FACT SHEET
HEALTH PROPOSALS IN PRESIDENT BUSH'S FY 2007 BUDGET

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President Bush's FY 2007 Budget Undermines Health Needs: Pushes Costs onto Beneficiaries, Consumers, Providers, and States

Overview

Less than a month ago, President Bush signed into law the Deficit Reduction Act (DRA), which included $50.7 billion in Medicare and Medicaid spending cuts over ten years. The President's fiscal year 2007 budget builds on these mandatory health reductions with a second round of Medicare and Medicaid cuts of $153.7 billion over ten years ($110.1 billion in new legislative proposals and $43.6 billion in new regulatory proposals) – more than three times the size of the original DRA cuts. The savings from new legislative and regulatory spending cuts in Medicare and Medicaid, as well as other spending cuts, would be more than wiped out by the $1.7 trillion ten-year cost ($2 trillion with debt service) of the President's tax cut proposals.

In addition to cuts in mandatory health programs, the President's budget targets important discretionary health programs for cuts, including significant funding reductions for preventative health care, cancer research, rural health programs, substance abuse and mental health treatment, and Indian health facility construction.

In general, the Bush administration characterizes its health proposals as efforts to slow the growth in health expenditures, to expand coverage of the uninsured, and to reprioritize and reprogram discretionary health funding toward more urgent needs with measurable outcomes. However, the primary consequence of most of the President's proposals will simply be to shift existing health care costs to other entities. For example, the President's health budget:

- Shifts costs to states and local governments, by significantly limiting what Medicaid expenditures the federal government will match or reimburse.

- Shifts costs to health care providers, by cutting fee-for-service provider payments to nursing homes, doctors, hospitals, ambulance providers and others – cuts that may ultimately lead to higher beneficiary costs and lower access to quality health care.

- Shifts costs to beneficiaries, by establishing new medical care enrollment fees and increasing prescription drug co-pays for veterans, and by increasing Medicare Part B premiums for certain Medicare beneficiaries;

- Shifts costs to health care consumers, by encouraging employers to offer high deductible health plans (HDHPs), which force employees to choose between no health coverage or high, upfront out-of-pocket health care costs.

Medicare

The President's FY 2007 budget includes legislative proposals that would cut Medicare spending by $105 billion over the next ten years. On top of that, the President's budget assumes additional Medicare cuts from proposed regulatory changes. These legislative and regulatory proposals would achieve savings primarily through cuts in payments to fee-for-service (FFS) providers, like hospitals and skilled nursing facilities. Yet, the President's budget includes no proposals to eliminate Medicare overpayments to private managed care plans. Separately, the President's budget also provides for additional arbitrary across-the-board provider payment cuts if general-revenue financing of Medicare exceeds 45 percent in the future.

Legislative Medicare Cuts

The President's budget cuts Medicare spending by $35.9 billion over five years and $105 billion over ten years. The administration has asserted that many of these proposed cuts are based on Medicare Payment Advisory Commission (MedPAC) recommendations. However, MedPAC only makes recommendations for one year at a time, while many of the proposals in the President's budget are permanent cuts or cuts that extend beyond 2007. In addition, many of the President's cuts – such as cuts to ambulance and hospice services – have not been recommended by MedPAC. The President's budget ignored MedPAC's recommendations to reduce overpayments to Medicare Advantage (MA) plans.

Shifting Costs to Providers – Most of the savings in the President's Medicare proposals are achieved by cutting, freezing, or slowing the growth in payments to fee-for-service providers. The administration asserts that their proposals simply "slow" Medicare spending growth – and cannot be characterized as cuts. In addition, the administration asserts that these proposals will not affect the quality of Medicare beneficiaries' health care. However, cuts of this magnitude, on top of cuts in the DRA, may cause some providers to stop providing services to Medicare beneficiaries or to deliver lower quality service. The greatest impact of these cuts may be felt in rural areas and other underserved or underpriveleged areas, where Medicare payments do not currently cover providers' costs.

Shifting Costs to Beneficiaries – The President's budget also proposes to push a greater share of Medicare Part B costs onto upper-middle income beneficiaries. Under current law, next year, beneficiaries with incomes over $80,000 ($160,000/couple) will be subject to higher Part B premiums. The income thresholds for income-related Part B premiums are indexed to annual increases in inflation. The President's budget proposes to eliminate annual inflation indexing for these income thresholds, starting in 2008. As a result, over time, more and more seniors will be subject to higher, income-related Part B premiums. By 2016, twice as many seniors will be subject to higher premiums, compared to current law. The administration estimates this provision would save $10.1 billion over ten years – $9.8 billion from higher Part B premiums and $350 million from lower Part B enrollment.

Ignoring Automatic Cuts to Physician Payments in 2007 – The DRA froze physician payments at 2005 levels, preventing an automatic cut of 4.4 percent that was scheduled to go into effect in 2006. Without further action, an automatic across-the-board cut of over four percent in physician payments will go into effect in 2007. The President's budget does not propose to prevent this cut and provides no budgetary resources to address this significant payment cut to doctors.

Table 1 – Proposed Medicare Cuts in President's FY 2007 Budget		
($ in billions)	**2007-11**	**2007-16**
Freeze payments to Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs) in 2007 and provide an update, minus 0.4%, in 2008 and 2009	-10.3	-25.3
Eliminate Bad Debt Payments (Medicare currently covers a portion of payments owed by Medicare beneficiaries to providers, but not paid)	-6.2	-22.5
Cut automatic inpatient and outpatient hospital updates by 0.45% in 2007 and by 0.4% in 2008 and 2009 updates	-8.1	-22.0
Limit Oxygen Rental to 13 Months and Cut Rental Payment by ~50% (note: the DRA capped the oxygen rental period at 36 months)	-6.6	-18.0
Part B Indexing Proposal	-1.9	-10.1
Adjust payments for hip and knee replacements	-2.4	-5.8
Expand competitive bidding to include lab services	-1.4	-5.2
Extend the Medicare Secondary-Payer Program to End-Stage Renal Disease (ESRD) payments from 30 to 60 months and establish a federal MSP data-sharing clearinghouse to ensure Medicare does not make inappropriate payments	-1.6	-3.8
Cut the hospice payment and ambulance fee schedule updates by 0.4% in 2007, 2008, and 2009	-0.8	-2.4
Pay for Short-Term Power Wheelchairs Based on Actual Use	-0.5	-1.1
Interactions with Part B Premiums	3.8	11.2
TOTAL, Net Medicare Cuts	**-35.9**	**-105.0**

Regulatory Medicare Cuts

The President's budget also includes regulatory proposals that would cut Medicare spending by $7.9 billion over five years and $19 billion over ten years. Excluding savings from previous proposals that have already been published as proposed regulations (including a 1.9 percent reduction in IRF payments for 2006 and changes to the inhalation drug dispensing fee and the oral drug supplying fee), the *new* regulatory proposals in the President's budget would save $5.4 billion over five years and $13.2 billion over ten years. The President's new regulatory proposals include:

- Cutting IRF payments by 2.3 percent in 2007 (saving $2.6 billion over ten years).
- Freezing Long-Term Care Hospital (LTCH) payments in 2007 and 2008 and reducing payments for short-stays at LTCHs starting in 2007 (saving $6.1 billion over ten years).
- Cutting payments for wheelchairs and other "excessively-priced" durable medical equipment (saving $4.6 billion over ten years).

Arbitrary Across-the-Board Cuts in Future Medicare Payments

The Medicare Modernization Act (MMA) requires Medicare's trustees to measure the portion of Medicare funding that comes from general revenues. If the trustees conclude in two consecutive annual reports that general-revenue financing is projected to exceed 45 percent within seven years, the President must submit legislation to Congress to address the shortfall. Congress is

required to consider the proposal on an expedited basis. The President's budget includes a new budget reform proposal that would automatically trigger across-the-board cuts of 0.4 percent to all Medicare provider payments, if the 45 percent threshold is breached. The cuts would grow by 0.4 percent every year the shortfall continued to occur. According to the administration, even assuming adoption of the Medicare cuts in the President's budget, the 45 percent threshold would be breached and the automatic cuts would be triggered in 2017.

Medicaid

Overall, the administration proposes $14 billion in net legislative and regulatory cuts to Medicaid over five years and $35.5 billion over ten years ($17.2 billion over five years and $42.3 billion over ten years in gross cuts, if new proposed spending is excluded). These savings generally result from shifting costs to beneficiaries and the states or cutting payments to providers.

Legislative Medicaid Cuts

The administration proposes policy changes resulting in $1.8 billion in net Medicaid cuts over five years and $5.1 billion over ten years. This net total includes gross Medicaid cuts of $5 billion over five years and $11.9 billion over ten years and new Medicaid spending of $3.2 billion over five years and $6.8 billion over ten years. The President's legislative Medicaid cut proposals include:

Reducing Targeted Case Management (TCM) Match (saving $3.1 billion over ten years). The budget proposes changing the TCM reimbursement level from the FMAP, which currently varies by state from 50 percent to 83 percent, to a flat rate of 50 percent for all states. It reduces the federal reimbursement for TCM services for the 38 states that have FMAPs higher than 50 percent.

Restructuring Pharmacy Reimbursement (saving $3.4 billion over ten years). The budget proposes limiting Medicaid payments for multi-source drugs to 150 percent of the average manufacturer's price.

Optional Managed Formulary for Prescription Drugs (saving $469 million over ten years). The budget proposes permitting states to close their Medicaid formularies and allowing states to negotiate with drug manufacturers for better discounts. Allowing states to restrict their Medicaid formularies would be a major departure from current law, which requires states to provide exceptions to the formulary where medically necessary.

Delaying Payment of Prenatal and Pediatric Care (saving $1.2 billion over ten years). The budget proposes allowing states to avoid payments of 1) prenatal and pediatric care if there is a potential liable third party (e.g., private insurer), and 2) medical care for a child where a non-custodial parent may be liable for payment for at least 90 days. Under current law, states must pay the provider first, then seek reimbursement from the liable party.

Cutting Medicaid Payments for Administrative Costs (saving $3.7 billion over ten years). The budget proposes cutting federal reimbursement for Medicaid administrative costs to reflect the shared costs of Medicaid and the Temporary Assistance for Needy Families (TANF) program.

Regulatory Medicaid Cuts

In addition, the President's budget baseline assumes Medicaid cuts of $12.2 billion over five years, and $30.4 billion over ten years, from proposed regulatory changes. The President's regulatory Medicaid cut proposals include:

Capping Government Providers (saving $9 billion over ten years). The budget proposes cutting payments to providers by prohibiting states from paying government-owned providers more than "cost."

Phasing Down Provider Tax (saving $5.5 billion over ten years). Under current law, states can levy taxes of up to 6 percent against certain classes of providers and receive a federal Medicaid match for the amounts collected. The budget proposes limiting the amount of the tax to 3 percent.

Limiting Reimbursement of Rehabilitation Services (saving $6.1 billion over ten years). The budget proposes limiting what services may be claimed as Medicaid rehabilitation services.

Delaying Pharmacy Payments (saving $685 million over ten years). The budget proposes requiring states to pursue liable third-party reimbursement before paying pharmacies for Medicaid claims.

Eliminate Reimbursement of School-Based Administration (saving $9 billion over ten years). The budget prohibits federal Medicaid reimbursement for IDEA-related school-based administration and transportation costs.

Program Reinvestments

The budget proposes $6.8 billion, over ten years, in program reinvestments. Approximately $4.9 billion of this spending reflects increased Medicaid enrollment under the administration's "Cover the Kids" outreach initiative, which seeks to work with states, schools, and community organizations to enroll eligible children in SCHIP and Medicaid. Other reinvestments include:

Extending Transitional Medical Assistance (costing $360 million over ten years). The budget proposes extending the Transitional Medical Assistance (TMA) program from December 31, 2006, through September 30, 2007.

Vaccines for Children (VFC) (costing $1.4 billion over ten years). The budget proposes allowing underinsured children to receive VFC vaccines at state and local health clinics.

Extending the Refugee Exemption (costing $134 million over ten years). The budget proposes extending Supplemental Security Income (SSI) and SSI-related Medicaid eligibility for refugees and asylees from seven to eight years.

Table 2 – Proposed Medicaid Cuts in President's FY 2007 Budget		
($ in billions)	**FY2007 - 2011**	**FY2007-2016**
Legislative Cuts:		
Reduce Payment for Targeted Case Management	-1.2	-3.1
Restructure Pharmacy Reimbursement	-1.3	-3.4
Optional Closed Drug Formulary	-0.2	-0.5
Avoid Payment of Prenatal and Pediatric Care	-0.5	-1.2
Cut Administrative Costs	-1.8	-3.7
Total Legislative Cuts	*-5.0*	*-11.9*
Regulatory Cuts:		
Cap Government Providers	-3.8	-9.0
Phase Down Provider Tax	-2.1	-5.5
Limit Reimbursement of Rehabilitation Services	-2.3	-6.1
Delay Pharmacy Payments	-0.4	-0.7
Eliminate IDEA Related School Costs	-3.6	-9.1
Total Regulatory Cuts	*-12.2*	*-30.4*
Total Legislative and Regulatory Cuts	**-17.2**	**-42.3**
Program Reinvestments:		
Extend Transitional Medical Assistance	0.4	0.4
Vaccines for Children	0.7	1.4
Cover the Kids Initiative Effect	2.0	4.9
Medicaid Effects of Refugee Extension	0.1	0.1
Total Program Reinvestments	*3.2*	*6.8*
TOTAL, Net Legislative and Regulatory Cuts	**-14.0**	**-35.5**

Department of Veterans Affairs (VA) Medical Care

Enrollment Fee and Increased Co-payments for Veterans – The administration once again proposes new and increased fees on Priority 7 and Priority 8 veterans, which would save $3.7 billion over five years. These are veterans without service-connected disabilities who generally have incomes above $26,903. The administration proposes a $250 annual enrollment fee (saving $2.1 billion over five years) and increases pharmacy co-payments from $8 to $15 for a 30-day supply of drugs (saving $1.6 billion over five years). The VA estimates that as a result of the enrollment fee proposal, it expects to treat approximately 200,000 fewer Priority 7 and Priority 8 veterans. The VA asserts these veterans will merely shift into private coverage or Medicare, which the budget proposes to cut by $105 billion over ten years.

Discretionary Health Programs

Overall, the President's budget provides $68.3 billion for discretionary spending programs at the Department of Health and Human Services (DHHS), which funds agencies such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). This funding level represents a $2.6 billion (3.7 percent) cut below the FY 2006 enacted level. When emergency pandemic flu funding for FY 2006 and FY 2007 is factored out, the budget request provides a 2.1 percent cut compared to the FY 2006 enacted level.

Flat Funding at the National Institutes of Health (NIH) – The budget level-funds NIH at the FY 2006 enacted level of $28.4 billion. According to the Congressional Research Service, the FY 2006 enacted level provided the first cut in NIH funding since 1970. The budget would cut funding at 18 of the 19 NIH institutes, including a $40 million cut to the National Cancer Institute and a $21 million cut to the National Heart, Lung, and Blood Institute.

6 Percent Cut for the Centers for Disease Control and Prevention (CDC) – The budget provides $5.8 billion for the CDC, a $367 million (6 percent) cut below the FY 2006 enacted level. As part of this cut, the Preventive Health Services Block grant would be eliminated and the CDC building and facilities account would be reduced by $129 million.

3.9 Percent Cut for Health Resources and Services Administration (HRSA) – The budget provides $6.3 billion for HRSA, a $255 million (3.9 percent) net cut from the FY 2006 enacted level. This net cut consists of $531 million in gross cuts and $276 million in spending increases for Community Health Centers (+$181 million) and a Presidential Initiative on HIV/AIDS (+$95 million).

HRSA Rural Health programs are cut by $133 million (83 percent), which include a $28.5 million cut to the Rural Health Care Services Outreach grants and the elimination of the Rural Access to Emergency Devices and Public Access Defibrillation Demonstration projects (-$1.5 million), Rural Hospital Flexibility grants (-$63.5 million) and the Denali Commission (-$39.3 million).

Other cuts include Children's Hospitals Graduate Medical Education (-$198 million); Scholarships for Disadvantaged Students (-$37 million); and Poison Control Centers (-$10 million). The HRSA budget also eliminates a number of programs including Health Professions (-$99 million); Traumatic Brain Injury (-$9 million); Emergency Medical Services for Children (-$20 million); and Cord Blood Stem Cell Bank (-$4 million).

Indian Health Services (IHS) – The budget proposes a $4 billion program level for IHS, a net increase of $124 million over the FY 2006 enacted level. This program level consists of $2.8 billion (+$130 million) in budget authority for health services and $347 million (-$6 million) in budget authority for Indian Health facilities funding, for a total of $3.2 billion in budget authority and $834 million in collections.

The budget eliminates funding ($32.7 million in FY 2006) for the Urban Indian Health program. The budget proposes that urban Indians receive health care through other federal, state, and local providers. The budget provides $17.7 million for health facilities construction, a $20 million (53 percent) cut from the FY 2006 enacted level.

2.2 Percent Cut for the Substance Abuse and Mental Health Services Administration (SAMHSA) – The budget provides $3.1 billion for SAMHSA, a net $72 million (2.2 percent) cut below the FY

2006 enacted level – including a $36 million cut to substance abuse treatment and prevention programs and a $35 million cut to mental health programs.

Tax Incentives for Health Savings Accounts (HSAs)

The President's budget proposes three tax incentives, costing $156.1 billion over ten years, intended to facilitate the growth of HSA-eligible health coverage. These tax incentives include:

- an above-the-line deduction for the purchase cost of non-group high deductible health plan (HDHP) premiums, and a refundable tax credit equal to the lesser of 15.3 percent of the premium or 15.3 percent of the individual's wages subject to the Social Security payroll tax (costing $41.3 billion over ten years, including $3.2 billion in outlays);

- a refundable tax credit for lower income individuals to purchase non-group HDHP insurance – individuals claiming this credit could not take the above-the-line deduction (costing $24.1 billion over ten years, including $12.9 billion in outlays); and

- an increase in the maximum annual HSA contribution from the current limits of $2,700 (self-only coverage) and $5,450 (family coverage) to $5,250 and $10,500, respectively, and a refundable tax credit for HSA contributions not made by employers (costing $90.7 billion over ten years, including $3.5 billion in outlays).

The administration argues that expanding HSAs will help stem the trend of rising health care costs by placing more medical care decision making authority in the hands of consumers rather than relying on third-party payors. The administration contends that current tax law provides such generous subsidies to employer-based health plans that plan participants become insensitive to the cost of care. The administration also asserts that generous employer-based health plans inhibit the dynamism of the labor market because workers may refuse to leave jobs in order to retain insurance coverage.

However, expanded HSAs pose a significant adverse selection risk. They would likely attract younger and healthier workers, leaving an employer's risk pool with a disproportionate share of workers who are less healthy and more likely to anticipate large medical costs. This, in turn, could increase the employer's costs to a level that forces the plan's termination and increase the number of uninsured. In fact, Jonathan Gruber, a noted health economist at M.I.T., has estimated that when fully phased in, the President's HSA proposal would on net increase the number of uninsured by 600,000 people.

Health care consumers would not necessarily be the best judges of cost-efficiency. In a health emergency, there would be no time for an economic analysis of a range of possible choices. When confronted with preventive care options or a decision on a high-cost test that could provide an early diagnosis of a dangerous condition, many consumers will not have the expertise to make the most cost-effective choice.

Finally, under the current income tax rate structure the HSA expansion would provide larger benefits to higher-income households than to lower-income households. Because those with higher incomes are more likely to have financial resources already available for medical expenses, the practical result of the proposals could be simply a transfer of those existing resources to HSAs for the sake of the tax benefit.

Table 3 – HSA Tax Proposals in President's FY 2007 Budget		
($ in billions)	2007-11	2007-16
HDHP Premium Deduction/Payroll Tax Credit	-19.0	-41.3
HDHP Low-Income Refundable Tax Credit	-9.9	-24.1
HSA Contribution Limit Increase/Refundable Tax Credit	-30.2	-90.7
TOTAL Budget Impact (including outlay impact)	**-59.1**	**-156.1**

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