From Families USA

President Bush's Fiscal Year 2007 Budget: Analysis of Key Health Care Provisions

On February 6, 2006, President Bush released his proposed federal budget for fiscal year 2007, which begins on October 1, 2006. This year, the President explicitly recognized the growing health care crisis in his budget plan, which includes a number of specific proposals purportedly aimed at helping the uninsured and reducing health care costs.

This budget offers the clearest insight to date into the Bush Administration's overall view of the health care system in this country and what should be done to make health care more available and more affordable. Across the board—in Medicaid and Medicare, as well as in the arena of private insurance—the Administration proposes to push or prod Americans away from the existing system of sharing risk and toward a privatized system in which individuals bear more of the burden. Americans are overusing health care services, the Administration believes, and the only way to bring costs under control is to make sure health care consumers have "skin in the game." In other words, consumers should feel the sting of health care costs so they are encouraged to shop for cheaper care and avoid unnecessary services and procedures.

The Administration's cure for this illness consists of a series of proposals that will shift costs away from government and business and onto individual consumers. These proposals, designed to move consumers who have private insurance away from employer-based coverage and into the individual insurance market—as well as to encourage privatization in Medicaid and Medicare—are all described more fully below.

In addition to these proposals, the President's budget seeks more cuts in federal health care programs. His proposal piles more cuts onto Medicaid in addition to the drastic cuts contained in the recently enacted budget reconciliation legislation while also shifting substantial costs to the states. As for Medicare, the President's proposed budget contains significant cuts to providers, as well as a controversial measure that would require means-testing for the Part B premium.

Note: The budget provides estimates of the budget impact of existing programs and new initiatives for the year 2007 and for the five-year period of 2007-2011. In some, but not all, instances, 10-year cost estimates are provided. This analysis reports one-, five-, and 10-year cost estimates for Medicaid and Medicare (as available). For private market initiatives, we report five-year and 10-year cost estimates, since these initiatives are primarily tax code changes, and their impact is generally delayed.

About Health Savings Accounts (HSAs)

HSAs are savings accounts that enjoy special tax breaks, but *only if they are tied to a high-deductible insurance policy*. Money deposited into an HSA is tax deductible, the earnings on the deposit are tax-free, and withdrawals for medical expenses are tax-free. This is an unprecedented change from all previous tax-favored savings accounts like IRAs or 401(k)s, where taxes are imposed either on initial contributions or on subsequent withdrawals, but the money is not sheltered both going in and coming out.

Under current law:

- the size of tax-sheltered HSAs is limited to the size of the deductible of the high-deductible plans to which they are linked, and this cannot exceed $2,700 for individuals and $5,450 for families;
- withdrawals are allowed only for specified medical expenses, other withdrawals are taxed and penalized;
- money in an HSA cannot be used for premiums; and
- only employer contributions—not employee contributions—to HSAs are excluded from income for payroll tax purposes.

The Private Insurance Market

- **Expand Tax Breaks for Health Savings Accounts Tied to High-Deductible Health Insurance Policies**: The President proposes a substantial expansion of Health Savings Accounts (HSAs), which were first created by the Medicare Modernization Act of 2003. The budget includes a series of (mostly small and complicated) tax code changes that, taken together, would increase the amount of income that could be sheltered in an HSA and also hasten the shift from employer-based coverage to coverage in the individual market. The President proposes changes to the tax code to favor HSA-linked, high-deductible health insurance plans by:
  - Raising the maximum that individuals can put into an HSA to the amount of the *out-of-pocket limit* of the high-deductible plan rather than to the size of the deductible, as under current law. The President's proposal would allow individuals to shelter up to $5,250 and families to shelter $10,500, nearly doubling the current annual limits on tax-deductible contributions.
  - Permitting the use of HSA funds to pay the premiums for high-deductible plans purchased in the individual market.
  - Exempting HSA contributions and premium payments made by individuals from gross income subject to FICA and other payroll taxes.

- Allowing employers to move unspent dollars employees have in Health Reimbursement Arrangement (HRA) accounts to their HSAs.
- Allowing individuals to take a tax deduction—whether or not they itemize—for the cost of premiums paid *only for high-deductible policies* purchased in the individual market.
- Allowing employers to make larger contributions to HSAs for workers who are chronically ill or who have spouses with chronic illnesses.

> ***Budget Impact:*** The expansion of HSAs proposed by the President would cost $30.2 billion over five years and $90.7 billion over 10 years. The proposals to tax-advantage only high-deductible plans would cost an additional $19.019 billion over five years and $41.327 billion over 10 years.

- **Individual Tax Credits for People Who Buy High-Deductible Plans:** The President again proposes a tax credit for the purchase of an insurance policy, but this year he proposes to provide such a tax credit *only to individuals and families who purchase a high-deductible plan*.

  Lower-income individuals could receive up to a $1,000 refundable tax credit annually toward the purchase of health insurance, and families could receive up to a $3,000 tax credit. The tax credit would be phased out at $30,000 annual income for an individual and $60,000 for a family. The credit would pay for 90 percent of the cost of the premium of a high-deductible health plan (up to the $1,000 limit). The tax credit is only available to individuals and families who do not have employer-based coverage and who purchase health insurance in the non-group individual market or through a private purchasing group, a state-sponsored purchasing pool, or a state high-risk pool.

> ***Budget Impact:*** This proposal would cost $9.890 billion over five years and $24.093 billion over 10 years.

- **Association Health Plans:** The budget proposal reiterates the President's support for bills pending in Congress that would allow small employers, civic groups, and community organizations to band together to form Association Health Plans (AHPs) to purchase health insurance. These bills would exempt AHPs from most state insurance laws and regulatory protections.

> ***Budget Impact:*** No cost reported.

- **"National Marketplace for Health Insurance":** The budget proposal reiterates the President's support for the creation of a "national marketplace for health insurance" so that individuals can purchase health insurance in the individual market across states lines.

  Budget Impact: No cost reported.

Families USA's Commentary on Private Market Proposals

The President proposes a series of tax breaks that are *available only to people who purchase a high-deductible health insurance plan.* These plans require Americans to spend significantly more out of pocket before their health insurance begins to pays for most health care services. The President's rationale for this proposal is that, if consumers have "skin in the game," they will be more prudent purchasers of health care. But there are numerous reasons why HSAs will cause more harm than good:

- The overwhelming majority of America's health care costs are spent for people with major illnesses and disabilities and on end-of-life care. High-deductible health insurance policies will have no impact on those costs.
- High-deductible insurance policies, however, do deter people from spending the first-dollar costs needed for primary and preventive care. It is this care that is most important for protecting the health of the American public and avoiding the spread of illnesses.
- As the wealthy who are healthy leave traditional insurance coverage, less wealthy Americans and those who expect to need health care—including those with chronic health problems—will be forced to pay skyrocketing premiums because traditional insurance pools will have higher and higher per-capita costs.
- HSAs will drain critical federal resources needed to strengthen the health care safety net, such as Medicaid and the State Children's Health Insurance Program (SCHIP).
- The expanded tax breaks for HSAs do not benefit low-income individuals and families. About half of uninsured Americans do not earn enough to pay taxes, so they would receive no benefit from these proposals. Other uninsured working Americans would only get help with 10 or 15 percent of the cost of their premiums—not enough to make health insurance affordable for lower-wage families.

In short, the President has recognized the problem but is offering the American people the wrong solution.

Similarly, the refundable tax credit, while intended to help low- to moderate-income Americans afford health insurance, provides no meaningful help with the high cost of health insurance coverage. In 2005, the average premium for a high-deductible health insurance plan linked to an HSA for a family was $7,909. The deductible for this plan averaged $4,070. Even after receiving the $3,000 tax credit, a low-income family would be left to pay at least $8,979 out of pocket for health insurance before receiving any benefit from the health insurance.[1] And then the family would also have to make any copayments for covered health care services.

Two initiatives touted by the President—Association Health Plans and the so-called "National Marketplace for Health Insurance"—would eliminate state regulation of insurance products. This deregulation would leave many consumers with higher premiums. What's more, it would put consumers at risk of paying premiums for what they could later discover to be substandard polices where basic health care services are not covered—or where an insurer cannot pay claims for health care services.

The AHP proposal, in particular, is unnecessary: *No state or federal laws prevent small businesses from forming groups now to leverage their buying power.* Moreover, the current AHP proposal would find cost savings not through building group buying power but by overriding state laws and providing less generous benefits. The resulting skimpy packages, by attracting and skimming off firms with healthy employees, would directly harm those businesses with employees who need the excluded health benefits provided by more comprehensive packages. In fact, the Congressional Budget Office (CBO) has estimated that 80 percent of workers would be worse off under AHPs: 20 million employees of small employers and their dependents would experience a rate *increase*.

The "National Marketplace" proposal would encourage a race to the bottom, removing critical state consumer protections, allowing cherry picking, creating the potential for more insolvent plans, and jeopardizing states' ability to effectively regulate insurance. This proposal would hurt millions of Americans who are not offered health coverage through their employer or who are self-employed and purchase insurance in the individual market.

Medicaid and the State Children's Health Insurance Program (SCHIP)

- **Shifting Costs to States:** The President's budget includes several provisions that would reduce federal funding for Medicaid without reducing state or local liability for such health care costs, as follows:
  - **Reduce provider taxes:** This proposal would reduce the maximum amount states can tax providers from 6 percent to 3 percent [administrative change].

    Budget Impact: This proposal would save $0 in the first year, $2.1 billion over five years, and $5.5 billion over 10 years.

  - **Cut services for children with disabilities:** The budget proposal would eliminate federal funding for certain rehabilitation services for which states are now receiving a federal match through Medicaid. It would also prohibit federal reimbursement for certain administrative and transportation costs related to Medicaid services that some children receive in school [administrative change].

    Budget Impact: This proposal would save $840 million in the first year, $5.9 billion over five years, and $15.2 billion over 10 years.

  - **Cap Medicaid payments to government providers and cap DSH funding:** This proposal would limit the amount of money that hospitals and certain other providers can get for providing services to people with Medicaid and the uninsured by limiting payments for the cost of furnishing services to people enrolled in Medicaid. It would also build on existing CMS efforts to detect and recover overpayments to government providers that are sometimes returned to the state and used to draw down additional federal dollars. CMS is also proposing to create new regulations to clarify how states can use funds designated as Disproportionate Share Hospital (DSH) funding [administrative change].

    Budget Impact: This proposal would save $384 million in the first year, $3.8 billion over five years, and $9 billion over 10 years.

  - **Recovery of duplicated administrative costs:** The budget proposes to prohibit states from billing Medicaid for the cost of eligibility determinations for people who are applying for or who have Medicaid, TANF, and food stamps. It also allows the federal government to recoup funds that have been paid for these determinations in the past. The Administration believes these costs were included in the TANF block grant [legislative change].

    Budget Impact: This proposal would save $280 million in the first year, $1.8 billion over five years, and $3.7 billion over 10 years.

- **Targeted case management:** The budget proposal would lower the reimbursement rate for targeted case management services from the full Medicaid matching rate to the 50 percent administrative rate [legislative change].

  Budget Impact: This proposal would save $208 million the first year, $1.2 billion over five years, and $3.1 billion over 10 years.

- **Increasing Third Party Payment:** Some people have both Medicaid and private insurance coverage. For these individuals, Medicaid provides coverage for services that are not covered by their private insurance company and is considered the "payer of last resort." Current Medicaid law allows states to pay these claims through Medicaid and then pursue payment from the private insurance company. The President's budget proposal would make the following changes to current policy:
  - **Stop "pay and chase":** The budget proposal would require states to seek reimbursement from any applicable third party payers for all pharmacy claims before allowing Medicaid to pay the claim [administrative change].

    Budget Impact: This proposal would save $105 million in the first year, $430 million over five years, and $685 million over 10 years.

  - **Third party liability:** The budget proposal would require states to collect payments for prenatal or pediatric services owed by third party payers (such as non-custodial parents) before allowing Medicaid to pay the claim [legislative change].

    Budget Impact: This proposal would save $90 million in the first year, $525 million over five years, and $1.2 billion over 10 years.

- **Prescription Drug Reimbursement:**
  - **Drug rebate formula:** This proposal would eliminate the use of "best price" to calculate the rebate drug manufacturers pay and instead allow manufacturers to negotiate lower drug prices [legislative change].

    Budget Impact: This proposal is estimated to be budget-neutral.

  - **Multiple source drugs:** The budget proposal would limit reimbursement to 150 percent of the average manufacturer's price in order to stem overpayment for drugs and to encourage the use of generics [legislative change].

    Budget Impact: This proposal would save $130 million in the first year, $1.3 billion over five years, and $3.4 billion over 10 years.

Managed formularies: The budget proposal would allow states to use unspecified "private sector techniques" to help them negotiate greater discounts with drug manufacturers [legislative change].

> ***Budget Impact:*** This proposal would save $15 million in the first year, $177 million over five years, and $469 million over 10 years.

- **Proposals That Increase Medicaid and SCHIP Spending:** The budget does include a few proposals that would increase federal spending on Medicaid and SCHIP. These include the following:
  - **Extension of Transitional Medical Assistance (TMA):** The budget proposal would allow TMA (which extends Medicaid eligibility for up to 12 months after a person enters the workforce and loses welfare cash benefits) to continue through September 30, 2007 [legislative change].

    > ***Budget Impact:*** This proposal would cost $180 million in the first year and $360 million over five years.

  - **Cover the Kids:** The budget proposal would provide $100 million in annual grants to states to work with schools and community groups to conduct outreach and enrollment for children eligible for, but not enrolled in, Medicaid and SCHIP [legislative change].

    > ***Budget Impact:*** This proposal would cost the Medicaid program $203 million in the first year and $2 billion over five years. It would cost SCHIP $69 million in the first year, $330 million over five years, and $5 billion over 10 years.

  - **SCHIP funding:** The budget also includes a commitment to address SCHIP funding shortfalls by "seeking authority to target SCHIP funds more efficiently to States with the most need." No details were given as to how this would be achieved [legislative change].

    > ***Budget Impact:*** This proposal would cost $635 million in the first year, $110 million over five years, and $15 million over 10 years.

Families USA's Commentary on Medicaid Proposals

The President's FY 2007 budget proposes net cuts of $13.6 billion for Medicaid and the State Children's Health Insurance Program (SCHIP) over the next five years and $35.4 billion over the next 10 years. Coming on the heels of passage of the Deficit Reduction Act (DRA), where many of the Administration's previous budget proposals were adopted, these cuts would constitute a significant financial hardship for states. Many states are also feeling a budget squeeze because of the additional dollars they have spent fixing problems in the implementation of Part D in Medicare. Taken together, these budget pressures could result in states passing the buck to beneficiaries—the people who are least able to pay—in the form of increased cost-sharing or decreased benefits. Such cost-shifting could leave many children and adults without access to health care, even when they have Medicaid coverage.

Notably, the Administration plans to accomplish the majority of these policy changes by issuing regulations rather than by seeking legislation. Several of these big-ticket items have been offered in other years as legislative proposals, where they were either rejected by, or not brought up in, Congress. Now, the Administration believes it has enough authority to make these changes unilaterally, and it will be important for health care advocates to monitor and respond to any regulatory action the Administration takes on these proposals.

In addition to the specific budget cutting proposals discussed above, the President's budget contains language that suggests a continued attack on the structure and role of the Medicaid program. The budget documents announce a new plan to encourage the use of state waiver initiatives to emphasize "market-based," "consumer-driven" approaches to care; they hold out Florida's recently approved waiver as an exemplary model.[2] Because waivers must be budget-neutral, this initiative does not appear with a cost attached to it, but it is sure to play a major role in the Administration's plan to restructure Medicaid, one state at a time.

Medicare

- **Reduce Provider Payments under Medicare Parts A and B:** The budget includes reductions in, or freezes to, Medicare payments for a long list of providers. Those targeted include hospitals, skilled nursing facilities, home health care, inpatient rehabilitation facilities, hospices, and ambulances. In addition, bad debt payments are phased out, further reducing payments to providers.

  Budget Impact: Direct reductions in or caps to provider payments plus the bad debt phase-out in Parts A and B would total $2.36 billion over the first year and $84.82 billion over five years.

- **Make Higher-Income Beneficiaries Pay Higher Amounts for Part B Premiums**: The budget proposes changing current law to require more Medicare beneficiaries to pay a higher percent of Part B Premiums.

  In 2007, higher-income people in Medicare (individuals with annual incomes of at least $80,000, couples with incomes of at least $160,000) would have to pay a higher percent of the costs of Medicare Part B, the portion of Medicare that pays for physician and other outpatient services. Currently, beneficiaries pay 25 percent of total Part B costs through premiums, and the government pays the rest. Under current law, in 2007, higher-income individuals will pay an increasing percent of Part B premiums, and that percent will increase with income. The income threshold that triggers higher premium payments increases annually with inflation. The budget proposes legislative changes that would hold the income threshold constant—the trigger for higher premium payments would stay at $80,000 for an individual and $160,000 for a couple, even as incomes increase.

  Budget Impact: This proposal would save $0 in the first year and $40 million over five years.

- **Add an HSA Option to Medicare**: The budget documents note that the Administration is developing Health Savings Accounts—high deductible, tax-advantaged individual insurance—for people in Medicare. There are no details on this new option in the budget.

  Budget Impact: No details are available.

Families USA's Commentary on the Medicare Proposals

The President seeks Medicare savings through arbitrary reductions in provider payments, by shifting more costs to beneficiaries, and by introducing programs that would potentially undermine traditional Medicare. All of these proposals weaken Medicare.

Cuts in provider payments will make participating in Medicare less attractive for many providers. What's more, lower provider payments for Medicare Parts A and B will also reduce payments to Medicare managed care plans—Medicare Advantage. This is because Medicare Advantage payments are, by law, tied to costs for Parts A and B. As costs for Parts A and B go down, payments to Medicare Advantage plans will be cut as well, making these plans more likely to push for lower payments to plan providers, too. Providers will respond by reducing services or quality, or by passing costs on to beneficiaries and private payers. This is not a constructive step toward addressing the issue of rising health care costs. The end result will be reduced access and lower quality of care or continued rising costs for beneficiaries and employers—or both.

Requiring higher-income beneficiaries to make higher payments, particularly coupled with the addition of HSAs to Medicare, will make traditional Medicare less attractive to healthier, wealthier beneficiaries. The end result could be a migration of high-income beneficiaries to HSAs, undermining the strength of traditional Medicare. And while it is unclear how Medicare HSAs will work, these high-deductible plans have been unsuccessful when it comes to providing real choice or keeping down medical costs in the non-Medicare market (see the discussion of HSAs on page 2). Including these plans in Medicare would thus be another step in the Administration's effort to move Medicare from a program with a reliable, consistent benefit for everyone to one that requires seniors to navigate numerous options and fend for themselves with private insurance plans.

In spite of taking a big cut out of provider payments, the budget continues to include massive additional payments to insurance companies that participate in Medicare. These payments, which were mandated by the MMA, come in the form of a "stabilization fund" that was designed to encourage the development of regional PPOs. As part of the MMA, Congress added a regional PPO option to the list of managed care plans available to those in Medicare. To encourage development of these plans, Congress created a $10 billion "stabilization fund" with funds to be used through 2013 to entice PPOs to serve an entire region, to keep regional PPOs from leaving Medicare, and to give a bonus to the first regional Medicare PPO to be available nationally. In 2007, these industry payments are budgeted at $1.3 billion. However, the Medicare Payment Advisory Commission (MedPac), the independent commission that advises Congress on Medicare policy, has stated that the "stabilization fund" was unnecessary and should be eliminated.

Finally, while the budget did not include any changes to Medicare Part D, the new cost estimates for the program put forth by the Administration are highly questionable. HHS is projecting that Part D costs will be significantly lower than anticipated—approximately $8 billion less over five years and $130 billion less over 10 years. These lower estimates are based on just one month of program operations and are likely unrealistic (see *Secretary's One-Month Progress Report on the Medicare Drug Benefit*, February 1, 2006). To the extent that these cost estimates are used in the budget projections, they likely seriously underestimate the actual costs of Part D.

It is extremely premature to make changes to previous cost estimates based on one month of program operations—particularly a program that has had as low an initial take-up as Medicare Part D. In its one-month progress report, CMS noted that Part D costs would be less because Part D drug plan premiums were averaging $25 a month rather than $32 a month ($32 was previously estimated to be the national average premium). This is hardly surprising in light of the fact that two-thirds of those enrolled in Part D plans at the end of January 2006 were dual Medicare/Medicaid eligibles—individuals eligible for low-income help. CMS was supposed to automatically enroll these individuals in plans with premiums that are *at or below the national average*. When two-thirds of the individuals using a program are automatically enrolled in plans with lower-than-average premiums, it is neither surprising nor a case for congratulations that premiums for program users are lower than the national average. It is also not a cost figure that should be relied on for planning purposes.

Medicare beneficiaries have until May 15 to sign up for Part D and avoid late enrollment penalties. If the program does start to attract new enrollees—enrollees who are not automatically assigned to low-cost plans—premiums may well go up. Cost estimates for Part D should be based on the assumption that some future enrollees will choose plans with higher premiums—unless HHS is conceding that there will be few additional enrollees.

Other HHS Agencies

Federal Drug Administration (FDA)

- **Expanding Existing and Adding New Industry User Fees:** The budget proposes adding new—or expanding existing—fees that drug and medical device companies pay directly to the FDA to help pay for the agency's operations.

> ***Budget Impact:*** New user fees are estimated at $26 million for the first year, $135 million over five years, and $286 million over 10 years.

Families USA's Commentary on the FDA Budget: In 2007, combined new and existing fees paid by the industries the FDA regulates will make up over 20 percent of the agency's funding. At a time when a cloud hangs over the FDA because several high-profile drugs have been removed from the market and there are questions about the agency's independence, the decision to increase the amount the industry pays to fund the agency that regulates it is questionable at best.

National Institutes of Health (NIH)

- **No Increase in Funding for NIH.**

> ***Budget Impact:*** None

Families USA's Commentary on the NIH Budget: While the budget includes added funding for research on pandemic flu and bioterrorist countermeasures, overall funding is flat. Budgets for 18 of the 19 Institutes are reduced. These reductions come at a time when more—not less—funding is needed to address pressing global health issues such as the spread of HIV/AIDS. The science performed at NIH is critical to the development of new treatments and vaccines, particularly in areas that are not of interest to the drug industry (either because the target market would not be profitable or because new treatments or vaccines would significantly reduce profits from current products). As the U.S. population ages, and as global health crises affect political stability in other countries, the type of research only the NIH can provide is essential—but this research will be stunted if funding stagnates.

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[1] These figures are based on a survey of employer-based coverage as comparable figures are not available for the individual market. Due to underwriting, for many low-income families, the premiums would be higher. The Kaiser Family Foundation and The Health Research and Education Trust, *Employer Benefits 2005 Annual Survey*, Exhibit 8.4 (Washington: The Kaiser Family Foundation, 2005). High-deductible health insurance plans linked to HSAs may, but are not required to, provide coverage for certain specified preventive health care services (such as checkups—but not any follow-up treatment) before a person has spent the deductible amount out of pocket.

[2] There have been some recent, successful demonstrations of "consumer-driven" care in Medicaid under the "Cash and Counseling" initiative that allows people with disabilities to have more control over the health care they receive. But these demonstrations are very different from the new "consumer-driven" experiments the Administration plans to encourage. Families USA will issue a more detailed analysis of these new experiments shortly.