CBO TESTIMONY

Statement of
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Projections of Medicare and Prescription Drug Spending

before the
Committee on Finance
United States Senate

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Mr. Chairman, Senator Grassley, and Members of the Committee, I am pleased to be here with you today. This morning I will discuss the Congressional Budget Office's (CBO's) projections of Medicare spending for 2003 through 2012 and compare them with those of the Administration. I will then summarize CBO's estimates of the cost of the President's budgetary proposals for Medicare. Last, I will describe CBO's new projections of prescription drug spending for the Medicare population and outline some general approaches for providing prescription drug coverage through Medicare.

THE IMPACT OF CHANGING DEMOGRAPHICS ON SPENDING FOR MEDICARE

Before describing CBO's projections, I would first like to underscore that the long-range picture of federal spending that I described to you last year remains unchanged. Looking at Medicare's near-term situation and proposals to increase payments to providers or to add a prescription drug benefit within the context of the program's long-term financial pressures can provide a beneficial perspective.

The aging of the baby boomers has dramatic fiscal implications for Medicare (see Figure 1 on page 16). If the nation spent the same fraction of gross domestic product (GDP) on each Medicare beneficiary in 2030 as it does today—a proposition reflecting only the increased number of beneficiaries in the program at that point—spending for Medicare would grow from today's 2.3 percent share of GDP to 4.5 percent by 2030. However, the fiscal implications of the baby boomers' aging are compounded by the fact that health care costs measured per beneficiary routinely grow significantly faster than does the economy measured on a per capita basis. As a result, if current law remains unchanged, CBO expects that spending for Medicare will climb to 5.4 percent of GDP by 2030.

Also projected to rise is spending for the "big three" entitlement programs—Social Security, Medicare, and Medicaid—taken as a whole. Between now and 2030, such spending as a share of GDP will virtually double. Expenditures for those programs will grow from 7.8 percent of GDP to 14.7 percent by 2030 (see Figure 2).

That increase in spending of almost 7 percentage points will occur under current law. Proposals to increase payments to providers of services in the Medicare program or to expand the program's benefits through prescription drug coverage would exacerbate the long-term budgetary pressures projected for the next several decades. As this Committee knows, paying for those increased costs will require either dramatic reductions in spending, sizable increases in taxes, or large-scale borrowing.

Within the context of that longer-term perspective, I will now turn to CBO's projections of Medicare spending for the next 10 years, which we have just completed updating as part of our analysis of the President's budgetary proposals. CBO's new baseline projections of Medicare spending over the 2003-2012 period are lower by about $80 billion relative to its estimates in January. The revisions, which are mainly the result of new information, leave CBO's overall estimate for the period about $225 billion higher than the Administration's. That amounts to a difference of about 7 percent over the 10-year projection period, but CBO's and the Administration's estimates differ by only 4 percent over the five-year budget window. And regardless of their differences, both CBO's and the Administration's baseline projections reflect underlying forces that are likely to continue to exert upward pressure on spending in the Medicare program.

CBO'S PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

CBO projects that gross mandatory outlays for Medicare will total $248 billion in 2002 (or 2.4 percent of GDP) and $3.6 trillion over the 2003-2012 period, reaching 2.8 percent of GDP by 2012 (see Table 1). After deducting projected premium payments by beneficiaries of $26 billion in 2002 and about $400 billion over the 10 years, CBO estimates that net mandatory spending for Medicare will total $223 billion in 2002 and $3.2 trillion from 2003 through 2012 (see the table below).[1] All of CBO's projections incorporate the assumption that current law remains unchanged.

Projected Growth of Spending and Payments to Medicare Service Providers

CBO projects that net mandatory spending for Medicare will grow at a rate of 7.1 percent in 2002 and at an annual average rate of 6.6 percent over the 2003-2012 period. Those rates take into account a shift in the timing of some payments, which is described below.

1. In addition, the costs of administering the program, which are funded annually by appropriations, will amount to an estimated $3.6 billion in 2002.

SUMMARY OF CBO'S MARCH 2002 BASELINE PROJECTIONS
OF MANDATORY MEDICARE OUTLAYS (By fiscal year)

	Billions of Dollars		Average Annual Rate of Growth, 2003-2012 (Percent)
	2002	2003-2012	
Gross Mandatory Outlays	248	3,590	6.9
Premiums	-26	-413	8.4
Net Mandatory Outlays			
Unadjusted	223	3,177	6.7
Adjusted for timing shifts[a]	226	3,177	6.6

SOURCE: Congressional Budget Office.

a. Outlays are adjusted to eliminate the effect of accelerating payments to group plans from October to September in some years.

In recent years, the annual growth rate of spending for Medicare has varied considerably. Growth averaged 1.2 percent annually during the 1997-2000 period but then shot up to 10.3 percent in 2001. That jump stemmed in part from a provision of the Balanced Budget Act of 1997 (BBA) that accelerated $3 billion in payments to group plans (mainly Medicare+Choice) from October to September 2001—or from fiscal year 2002 to fiscal year 2001. (Another reason for the resumption of significant growth in 2001 was that by that time, Medicare had absorbed the substantial changes in payment rules enacted in the BBA. Other sources of growth were increases in payment rates and other changes enacted in the Balanced Budget Refinement Act and the Benefits Improvement and Protection Act.) Adjusted for the shift in group-plan payments, the underlying rate of growth in 2001 was 8.7 percent.

Over the next decade, CBO expects several factors to play a major role in the program's spending growth. Those factors include rising enrollment in Medicare, automatic increases in payment rates in the fee-for-service sector (to adjust rates for the rising prices of inputs), and changes in the use of Medicare's services, which will lead to more services being furnished per enrollee and to a shift in the mix of services toward those that are higher-priced and (often) more technologically advanced. In part offsetting the effects of those spending components will be smaller updates (adjustments) to the rates paid to Medicare+Choice plans relative to updates to rates in the fee-for-service sector. (Overall, CBO expects that spending for Medicare+ Choice

and other group plans will decline through 2006 and then grow slowly, returning to its 2001 level by 2012.)

The growth rates of Medicare's payments for services vary for particular types of Medicare service providers. Payments to hospitals for inpatient services and payments to physicians, which account for two-thirds of outlays, are the slowest-growing components of spending in the fee-for-service sector, respectively averaging 6.3 percent and 5.4 percent annually in CBO's baseline projections through 2012. By contrast, the rates of increase in payments for other services—for example, those provided by home health agencies and nonphysician professionals—are projected to average 9 percent to 16 percent annually.

Changes in CBO's Baseline Projections Since January

As I mentioned earlier, CBO's March baseline projection of $3.2 trillion in net mandatory spending for Medicare over the next 10 years is about $80 billion—or 2.5 percent—lower than the projection of that spending made in January. Three factors account for that overall revision:

- A reduction of about $30 billion in projections of payments to Medicare+ Choice plans. That change reflects the Administration's announcement in January of preliminary Medicare+Choice payment rates for 2003 and updates to CBO's projections of enrollment in those plans.[2] (CBO now projects that the percentage of Medicare enrollees in Medicare+Choice plans will decline from 15 percent in 2001 to 8 percent by 2012.)

- A reduction of about $35 billion in projections of payments for hospital outpatient services. That change reflects the Administration's announcement implementing lower "pass-through" payments for certain new technologies used in delivering services, coupled with an analysis of updated data on the cost of Medicare's "buying down" (contributing more to) coinsurance paid by beneficiaries for hospital outpatient services.

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2. For its January projection, CBO assumed that, overall, payment rates for Medicare+Choice (M+C) plans would grow at the same rate as spending per capita in the fee-for-service sector. CBO now estimates that M+C payment rates in all areas will increase by 2 percent in both 2003 and 2004. Rates in areas subject to a "floor" amount will increase by more than 2 percent in 2005 and grow with fee-for-service spending in subsequent years, but all other rates will increase by 2 percent annually until they reach the level of the floor amount or a 50/50 blend of local and national rates. (CBO estimates that the proportion of payments made at floor amounts or at 50/50-blend rates will increase from about 40 percent in 2005 to 95 percent by 2012.)

- A reduction of another $15 billion in projected spending to better reflect the changing age distribution of Medicare beneficiaries, an improved method for constructing price indexes for projecting updates to payment rates, and the effects of revised projections of outlays on the premiums paid by beneficiaries.

COMPARISON OF CBO'S AND THE ADMINISTRATION'S MEDICARE PROJECTIONS

The Administration's baseline estimate of $3.0 trillion in net mandatory spending for Medicare over the 2003-2012 period is about $225 billion, or 7 percent, lower than CBO's projection for the same period (see Figure 3). For 2003, the difference between the two projections amounts to 1.8 percent; over the 2003-2007 period, the difference is 4.2 percent. The Administration projects that net mandatory spending for Medicare will grow at an average annual rate of 5.4 percent through 2012, in comparison with CBO's projected (and adjusted) rate of 6.6 percent (see Table 2). The Administration's projection shows spending growing more slowly than that 10-year average through 2006 (average annual growth of 4.0 percent) and more quickly after 2006 (average annual growth of 6.4 percent). The pattern of growth in CBO's projection is similar. Rates are relatively low through 2006 (averaging 5.7 percent a year), and higher after 2006 (averaging 7.7 percent a year). The factors that contribute to the difference between the two projections—which, in the context of Medicare spending, is not large—are discussed in Appendix A.

CBO'S ESTIMATES OF THE COSTS OF THE PRESIDENT'S BUDGETARY PROPOSALS FOR MEDICARE

The President's budgetary proposals for Medicare include two major components: a Medicare-funded program that would give states the option of providing prescription drug benefits administered by their Medicaid programs to Medicare beneficiaries whose income is below 150 percent of the poverty level, and an allowance of $116 billion over the 2006-2012 period for a "Medicare Modernization" program. As a temporary measure, pending implementation of the modernization program, the President proposes to increase the payment rates for Medicare+Choice plans during the 2003-2005 period. The President's budget also includes three provisions to reduce Medicare spending—first, by establishing competitive bidding for some durable medical equipment; second, by adding new options for supplemental insurance (medigap); and third, by strengthening requirements for insurers that process Medicare claims to report beneficiaries for whom Medicare might be the secondary payer.

CBO estimates that the President's proposals would increase spending by $1.6 billion in 2003 and $169 billion over the 2003-2012 period. In contrast, the Administration estimates that those provisions would increase spending by $190 billion over 10 years.[3] Nearly all of the difference between the two numbers lies in estimates of the cost of offering coverage for prescription drugs to low-income Medicare beneficiaries. The difference arises largely because of differing assumptions about how many beneficiaries would participate in the benefit and what, on average, those benefits would cost.

Medicare Modernization and Medicare+Choice

The Administration has stated that it will work with the Congress to develop legislation to modernize Medicare, including providing coverage for prescription drugs and preventive health care services and protecting beneficiaries from catastrophic costs. In its analysis of the President's budgetary proposals, CBO used the Administration's estimate of $116 billion for the Medicare Modernization proposal because that proposal lacks sufficient details for CBO to develop an independent estimate.

Offering beneficiaries a choice among multiple health plans is an important element of a modernized Medicare, according to the Administration. To encourage health plans to participate in Medicare, the President's budget contains a proposal that, beginning in 2003, would increase the level of payments to Medicare+Choice plans and establish incentive payments to encourage new or existing plans to expand into new geographic markets. CBO estimates that those provisions would increase spending by $3 billion over the 2003-2005 period, which contrasts with the Administration's estimate of nearly $4 billion. The Administration (and CBO) did not estimate the cost of the provisions beyond 2005 because the budgetary effects in subsequent years are included in the $116 billion allowance for modernizing Medicare.

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3. CBO assumes that the components of the President's budgetary proposals need not sum to $190 billion over the 10-year period. As a result, CBO's lower estimate, relative to the Administration's, of the President's proposal for a prescription drug benefit for low-income beneficiaries does not mean that additional funds would be available for Medicare modernization.

Prescription Drug Benefits for Low-Income Medicare Beneficiaries

The President's budget includes a proposal that would give states the option of providing prescription drug benefits to certain low-income Medicare beneficiaries whose income is below 150 percent of the poverty level. The benefits would be administered through the beneficiaries' state Medicaid programs, which Medicare would reimburse for the costs of the program. States would have considerable flexibility in determining the drug benefits that would be provided, the amounts that beneficiaries would pay in the form of premiums or copayments, and any restrictions on eligibility for individuals with assets. Beneficiaries covered by the proposal would receive only prescription drug benefits; they would not be eligible for the full package of benefits under Medicaid. The federal government would reimburse the states at the usual matching rate for Medicaid (57 percent, on average) for spending on beneficiaries whose income falls below the poverty level. The matching rate would be 90 percent for spending on beneficiaries between 100 percent and 150 percent of the poverty level.

CBO estimates that this proposal would increase spending by a total of $57 billion over the 2003-2012 period, whereas the Administration projects a cost of $77 billion over the same span. Differing assumptions about rates of participation and per capita costs (see Appendix B for more information) are the main reason that CBO's estimate differs from that of the Administration.

Provisions to Reduce Spending by the Medicare Program

The President's budget also contains several provisions that would reduce Medicare spending over the 2003-2012 period, including:

- A proposal for a nationwide competitive-bidding system that would encourage companies to sell durable medical equipment at prices lower than those Medicare currently pays. Both CBO and the Administration estimate that this proposal would decrease Medicare spending by approximately $4 billion over the 10-year period.

- A proposal to add two private medigap plans with high deductibles to the 10 standard medigap plans already available to beneficiaries. Enrollees in the new plans, which would provide catastrophic coverage, would probably use fewer Medicare-covered services because the plans would not cover as much of beneficiaries' initial cost sharing as many current medigap policies cover. Both

CBO and the Administration estimate that this proposal would reduce Medicare spending by approximately $1 billion over the 2003-2012 period.

- A proposal requiring that insurers and group health plans periodically report to Medicare those beneficiaries for whom Medicare could be the secondary payer. Both CBO and the Administration estimate that this proposal would decrease Medicare spending by approximately $1 billion over the 10-year period.

PROVIDING COVERAGE FOR PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

CBO has analyzed data on beneficiaries' current spending for prescription drugs and developed preliminary projections of spending for outpatient drugs not currently covered by Medicare. Several approaches to providing drug coverage may be suggested by those data. However, in considering ways to provide a prescription drug benefit, a key factor to keep in mind is the implication of CBO's projections for the Medicare program.

Beneficiaries' Current Spending for Prescription Drugs

CBO's analysis of Medicare's Current Beneficiary Survey suggests that in 1999, one-quarter of the Medicare population had no prescription drug coverage, although 75 percent had coverage for at least part of the year. On average, the share of their drug expenditures that Medicare beneficiaries paid out of pocket was nearly 40 percent—the same share paid out of pocket by the U.S. population as a whole (see Figure 4). But because Medicare beneficiaries are generally elderly or disabled, they are more likely to have chronic health conditions and to use more prescription drugs than the general population: consequently, nearly 90 percent filled at least one prescription in 1999. Medicare beneficiaries made up almost 15 percent of the population that year, yet they accounted for about 40 percent of the more than $100 billion spent on outpatient prescription drugs in the United States.

Those factors suggest that growth in spending for prescription drugs has a larger financial impact on the Medicare population than on other groups in the population. Nevertheless, overall statistics mask a wide variety of personal circumstances. In 1999, for example, nearly 30 percent of Medicare beneficiaries obtained coverage for prescription drugs through employer-sponsored retiree benefits, and another 16 percent had coverage through state Medicaid programs. Although the extent of coverage by

employers and state Medicaid programs varies considerably, in general, those kinds of plans typically include relatively low deductibles and small copayments. About 11 percent of beneficiaries had drug coverage through individually purchased medigap policies in 1999, but that coverage tends to be much less generous, with higher deductibles, coinsurance of 50 percent, and annual limits on benefits.[4] In 1999, 25 percent of Medicare beneficiaries had no drug coverage at all, paying out of pocket for all of their spending on drugs.

CBO's Projection of Prescription Drug Spending for the Medicare Population

Last May, CBO estimated that spending by or on behalf of Medicare enrollees for outpatient prescription drugs not covered by Medicare would total $1.5 trillion between 2002 and 2011 (see Table 3). This year, CBO's preliminary projection for the same period is $1.6 trillion, or about 8 percent higher.

However, CBO's estimate of spending for prescription drugs over the current 10-year projection period of 2003 through 2012 is roughly $1.8 trillion—or 21 percent higher than last year's projection for the 2002-2011 period. Nearly two-thirds of that increase simply reflects the shift in the so-called projection window, which effectively substitutes a high-cost year (2012) for a relatively low-cost one (2002). The remaining growth reflects changes to CBO's estimates of how much, on average, is spent on a Medicare beneficiary to purchase prescription drugs both today and in the future.

Note that the projections I have just described are preliminary in nature. In developing them, CBO used information from its March baseline projections of Medicare spending, which were released last week. We have been working quickly to prepare estimates of prescription drug spending because we understand the Committee's need to develop legislative proposals in a timely manner. However, I would emphasize that CBO is still reviewing its projections and their underlying assumptions.

For 2003, CBO's preliminary projections suggest that, on average, a Medicare beneficiary will incur more than $2,400 in spending for prescription drugs used on an outpatient basis (see Table 4). The median value, a more representative measure of what most people spend, will be nearly $1,500 per person that year.

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4. CBO estimates that about 14 percent of Medicare beneficiaries obtained drug coverage through health maintenance organizations, primarily Medicare+Choice plans. And over 4 percent of Medicare beneficiaries received some drug coverage through other public programs, such as state pharmacy assistance programs or benefits through the Department of Veterans Affairs. All estimates of coverage are based on CBO's analysis of the Medicare Current Beneficiary Survey Cost and Use files for 1999.

Even without a Medicare prescription drug benefit, CBO expects average spending for prescription drugs to grow rapidly—at an average annual rate of about 10 percent per beneficiary—over the 2003-2012 period. That rate is considerably faster than the rate of growth projected for the combined costs of Medicare's Hospital Insurance and Supplementary Medical Insurance programs (Parts A and B) and for the nation's economy. However, that rate is also significantly lower than recent rates of growth: the Centers for Medicare and Medicaid Services estimates that spending per person for prescription drugs, averaged among everyone in the United States, grew by nearly 14 percent annually between 1995 and 2000 and peaked at more than 18 percent in 1999. Some of the slowdown in growth is associated with brand-name drugs whose patents will expire between now and the middle of the decade; some of it arises as well from a decline in the number of new drugs in development.

Implications of CBO's Estimates for the Costs of a Medicare Prescription Drug Benefit

To get a sense of what a proposal for prescription drug coverage might cost, consider a benefit that covered purchases of drugs only after an enrollee spent more than a deductible amount of $3,000. CBO's preliminary estimates suggest that in 2005, about a third of Medicare beneficiaries will spend $3,000 or more purchasing prescription drugs. Spending at or above that level would equal $52 billion, or about 41 percent, of a total of $128 billion in prescription drug expenditures that year (see Table 5). If the Medicare program subsidized 50 percent of beneficiaries' prescription drug spending at or above the $3,000 level, its costs for that benefit would total roughly $26 billion that year, with enrollees paying the remaining $26 billion through premiums, cost sharing, and payments by other insurers. (Enrollees and their non-Medicare insurers would also be responsible for covering the first $76 billion in prescription drug spending—that is, the costs of their purchases before reaching the $3,000 deductible amount.)

Although that example indicates the magnitude of Medicare's spending for such a benefit, it ignores some potentially large costs, such as subsidies to cover the federal share of premiums and cost sharing for low-income enrollees as well as the costs of creating and administering the new benefit. Moreover, most proposals for prescription drug coverage have had much more complicated structures—with lower deductibles to encourage broader enrollment and often caps on benefits to constrain costs to the Medicare program—than does the structure described in this example of a traditional insurance arrangement.

My presentation of CBO's estimates of prescription drug spending at today's hearing does not signal that CBO is fully prepared to score new proposals immediately. We are now "benchmarking" our models, in part by updating our estimates for some of the options developed in the 106th Congress. As part of that process, CBO is reviewing assumptions that were incorporated in earlier cost estimates in the light of more recent data and developments in the market for prescription drugs. We expect to be ready to provide briefings on the updated estimates and assumptions within a month.

The changes to CBO's baseline projections—to incorporate higher drug spending per capita and a new high-cost year in the projection window—imply that the price tags on proposals for a prescription drug benefit will be bigger today than they were last year. Exactly how much more costly is difficult to say, but recent experience may offer some guidance. Last year, CBO's baseline projection for total drug spending over the 2002-2011 period was 33 percent higher than the preceding projection as a result of the shift in the budget window and increases in estimates of prescription drug spending per person. Although that growth of 33 percent affected all proposals, the increase in costs for any specific option depended on the structure of its benefit package. For some of the proposals that CBO updated last year, the increase in costs of the Medicare drug benefit was considerably higher than the percentage increase in the baseline projection.

In updating its estimate of a proposal, CBO uses the same nominal values for deductibles, benefit limits, and stop-loss amounts (the cap on beneficiaries' out-of-pocket spending) that it used in estimating costs when the proposal was introduced.[5] Keeping those nominal features the same when drug spending is growing makes a bill's deductibles and stop-loss amounts relatively more generous. In contrast, for proposals that cap Medicare's drug benefit at a fixed dollar amount, keeping the same value for that limit would make the proposal relatively less generous as drug spending grew.

Under the nominal-dollar approach, some proposals introduced in the past would now be considerably more generous than they were when introduced—which means that the federal government would subsidize more of enrollees' prescription drug spending. For some proposals, a higher share of covered benefits would also translate into higher rates of enrollment, which would lead to even larger costs for the Medicare program.

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5. For example, if a proposal called for a deductible of $250 and a stop-loss amount of $5,000 beginning in 2004, CBO would use those same values of $250 and $5,000 but assume that the benefit would start in 2005.

Although this year's updated estimates of similar proposals will undoubtedly be higher than last year's estimates, they will not necessarily be 21 percent higher. Indeed, CBO's updated cost estimates could reflect higher rates of growth than the growth in baseline spending, depending on the structure of the proposals' benefits.

Patterns of Spending for Drugs and Other Health Services

The distribution of drug spending for Medicare beneficiaries is skewed: although nearly 90 percent of Medicare beneficiaries use some prescription drugs, the bulk of the population's drug spending is concentrated among a smaller group of individuals. For example, CBO projects that by 2005—the first year in which Medicare could probably begin to implement a new benefit—17 percent of enrollees will account for 55 percent of total drug spending by the Medicare population. Moreover, the annual spending of an individual enrollee among that 17 percent is likely to exceed $5,000. About 25 percent of Medicare beneficiaries are expected to have spending of $500 or less. Spending by those beneficiaries would make up just 1 percent of total prescription drug spending.

Yet even with that degree of asymmetry, spending for Medicare beneficiaries' outpatient prescription drugs is less concentrated than is spending for benefits that are already covered by the Medicare program. For example, the 10 percent of beneficiaries who have the highest spending for prescription drugs account for 40 percent of all outpatient prescription drug spending, whereas the 10 percent of beneficiaries who have the highest spending for the combination of services covered by Parts A and B of the program account for 65 percent of all Medicare spending.

Another characteristic of beneficiaries' prescription drug spending is that much of it is related to chronic health conditions, which often call for long-term drug therapies.[6] One implication of the association between chronic conditions and drug spending is that people with the very highest spending for drugs are likely to continue to have high spending in the future.[7]

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6. One study of prescription drug use among an insured senior population found that the top 10 categories of therapies ranked by number of prescriptions per person per year were for conditions that were primarily chronic in nature. Those therapies represented 55 percent of all claims. See Emily Cox and Catherine Roe, *Prescription Use Among a Commercially Insured Senior Population, 1998* (St. Louis: Express Scripts, Inc., May 2001).

7. A study of the drug spending of people age 65 or older found that those with the highest costs tended to use drugs from multiple therapeutic classes, suggesting the presence of several chronic conditions. See Cindy Thomas, Grant Ritter, and Stanley Wallack, "Growth in Prescription Drug Spending Among Insured Elders," *Health Affairs*, vol. 20, no. 5 (September/October 2001).

In comparison with spending for prescription drugs, spending for some services now covered by Medicare is much more variable for individuals over time—particularly expenditures for services related to hospitalizations and stays in other facilities. Even though many hospital admissions are ultimately related to an individual's chronic conditions, anticipating the timing of any one person's use of inpatient services is difficult. Nevertheless, there may be a certain proportion of Medicare beneficiaries—probably those with chronic conditions—who have high expenditures and who account for a large share of Medicare spending consistently from year to year.

More analysis is needed to understand the relationship between the use of outpatient drugs and spending for Medicare benefits. That relationship may vary by disease, by type of benefit, or by patient characteristic. However, for some beneficiaries who are very ill, one would expect spending for all types of health care services to be high. For others, the relationship may not be as clear.

CBO is analyzing the distribution of costs for Medicare services among beneficiaries in an effort to identify trends in spending and the characteristics associated with high levels of expenditures. What is now known is that, not surprisingly, Medicare beneficiaries who generate high costs for the program are very sick people, and a significant fraction of them die during or soon after the spell of illness that prompts those expenditures. But over half of the beneficiaries with high levels of expenditures survive, and some of them continue to generate high costs in succeeding years. Some of the goals of CBO's analysis are to identify beneficiaries with high costs for currently covered Medicare services, determine whether there is a percentage of the population that consistently generates high costs, distinguish the clinical characteristics of that population, and assess whether high-cost individuals can be identified.

Providing a Medicare Drug Benefit

Thus far, the debate over providing a prescription drug benefit under Medicare has focused on two general approaches: offering coverage to all Medicare beneficiaries or targeting coverage toward people with low income. However, other approaches are also available, although some have received less attention during the debate. Some policymakers advocate expanding Medicare benefits as part of a broader reform of the Medicare program. The organization and financing of health care have changed substantially since Medicare was established, and many private and public plans typically offer broader and more flexible packages of benefits. Medicaid has also moved toward offering broader coverage and flexibility to states in the structuring and administration of their programs.

An alternative approach is to target a Medicare drug benefit toward enrollees with specific clinical conditions rather than particular economic circumstances. For example, an integrated package of Medicare benefits could be developed that included a strategy for coordinating care and prescription drugs to help manage patients with certain diseases or chronic conditions. Along those lines, the Centers for Medicare and Medicaid Services recently announced a three-year demonstration project mandated by the Congress under which several disease-management organizations will develop approaches for managing patients with advanced-stage congestive heart failure, diabetes, and coronary heart disease. The announcement of the initiative noted that the demonstration will include coverage of prescription drugs for participating beneficiaries.

CONCLUSION

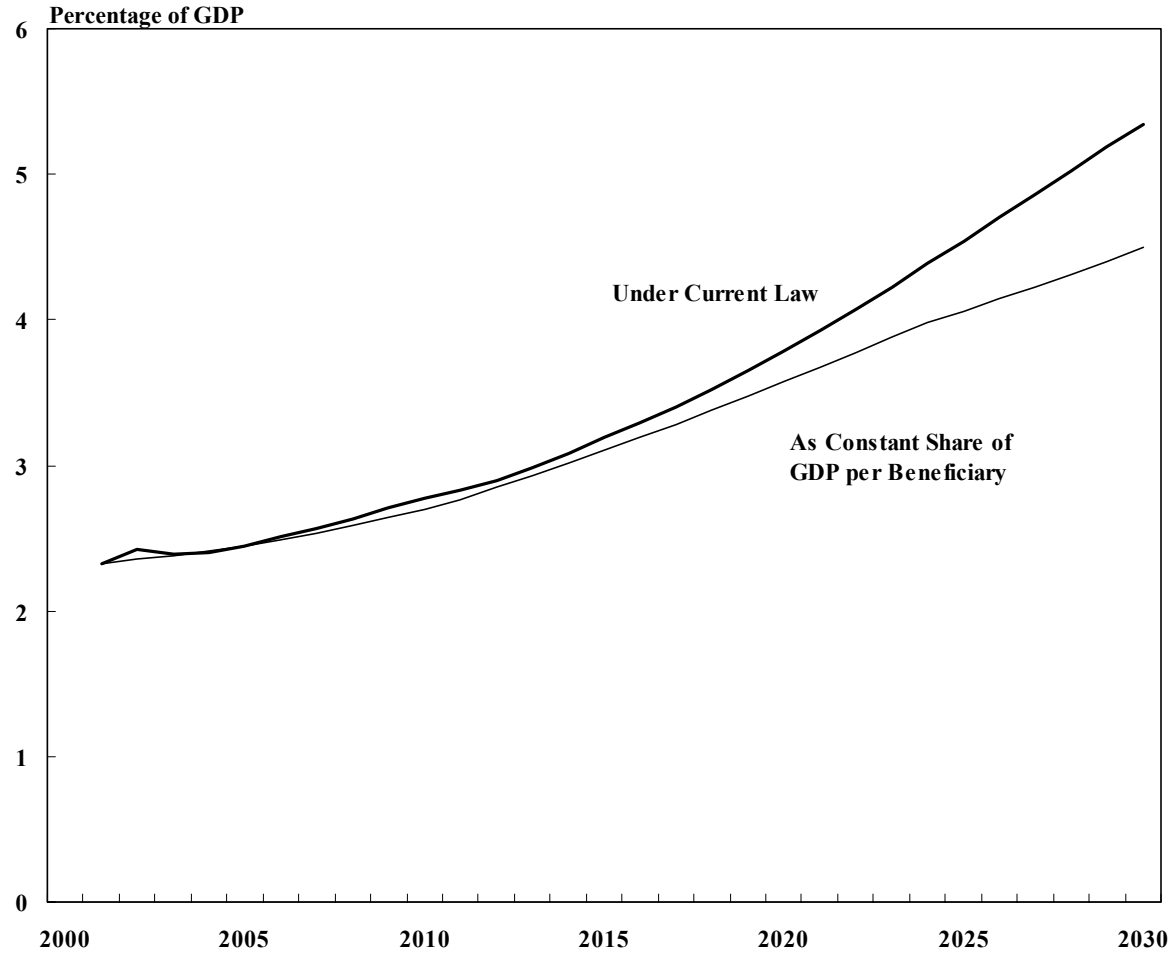
CBO's March baseline projection of $3.2 trillion in net mandatory spending for Medicare over the 2003-2012 period is about $80 billion, or 2.5 percent, lower than the projection released in January. Nevertheless, CBO's current projection and that of the Administration reflect underlying forces that will lead to faster growth in Medicare spending than in the economy as a whole. Some of those forces are the increases in payments to providers, which are linked automatically to changes in the prices of inputs; the rising volume of services being provided and changes in the mix of services toward those that are more technologically advanced and, in general, more costly; and increases in enrollment in the Medicare program.

Those factors contribute to the upward pressure on spending that is inherent in the Medicare program's structure under current law, and proposals to increase payments for certain providers would intensify that pressure. But the effects of those forces are overwhelmed by the dramatic growth of spending projected to begin at the end of this decade, as the baby-boom generation starts to become eligible for Medicare.

CBO's preliminary estimates suggest that spending for outpatient prescription drugs for the Medicare population will total $1.8 trillion between 2003 and 2012. That amount is 21 percent larger than last year's 10-year total, primarily because of the addition of a high-cost year (2012) and the loss of a low-cost one (2002). If the Medicare program subsidized a significant portion of beneficiaries' total drug expenditures, federal spending would jump. Moreover, CBO projects that over the 2003-2012 period, per-person spending for prescription drugs will grow at rates of more than 10 percent annually. Thus, without other changes to Medicare's benefits or

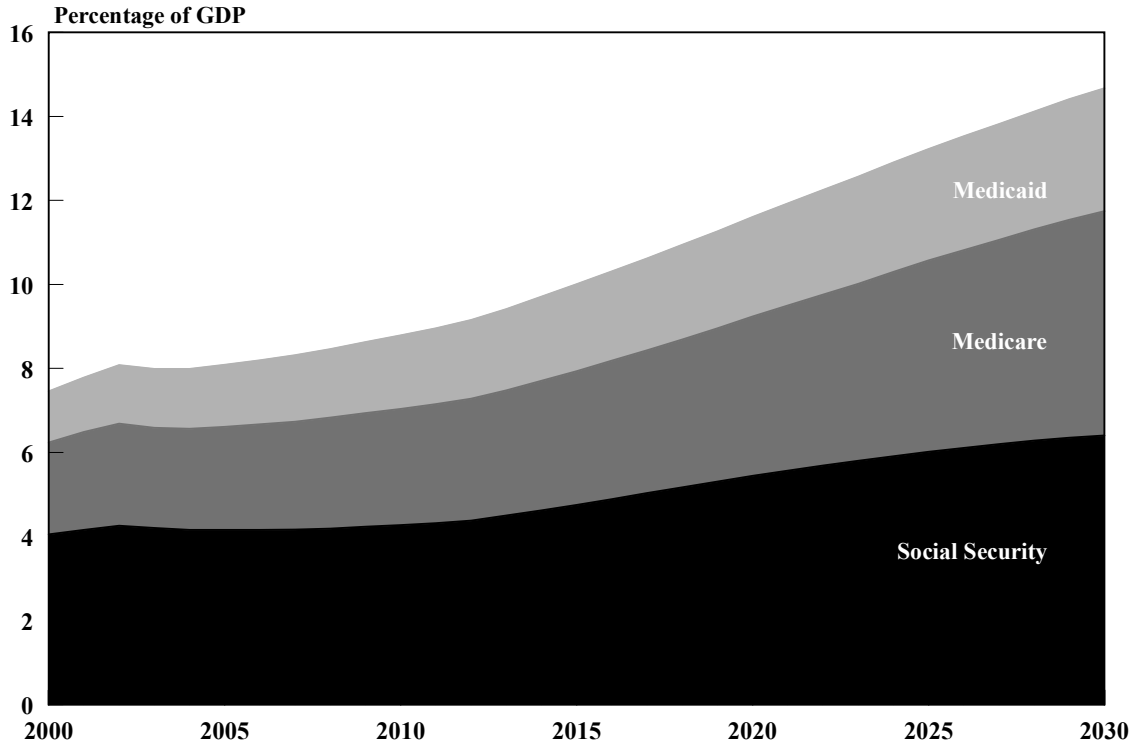
the way in which the program is financed, adding a comprehensive prescription drug benefit would add significantly to the program's future budgetary pressures.

FIGURE 1. PROJECTED MEDICARE SPENDING UNDER ALTERNATIVE ASSUMPTIONS, 2001-2030



SOURCE: Congressional Budget Office.

FIGURE 2. SPENDING FOR SOCIAL SECURITY, MEDICARE, AND MEDICAID, 2000-2030



SOURCE: Congressional Budget Office based on its midrange assumptions about growth of gross domestic product and program spending. For further details, see Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2003-2012* (January 2002), Chapter 6.

TABLE 1. CBO'S MARCH 2002 BASELINE PROJECTIONS OF MANDATORY OUTLAYS FOR MEDICARE, 2002-2012 (In billions of dollars)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total, 2003-2012
Part A: Hospital Insurance												
Fee-for-service program												
Hospital inpatient care	102	108	115	122	130	138	147	156	166	176	188	1,445
Hospice	4	4	4	5	5	6	6	6	7	7	8	59
Skilled nursing facilities	14	14	15	17	19	21	23	25	27	30	33	224
Home health services	6	6	6	7	9	10	12	13	15	17	19	115
Subtotal	126	132	141	151	162	174	187	201	215	231	248	1,843
Group plans[a]	18	18	17	18	15	17	17	18	18	21	19	177
Total, Part A Benefits	144	150	158	169	177	191	204	218	234	252	267	2,020
Part B: Supplementary Medical Insurance												
Fee-for-service program												
Physician fee schedule	43	44	44	46	49	52	56	60	64	68	72	556
Other professional and outpatient ancillary services[b]	19	21	23	26	29	32	35	38	42	46	50	341
Other facilities[c]	21	22	24	27	29	32	36	39	43	46	51	350
Home health services	6	7	8	10	11	13	15	17	20	23	26	149
Subtotal	88	94	100	108	118	129	142	155	168	183	199	1,396
Group plans[a]	15	16	15	16	13	15	15	16	17	19	17	159
Total, Part B Benefits	103	109	115	124	131	144	157	171	185	202	216	1,555
All Medicare Benefits	247	259	273	293	309	335	361	389	419	454	483	3,575
Other Mandatory Outlays	2	2	2	1	2	2	1	2	2	1	2	15
Gross Mandatory Outlays	248	261	274	294	310	336	363	391	420	456	484	3,590
Premiums	-26	-28	-30	-32	-35	-39	-42	-46	-50	-54	-58	-413
Net Mandatory Outlays	223	233	245	262	275	298	321	345	371	402	426	3,177
Memorandum:												
All Home Health Agencies	11	12	14	17	20	23	27	31	35	40	45	264
All Group Plans	33	34	31	33	28	32	32	34	35	41	36	336
All Fee-for Service Programs	214	225	241	260	280	303	329	355	384	414	447	3,238
Net Outlays as a Percentage of GDP	2.2	2.1	2.1	2.2	2.1	2.2	2.3	2.3	2.4	2.4	2.5	n.a.

SOURCE: Congressional Budget Office.

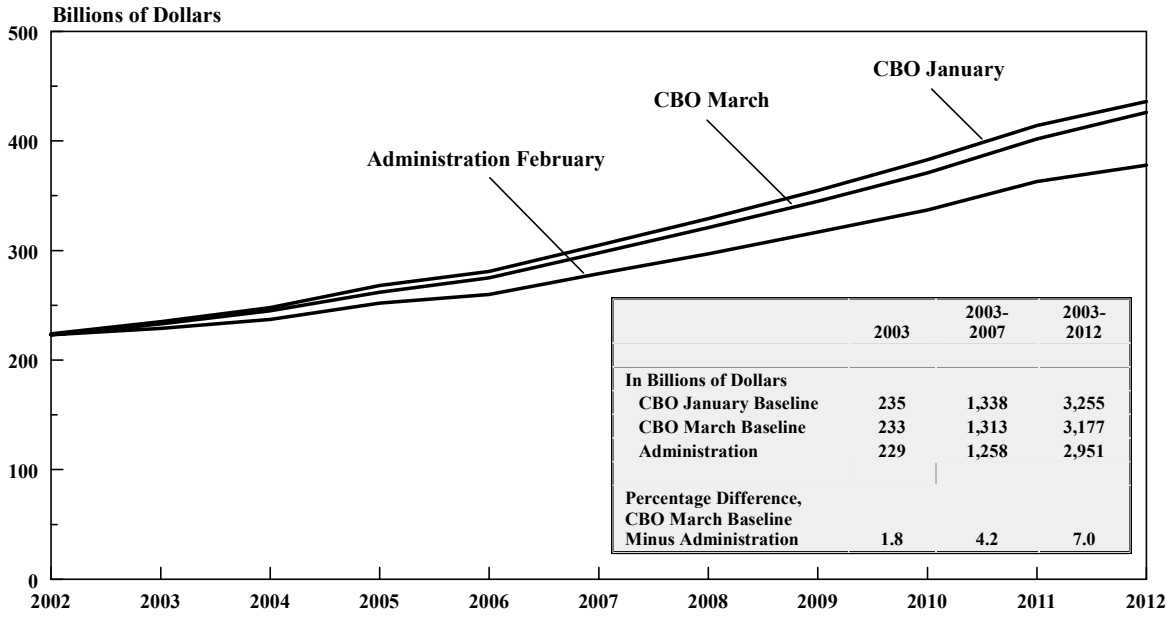
NOTE: Numbers may not add up to totals because of rounding.

a. Group plans include Medicare+Choice plans, plans paid on a cost basis, health care prepayment plans, and some demonstrations. Nearly all enrollment and spending is in Medicare+Choice plans.

b. Includes durable medical equipment, independent and physician in-office laboratory services, ambulance services, and other services paid by carriers.

c. Includes hospital outpatient services, laboratory services in hospital outpatient departments, rural health clinic services, outpatient dialysis, and other services paid by fiscal intermediaries. Also includes payments to skilled nursing facilities for services covered under Part B.

FIGURE 3. CBO'S AND THE ADMINISTRATION'S BASELINE PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE, 2002-2012



	2003	2003-2007	2003-2012
In Billions of Dollars			
CBO January Baseline	235	1,338	3,255
CBO March Baseline	233	1,313	3,177
Administration	229	1,258	2,951
Percentage Difference, CBO March Baseline Minus Administration	1.8	4.2	7.0

SOURCE: Congressional Budget Office.

TABLE 2. COMPARISON OF CBO'S AND THE ADMINISTRATION'S BASELINE PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE, 2002-2012

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total, 2003-2012
Net Mandatory Outlays (Billions of dollars)												
CBO	223	233	245	262	275	298	321	345	371	402	426	3,177
Administration	223	229	237	252	260	279	297	317	337	363	378	2,951
Difference (CBO minus Administration)	0	4	7	10	15	19	23	28	34	39	48	226
Annual Percentage Change in Spending												
CBO	4.0	4.7	4.9	7.3	4.8	8.3	7.6	7.6	7.5	8.3	6.1	6.6[a]
Administration	4.0	2.8	3.6	6.4	3.2	7.3	6.4	6.6	6.4	7.8	4.2	5.4[b]

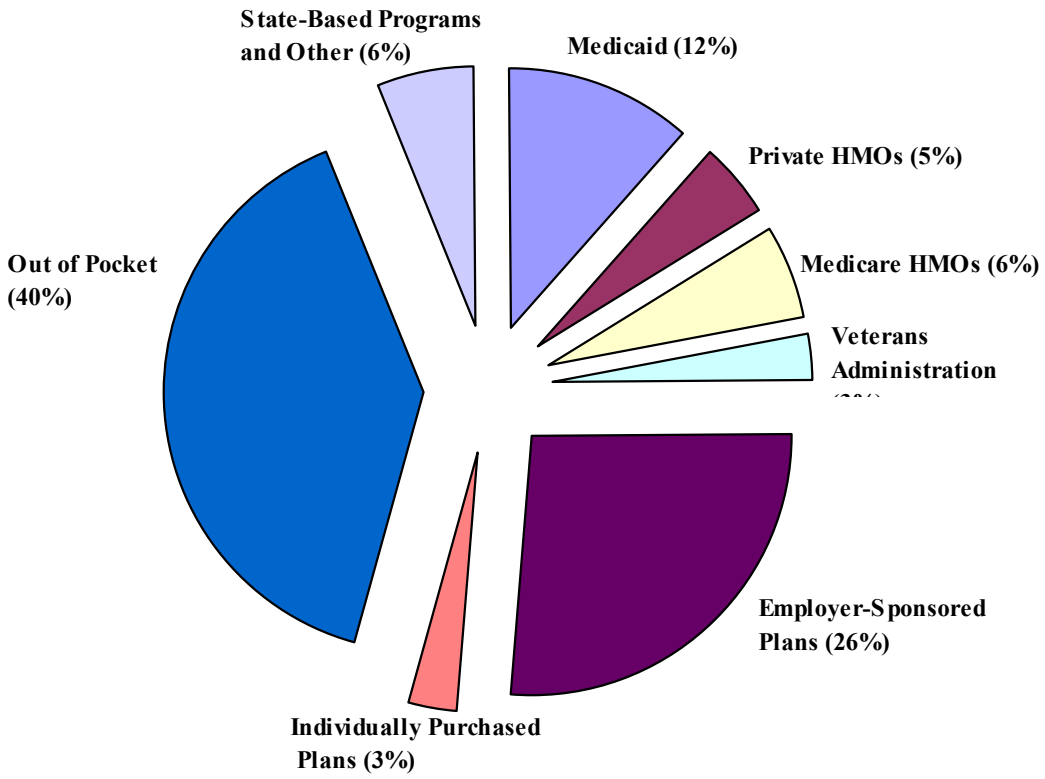
SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

a. Average annual rate adjusted to eliminate the effect of accelerating payments to group plans from October to September in some years.

b. Average annual rate.

FIGURE 4. DISTRIBUTION OF DRUG SPENDING FOR MEDICARE BENEFICIARIES, BY PAYER, IN 1999



SOURCE: Congressional Budget Office.

NOTE: HMOs = health maintenance organizations.

TABLE 3. COMPARISON OF CBO'S MARCH 2002 AND MAY 2001 BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING BY THE MEDICARE POPULATION (In billions of dollars)

Calendar Year	March 2002 Estimate	May 2001 Estimate
2002	87	81
2003	100	92
2004	113	104
2005	128	117
2006	143	131
2007	160	148
2008	179	166
2009	200	186
2010	222	208
2011	248	236
2012	278	n.a.
Total		
2002-2011	1,581	1,467
2003-2012	1,773	n.a.
Memorandum:		
Percentage Increase in Total Spending, March 2002 Estimates Over May 2001 Estimates, for 10 Years Ending in 2011		7.8
Percentage Increase in Total Spending, 10 Years Ending in 2012 (using March 2002 estimates) Over 10 Years Ending in 2011 (using May 2001 estimates)		20.8

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add up to totals because of rounding.

n.a. = not applicable.

TABLE 4. CBO'S BASELINE PROJECTIONS OF PRESCRIPTION DRUG SPENDING AND MEDICARE BENEFITS PER ENROLLEE, CALENDAR YEARS 2003-2012

	Spending per Enrollee (Dollars)		Average Annual Percentage Change, 2003-2012
	2003	2012	
Mean Drug Spending[a]	2,440	5,820	10.1
Median Drug Spending[b]	1,460	3,490	10.2
Medicare Benefits[c]	6,585	10,631	5.5
Memorandum:			
Gross Domestic Product per Capita	37,900	55,800	4.4

SOURCE: Congressional Budget Office.

a. Total spending per enrollee on outpatient prescription drugs not currently covered under Medicare, regardless of payer. Numbers based on CBO's March 2002 projections.

b. The median reflects the point at which half of all beneficiaries are projected to spend more than that amount and half are projected to spend less. Based on CBO's March 2002 projections.

c. Medicare benefits per enrollee under the Hospital Insurance and Supplementary Medical Insurance programs. Based on CBO's March 2002 baseline projections.

TABLE 5. PROJECTED SPENDING ON PRESCRIPTION DRUGS BY OR FOR MEDICARE ENROLLEES IN CALENDAR YEAR 2005

Spending Level per Enrollee (Dollars)	Spending At or Above the Level (Billions of dollars)	Share of Enrollees with Spending Above the Level (Percent)	Share of Total Drug Spending Above the Level (Percent)
0	128.1	89.8	100.0
500	110.0	75.1	85.9
1,000	94.7	64.4	73.9
2,000	70.2	47.4	54.8
3,000	52.4	33.7	40.9
4,000	39.7	24.5	31.0
5,000	30.5	17.3	23.8
6,000	24.1	12.4	18.8
7,000	19.3	9.3	15.1
8,000	15.8	6.9	12.3
9,000	13.1	5.5	10.2
10,000	10.9	4.3	8.5

SOURCE: Congressional Budget Office.

NOTES: Numbers are based on CBO's March 2002 projections.

Total Medicare enrollment for 2005 is projected to be 41.9 million people.

APPENDIX A: SOURCES OF VARIATION BETWEEN CBO'S AND THE ADMINISTRATION'S MEDICARE BASELINES

The Congressional Budget Office's (CBO's) and the Administration's projections of Medicare spending differ by about $225 billion over the 2003-2012 period. That difference stems from divergences in the assumptions underlying those estimates.

Differences Arising from Economic Assumptions

About $40 billion of the 10-year difference between CBO's and the Administration's estimates results from differing economic projections. Payment rates for most services are adjusted, or updated, each year to reflect changes in the prices of inputs. In general, CBO projects that those updates to payment rates will be 0.1 or 0.2 percentage points higher than the Administration's projected updates.

Differences Resulting from Assumptions About Administrative Actions

Another $10 billion to $20 billion of the 10-year difference stems from possible administrative actions that the Administration's baseline takes account of but that CBO's does not. The Administration's baseline incorporates the assumption that the payment method for outpatient prescription drugs covered under the Medicare program will change in 2003. However, the Administration has not yet put forward a specific proposal for changing the payment rules. As a result, CBO's projections incorporate the assumption that Medicare continues to use the existing payment method.

Differences Stemming from Technical Assumptions

The remaining difference of about $175 billion over 10 years reflects different technical assumptions about enrollment in Medicare+Choice plans and in the rate of increase in the volume and mix of services provided to beneficiaries in the fee-for-service sector. A clear comparison of CBO's and the Administration's baselines by payment category is difficult, because the two groups of estimates reflect very different assumptions about the proportion of beneficiaries who will participate in Medicare+Choice plans.

Assumptions About Medicare+Choice. The Administration projects that the proportion of beneficiaries enrolled in Medicare+Choice plans will remain fairly stable (in the range of 14 percent to 15 percent) over the coming decade, whereas CBO projects a sharp decline in that share (to 8 percent) by 2012. The Administration's assumption that a relatively large share of Medicare enrollees will remain in Medicare+Choice plans while the plans' payment rates are growing much more slowly than rates in the fee-for-service

sector may contribute significantly to the differences between CBO's and the Administration's baseline projections of Medicare spending.

Assumptions About Growth Stemming from the Volume and Mix of Services in the Fee-for-Service Sector. The projections of both CBO and the Administration incorporate the assumption that spending per capita for services in the fee-for-service sector of Medicare will grow at a faster rate than will the adjustments to payment rates for changes in input prices. In general, however, CBO projects larger increases in per capita spending as a result of changes in the volume and mix of services than the Administration does.

Those assumptions about spending increases differ the most for the areas of skilled nursing services, hospital outpatient services, and home health services. The payment systems in all three settings have changed substantially in the past few years, and whether and how the volume and mix of services will change under the new systems is uncertain. Both CBO and the Administration assume that increases in the volume and changes in the mix of those services will contribute less to growth in spending under current law than they contributed under the payment systems that existed before the Balanced Budget Act of 1997 was enacted. CBO estimates that the contributions to growth made by volume and mix changes will steadily decline over the coming decade as follows:

- For skilled nursing services, dropping from about 7 percentage points a year in the next few years to 4.5 percentage points by 2012;

- For hospital outpatient services and other payments to facilities for services covered under Part B of Medicare, falling from about 5.3 percentage points annually to 3.8 percentage points; and

- For home health services, declining from 12.5 percentage points to 7 percentage points a year.

The Administration appears to make a similar assumption about the steadily lessening effect of changes in the volume and mix of services—although it projects a more rapid decline than does CBO—for skilled nursing services and hospital outpatient services. Compared with CBO's assumption about the effects of volume and mix changes for home health services, however, the Administration's assumption seems to reflect more-rapid increases in the effects of volume and mix changes for home health services through 2005 or 2006 and a more rapid decline in subsequent years.

CBO and the Administration make very similar assumptions about the effects of volume and mix changes in relation to the sustainable growth rate (SGR) system of payment for

services on the physician fee schedule and in relation to payments to hospitals for inpatient services.

The SGR system automatically adjusts payment rates for services on the schedule to compensate for changes in the volume and mix of services. Therefore, the differences between CBO's projections of payments under the physician fee schedule and the Administration's projections are almost entirely attributable to economic factors and to differences in the projected number of beneficiaries in the fee-for-service sector. Likewise, both CBO and the Administration assume that changes in the mix and volume of services contribute about 1 percentage point to annual increases in payments to hospitals for inpatient services—1 percentage point, that is, above the growth resulting from increases in enrollment and adjustments for inflation.

APPENDIX B: CBO'S ASSUMPTIONS FOR ITS ESTIMATE OF THE ADMINISTRATION'S PRESCRIPTION DRUG PROPOSAL

In developing estimates of the costs of the President's recent proposal for prescription drug coverage, the Administration and the Congressional Budget Office (CBO) used different assumptions for three factors: which states would participate by offering coverage, how many eligible beneficiaries would enroll for the benefit, and the level of spending per enrollee.

Participation by States

CBO anticipated that certain states would be more likely than others to provide coverage for prescription drugs under this proposal. First, states that have pharmacy assistance programs (23 at last count) would be more likely to participate because the proposal would allow them to receive federal matching funds for those programs, which are now entirely state-funded. Second, states whose Medicaid programs already cover all aged and disabled individuals below the poverty level would be more likely to participate than states that do not provide such coverage. For the states that already covered those low-income people, expanded coverage for prescription drugs would qualify for the higher federal matching rate of 90 percent and thus require relatively little additional state spending. At least 15 states fall into that category, and another four have eligibility limits that are just below the poverty level. In contrast, states with less generous Medicaid programs would have to expand eligibility significantly—and on average pay 43 percent of the resulting costs—before they would receive the 90 percent federal match.

Of the remaining states, CBO expects that a portion would participate and that they would be less likely than other states to expand coverage fully to 150 percent of the poverty level.

CBO assumed that about 65 percent of the population eligible for the proposed benefit would reside in participating states. The Administration assumed that about 70 percent of the eligible population would come from those states.

Participation by Beneficiaries

In developing its estimate, CBO also made an assumption about the level of participation of Medicare beneficiaries in states that decided to offer prescription drug coverage under the proposal. CBO assumed that almost 60 percent of eligible Medicare beneficiaries would ultimately participate, on the basis of experience with Medicaid and other low-income programs as well as the extent of employer-sponsored coverage among the eligible population. Thus, CBO estimated, the total number of participants in the

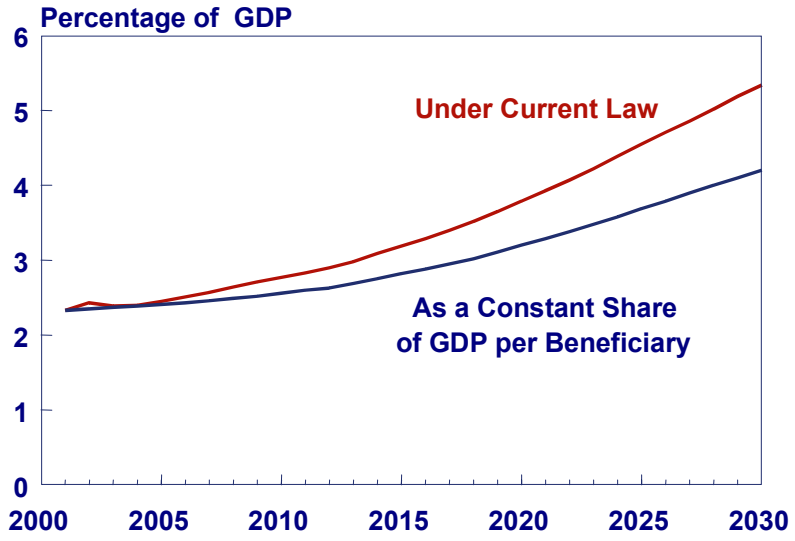
program would gradually rise from about 900,000 in 2003 to 2.4 million by 2007; participants would constitute about 6 percent of all Medicare beneficiaries and 18 percent of beneficiaries with income below 150 percent of the poverty level. By comparison, the Administration assumed that about 70 percent of eligible beneficiaries would participate. Those differing assumptions are the primary reason that CBO's estimate is lower than the Administration's.

Per Capita Costs

Finally, CBO assumed that the generosity of the prescription drug benefits offered under the proposal would vary from state to state, ranging from the benefits provided by pharmacy assistance programs to those provided under employer-sponsored coverage. CBO also anticipated that the prescription drug benefits typically offered by the states would be less generous than those provided in existing state Medicaid programs. The Administration's estimate incorporated the assumption that the drug benefits provided under the proposal would equal average drug spending for the overall Medicare population, as calculated from the accounts maintained by the Centers for Medicare and Medicaid Services.

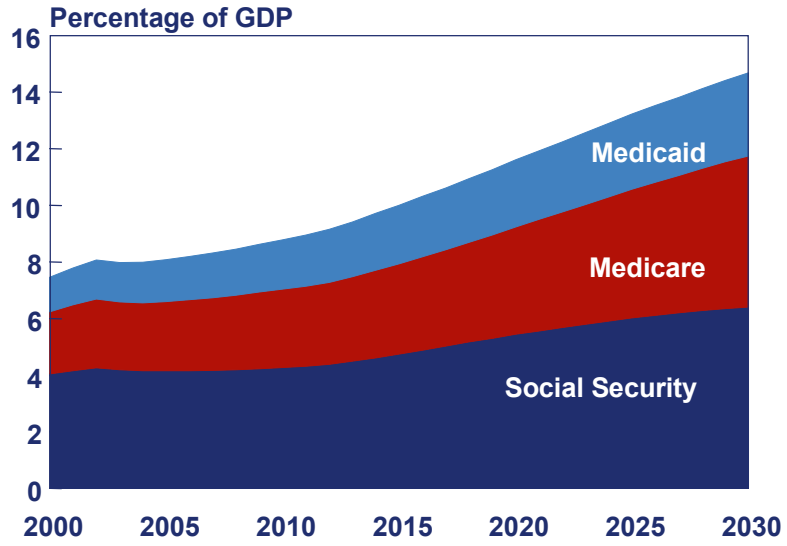
Charts Presented at the Hearing

Projected Medicare Spending: Current Law Versus Population Growth Only



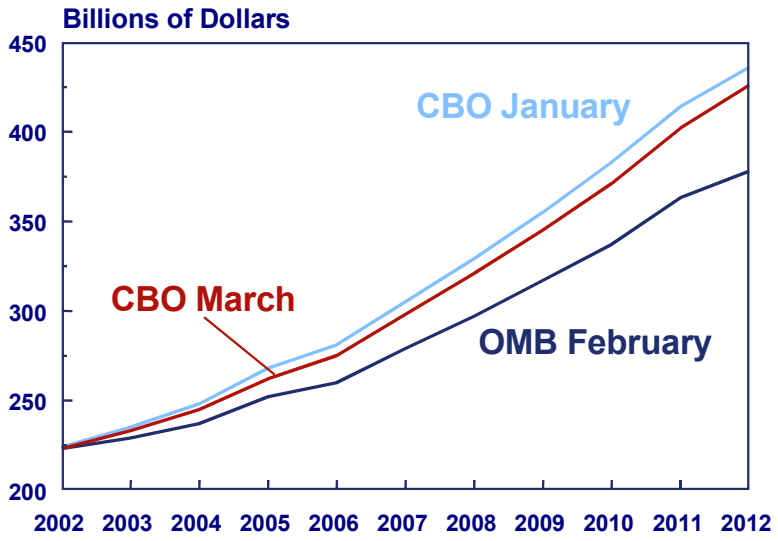
CBO-SenFin (3-07)

Spending for Social Security, Medicare, and Medicaid, 2000-2030



CBO-SenFin (3-07)

Baseline Projections of Medicare Spending

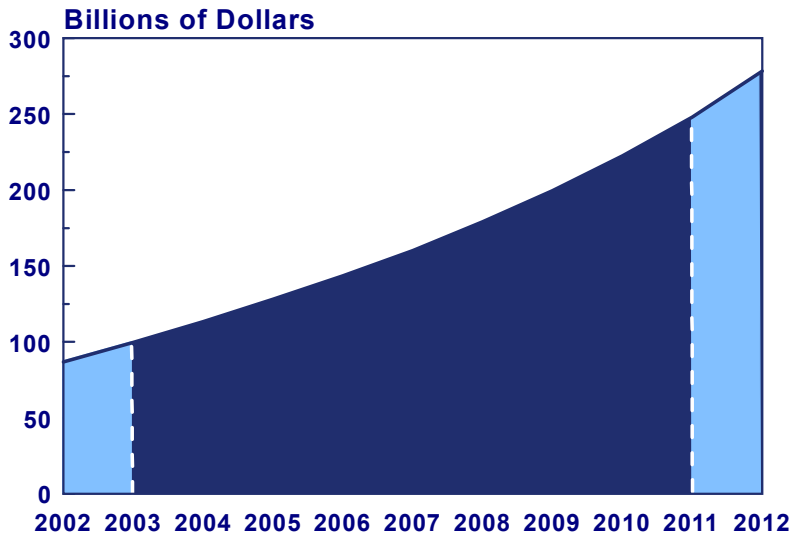


CBO-SenFin (3-07)

	2003	2003-2007	2003-2012
In Billions of Dollars			
CBO January Baseline	235	1,338	3,255
CBO March Baseline	233	1,313	3,177
Administration	229	1,258	2,951
Percentage Difference, CBO March Baseline Minus Administration	1.8	4.2	7.0

CBO-SenFin (3-07)

Total Prescription Drug Spending Not Covered by Medicare

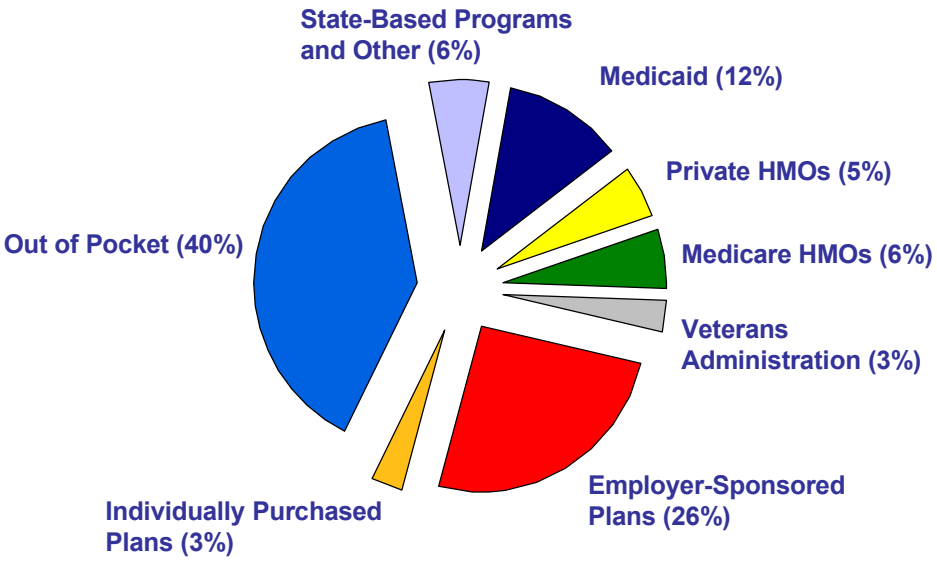


CBO-SenFin (3-07)

	2002	2012	Average Annual Change, 2003-2012
Spending per Capita (Dollars)	2,440	5,820	10.1%
			Cumulative, 2003-2012
Total Drug Spending (Billions of dollars)	100	278	1,773

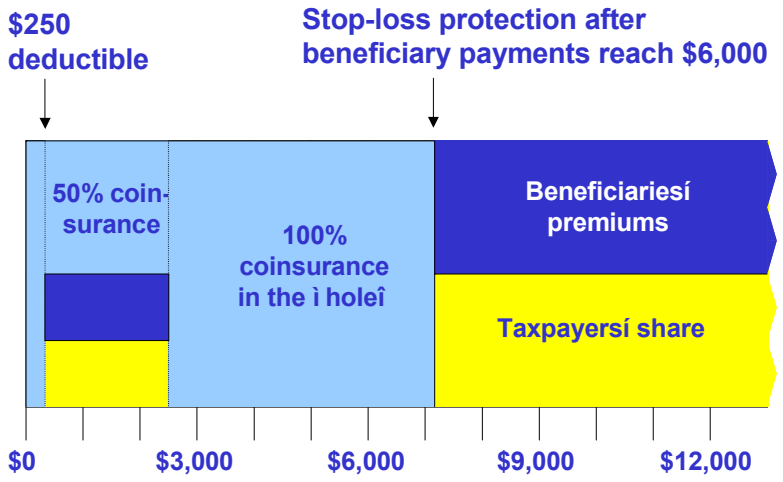
CBO-SenFin (3-07)

Who Paid for Medicare Beneficiariesí Prescription Drugs in 1999?



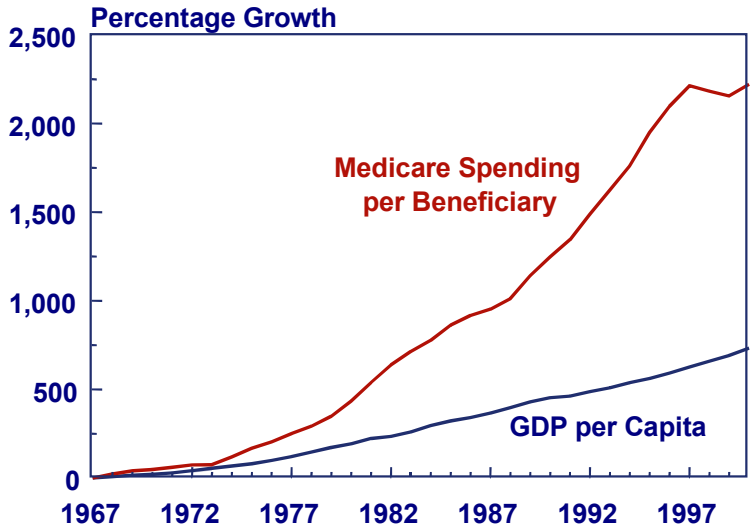
CBO-SenFin (3-07)

Hypothetical Structure of a Medicare Prescription Drug Benefit



CBO-SenFin (3-07)

Growth Since 1967 in Medicare Spending per Beneficiary and in GDP per Capita



CBO-SenFin (3-07)