 percent below the price that the manufacturers charge wholesalers.[16]

Although most federal prescription drug purchases are made at FSS prices, in some cases, federal agencies are able to purchase drugs at even lower prices. For example, VA has used national contracts awarded on a competitive basis for specific drugs considered therapeutically interchangeable. These contracts enable VA to obtain larger discounts from manufacturers by channeling greater volume to certain pharmaceutical products.

Providing Medicare beneficiaries access to the lowest federal prices could result in important out-of-pocket savings to those without coverage who are paying close to retail prices. However, concerns exist that extending federal discounts to Medicare beneficiaries could lead to price increases to federal agencies and other purchasers since the discount is based on prices determined by manufacturers. Federal efforts to lower Medicaid drug prices demonstrate the potential for this to occur. While it is not possible to predict how federal drug prices would change if Medicare beneficiaries are given access to them, the larger the market that seeks to take advantage of these prices, the greater the economic incentive would be for drug manufacturers to raise federal prices to limit the impact of giving lower prices to more purchasers.

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

The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other hand, Medicare's benefit package contains gaps in desired coverage, most notably the lack of outpatient prescription drug coverage, compared with private employer coverage. Any option to modernize the benefits runs the risk of exacerbating the fiscal imbalance of the programs. That is why we believe that expansions should be made in the context of overall program reforms that are designed to make the program more sustainable over the long term. Any discussions about expanding beneficiary access to prescription drugs should carefully consider targeting financial help to those most in need and minimizing the substitution of public funds for

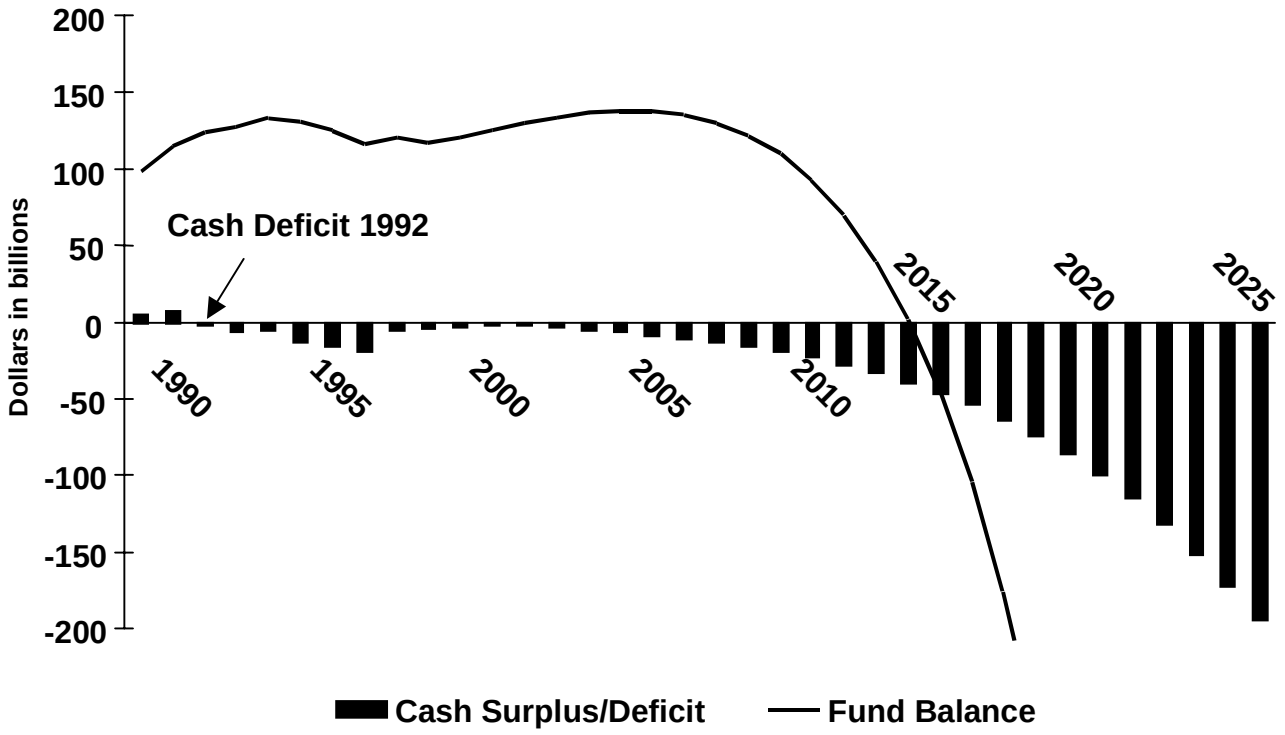
[16]The act requires that manufacturers sell drugs covered by the act at no more that 76 percent of the nonfederal average manufacturer's price, a level referred to as the federal ceiling price. The nonfederal average manufacturer's price is the weighted average price of each single form and dosage unit of a drug that is paid by wholesalers in the United States to a manufacturer, taking into account any cash discounts or similar price reductiions. Prices paid by the fereral government are excluded from this calculation.

private funds. Employers that offer drug coverage through a retiree health plan may choose to adapt their health coverage if a Medicare drug benefit is available. A key characteristic of America's voluntary, employer-based system of health insurance is an employer's freedom to modify the conditions of coverage or to terminate benefits.

Medicare's Financial Condition

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, the 1999 Trustees' annual report showed that Medicare's HI component has been, on a cash basis, in the red since 1992, and in fiscal year 1998, earmarked payroll taxes covered only 89 percent of HI spending. In the Trustees' report, issued in March 1999, projected continued cash deficits for the HI trust fund. (See fig. 3.)

Figure 3: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund.

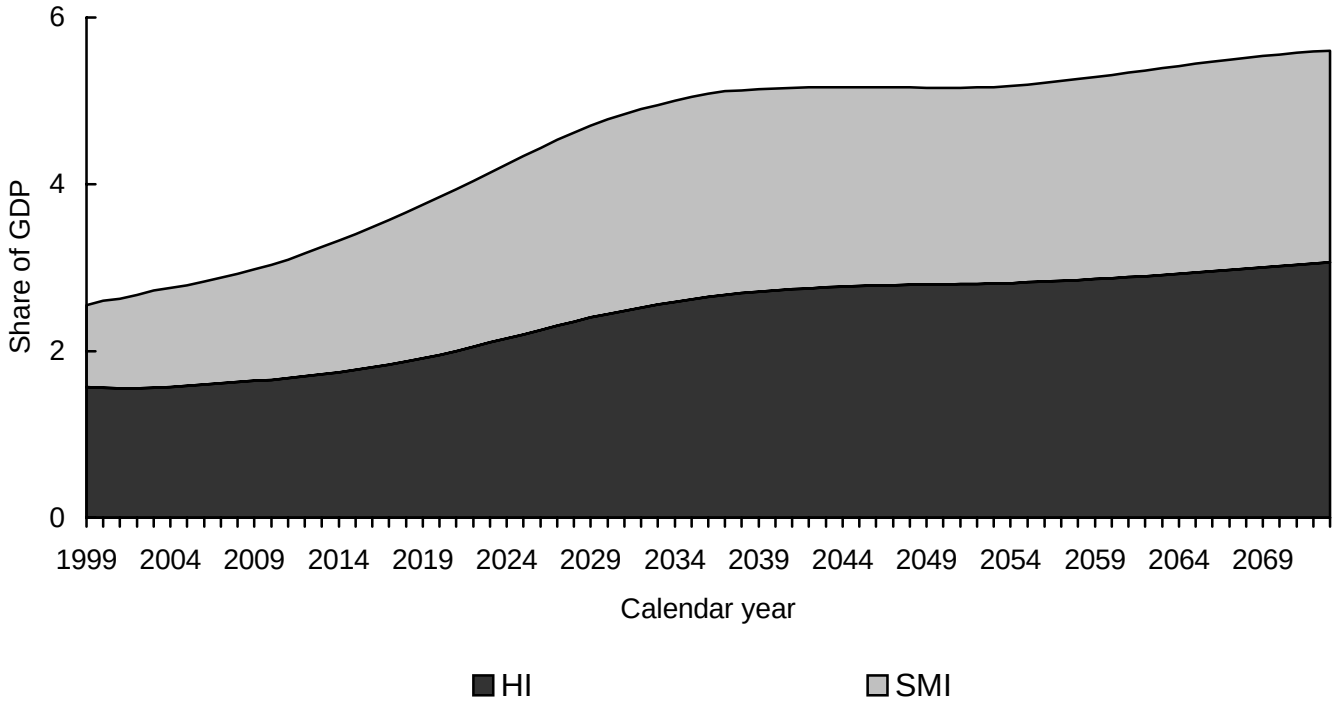
When the program has a cash deficit, as it did from 1992 through 1998, Medicare is a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. To finance these cash deficits, Medicare drew on its special issue Treasury securities acquired during the years when the program generates a cash surplus. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)–physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies–are already funded largely through general revenues.

Although the Office of Management and Budget (OMB) has recently reported a $12 billion cash surplus for the HI program in fiscal year 1999

due to lower than expected program outlays, the long-term financial outlook for Medicare is expected to deteriorate. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees declines from 3.4 to 1 today to roughly 2 to 1.

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from about 12 percent in 1999 to about a quarter of all federal revenues by mid-century. Over the same time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 4.

Figure 4: Medicare Spending as a Percentage of Gross Domestic Product (GDP) 1999 to 2073

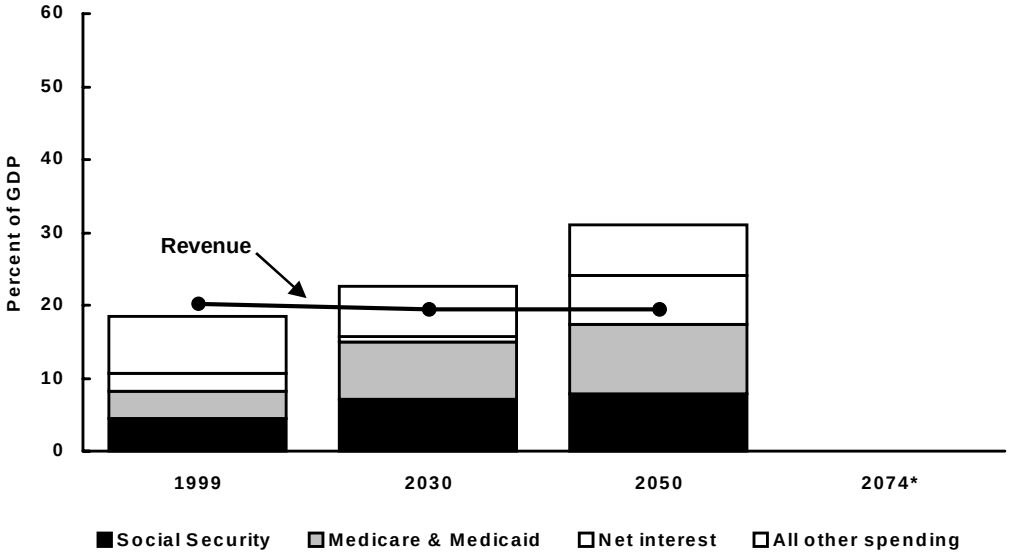


Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly population, but Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the President adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would absorb more than three-quarters of total federal revenue. (See fig. 5.) Budgetary flexibility would be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.

Figure 5: Composition of Spending as a Share of GDP Under "Eliminate Non-Social Security Surpluses" Simulation



*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

Notes:

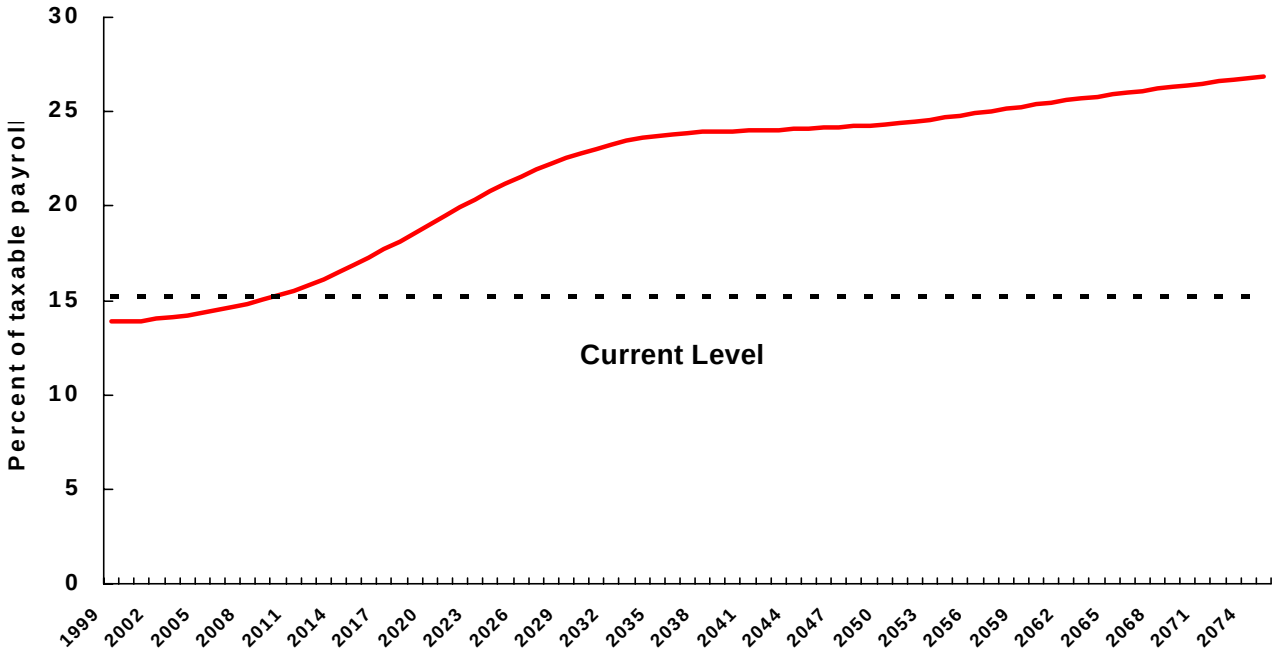
Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.

Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.

When viewed together with Social Security, the financial burden of Medicare on future taxpayers becomes unsustainable, absent reform. As figure 6 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers.

Figure 6: Social Security and Medicare HI as a Percentage of Taxable Payroll, 1999 to 2074



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report*, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding.

The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Although this may eventually prove necessary, such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns us most is that devoting general funds to the HI trust fund may be used to extend HI's solvency without addressing the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI trust fund balance alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macroeconomic perspective, the critical question is not how much a trust fund has in assets but whether the government as a whole has the economic capacity to finance all Medicare's promised benefits—both now and in the future. We must keep in mind the unprecedented challenge facing future generations in our aging society. Relieving them of some of the financial burden of today's commitments would help preserve some budgetary flexibility for future generations to make their own choices.

If more fundamental program reforms are not made, we fear that general fund infusions would interfere with the vital signaling function that trust fund mechanisms can have for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that dedicating general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. Furthermore, increasing the trust fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades, assuming no additional SMI benefits.

The issue of the extent to which general funds are an appropriate financing mechanism for the Medicare program would remain important under financing arrangements that differed from those in place in the current HI and SMI structures. For example, under approaches that would combine the two trust funds, a continued need would exist for measures of program sustainability that would 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 devoted to Medicare, or program

spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding. Regardless of the measure chosen, the real question would be what actions should be taken when and if the chosen cap is reached.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or the tax side. Commitments often prove to be permanent, while projected surpluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when carried out over a decade. In its January 2000 report,[17] CBO compared the actual deficits or surpluses for 1986 through 1999 with the first projection it had produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO stated that its errors in projecting the federal surplus or deficit averaged about 2.4 percent of GDP in the fifth year beyond the current year. For example, such a shift in 2005 would mean a potential swing of about $285 billion in the projected surplus for that year.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead to stronger economic growth and higher incomes over the long term.

[17] *The Economic and Budget Outlook: Fiscal Years 2001-2010* (CBO, Jan. 2000).

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[18] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita. Over a 50-year period, GDP per capita is estimated to more than double from present levels by saving all or most of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

Concluding Observations

Updating the Medicare benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Expanding access to prescription drugs could ease the significant financial burden some Medicare beneficiaries face because of outpatient drug costs. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. Balancing these competing concerns may require the best from government-run programs and private sector efforts to modernize Medicare for the future. Further, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide new benefits such as prescription drugs.

The Congress and the President may ultimately decide to include some form of prescription drug coverage as part of Medicare. Given this expectation and the future projected growth of the program, some additional revenue sources may in fact be a necessary component of Medicare reform. However, it is essential that we not take our eye off the ball. The most critical issue facing Medicare is the need to ensure the program's long range financial integrity and sustainability. The 1999 annual reports of the Medicare Trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program be balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances.

[18]See *Budget Issues: Long-Term Fiscal Outlook* (GAO/T-AIMD/OCE-98-83, Feb. 25, 1998) and *Budget Issues: Analysis of Long-Term Fiscal Outlook* (GAO/AIMD/OCE-98-19, Oct. 22, 1997).

Current budget surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term, but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead-time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

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

GAO Contacts and Acknowledgments

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