

**The Cost of Adding a Prescription Drug Benefit to Medicare**

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Mr. Chairman and Members of the Committee: Thank you for inviting me to appear before you. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute. I am also adjunct professor in the School of Public Health at the University of North Carolina at Chapel Hill. I have previously served as the assistant director for health and human resources at the Congressional Budget Office (CBO), and earlier held several research and management positions in the Health Care Financing Administration, the precursor to the Centers for Medicare and Medicaid Services (CMS). The coauthor of this testimony is Jagadeesh Gokhale, visiting scholar at the American Enterprise Institute and an expert in fiscal policy. Dr. Gokhale developed the estimates of Medicare's long-term fiscal imbalance that I will describe later. The views I present today are my own and those of my coauthor, and do not represent the position of the institutions with which we are associated.

The Medicare program faces unprecedented challenges. Medicare's benefit structure is outmoded and inadequate, failing to cover outpatient prescription drugs or to provide adequate financial protection for millions of enrollees. Physicians, hospitals, and other providers have developed new and better ways to diagnose, treat, and cure diseases—causing Medicare spending per enrollee to grow rapidly. The impending retirement of 78 million baby-boomers, beginning in just 8 years, will rapidly escalate demands on Medicare's finances.

These challenges cannot be avoided. Steps must be taken to improve and strengthen Medicare so that it can meet the changing needs of seniors and the disabled, now and in the future. That means the passage of a prescription drug benefit and prudent reforms that will encourage competition among health plans, give beneficiaries realistic choices, and begin to slow the overall growth of Medicare costs. Adding a drug benefit alone would sharply increase the cost of Medicare to future taxpayers and jeopardize the financial viability of the program.

My testimony today will examine the likely cost of a Medicare prescription drug benefit over the next ten years and in the decades to come. I will make three points:

- ★ Actual program spending for Medicare prescription drugs through 2013 will probably exceed the \$400 billion currently projected by the CBO.
- ★ Spending for prescription drugs could be constrained, but there are risks in that approach. A more comprehensive strategy is needed to limit taxpayer cost while assuring that beneficiaries receive appropriate services.
- ★ The long-term cost of the new drug benefit is astronomical and will largely fall on our children and grandchildren.

### **The Drug Benefit Will Cost More**

Proposals for a Medicare prescription drug benefit under H.R. 1 in the House and S. 1 in the Senate would increase federal outlays by just over \$400 billion through 2013, according to the CBO. That estimate could greatly understate actual outlays under a Medicare drug benefit for

two reasons. First, CBO had to make numerous assumptions about how the complex policies proposed in the two bills would actually work. The resulting estimate is highly uncertain, and there is nothing in the legislation that would hold spending to \$400 billion. Second, the CBO estimate cannot account for future legislation that could substantially increase program outlays.

The House and Senate bills posed an unusually difficult challenge to CBO. Each proposal is a major departure from the way Medicare has operated in the past, making it very difficult to arrive at an accurate estimate. Since many of the features of the new benefit are unique, the empirical evidence used to develop the cost estimate is more limited than usual. If the new drug plans are less effective in containing costs the CBO has assumed or if more employers drop retiree drug coverage than expected, federal spending could be substantially greater than currently estimated. Numerous other factors could drive federal outlays above estimated levels, including changes in physician prescribing behavior, unexpected increases in demand for prescription drugs by patients, and changes in the pricing and marketing of drugs by manufacturers.

Actual outlays are likely to be driven well above the \$400 billion level by changes in law that the CBO cannot consider in its estimates. Even before a drug benefit can be enacted, the campaign to expand its generosity has begun. Senator Kennedy has gone on record that the Senate bill represents a mere down payment on adequate drug coverage.

One indication of the cost of possible expansions is the proposal by House Democrats that offers very generous coverage for prescription drugs. That proposal would increase outlays by \$1 trillion in total over the next 10 years. If future policymakers fill in some of the significant gaps in coverage under H.R. 1, the \$400 billion drug benefit that is enacted this year could conceivably cost double that amount by 2013.

The history of Medicare cost estimating does not leave one sanguine about the accuracy of CBO's estimate. Actual spending has usually come in much higher than initial projections, reflecting changes that could not be anticipated in the behavior of patients and providers, changes in the practice of medicine, and changes in legislation. For example, in 1965 the actuaries estimated that Hospital Insurance under Medicare would cost about \$9 billion by 1990. Actual spending was about \$67 billion in that year.

History will almost certainly repeat itself. Congress is considering what appears to be a \$400 billion benefit, but the real cost is likely to be much higher.

### **Medicare Drug Spending Could Be Held to \$400 Billion**

House Speaker Dennis Hastert (R-Ill.) has promised that the final Medicare bill will have a cost-containment provision to prevent prescription drug spending from skyrocketing. Unless considerable flexibility and consumer choice are built into the Medicare program, spending control measures could have unintended consequences. If poorly designed spending limits

caused beneficiaries to shift from prescription drugs to other, less restricted forms of treatment, that could raise overall program costs and lower health outcomes.

One approach would cap total spending for prescription drugs in each year. Spending in excess of the cap in one year could be “recouped” the following year by reducing the federal prescription drug subsidy. Plans would pass that reduction to beneficiaries by raising premiums or reducing the benefit (through increased cost-sharing requirements and tighter drug formularies). Stuart Butler of the Heritage Foundation suggests that cost sharing could be automatically increased for middle- and upper-income beneficiaries, while protecting from cost increases those with low incomes.<sup>1</sup>

This general approach could be effective in reining in the government’s prescription drug costs. But the exclusive focus on prescription drugs overlooks the broader fiscal problem facing Medicare. Even without a new drug benefit, Medicare spending is rising at an unsustainably high rate. The Medicare program has been growing substantially faster than the economy since 1965. The baby boomers, who begin to turn age 65 in eight years, will place an unprecedented new demand on Medicare.

Moreover, by singling out the new drug benefit for spending controls, we run the risk of biasing treatment decisions, which could frustrate attempts to slow Medicare spending without harming patient welfare. Rather than trying to control the costs of individual health services, as Medicare has tried unsuccessfully over the past three decades, we should integrate prescription drugs with all other benefits. Our proper concern should be on the overall growth in health spending. Micromanaging the cost of individual services has proven to be both ineffective and inefficient.

The traditional Medicare program is an uncapped entitlement to payment for health care providers. The payment incentives foster ever-expanding spending growth for services that, at the margin, are not worth what they cost. A new approach, modeled after the premium support system of the Federal Employees Health Benefits Program (FEHBP), is needed if we are to control costs sensibly. By offering beneficiaries real choice among health plans, we can promote competition that over time can slow the growth of spending and improve the value of what we purchase.

H.R. 1 would introduce a new approach to competition that places the traditional Medicare program and the private plans on a more even footing. Beginning in 2010 in selected market areas, all plans (including traditional Medicare) would bid against the same benchmark. Beneficiaries would pay lower premiums if they select plans with below-average costs. Those choosing traditional Medicare might face higher or lower premiums, depending on whether the traditional program is more effective in containing cost. Although it could be improved, this provision represents a very significant step toward premium support and fair competition among all the health plans in Medicare.

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<sup>1</sup>Stuart Butler, “The Crucial Elements of an Acceptable Medicare Bill,” The Heritage Foundation, WebMemo #311 (July 10, 2003).

## **Huge Long-Term Cost Will Be Borne By Younger Generations**

Although the political debate has focused on the \$400 billion cost to taxpayers over the next 10 years, that ignores the fact that the Medicare drug benefit will cost hundreds of billions more after 2013. Both the House and Senate bills make a permanent commitment to a new subsidy, but neither bill explicitly mentions how that subsidy will be paid for. Instead, the proposals rely on transfers from general funds—in other words, increasing the federal budget deficit.

Congress should have a better idea of the cost before it enacts the permanent new drug entitlement. Federal outlays for Medicare prescription drugs will increase sharply as the baby boomers retire and enroll in the benefit. Since the program does not terminate, additional federal costs will be incurred for the indefinite future.

The government's unfunded obligation for the new drug benefit proposed in S. 1 is between \$7 trillion and \$12 trillion measured in today's dollars. Those figures are based on CBO's estimate of the Senate bill. The lower estimate assumes that the per-beneficiary growth in drug spending slows sharply starting in 2014. The higher estimate, which is more realistic, assumes that the dramatic slowdown in spending growth does not begin until 2041.

The \$7 trillion to \$12 trillion figure is the increased unfunded liability resulting from the new benefit. That is on top of Medicare's existing shortfall, some \$30 trillion in today's dollars. By comparison, Social Security is a model of fiscal prudence, with unfunded obligations of about \$7 trillion.

Those figures do not reflect any program savings that might accrue because of other reforms. The Senate bill does not include any incentives for broader competition that would yield future cost savings. As mentioned earlier, the House bill does include such incentives, and the potential savings could be quite significant over time. Although we could not make a direct estimate of the impact of H.R. 1's reform provisions, the administration's original proposal provides some basis for speculation. The latter proposal, which included strong incentives for competition, would generate about \$6 trillion in unfunded obligations. That cuts the long-term cost of the drug benefit in half.

Although the proposals do not address financing, ultimately someone will have to pay the bill. Congress will no doubt try to reduce overall Medicare spending in future budget deals, once the size of the financial commitment becomes known. It may force wider-ranging cuts, putting housing, education, transportation, and other services at risk. Or Congress could raise taxes to prevent the burgeoning deficits from damaging economic growth. Tax hikes appear to be the most probable outcome, simply because once the baby boomers retire, they will constitute a potent political force seeking to preserve and expand their entitlement to Medicare benefits.

One possible funding approach is a new permanent tax on wages sufficient to pay for the benefit. Suppose such a tax was imposed starting in 2004. Today's seniors would pay little

additional tax under that approach, since they are already out of the labor force. After taxes, the average person over the age of 56 would gain nearly \$10,000 in drug benefits measured in today's dollars. Baby boomers would shoulder some of the cost, but they would still come out ahead. Measured in today's dollars, the average boomer would gain \$21,000 in new benefits, and would pay about \$18,000 in new taxes.

The big losers are 150 million Generation-Xers and others born after 1964. They would receive about \$23,000 in benefits per person, but each would have to pay about \$30,000 in new taxes over their lifetimes (measured in today's dollars). Children, who obviously do not get a vote, would pay the most.

Congress is unlikely to consider ways to pay for the new Medicare outlays until there is a fiscal crisis brought on by rising budget deficits. The longer Congress waits to pay its bills, the more those costs will be shifted from older generations to younger ones. Delaying the tax increase to 2014, for example, reduces the tax burden of boomers by about \$11,000 per person. Their children and grandchildren would have to pay even higher taxes as a result.

If we fail to take the first steps toward real reform, we run the risk of upsetting the social compact that has sustained Medicare since 1965. The beneficiary population will rise sharply as the boomers reach age 65, outstripping growth in the number of workers paying their bills. Younger generations will eventually find that the massive shift of resources from them to their elders has become unbearable, and political support for the status quo will vanish to the detriment of everyone. The unraveling of Medicare could be avoided, but only if we begin to face the inescapable facts about the program's future.

## **Conclusion**

The Medicare prescription drug benefit advancing through Congress will cost much more, and do less good, than many legislators realize. Federal outlays will almost certainly grow faster over the next decade than current estimates indicate, and the added liability that will be incurred over the long term is enormous. That money is not well spent, as the proposals displace the good coverage that many Medicare beneficiaries already have and extend generous subsidies even to the wealthy. For all of that spending, Congress will hear plenty of complaints over the coming years that the benefit is not good enough.

Medicare clearly needs to be modernized, and prescription drugs are an essential part of that modernization. Medicare remains firmly rooted in the insurance market of 1965. The four-year debate over a prescription drug benefit is proof that the program as currently structured is not responsive to the changing needs of consumers or the changing face of medicine, and does little to foster cost-effective health care. Simply adding a new benefit would not resolve Medicare's fundamental problems that drive spending levels skyward.

Reforms that go beyond prescription drugs are needed if the program is to survive the financial pressures created by the baby boomers, who will double Medicare enrollment by 2030.

The policy objective should be to moderate the growth in health costs without also cutting the value of what we buy. The FEHBP, which has served federal employees and retirees well for 40 years, presents a practical model to achieve that objective in Medicare. Congress has an opportunity in the current legislation to adopt elements of an FEHBP-style reform and improve upon them. This might be the last, best chance that Medicare will have to prepare for a demanding and difficult future.