

HEALTH
Budget Highlights
Fiscal Year 2007 Request

February 28, 2006

SUMMARY

The President's budget for Fiscal Year 2007 makes significant cuts in critical health insurance programs. The budget makes legislative and regulatory proposals that cut \$17.2 billion from Medicaid over five years, and \$42 billion over 10 years.¹ In addition, the President proposes legislative changes that cut \$35.8 billion from the Medicare fee-for-service program over five years for a total of \$105 billion in Medicare budget cuts over 10 years.² At the same time, the President proposes allocating \$59 billion over five years and \$156 billion over 10 years for tax cuts related to Health Savings Accounts, a program that primarily benefits higher-income individuals, weakens employer-based health insurance, and does little to help the uninsured.³

In addition, budget process changes sought in the President's Budget would make it considerably more difficult to make positive improvements to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP). The President's FY2007 budget would require any additional spending in these programs to be offset only by cuts in other entitlement programs.

The President's budget cuts many popular public health programs. For example, under the President's plan the budget for the Centers for Disease Control and Prevention (CDC) would be reduced by at least \$179 million. While the Nation's top three causes of death are chronic diseases – heart disease, cancer, and stroke – the President proposes cuts in CDC's chronic disease prevention and health promotion programs of \$34 million and elimination of almost \$100 million in preventive health and health services grants. The National Institutes of Health (NIH) is flat funded, which means that due to inflation, fewer programs will be supported this year. With proposed increases in infectious disease research, many other institutes and centers will be asked to endure significant cuts.

The proposed budget for the Food and Drug Administration (FDA) contains some modest program increases, but concerns remain over the adequacy of that agency's resources in view of its vast responsibilities to assure the safety of foods, drugs, dietary supplements, and medical devices. The budget also proposes to shift resources within FDA, notably reducing the number of full-time employees in the Office of Generic Drugs.

¹ President's Budget for Fiscal Year 2007 Summary table S-6; Department of Health and Human Services Budget in Brief, page 69.

² President's Budget for Fiscal Year 2007 Summary table S-6.

³ President's Budget for Fiscal Year 2007 Summary table S-7.

MEDICAID

The Medicaid program provides health insurance coverage for more than 52 million Americans.⁴ Even after the Deficit Reduction Act was enacted earlier this year by the House and Senate and cut \$28 billion over 10 years⁵ from Medicaid, the Administration again is proposing significant cuts to this program. The President's FY2007 budget proposes legislative measures that cut Medicaid by \$4.9 billion over five years. The President's budget, however, also proposes a number of regulatory changes in Medicaid that cut another \$12.3 billion from Federal Medicaid payments over five years that result in a total savings of \$17.2 over five years. The budget proposes \$3.2 billion in spending initiatives for a net legislative and regulatory loss of \$13.6 billion over five years. Over 10 years the President's budget proposes \$11.9 billion in legislative cuts and \$30.4 billion in regulatory cuts, for a total of \$42.3 billion in cuts over 10 years.

Medicaid Legislative Proposals (-\$4.9 billion/5 years)

Approximately \$3 billion of the \$4.9 billion in legislative cuts are directly attributable to shifting costs from the Federal Government to the States. A number of these changes will also restrict access to services, such as targeted case management or school-based health care for beneficiaries.

Reduction in Federal Payments for Targeted Case Management (-\$1.2 billion/5 years). The President's budget proposes cutting \$1.2 billion over five years by reducing Federal payments for targeted case management (TCM).⁶ These cuts come on top of cuts of \$760 million over five years (\$2.1 billion over 10 years) to targeted case management recently enacted in the Deficit Reduction Act.⁷

Section 1915(g) of the Social Security Act defines case management as services that assist individuals in gaining access to needed medical, social, educational, and other services. TCM involves assessment and facilitation of meeting service needs, not the provision of the services itself. The Administration believes these services should be claimed as administrative services, not medical services. The President's budget proposes to lower the Federal matching payment rate for TCM services from the State's current payment matching rate for medical services (60 percent on average) to 50 percent. This change will affect only those States that have Federal matching rates in excess of 50 percent. Targeted populations receiving case management services include children with developmental disabilities, the mentally ill, abused and neglected children in the child welfare system, people with AIDS, and foster children. TCM

⁴ <http://www.kff.org/medicaid/upload/The-Medicaid-Program-at-a-Glance-Fact-Sheet.pdf>

⁵ Congressional Budget Office Cost Estimate, S. 1932 Deficit Reduction Act, January 27, 2006.

⁶ President's Budget for Fiscal Year 2007 Summary table S-6.

⁷ Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.

services are important for those living with disabilities to manage their care in the community and these services can eliminate or reduce the need for more intensive or expensive Medicaid services needed in the future.⁸

Reductions in Payments for Prenatal and Preventive Pediatric Care (-\$525 million/5 years). The President's budget request proposes allowing States to withhold payment from providers for prenatal and preventive pediatric care where a non-custodial parent may have insurance and potentially be liable for payment. While the budget states that it will protect providers, women, and children, it provides no details as to how this policy would be implemented without restricting access to care or reducing or delaying payments to pediatric providers. The policy would also allow States to use liens against liability settlements to recover Federal matching payments, but no additional details are provided.

Remove Best Price and Replace with a Flat Rebate (budget neutral). The Medicaid drug rebate program, under current law, requires all drug manufacturers to pay a rebate to States for drugs provided through Medicaid. For brand name drugs, the rebate amount is the greater of either (1) the average manufacturer's price (AMP) minus 15.1 percent or (2) the difference between the AMP and the manufacturer's "best price" for that drug.⁹ According to the Administration, the "best price" requirement prohibits manufacturers from negotiating discounts with large non-Medicaid purchasers such as hospitals and HMOs, because otherwise that price would become the "best price" and extend to all prescriptions paid by Medicaid. The President's budget proposes to replace the best price with a "budget neutral" flat rebate amount, which would then allow private purchasers to negotiate lower drug prices. The Administration did not specify what level of "flat rebate" would be required for the proposal to be budget neutral, but eliminating the best price without a corresponding increase in the minimum rebate would provide a substantial windfall to drug manufacturers. It is unclear whether this policy would lead to lower drug prices under Medicaid but it is clear that this policy is intended to allow private payors to receive a better price on prescription drugs than the Medicaid program. This proposal was also included in the President's FY2006 budget.

Restructure Medicaid Prescription Drug Reimbursement (-\$1.3billion/5 years). The President's budget proposes to limit payments for multiple-source drugs to 150 percent of the average manufacturers' price. This would save \$130 million in 2007 and \$1.3 billion over five years.

Allowing States to Further Restrict Formularies (-\$177 million/5 years). The Administration proposes allowing States to make additional restrictions to prescription drug formularies under Medicaid by allowing the use of "managed formularies." The Administration's budget submission provides no guidance on what this proposal entails but under current law, Medicaid is required to cover all drugs, though States may establish preferred

⁸ Child Welfare League of America, Targeted Case Management for the Child Welfare Population, July 2005.

⁹ Section 1927 of the Social Security Act.

drug lists or require prior authorization before a drug is dispensed.¹⁰ More restrictive formularies, such as those permitted in private insurance, could apply additional barriers to accessing needed medications that will make it more difficult for low-income individuals to obtain their prescriptions. Examples of such policies include prior authorization requirements, step therapy where an individual is required to take one drug and fail before another is permitted, therapeutic interchange between drugs and tiered cost-sharing for different prescription drugs.

This could be particularly burdensome for chronically ill, low-income beneficiaries who generally have numerous prescriptions to take. The recently enacted budget reconciliation spending legislation allowed States to set a preferred drug list and charge significantly more for all but the “least costly” non-preferred drugs and cut Medicaid by \$960 million over five years and \$5.4 billion over 10 years by permitting States to charge significantly higher cost-sharing for non-preferred drugs for all beneficiaries including children. The Congressional Budget Office estimated that 20 million beneficiaries will face higher cost-sharing for prescription drugs under the Reconciliation spending cuts law by 2015.¹¹ The President’s proposal in the FY2007 budget would allow new and additional barriers to those recently established in the reconciliation spending Act, making it even harder for those with illnesses to access needed medicines.

Reduction of Medicaid Payments for Administrative Costs (Cost Allocation) (-\$1.8 billion/5 years). The Administration believes that Medicaid is inappropriately paying for certain costs under the Temporary Assistance for Needy Families (TANF) program and thus proposes to reduce Medicaid administrative funding to reflect costs covered by TANF, saving \$1.8 billion over five years. Medicaid administrative payments fund a variety of important activities such as nursing home survey and certification, quality inspections, and other items that could be jeopardized in States as a result of this proposal. States will become fully responsible for any costs that are excluded as a result of this policy under Medicaid yet are unfunded under TANF. To that extent, this policy is a cost shift to States.

Medicaid Regulatory Proposals (-\$12 billion/5 years).¹²

The President’s budget includes a number of regulatory changes that will reduce Medicaid spending by \$12 billion over the next five years or \$30 billion over 10 years. Many of these changes will affect essential community providers and may negatively affect access to care both for those covered under Medicaid and others who rely on these providers for their care.

Reductions in Payments to Governmental Providers (-\$3.8 billion/5 years). The President’s budget proposes \$3.8 billion in cuts to payments to providers over five years by prohibiting States from paying Government providers such as nursing homes and hospitals more

¹⁰ Section 1927 of the Social Security Act.

¹¹ Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.

¹² Analytical Perspectives, President’s Fiscal Year 2007 Budget, Table 25-2 p. 363.

than their “cost” to treat individuals. The savings from this proposal, -\$3.8 billion over five years, are more than twice the savings identified from a similar proposal included in the President’s FY2006 budget, -\$1.2 billion over five years.

Under current law, Medicaid can pay Government-owned providers up to the Medicare payment rate which can be higher than Medicaid rates (known as the upper payment limit or UPL). Some States use these higher provider payments to draw down Federal matching dollars, but then the Government-owned provider can be required to return the extra funds (now supplemented by Federal dollars) to the State coffers. This funding is frequently, but not necessarily, either reinvested in the Medicaid program or used for other healthcare programs. Congress took steps to curb inappropriate schemes most recently in 2000 and 2001. A number of States are still phasing out certain UPL mechanisms as a result of the 2000 law.

Last year, the Administration sent a legislative proposal to Congress on this matter, but it was not enacted because many questions remain including how the Administration would define a provider’s “costs” for this purpose and what kind of reporting burden this will place on providers and States to document costs. It now appears that the Administration believes it can do this through regulations. Other issues are whether the Centers for Medicare and Medicaid Services (CMS) will apply a uniform policy to private and public providers, State and local providers, and across different States. In contrast, Congress has been moving away from paying providers based on costs in Medicare.

Reductions in Allowable Provider Taxes (-\$2.1 billion/5 years). The President’s budget proposes to phase down the allowable provider tax rate under Medicaid from six percent to three percent. Currently, States are legally allowed to levy taxes of up to six percent on different classes of providers (hospitals, HMOs, nursing homes, etc) so long as those taxes are generally broad-based and uniform. States use revenues raised through such taxes to increase provider payment rates under Medicaid. This proposal will curtail the ability of States to increase provider payment rates. The result could be decreased access to services for beneficiaries. This proposal was included in the President’s FY06 budget as well.

Reductions and Delays in Payments to Pharmacies (-\$430 million/5 years). The President’s FY2007 budget proposes to require States to exhaust all other third-party sources of payments before paying Medicaid pharmacy claims. Today, States are able to pay claims as received and then later bill other sources of coverage. This policy will result in payment delays for pharmacies, and may result in a reduced willingness of pharmacies to participate in the Medicaid program, reducing access to beneficiaries.

Reductions in School-Based Administration and Transportation (-\$3.6 billion/5 years). The President’s budget proposes administrative changes that would cut Federal payments for school-based administration and transportation services currently covered under Medicaid by \$3.6 billion over five years. Few details are available on this policy. To the extent that States do not have the funding for these services under IDEA (Individuals with Disabilities Education Act), this proposal would be a direct cost-shift to schools, local governments, and States who are required by law to fund these activities.

Stricter Reimbursement Policies for Rehabilitation Services (\$2.3 billion/5 years). The Administration plans to clarify through regulation the allowable services that can be claimed as rehabilitation services. Currently, rehabilitation services include any medical or remedial services recommended by a physician for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level. Narrowing this further could result in beneficiaries losing needed and helpful services.

Other Regulatory Proposals (\$0/5 years)

The President's budget also mentions issuing new regulations on disproportionate share hospital payments (DSH) and provider taxes. The Administration plans to clarify through regulation the statutory DSH program provisions, to ensure proper use of Federal funds. The Administration will also take steps, including revising regulations, to clarify and codify existing policies used to determine whether provider taxes comply with the statute. There is no score associated with these proposals and no further detail provided as to how they will affect different States.

New Medicaid and SCHIP Spending Proposals of \$3.5 Billion Over Five Years

Extension of Transitional Medical Assistance (-\$360 million/5 years). The TMA program, which provides health insurance for working mothers as they transition from welfare to work, will expire in December of 2006. The President's budget would extend this program for nine months through September of 2007 at a cost of \$180 million in 2007 and \$360 million over five years. Unlike most healthcare programs for low-income individuals, this program relies on year-to-year funding, making long-term planning by States difficult and threatening the stability of the program.

Health Insurance Portability and Accountability Act Proposals Related to Medicaid and SCHIP (no cost). Special Enrollment Period in Group Market for Medicaid/SCHIP. As in the past three years, the Administration's FY2007 budget would make eligibility for SCHIP and Medicaid a "qualifying event" for the purposes of enrolling in employer-sponsored insurance. This proposal would allow beneficiaries to enroll immediately in employer-sponsored insurance rather than waiting until the employer's open season. The concern with this proposal is that for many beneficiaries who are eligible for Medicaid or SCHIP, employer-sponsored coverage may be inadequate, either in terms of paucity of benefits or unaffordable out-of-pocket costs. The Administration's budget does not include a requirement that in the event a Medicaid or SCHIP-eligible person were to enroll in employer-sponsored coverage, the State would fill in the gaps for missing benefits or excess costs to ensure that coverage under the employer plans meets the statutory requirements under Medicaid/SCHIP.

While the Administration has encouraged States to enroll Medicaid and SCHIP beneficiaries eligible for employer coverage in the employer-sponsored plan as a way to reduce costs in the Medicaid and SCHIP programs, the Administration's approach does not guarantee that families will get either adequate coverage or that it will in any way reduce costs for the State. Medicaid and SCHIP were specifically designed to address the needs of the poor, those with disabilities, and chronically-ill individuals whose needs were not being met in the

marketplace. Making sure that an individual has access to the services they need will improve their health and lower long-term costs to the Medicaid program. For example, Rhode Island and New Jersey have documented program savings and provided coverage through Medicaid for costs and services that the employer-sponsored plans do not cover. In the other States that have pursued this approach, however, coverage is not required to meet Medicaid benefit and cost-sharing standards, and it is not clear that these States are saving money.¹³

Creditable Coverage Certificates under SCHIP. The Administration's FY2007 budget also proposes requiring States to issue certificates of creditable coverage to meet requirements of the Health Insurance Portability and Accountability Act that would allow them to move from SCHIP into private coverage without having preexisting condition exclusions (still verifying this last part).

Cover the Kids Outreach Grants (\$2 billion/5 years). The President proposes to increase coverage of uninsured, low-income children by spending \$100 million a year for five years on an outreach campaign in Medicaid and SCHIP. The Administration is expecting that this outreach will result in additional Medicaid enrollment costing \$1.5 billion over five years and additional SCHIP enrollment costing \$330 million over five years.

While well intentioned, this program is likely to be a false promise to uninsured children. Current estimates reveal that more than 80 percent of the Nation's uninsured, low-income children are already eligible for either Medicaid or SCHIP.¹⁴ Unfortunately, given the current fiscal situation facing the States, many either do not have enough SCHIP funding in their block grant to cover currently enrolled children or do not have the State matching funds to pay for any increase in enrollment in either Medicaid or SCHIP. This means that new children identified as eligible through this campaign would likely be placed on a waiting list or be subjected to complicated and burdensome administrative procedures to deter enrollment.

States are already making it more difficult for eligible families to enroll in Medicaid and SCHIP. Between April 2003 and July 2004, nearly half of the States took some action to make it more difficult for eligible children and families to acquire health coverage. The procedural barriers imposed in Texas, including eliminating 12-month continuous eligibility, post-eligibility waiting periods, and new premiums, caused more than 149,000 children to lose coverage in the first six months of 2004.¹⁵ In addition, the recently enacted Reconciliation law included new documentation requirements that will make it more difficult and burdensome for low-income

¹³ Joan Alker, "Premium Assistance Programs: How are they financed and do states save money?", Kaiser Family Foundation, October 2005.

¹⁴ Kaiser Family Foundation, Health Coverage for Low Income Children, September 2004.

¹⁵ Donna Cohen Ross and Laura Cox, Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, Kaiser Family Foundation, October 2004.

families to enroll their children in coverage. According to the Congressional Budget Office, this documentation provision will reduce Medicaid spending by \$220 million over five years and \$735 million over 10 years as a result of 35,000 Medicaid enrollees losing coverage by 2015.¹⁶

Ironically, by proposing simultaneous cuts in Medicaid, this outreach initiative to find more children would effectively come at the expense of the more than 25 million children with even lower incomes than those in SCHIP.

Medicaid and SCHIP Waivers. The President's FY2007 budget includes a new Medicaid waiver initiative, the details of which, according to Administration representatives, will be forthcoming. Administration representatives were unable to provide additional detail on the policy when the budget was released.

The President's budget references increased coverage gains under the Health Insurance Flexibility and Accountability "HIFA" waivers stating that "at full implementation, approximately 825,000 individuals may receive coverage through 11 approved HIFA waivers. It is important to note that while a number of individuals *may* receive coverage, those coverage gains are not guaranteed and the benefits they receive under these waivers are often inadequate and result in individuals being "under-insured." According to the Kaiser Family Foundation, using waivers for expansions has limitations because there is no new Federal funding associated with waivers.¹⁷ Moreover, many States have used waivers as a way of addressing State budget shortfalls by reducing services under Medicaid.¹⁸ Under the HIFA waivers, States are permitted to reduce benefits, limit eligibility, and increase costs on certain groups of beneficiaries in order to "offset" the cost of providing reduced-benefits package to people who today are not covered under Medicaid.¹⁹ States, however, are not required to implement all or even part of the promised coverage expansion.

The President's budget also discusses implementing new "market-driven" approaches in Medicaid, such as the one being implemented in Florida that provides enhanced benefits to those living healthier lifestyles. This builds on the Health Opportunity Accounts in the Deficit Reduction Act (DRA). The DRA permits States to provide a select group of Medicaid beneficiaries a lesser benefits package with higher cost-sharing, something more akin to market-driven private health insurance plans such as high-deductible plans. It has already been shown

¹⁶ Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.

¹⁷ The Kaiser Commission on Medicaid and the Uninsured, Federal Medicaid Waiver Financing: Issues for California, July 28, 2004.

¹⁸ The Kaiser Commission on Medicaid and the Uninsured, Federal Medicaid Waiver Financing: Issues for California, July 28, 2004.

¹⁹ The Kaiser Commission on Medicaid and the Uninsured, Federal Medicaid Waiver Financing: Issues for California, July 28, 2004.

that cost-sharing inhibits access to needed care, particularly among low-income individuals.²⁰ Furthermore, according to the Congressional Budget Office, about 1.6 million enrollees will be affected by the year 2015 and will lose services such as dental, vision, mental health, and certain therapies.²¹

Redistribution of SCHIP Funding (\$110 million/5 years). The Administration's FY2007 budget includes a proposal to allow States only two years to spend SCHIP funding rather than three years. This proposal spends \$635 million in FY2007 but only \$110 million over five years. In 2007, approximately 18 States are projected to have insufficient Federal funding to provide coverage for eligible children under their SCHIP programs.²² The Administration proposes to target these States but offers no details about how it intends to accomplish this goal.

Vaccines for Children (\$700 million/5 years). This proposal would allow additional sites to administer vaccines and be reimbursed by Medicaid under the VFC program. The increase in spending comes from expanded coverage and from additional vaccines being approved and additional vaccines being administered as a result of expanded access.

Grant Program for Chronically Ill (\$2.1 billion/5 years). The President's budget proposes a competitive program of grants to States to promote insurance of the chronically ill. The budget provides no details on how these grants would be awarded or for what purpose. In addition, it is unclear how what is covered or provided for by the grant funding would be different and not duplicate the benefits Medicaid already covers for those with disabilities or chronic illnesses. It is also unclear how these grants will be distributed to States, whether there will be a sound methodology for distributing them or whether they will be given out at the complete discretion of the Secretary.

MEDICARE

The Medicare program provides health insurance coverage to nearly 44 million seniors and individuals with disabilities. The President's FY2007 budget includes substantial cuts to Medicare providers such as doctors and hospitals while protecting private plan overpayments to HMOs and PPOs. The budget ignores problems with the new Medicare Part D benefit that went into effect on January 1, 2006, and offers no remedies to make it work. The budget proposes legislative changes that would cut \$36 billion from the Medicare program over five years, as well as a number of regulatory changes²³ that would make additional cuts of \$8 billion over five

²⁰ M. Edith Rasell, *Cost Sharing In Health Insurance – A Reexamination*, The New England Journal of Medicine, April 27, 1995, reviewing Joseph P. Newhouse, *Free For All? Lessons from the Rand Health Insurance Experiment*, Cambridge, 1996.

²¹ Congressional Budget Office Cost Estimate, S. 1932, Deficit Reduction Act, January 27, 2006.

²² Center on Budget and Policy Priorities, Congress Can Preserve \$1.1 Billion in Expiring Children's Health Insurance Funds and Help Avert SCHIP Cutbacks, September 28, 2004.

²³ This includes regulatory changes already finalized that the Administration has included in its budget.

years to payment rates for a five year total of \$44 billion in cuts to Medicare.²⁴ Over ten years the President's proposed legislative proposals would yield \$105 billion out of Medicare and the regulatory proposals would yield an additional \$19 billion from Medicare providers.²⁵ Hospitals bear the brunt of the cuts to providers in the FY2007 budget.

Forty-five Percent Trigger for Cutting Medicare Across the Board. The President's FY2007 budget includes a program cap that would automatically cut Medicare payment rates by four-tenths of one percent in the first year in which general revenues are projected to exceed an arbitrarily set cap of 45 percent of program spending. The reduction would grow by four-tenths of one percent every year that the 45 percent threshold is exceeded. This would mean payment cuts to all providers in Medicare Parts A, B, C and D.²⁶ According to CMS actuaries, if this provision were enacted, it could take effect as soon as 2012, one year outside of the five-year budget window. Thus, the effects are not apparent in the President's budget. And, if all of the Medicare changes proposed in the President's budget were enacted, the automatic reduction would not be triggered until 2017. This is proposed at a time when 77 million baby boomers are expected to enter the program.

Under the Medicare Modernization Act (MMA) of 2003, there is already an expenditure cap of 45 percent in law. When the Medicare trustees project for the second time that the general revenue funds share for Medicare expenditures will exceed 45 percent in any of the next seven years, two things would occur: (1) the President would be required to submit legislation to Congress, and (2) a new Senate rule would automatically come into effect barring consideration of any improvements in Medicare or any Medicare payments to providers unless any extra costs are fully offset. Even given this law, the President decided to put forward a more restrictive proposal in his budget.

Medicare Part D - The Medicare Prescription Drug Program. The President's budget fails to address, either legislatively or administratively, the numerous problems that have plagued the new privately-run Part D benefit. In fact, there is no mention of such problems anywhere in the budget document. The budget fails to include any proposals that would: (a) address the confusion associated with the privately-run benefit by increasing funding for beneficiary assistance or by simplifying choices; (b) address denials of prescription drugs through excessive prior authorization and confusing appeals processes run by the private plans; or (c) provide beneficiaries with the low prescription drug costs obtained by other Government programs.

²⁴ President's Budget for Fiscal Year 2007; Department of Health and Human Services Budget in Brief, Fiscal Year 2007; Budget of the United States Government: Analytical Perspectives, Fiscal Year 2007; Medicare Part A and B Tables for Program Year (PY) 2007 President's Budget, January 11, 2006.

²⁵ President's Budget for Fiscal Year 2007; Department of Health and Human Services Budget in Brief, Fiscal Year 2007; Budget of the United States Government: Analytical Perspectives, Fiscal Year 2007; Medicare Part A and B Tables for PY 2007 President's Budget, January 11, 2006.

²⁶ According to HHS staff the cuts would affect all Parts of Medicare, however, they have also indicated there is no further information available on how this policy would be implemented.

Moreover, the budget projects that the privately-run benefit will cost less than anticipated. The majority of the decrease in costs is due to changes in the Administration's baseline and plan premiums coming in lower than expected. These lower than anticipated premiums are likely a result of insurance companies' efforts to grab market share through lower premiums during the first year of the benefit. For example, according to the *Wall Street Journal*, Humana has one of the lowest premium plans in the market by far. But according to the article, they are hoping to enroll these people in the first year and then migrate them to their much more lucrative, due to overpayments, Medicare Advantage Plan that would provide all of the person's Medicare benefits through this private plan, not just prescription drugs.²⁷ Given these types of expectations, the Federal Government's hopes of spending less through private plans will likely not come to fruition.

The numbers touting beneficiary participation in the new Part D benefit cited in the budget are also misleading. The President's budget describes 24 million beneficiaries as benefitting from the new Part D benefit. According to the most recently released detailed enrollment data by the Department of Health and Human Services, however, only 3.6 million of these seniors and individuals with disabilities are enrolled in the new stand alone prescription drug plans.²⁸ Of the rest, 6 million already had coverage through their employer retiree coverage, 4.5 million are in Medicare HMOs with prescription drug coverage, 6 million already had prescription drug coverage through Medicaid and were transferred to Medicare, and 3 million include TRICARE And FEHB retirees.²⁹

Part B Premium Increase (-\$2 billion/5 years). The President's FY2007 budget also proposes yet another increase in the Part B premium paid by beneficiaries, hitting beneficiaries with an additional \$2 billion increase over five years. In 2003 the Medicare Modernization Act changed Medicare's universal social insurance structure by relating premiums to income for the first time. Under this Republican-crafted legislation, individuals with higher incomes are going to be forced to pay more for Medicare Part B than lower-income Medicare beneficiaries beginning in 2007, phased in over five years through 2011. Higher-income beneficiaries were already paying a greater amount into the Medicare system through a payroll tax during their working years. This was the first step in turning Medicare into a means-tested welfare program.

The Reconciliation spending cuts bill, signed into law in February of 2006, increased Medicare Part B premiums again by accelerating the five-year phase in so that the premium increase will now be in full effect by 2009 as opposed to 2011.

The President's FY2007 budget now proposes another increase in premiums by eliminating the indexing of the income levels for individuals that will be subject to the premium increases. So, despite the fact that inflation and other factors will drive a person's income up over time, the level used to determine when a person would be required to pay higher amounts

²⁷ Sarah Lueck and Vanessa Fuhrmans, New Medicare Drug Benefit Sparks Industry Land Grab, *Wall Street Journal*, January 26, 2006.

²⁸ Centers for Medicare and Medicaid Services, Medicare Fact Sheet, January 19, 2006.

²⁹ Centers for Medicare and Medicaid Services, Medicare Fact Sheet, January 19, 2006.

for their Part B premium does not proportionately increase. The end result is that more and more beneficiaries would become subject to increased premiums every year, forever.

For example, under current law only 3.8 percent of Medicare beneficiaries – nearly 1.6 million people – will be subject to this premium cap in 2007 and 3.9 percent of beneficiaries, or a little more than 1.9 million people, will be subject in 2016. Under the President’s budget proposal, by 2016, double that number – 7.5 percent of beneficiaries or 3.8 million people – would be subject to these higher premiums.³⁰

Medicare Health Savings Accounts (HSAs). The Administration wants to broaden the availability of HSAs for Medicare beneficiaries, including allowing individuals to continue their existing HSAs when they age into Medicare. The budget does not include any particular legislative proposal, however, the Administration is considering using their “demonstration authority” under Medicare to expand the use of HSAs.³¹ While specific details about this proposal are unclear, research on HSAs has documented a number of concerns.

HSAs weaken the existing health insurance system by fragmenting the pooling of risk that helps the healthcare system function.³² In Medicare this would be particularly problematic as the older and less healthy beneficiaries, unlikely candidates for HSAs, could quickly become segmented into plans with rising premiums because, without the healthy beneficiaries, who are expected would go to HSAs, the costs for health care averaged out per beneficiary would be higher. For example, a recent Government Accountability Office (GAO) study of HSA enrollees in the Federal Employee Health Benefits Program (FEHBP) found that HSA enrollees are younger than enrollees in traditional healthcare plans. According to GAO, “individuals with certain demographic characteristics” (younger enrollees who have lower healthcare costs) “may be disproportionately attracted to these plans.” The average age of HSA enrollees was 46 years old compared to an average age of 59 for enrollees in traditional FEHB plans. The oldest enrollees, those who were retired, were only one fourth as likely to sign up for HSAs.³³

HSAs have little potential to improve the healthcare system and are not likely to greatly empower consumers.³⁴ In fact, GAO also found that HSAs failed to provide adequate information to enrollees to make those wise choices that HSA advocates claim will lower costs. According to GAO, “HDHPs [High Deductible Health Plans] ... are premised on the notion that

³⁰ Democratic Staff, Committee on Ways and Means, Fact Sheet: Charging Higher Income Medicare Beneficiaries More, February 7, 2006; Medicare Part B Tables for FY2007 President’s Budget, January 11, 2006.

³¹ Budget Briefing offered by the Department of Health and Human Services, February 6, 2006.

³² Center on Budget and Policy Priorities, Expansion in HSA Tax Breaks is Larger and More Problematic Than Previously Understood, February 4, 2006.

³³ GAO, First Year Savings With High Deductible Plans and Health Savings Accounts, January 2006. GAO-06-27.

³⁴ Center on Budget and Policy Priorities, Expansion in HSA Tax Breaks is Larger and More Problematic Than Previously Understood, February 4, 2006.

enrollees will become more actively involved in making health care purchase decisions To do so, enrollees need information to help them assess the cost and quality trade-offs between different health care treatments and providers.” The extent to which plans made such information available to enrollees, however, was varied and limited.³⁵

Even armed with information about prices for providers it is unclear how this would translate into better shopping under Medicare where payment rates are set by the Medicare program. The HSA policies may discourage consumers from seeking needed preventive or other basic care that could result in greater costs and medical problems in the long run. And for the higher cost procedures and medical problems, consumers often have few options. A beneficiary is not going to comparison shop hospitals to find the lowest cost before being admitted for a heart attack. And a beneficiary living in a rural area will not likely have much choice where he gets his dialysis.

Finally, the tax preferences given to HSAs provide the largest assistance for the most well-off. These products give the greatest benefit in terms of tax breaks for those who have the most income, yet provide little benefit for those who have the hardest time paying their medical bills. Evidence from the FEHBP confirms this. HSA enrollees are wealthier than enrollees in other FEHBP plans. HSA enrollees in the highest income bracket analyzed by GAO (those with incomes over \$75,000) were over three times as likely to sign up for HSAs.³⁶ This proposal would be yet another way for the healthy to shelter money from taxes to pass on to their heirs, yet would provide little, if any, benefit in Medicare.

The President proposes spending \$59 billion over five years and \$156 billion over 10 years in tax cuts related to Health Savings Accounts.³⁷

Health Care Fraud and Abuse Control Program (HCFAC) (\$118 million/5 years). The President’s budget proposes a two year discretionary fund to combat healthcare fraud and abuse, \$118 million in FY2007 and \$182.5 million in FY2008. This would be in addition to mandatory spending in the budget of \$1.1 billion for FY2007 and \$1.1 billion for FY2008 on these activities.³⁸ The majority of the additional discretionary funding would be for safeguarding the new Medicare prescription drug benefit and the Medicare Advantage plans against waste, fraud, and abuse. The remainder of the funding would be to expand program integrity oversight of the Medicaid program.

³⁵ GAO, First Year Savings With High Deductible Plans and Health Savings Accounts, January 2006. GAO-06-271.

³⁶ GAO, First Year Savings With High Deductible Plans and Health Savings Accounts, January 2006. GAO-06-271.

³⁷ President’s Budget for Fiscal Year 2007 Summary Table S-7.

³⁸ Department of Health and Human Services Budget in Brief, Fiscal Year 2007.

It has been shown that the Government receives a return investment of nearly 9 to 1 for every dollar spent on healthcare fraud and abuse activities.³⁹ This does not even include a calculation of the deterrent effect these activities have on fraud and abuse.⁴⁰

The new Medicare prescription drug benefit is fraught with confusion as a result of the many private plan choices Medicare beneficiaries have, the plans different benefit structures, formularies, and marketing strategies and the fact that many vendors offer not only a standalone Medicare prescription drug plan but also a Medicare Advantage plan. All of this confusion makes the Medicare program particularly susceptible to fraud and abuse.

Medicare Contractor Reform. The President's budget proposes accelerating by two years the implementation of contractor reform, completing the task in 2009 rather than 2011 as was statutorily directed under the Medicare Modernization Act. In addition, the Administration proposes consolidating contractors from the 40 that serve Medicare Parts A and B today to only 15 joint A/B contractors in single or multi-State regions.

Provider Payment Cuts in Traditional Medicare. The Medicare Payment Advisory Commission (MedPAC) recommended a number of payment changes including cuts and freezes to a variety of providers. The President decided to pick and chose only a handful of the recommendations having to do with cuts and freezes to providers such as hospitals and skilled nursing facilities but chose not to eliminate \$50 billion of overpayments to HMOs and PPOs through the Medicare Advantage plans as MedPAC recommended. The President's budget goes at the heart of the Medicare program. Rather than achieving savings by reducing the nearly \$50 billion in overpayments to HMOs and private insurance plans, the budget cuts come solely to providers serving beneficiaries in fee-for-service Medicare, which enrolls more than 85 percent of all seniors and people with disabilities. Below is additional detail on the provider cuts in the President's budget:

- ***Physicians.*** For 2007, MedPAC recommended giving physicians an update that reflects the change in input prices less a productivity adjustment. The President's budget includes no provisions on this matter, and does nothing to address the significant Medicare payment cuts that will be made to physician payments over the next 10 years beginning in 2007. In order to prevent the 4.4 percent cut that went into effect on January 1, 2006, the Reconciliation spending cuts law gave physicians a retroactive zero percent update in 2006, however failed to address the cuts in future years. Therefore, beginning in 2007, physicians will again see their payments under Medicare significantly reduced, with an average annual decline of 4.6 percent, or 34 percent total over nine years. In other words, doctors will see a real pay decrease totaling \$176 billion over the next nine years or on average \$26,000 per physician.⁴¹ The budget mentions supporting proposals that

³⁹ Taxpayers Against Fraud, *Fighting Medicare Fraud*, June 2003.

⁴⁰ Taxpayers Against Fraud, *Fighting Medicare Fraud*, June 2003.

⁴¹ Data from American Medical Association, February 2006, based on CMS assumptions from the 2005 Trustees Report. Projections include expiration of the GPCI floor in 2007 and the shortage bonus in 2008; they also use CMS's behavior offset assumptions.

include “differential updates initially for physicians that report on quality measures and later for physicians that achieve efficient and high-quality care”⁴² but the Administration fails to take the lead on this matter and put forward any solutions.

- **Hospitals.** Hospitals bear the brunt of the Medicare payment cuts in the President’s FY2007 budget.
- **Cuts on Inpatient Hospital Update (-\$6.6 billion/5 years).** For FY2007 a cut of market basket minus 0.45 percent. For fiscal years 2008 and 2009, market basket minus 0.4 percent.
- **Cut to Outpatient Hospital Update (-\$1.5/5 years).** For FY2007 a cut of market basket minus 0.45 percent. For fiscal years 2008 and 2009, market basket minus 0.4 percent

Elimination of Payments to Providers for Bad Debt (-\$6.2 billion/5 years). Part A (-\$3.4 billion/5 years) and Part B (-\$2.8 billion/5 years). The Administration’s budget put forward a proposal to push hospitals and skilled nursing facilities to aggressively go after beneficiaries who were unable to pay cost-sharing. The Administration will encourage this by eliminating Medicare bad debt payments by 2011. Bad debt payments are intended to compensate providers when they are unable to collect beneficiary cost-sharing amounts, for example because a beneficiary does not have the means to pay the bill. It allows providers to continue to see Medicare patients but have a source of some relief from unpaid bills. The President’s proposal will leave providers with no options but to bear the unpaid bills all on their own, go after the sick and poor elderly and disabled individuals, shift bad debt costs to paying patients, or no longer see Medicare patients. This will be a great burden on many providers. The President’s budget proposal was preceded by the Reconciliation spending cuts law that reduced bad debt reimbursement to skilled nursing facilities to 70 percent starting in 2006.

In addition, numerous other providers receive significant cuts:

- **Skilled Nursing Facilities (SNFs) (-\$5.1 billion/ 5 years).** For 2007, a 0 percent update, for 2008 and 2009, a cut of market basket minus 0.4 percent.
- **Home Health (-\$3.5 billion/5 years). Part A -\$1.7 billion/5 years and Part B - \$1.8 billion/5 years.** For 2007, a 0 percent update, for fiscal years 2008 and 2009, a cut of market basket minus 0.4 percent.
- **Inpatient Rehabilitation Facilities (IRFs) (-\$1.6 billion/5 years).** For FY2007, a 0 percent update, for fiscal years 2008 and 2009, a cut of market basket minus 0.4 percent.
- **Hospice (-\$550 million/5 years).** For FY2007 through FY2009, a cut of market basket minus 0.4 percent.

⁴² Department of Health and Human Services Budget in Brief, Fiscal Year 2007.
Prepared by Committee on Energy and Commerce Democratic staff

- **Ambulance (-\$290 million/5 years).** A cut of 0.4 percent off the update in 2007 through 2009.
- **Clinical Laboratories (-\$1.4 billion/5 years).** The President's budget plans to extend competitive bidding to clinical laboratories.
- **Oxygen Rental (-\$6.6 billion/5 years).** The Reconciliation law included a new rent-to-own payment policy for oxygen equipment. After a maximum of a 36-month rental period, all home stationary and portable oxygen technologies will be considered purchased by the Medicare beneficiary. Medicare will continue to pay for reasonable and necessary maintenance and service along with gaseous and liquid oxygen contents. The President's budget proposes to reduce that policy to 13 months. The President expects to save \$6.6 billion over five years under this policy.
- **Short-term Power Wheelchairs (-\$460 million/5 years).** Wheelchairs would be paid based on actual time used rather than paying up front at the full purchase price. This is expected to save \$50 million in 2007 and \$460 million over the next five years.
- **Establish Federal Data Sharing Clearinghouse (Medicare Secondary Payer) (-\$580 million/5 years). Part A -\$310 million/5 years and Part B -\$270 million/5 years.** Medicare secondary payer is the term used by Medicare when Medicare is not responsible for paying first, generally called coordination of benefits in the private sector. In 2001, Medicare hired a Coordination of Benefits Contractor to help maintain eligibility databases with regards to other health insurance that is primary to Medicare. The President's budget offers no details on this proposal.
- **Extend Medicare Secondary Payer Status for ESRD from 30 to 60 months (-\$510 million/5 years).** Under the Balanced Budget Act of 1997, Medicare is secondary payer for end stage renal disease (ESRD) services for the first 30 months if a beneficiary has coverage for ESRD through a group health plan; the group health plan would be the primary payer.⁴³ The President's budget appears to extend that to 60 months; however, there is no detail provided on this proposal.
- **Adjustment for Hip and Knee Replacement in Post Acute Care Setting (-\$2.4 billion/5 years).** The President's budget offers no further detail as to how this savings is achieved. It could be through a direct payment cut, restriction on the billing procedures, or some other mechanism.

Productivity Adjustment. The President's budget also recommends a productivity adjustment to inflation updates for provider payments to account for new technology. This amounts to yet another provider cut as payments will be reduced upon the adoption of new technological advances that increase productivity. The budgetary impact is tied into the payment updates and/or freezes projected for different providers above.

⁴³ Section 4631, Balanced Budget Act of 1997.

Conclusion

In short, the President's Fiscal Year 2007 budget makes significant cuts to fee-for-service providers totaling \$105 billion over the next 10 years that will seriously impair the ability of Medicare to continue providing the same high-quality care seniors and people living with disabilities have come to depend on. At the same time, the budget fails to address the documented overpayments to private healthcare plans, creating an unlevel playing field and unfair competition. These plans will use their extra payments to enhance profits and lure healthy beneficiaries out of the quality care in fee-for-service with the promise of "extra benefits," creating more difficulties for Medicare.

In addition, the lack of any measure in the President's budget to address the many documented problems with the Medicare prescription drug benefit is a real failure for the millions of seniors and people with disabilities, particularly those with low and modest incomes, who have no choice but to try to receive their medicines under this program.

Finally, the addition of a cap on the program, as described above, and an automatic cut to providers if general revenues exceeds program spending could result in major reductions to Medicare benefits.

HEALTH TAX AND UNINSURED PROPOSALS

More than 46 million Americans today have no health coverage. Under President Bush's watch, there are six million more uninsured Americans today than when he took office.⁴⁴ The President recently signed into law a bill that would add hundreds of thousands more to the number of uninsured, and also add to the growing number of under-insured.⁴⁵ The Administration proposes a range of tax incentive and policy changes to promote greater enrollment in high-deductible plans that are linked to Health Savings Accounts (HSAs), particularly through the individual market that is fraught with problems today. These proposals drain \$52 billion over five years, increasing to \$156 billion over 10 years, and would do little to improve the problems Americans are facing, but may in fact do great harm. In addition, by increasing the deficit substantially, the President's policies create a justification for further Medicare and Medicaid cuts that will only further increase the number of uninsured Americans.

By and large, the health tax policies in the FY2007 budget are recycled proposals from past Bush Administration budgets. In spite of his rhetoric, the President's health proposals primarily provide tax incentives to the wealthy, and little – if any – benefit to those most in need. In addition, these proposals undermine existing health coverage by segmenting the market and causing loss of employer-sponsored coverage.

⁴⁴ Center on Budget and Policy Priorities, Number of Uninsured Americans Continued To Rise in 2004, August 30, 2005.

⁴⁵ See Edwin Park and Robert Greenstein, "Proposal for New HSA Tax Deduction Found Likely to Increase the Ranks of the Uninsured," Center on Budget and Policy Priorities, May 10, 2004, and Mercer Consulting, "Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers," June 2003, and Congressional Budget Office, "Cost Estimate H.R. 2355 Health Care Choice Act of 2005," September 12, 2005.

Moreover, juxtaposed against the significant cuts – \$166 billion⁴⁶ over the next 10 years – that the President is proposing in Medicare and Medicaid, which together provide health insurance for more than 100 million Americans, President Bush has sent a clear message to working families: Republicans want to cut benefits and increase costs for families who today have coverage that meets their medical needs, and replace that coverage with less than adequate, bare-bones packages with greater out-of-pocket costs. In other words, giving working families less and making them pay more for it.

In addition, the health tax proposals in the President's FY2007 budget are significantly more regressive this year as compared to last year. This year's budget provides significantly more benefit to higher-income households through the health tax policies than to those in lower-income brackets that most need assistance. The President dramatically scaled back last year's proposal to provide refundable tax credits to low- and moderate-income families to purchase health insurance in the individual market by two-thirds from \$77 billion last year to only \$24 billion this year. At the same time the Administration has proposed \$132 billion in HSA-related health tax breaks that would go disproportionately to affluent households, as compared to only \$31 billion for such proposals last year.⁴⁷ More detail on these proposals is included below.

Health Savings Accounts (HSAs) Proposals

Description

A Health Savings Account (HSA) is a tax-exempt account that is used to pay or reimburse certain medical expenses for people who also have high-deductible health plans (HDHP).⁴⁸ Both individuals and employers may contribute to HSAs with pre-tax dollars. Account balances roll over from year-to-year and earnings on these accounts accrue tax free. Withdrawals from these accounts are not taxed if they are used to pay for qualified medical expenses, as determined by the Internal Revenue Service. The President's FY2007 budget includes a number of proposals related to HSAs.

Provide an above-the-line deduction and income tax credit for the purchase of HSA-eligible coverage in the individual market (\$19 billion/5 years and \$41.3 billion/10 years). Individuals with HSA-eligible high-deductible health plans in the individual market could take an above-the-line deduction for the amount of their premium in determining adjusted gross income, regardless of whether the person itemizes deductions. Individuals are not eligible for this credit if they have other health insurance that is not high deductible.

⁴⁶ This includes Medicare and Medicaid legislative proposals as well as new and finalized regulatory proposals included in the President's FY2007 budget.

⁴⁷ Center on Budget and Policy Priorities, "President Greatly Reduced His Health Proposals For Lower-Income Families While Expanding Health Benefits for the More Affluent," February 8, 2006.

⁴⁸ The deductible for high-deductible health plans is defined in statute (a minimum of \$1,050 and maximum of \$5,250 for an individual and \$2,100 and \$10,500 for a family under current law), on average more than three times the deductible in typical employer sponsored health insurance. These policies have an annual out-of-pocket – or catastrophic – limit and the insurer has the authority to determine which medical expenses count toward the deductible and out-of-pocket limit.

In addition, individuals could get a refundable credit of the lesser of (1) 15.3 percent of the high-deductible premium or (2) 15.3 percent of the individual's wages subject to employment taxes. This latter credit removes any incentive for the purchase of employer-based insurance. Conservative analysts note that without removing this latter incentive any shift toward the individual market would be limited and gradual.⁴⁹ Essentially by adopting this latter policy, the President is encouraging employers to drop employer-sponsored coverage, without any alternative mechanism such as that in employer-sponsored coverage, to pool risk. In other words, there is no protection to ensure that those with illnesses are not priced out of the market.

Increase the amounts that can be contributed to HSAs and provide a refundable income tax credit to offset employment taxes on HSA contributions not made by an employer (\$30 billion/5 years and \$90 billion/10 years). Under current law, a taxpayer with a high-deductible health insurance policy can make tax-deductible contributions to an HSA of \$2,700 for an individual and \$5,450 for a family. The President proposes increasing the maximum annual HSA contribution to equal the out-of-pocket limit for a participant's high deductible policy – for 2006 those limits are \$5,250 for individual coverage or \$10,500 for family coverage. In addition, taxpayers making after-tax contributions to an HSA for the year would be allowed a refundable credit equal to a percentage of the after-tax HSA contributions to offset the employment taxes on the contribution.

Provide a refundable tax credit to lower-income individuals for the purchase of HSA-eligible health coverage (\$9.9 billion/5 years and \$24.1 billion/10 years). Low-income individuals under age 65 could get a refundable health insurance tax credit for the cost of an HSA-eligible high-deductible health plan. The credit would offset 90 percent of the health insurance premium up to a maximum of \$1,000 for an individual, \$2,000 for a couple, and \$3,000 for a family. The subsidy is phased out from 90 percent to 50 percent between \$15,000 and \$20,000 of modified adjusted gross income, and then phased out completely at \$30,000 of modified adjusted gross income. For married taxpayers with a policy covering one adult or only one child, the subsidy is phased out between \$25,000 and \$40,000 of modified adjusted gross income, and for a policy covering more than one person between \$25,000 and \$60,000.

Note: This policy is similar to the Administration's tax credit proposal from budgets from FY2003 through FY2006, however, there is one important change. In previous budgets the tax credit was not limited to only those who were in an HDHP/HSA it could be used for comprehensive health insurance policies as well. Under the FY2007 budget, *only* those with an HDHP/HSA would qualify for this credit.

In addition, after December 31, 2007, certain individuals who would not otherwise be eligible for public coverage through Medicaid or SCHIP could use their refundable credit to buy into that public coverage – but only into a private insurance plan in those programs (or the State employee's program in States where Medicaid and SCHIP do not use private insurance).

⁴⁹ John Cogan, Glen Hubbard, Daniel Kessler, *Healthy, Wealthy, and Wise*.

Other changes to expand the use of HSAs (\$228 million/5 years and \$628 million/10 years). The President proposes making a number of changes to HSAs that would expand their availability. The FY2007 budget proposes allowing qualified medical expenses to include any expense incurred during the year beginning on or after the first day of enrollment in HSA-eligible coverage. Reimbursement of the expenses from an HSA established before filing taxes for a taxable year would be excluded from income. Qualified medical expenses would be expanded to include premiums for HSAs purchased in the individual market. Employers could transfer Health Retirement Account balances (of accounts existing on the date of enactment) to HSAs.

Analysis

The President's HSA proposals spend a considerable amount of taxpayer dollars for very limited benefit and have the potential to undermine existing health insurance coverage. In addition, these proposals have only a modest ability to control costs.⁵⁰ Key concerns with the President's HSAs proposals are below:

- **Increases the Number of Uninsured and Underinsured.**
A 2004 study estimated that the expansion of HSAs could increase the number of uninsured by 350,000 people.⁵¹ According to this analysis, while 1.1 million people would gain coverage through HSAs in the individual market another 1.4 million would lose employer sponsored coverage. Those gaining coverage would likely be healthier as individual market insurers discriminate against those with even minor illnesses.
- **Favors the Healthy Over the Sick.**
Only individuals in HSAs in the individual market receive tax benefits under the President's proposal. It is more difficult for those in poorer health or who are older to obtain coverage in the individual market. Therefore, the proposal is skewed to favor those who are healthier. The President's proposal fails to provide any pooling mechanism or other individual market reforms that would enable people with pre-existing conditions or other health problems to obtain health insurance in the individual insurance market. Many with illnesses are unable to even buy a policy in the individual market, let alone an affordable one. For example, even the insurance industry's own advocacy organization has admitted that, on average, individual market carriers decline, add riders, or rate up 30

⁵⁰ Center on Budget and Policy Priorities, "Expansion in HSA Tax Breaks is Larger – and More Problematic – Than Previously Understood," February 7, 2006.

⁵¹ Kaiser Family Foundation, "Coverage and Cost Impacts of the President's Health Insurance tax Credit and Tax Deduction Proposals" March 2004.

percent of all applications for individual health insurance.⁵² Other studies have found fewer than 10 percent of all applicants get a “clean offer” of coverage.⁵³

In addition, there is no mechanism in the President’s proposals to ensure that the insurer does not drastically raise premiums and remain affordable for an individual who develops an illness after purchasing the policy.

Notwithstanding the fact that the design of this policy alone favors healthy individuals, evidence shows it is primarily the healthy that use HSAs. The GAO has found that HSAs attract primarily those who are healthy and note that, “individuals with certain demographic characteristics” – younger enrollees who have lower healthcare costs – “may be disproportionately attracted to these plans.”⁵⁴

HSAs allow a person to keep all the money from the tax-free account that is not otherwise used for medical services; therefore, they are most attractive to healthy individuals who expect to spend the least on medical care. By encouraging the more healthy people to withdraw from the employer-sponsored plans, a sicker population is left making that employer-sponsored insurance more expensive for all who remain; this is called adverse selection.

- **Limited Effect on Healthcare Costs.**

The top 10 percent of healthcare users account for about 70 percent of total health expenditures in the United States and those expenditures are generally above the deductible amount and thus continue to be covered by insurance. In contrast, the bottom half of healthcare users, those who are most likely to be attracted to HSAs account for only three percent of total health expenditures.⁵⁵

- **Favors the Well-off Over the Middle and Working Class.**

By substantially increasing the amounts that can be placed in HSAs and establishing new credits on top, the proposals would make HSAs a highly lucrative tax shelter for high-income families, enabling them to amass hundreds of thousands of dollars tax-free. For example, a family making \$15,000 a year (in the 0 percent tax bracket) would get no value from the President’s new tax deduction. If the family contributed \$1,000 to an HSA (unlikely given the family’s income), it could get only \$153 from the new credit. Families with

⁵² Council for Affordable Health Insurance, *Issues and Answers*, May 2002.

⁵³ Pollitz, Karen, Project Director, Georgetown University Health Policy Institute. See, www.kff.org/insurance/200010620a-index.cfm

⁵⁴ GAO 06-271, “Federal Employees Health Benefits Program: First Year Experience With High Deductible Health Plans and Health Savings Accounts,” January 2006.

⁵⁵ Center on Budget and Policy Priorities, “Expansion in HSA Tax Breaks is Larger – and More Problematic – Than Previously Understood,” February 7, 2006.

higher incomes could afford to contribute more to their HSA accounts. A family at the \$180,000 income level contributing the maximum \$10,500 allowed under the President's proposal would get a \$4,547 tax subsidy (\$3,316 higher than the subsidy the family would get under current law and significantly higher than the subsidy for the family earning \$15,000 a year).⁵⁶ In fact, the GAO found that higher-income individuals were three times as likely to sign up for HSAs than those at lower-income levels.⁵⁷

- **Opens the Door to Legal Tax Abuse.**

In addition, the President's proposals could encourage families to shift money from their retirement accounts into HSAs due to tax advantages and also provides incentives for people to engage in arbitrage to exploit the HSA tax breaks to their fullest extent. According to an analysis by the Center on Budget and Policy Priorities, high-income people who are already putting away the maximum allowed in a 401(k) each year could place another \$10,500 on top of this in an HSA and build up large tax-sheltered accounts. Steady contributions over a number of years could allow families to accumulate hundreds of thousands of dollars tax-free. Other people who could not afford putting in additional money in the HSAs might end up shifting savings from their 401(k) into an HSA.⁵⁸ This type of activity by affluent households would significantly increase budget deficits. In fact, these tax breaks could widen the deficit by at least \$132 billion over 10 years.⁵⁹

Individuals could also borrow money, deduct the interest, and invest the borrowed funds in HSAs. They could then take a tax deduction for the HSA contributions made with borrowed funds and invest the funds however they wanted with the investment earnings being tax-free. For many people, this could result in a negative tax rate on capital.⁶⁰

- **Shifts the Burden to those Living with Illness.**

This Administration's philosophy is that individuals will negotiate better rates with doctors, lower their own healthcare costs and make individual decisions to not seek care if they have to pay more out-of-pocket. The Administration believes that consumers can lower costs by shopping around to get a better deal

⁵⁶ Center on Budget and Policy Priorities, "Expansion in HSA Tax Breaks is Larger – and More Problematic – Than Previously Understood," February 7, 2006.

⁵⁷ GAO 06-271, "Federal Employees Health Benefits Program: First Year Experience With High Deductible Health Plans and Health Savings Accounts," January 2006.

⁵⁸ Center on Budget and Policy Priorities, "Expansion in HSA Tax Breaks is Larger – and More Problematic – Than Previously Understood," February 7, 2006.

⁵⁹ Sebastian Mallaby, "Ownership Society Redux, New Name, Same Policy," *Washington Post*, February 13, 2006.

⁶⁰ Center on Budget and Policy Priorities, "Expansion in HSA Tax Breaks is Larger – and More Problematic – Than Previously Understood," February 7, 2006.

from different providers. That ignores the reality of the health care experience for many Americans who go to the doctor when they are facing illness. It is difficult to imagine people negotiating very well when they are ill. What American is in the position to bargain for a better rate when they are lying on a hospital bed about to undergo emergency surgery? What cancer patient is going to be able to shop for the cheapest treatment when they do not know if it is the best treatment? In addition, HSAs will undermine the education and emphasis that has been given to preventative or maintenance care because these services do not cost enough to cause a person to reach their deductible in a high-deductible plan, and therefore individuals will have to pay the full cost out-of-pocket.

- **Discriminates against Americans living in Rural Areas.**

One of the Administration's rationales for increasing the use of high deductible policies is to encourage consumers to be more cost-conscious medical consumers. The hope is that people will shop for lower cost providers. This proposal, however, discriminates against the millions of Americans who live in rural areas where there are few healthcare providers. These consumers have no ability to negotiate discounts because there are no alternative providers to visit. A consumer driven healthcare model puts rural Americans at a significant disadvantage because they have little choice and the providers in the area have little incentive to compete and offer better quality or lower-priced care. If there is only one hospital within 80 miles, a consumer does not have the luxury of "shopping" and taking their business elsewhere when they need an appendectomy.

- **Fails to Provide Information for Smart Consumer Driven Care.**

Other problems aside, the President's proposal does not provide the necessary tools for the concept of consumer driven care to function. Consumers today do not have access to easily comprehensible information on quality and cost of different providers and medical procedures. Some of this information is under development by different organizations but we are years away from such a point. As is evidenced by the implementation of Medicare Part D, this Administration is unable to even provide the necessary, understandable information to allow consumers to choose among a number of different health plans. They are certainly a long way off from choosing among complex medical procedures or choosing among the many physicians in this country.

While the President's budget proposal envisions consumers shopping around to get discounts from providers, the model actually fragments consumers' purchasing power. Consumers are in a much better position to get a "discounted rate" when negotiating in a group such as under employer-sponsored insurance, rather than negotiating as one individual on their own behalf.

- Favor Special Interests.**
 Rather than having families enrolled together in comprehensive employer-sponsored insurance – where the employer can bargain for discounts, the President would fragment this bargaining power, leaving families on their own. One individual will have a much harder time bargaining for a discount in the doctor’s office than a group of 100,000 employees together. Prices for consumers will go up, not down. For example, WalMart can get better prices than individuals negotiating on their own behalf.

Health Coverage Tax Credit Proposals (HCTC) (\$73 million/5 years and \$190 million/10 years). The President’s budget includes a number of proposals that make changes to the Health Coverage Tax Credit (HCTC), created under the Trade Adjustment Assistance Reform Act of 2002 (TAA). The HCTC provides a refundable credit equal to 65 percent of the cost of qualified health insurance paid by individuals, such as recipients of TAA or Alternative TAA benefits, and certain individuals between the ages of 55 and 64 receiving benefits from the Pension Benefit Guaranty Corporation (PBGC).

The President proposes to allow State-based coverage under the HCTC to impose longer pre-existing condition waiting periods. The law currently only allows a three month pre-existing condition restriction, and the President’s budget proposes to allow plans to impose 12 months of pre-existing condition restrictions. The stated rationale is to conform the HCTC to existing rules under the Health Insurance Portability and Accountability Act, but the real effect of this policy will be to deny individuals coverage of critical benefits when they are in need.

The President proposes to allow spouses of HCTC-eligible individuals to claim the HCTC when the HCTC-eligible individual becomes entitled to Medicare coverage. The spouse would have to be at least 55 years old. This will help a small number of married couples who are insured through HCTC where one spouse ages into Medicare but the other is not yet eligible.

Other Changes. The President’s budget also proposes a number of other changes to HCTC: (1) clarifies that individuals who receive one time lump sum payments from PBGC and certain other PBGC payees are eligible for HCTC; (2) deems the Commonwealths and Territories to be “States” for the purposes of State-based coverage rules; (3) clarifies that State continuation coverage under State law would automatically qualify as “qualified health insurance” as Federally mandated COBRA continuation coverage does without meeting the requirements relating to State-based qualified coverage; and (4) applies the same list of “other specified coverage” to all eligible individuals by changing the definition of “other specified coverage” for “ATAA eligible recipients” to conform to the definition applied to other individuals.

Association Health Plans and Health Insurance Market Place Proposals

The President's budget includes two relatively similar proposals intended to "transform" the health insurance market place and provide access to low-cost health insurance for more Americans – Association Health Plans (AHPs) and "Health Insurance Market Place" initiatives. Unfortunately, neither is likely to provide any great benefit for consumers, and instead will make it more difficult for those with disabilities and chronic or other illnesses to get insurance coverage.

Association Health Plans. AHPs would allow small businesses and the self-employed to pool together to purchase insurance without generally being governed by State consumer protection laws and oversight. Insurers could offer policies that exclude people with illnesses or disabilities such as diabetes or exclude important benefits such as maternity care or prescription drugs. Insurers could get around State rules that require insurance companies to offer coverage to everyone or laws that prevent insurance companies from discriminating against the sick by charging them more or denying them coverage. Similarly, health plans could avoid State-based solvency requirements and oversight that are in place to assure that individuals and businesses are not left with medical bills if their AHP plan goes out of business.

Allowing these AHPs to operate outside of the protections in State insurance markets will create an unlevel playing field, which will be detrimental to sicker individuals. The American Academy of Actuaries noted, "The consequence of different rules for AHPs versus State-regulated insured plans is a fragmentation of the market. This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals."⁶¹

We already have experience with entities like AHPs, and that experience has been poor. Multiple Employer Welfare Arrangements (MEWAs) are very similar to AHPs. These entities have defrauded hundreds of thousands of Americans out of their health coverage, leaving them with hundreds of millions of dollars in unpaid medical bills. By 2003, the GAO reported that MEWAs had accounted for more than \$250 million in unpaid claims.

Moreover, AHPs will do little to reduce costs or increase coverage and could actually increase the number of uninsured. According to a 2003 Mercer study, leaving the sicker population behind in employer pools will actually increase health insurance premiums for most small businesses. Moreover, the Mercer study concluded that four years after implementation of an AHP proposal, the number of uninsured would increase by one million.⁶² And, it is important to note that already, those with employer coverage are paying the price of having so many Americans go with out insurance. Premiums for employer-provided family health insurance

⁶¹ American Academy of Actuaries, "Executive Summary: Association Health Plans," May 2004.

⁶² Mercer Consulting, "Impact of Association Health Plan Legislation on Premiums and Coverage for Small Employers," June 2003.

cost, on average, an extra \$922 in 2005 to cover the unpaid expenses of health care for the uninsured. These added costs account for \$1 out of every \$12 spent for employer-provided health insurance.⁶³

AHPs are likely to undermine and erode existing employer-based health insurance coverage. AHPs are likely to pull the healthy out of employer-based coverage by offering low premiums for skimpier benefits packages more likely to attract those who are well, leaving the sicker in employer-sponsored coverage. This will result in skyrocketing premiums for those left in employer coverage – raising costs for both the employer and the employees. In fact, the Congressional Budget Office reports that Association Health Plans would result in higher premium costs for 75 percent of employers.⁶⁴ And, according to the American Academy of Actuaries, AHPs are not expected to generate the higher provider discounts and lower administrative costs necessary to produce lower premium rates on a sustainable basis than premium rates currently available to small groups.⁶⁵

Numerous consumer groups have expressed concern that AHP's will cause harm to the existing insurance market place. For example, Families USA wrote, "We are very concerned that this law would encourage a race to the bottom in healthcare coverage, removing critical State consumer protections, creating unstable insurance markets, and increasing the potential for more insolvent plans."⁶⁶

Health Insurance Market Place Initiative. The President's FY2007 budget includes a proposal that would allow insurance companies to sell insurance across State lines without meeting the consumer protection requirements or other laws in other States. This is a flawed and misguided proposal that undermines State consumer protections and patient protections and will likely provide less healthcare choices, particularly for those who suffer from certain diseases or have disabilities. This proposal is similar to the Health Care Choice Act (H.R. 2355) ordered reported out of the House Committee on Energy and Commerce in July of 2005 by a vote of 24-23. Key concerns with this proposal are as follows:

The Market Place Initiative would erode consumer protections by permitting insurance companies to be licensed in one State but sell insurance in any other State, without meeting the laws of that other State. Under this approach, insurers could circumvent State-enacted consumer and patient protections designed to ensure coverage of certain benefits or conditions such as cancer, diabetes, asthma, or mental illness. Insurers would be exempt from critical consumer protections such as guaranteed coverage for individuals with preexisting conditions, and required coverage of critical health benefits like mammography screenings and preventive care. Insurers could also avoid HIPAA-guaranteed access protections for those losing group coverage and moving into the individual market.

⁶³ Families USA, *Paying A Premium: The Added Cost of Care for the Uninsured*, June 2005.

⁶⁴ CBO Paper, "Increasing Small Firm Health Insurance Coverage Through Association Health Plans and HealthMarts", January 2000.

⁶⁵ American Academy of Actuaries, "Issue Brief: FAQs on AHPs," March 2005.

⁶⁶ Families USA letter to U.S. House of Representatives, July 21, 2005.

According to the Congressional Budget Office (CBO), this approach would cause those in poorer health to lose coverage in the individual market. They write, “there would be an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage.”⁶⁷

The Market Place Initiative would raise costs for employer coverage as well as cause loss of employer-sponsored insurance. According to CBO, “...some people with relatively low health care costs who, under current law, will obtain health insurance coverage through an employer, would choose instead to purchase individual health insurance coverage from an out-of-State insurer. That would increase the per-person cost of the employers’ group health insurance and would result in additional employers deciding to drop the group coverage.”⁶⁸ CBO estimates that about one million people would lose employer-sponsored health insurance coverage under such an approach.

The Market Place Initiative would permit insurers to circumvent State consumer protection and patient protection laws such as those protecting consumers from unfair rates and rate hikes, or laws protecting coverage for particular conditions or benefits. This would clearly promote a “race to the bottom” as insurers would be greatly rewarded for licensing their individual products in States with less regulation and fewer personnel to oversee what could be a large influx of new products.⁶⁹

The Market Place Initiative would create regulatory confusion and make it difficult for consumers to seek recourse for problems. Under this proposal, there would be no effective enforcement mechanism to protect consumers as an individual’s State insurance commissioner (who today ensures the consumer’s rights) would not have the jurisdiction or ability to enforce rules for a policy issued through another State. According to the National Association of Insurance Commissioners, “state regulators would be unable to assist their own constituents, leaving consumers to seek assistance from the insurer’s home state. While that may be a theoretical possibility, in the real world of tight state budgets it will be virtually impossible to assist a nonresident consumer in a distant state.”⁷⁰

The Market Place Initiative would hurt rather than help small employers to afford coverage. According to the Blue Cross Blue Shield Association which operates 40 independently-owned and operated Blue Cross Blue Shield companies insuring more than 90 million Americans, “Although the bill does not apply to the small group market or to small businesses, it would have a negative impact on the ability of small employers to purchase affordable insurance. By creating a regulatory “race to the bottom” in terms of the non-group

⁶⁷ Congressional Budget Office, “Cost Estimate H.R. 2355 Health Care Choice Act of 2005,” September 12, 2005.

⁶⁸ Congressional Budget Office, “Cost Estimate H.R. 2355 Health Care Choice Act of 2005,” September 12, 2005.

⁶⁹ National Association of Insurance Commissioners, “Summary of Testimony Presented by the National Association of Insurance Commissioners on the Health Care Choice Act of 2005”, June 28, 2005.

⁷⁰ National Association of Insurance Commissioners, “Summary of Testimony Presented by the National Association of Insurance Commissioners on the Health Care Choice Act of 2005”, June 28, 2005.

market, the Act would drain healthier employees from the small group market because they would be quoted very low (albeit unstable) premiums in the non-group market. When these healthy individuals eventually get sick, they would face dramatic premium increases from their unregulated insurers that would drive them back to the small group market. Federal law (HIPAA) requires that small employers accept these employees back onto their coverage plans. This would increase the cost of coverage for small employers purchasing coverage, as only higher risk employees remained in the pool.”⁷¹

PUBLIC HEALTH AND FOOD AND DRUG ADMINISTRATION

The President’s budget cuts many popular public health programs. For example, under the President's plan the budget for the Centers for Disease Control and Prevention (CDC) would be reduced by at least \$179 million. While the Nation's top three causes of death are chronic diseases - heart disease, cancer, and stroke - the President proposes cuts in CDC’s chronic disease prevention and health promotion programs of \$34 million and elimination of almost \$100 million in preventive health and health services grants. Other cuts include proposed reductions of \$67 million in substance abuse and treatment programs. Also slated for elimination or dramatic cuts are programs dealing with poison control, emergency medical services for children, traumatic brain injury, newborn hearing screening, rural health, graduate medical education in children’s hospitals, and scholarships for disadvantaged students.

Many other programs of proven worth would get little or no increase in this budget. These include nurse training, health professions training, the Healthy Start program, telehealth, and others. Significantly, bioterrorism preparedness grants are flat funded, even though recent independent reviews of this Nation’s preparedness have shown there is much more to be done before we are ready to respond adequately to public health emergencies, whether they are caused by man or nature. The National Institutes of Health is flat funded, which means that due to inflation, fewer programs will be supported this year. With proposed increases in infectious disease research, many other institutes and centers will be asked to endure significant cuts.

The proposed budget for the Food and Drug Administration (FDA) contains some modest program increases, but concerns remain over the adequacy of that agency’s resources in view of its vast responsibilities to assure the safety of foods, drugs, dietary supplements, and medical devices. The budget also proposes to shift resources within FDA, notably reducing the number of full-time employees in the Office of Generic Drugs. In view of reports that consumer access to generic drugs is being delayed due to a slowdown in processing applications, any reduction in this function is worrisome.

Finally, the Administration’s budget continues a pattern of “evaluation” transfers of funds among agencies, which makes it difficult to analyze the true level of support for certain programs. For example, the entire budget of the Agency for Healthcare Research and Quality is funded by a transfer of funds from other agencies within the Department of Health and Human Services, including the NIH. The full extent of these transfers is not known at this time.

⁷¹ Blue Cross Blue Shield Association, “Blue Perspective,” *A regulatory vacuum that hurts consumers; doesn't address small employer concerns*, 2005.

Many organizations have provided comments and concerns about the public health budget. Excerpts from their comments follow:

National Association of Community Health Centers Response to the FY 2007 Budget Overview, February 6, 2006, Dan Hawkins, Vice President for Federal, State and Public Affairs
(<http://www.nachc.org/press/feb0606.asp>)

“The Health Resources and Services Administration Loan Guarantee Program has been a critical source of credit enhancement for health centers, especially ones that were damaged or destroyed after Hurricane Katrina. Unfortunately, the President’s budget proposes rescinding the balance of the program, which is a substantial setback for health centers that need to expand and improve their facilities to meet a growing medical need in America.”

“Even as the demand for fiscal restraint grows, we must not turn our back on affordable health. That is why programs such as the Ryan White CARE Act, the National Health Service Corps and other Health Professions Training programs are critical and deserve continuing support. To communities mired in medical neglect, these programs have a proven record, and bolster the efforts of health centers nationwide.”

“The President should be commended for his commitment to the health center program—since 2001 he has sought to expand the availability of affordable, effective primary and preventive care services in underserved areas of the nation. However, community health is just one function of our national public health. As Congress begins consideration of the President’s proposals, they should fully fund the programs necessary to ensure the public health of the nation is not harmed.”

American Public Health Association “Dismayed With President’s Proposed Budget, Calls on Congress to Choose Its Priorities Wisely,” February 6, 2006, George C. Benjamin, Executive Director
(<http://releases.usnewswire.com/GetRelease.asp?id=60598>)

“This administration has emphasized the importance of protecting our nation’s citizens but, ironically, has put the well-being of millions at risk with cuts to programs designed to improve health and save lives. While controlling federal spending is critical, it is also imperative that our nation’s government do whatever it can to protect the public’s health. Short-sighted and short-term savings will lead to greater health and medical expenditures in the long term.”

“It is fiscally and ethically irresponsible to weaken our nation’s efforts to protect men, women and children from chronic diseases and illnesses and other emergencies. We call on Congress to choose its priorities wisely and to protect the health of all Americans.”“APHA wants the budget to work to reduce or eliminate disparities in health outcomes and care, curtail medical errors and otherwise ensure that Americans have access to the best medical care available. The Administration’s plan cuts \$133 million from Rural Health programs, which curtails medical services to residents in rural communities that traditionally have more limited resources.”

“APHA is concerned with our nation’s growing work force shortages in health and public health practitioners, such as nurses, pharmacists and epidemiologists. The Administration’s plan purports to protect Americans yet cuts \$136 million from health professions training programs. These deductions come at a time when our public health infrastructure is struggling to provide more services with a smaller work force and diminished resources.”

“APHA supports policies that promote evidence-based preventive health services. The administration's budget fails to focus on the front-end needs b- such as preventing disease, injury and death -- of our nation's health care system. The administration's plan curtails funding for prevention programs, such as Universal Newborn Screening, the Urban Indian Health Program, the Community Services Block Grant and the Preventive Health Services Block Grants.”

American Nurses Association (ANA), “ANA Protests Narrow Focus of Bush's Health Care Proposals, Calls For Comprehensive Health Care Reform,” February 6, 2006, Barbara Blakeney, President, (<http://www.nursingworld.org/PRESSREL/2006/PR020106.htm>)

““While ANA agrees with the need to rein in skyrocketing health-care costs, these cuts should not shift the burden of payment onto the middle class, and they should not come at the expense of the poor, the chronically ill, the elderly and the uninsured,’ Blakeney noted. ‘Moreover, the proposals should not erode state laws that already require insurers to cover such preventive health care services as mammography screening, maternity care, mental health services and home health care.’”

American Diabetes Association, February 6, 2006, Robert A. Rizza, M.D., President, Medicine & Science, (<http://biz.yahoo.com/prnews/060206/dcm054.html?.v=30>)

“Under the Administration's budget proposal, funding for the National Institute of Diabetes & Digestive & Kidney Diseases (NIDDK) -- an NIH research division -- would be funded at \$11 million less than last year. Additionally, funding for chronic disease prevention at the CDC would be funded at \$819 million, a \$20 million reduction from last year. This would dramatically weaken the efforts of the CDC's Division of Diabetes Translation, which runs state-based Diabetes Prevention and Control Programs that help those suffering from diabetes better control and manage the disease and help those at risk prevent or delay its onset.”

“The American Diabetes Association strongly disapproves of the Administration's efforts to reduce funding for diabetes research and prevention at the National Institutes of Health and the Centers for Disease Control and Prevention. By any measure, diabetes is a disease that requires great federal attention, and yet the Administration's response is to weaken the federal resources needed to fight this national epidemic. Fortunately, the Administration's budget is just the start of the budget process. On behalf of the 20.8 million Americans with diabetes, we urge members of Congress to give researchers and health professionals -- who are fighting this disease in communities throughout the nation -- the vital tools and resources they need to combat diabetes, which can lead to serious long-term health complications such as heart disease, stroke, kidney disease, blindness and amputations.”

Association of American Medical Colleges, “AAMC Says Bush Budget Endangers Medical Research Progress,” February 6, 2006, Jordan J. Cohen, M.D., President, (<http://www.aamc.org/newsroom/pressrel/2006/060206.htm>)

“President Bush's proposal to freeze the budget for the National Institutes of Health (NIH) at last year's level is shortsighted in the extreme. At a time when scientific advances hold such promise for unprecedented improvements in the health and welfare of people, failing to seize the opportunity to invest more in medical research is deeply disappointing.”

“The AAMC is alarmed that the president's 2007 proposal continues to erode federal support for medical research. The recommendation to freeze the NIH budget marks the fourth year in a row that funding has fallen below the rate of inflation. In constant dollars, this means the NIH has lost nearly

\$2 billion in buying power since FY 2003. Unless there is more federal support, we cannot sustain the promise of medical discovery and preserve America's position as a global leader in research.”

“Disease and disability are unrelenting foes. As a nation, our commitment to improve health and save lives should be equally unrelenting. To achieve this goal, we must increase America's investment in research through the NIH. The nation's medical schools and teaching hospitals call on Congress to make this one of their top budget priorities.”

Association of American Universities, February 6, 2006, Nils Hasselmo, President
(<http://www.aau.edu/budget/07Statement.pdf>)

“There are important elements of the President’s budget that we believe are inconsistent with his emphasis on competitiveness. Continuing flat budgets at the National Institutes of Health (NIH) have already begun to undo the doubling of NIH funding that this Administration played a leadership role in completing.”

Federation of American Societies for Experimental Biology, “FASEB Says President Does Not Live up to Promises, Leaves America Vulnerable by Failure to Support Medical Research,” February 6, 2006, Bruce R. Bistrain, M.D., Ph.D., President,
(http://opa.faseb.org/pdf/Presidents_budget2.6.06.pdf)

“The budget released today does not reflect the promises made by President Bush to the millions of Americans suffering from debilitating diseases, and the countless others at risk for developing them in the future, whose only hope lies in medical research. The Federation of American Societies for Experimental Biology (FASEB) calls upon scientists, Congress, and the American people to express their disappointment and outrage over the funding level proposed for the National Institutes of Health (NIH) for FY 2007.”

“FASEB believes that flat or reduced funding of NIH will serve to slow the rate of research discovery, erode the gains made in the past decade, and discourage the best and brightest from scientific careers. We are leaving ourselves vulnerable to emerging threats like avian flu, and failing to prepare ourselves for the needs of our aging population. It’s as if we can see the tide rising, we’ve already bought the tools to build the floodgate, and are just letting ourselves be engulfed.”

Trust for America's Health (TFAH), “TFAH Decries Dramatic Cuts to CDC Core Programs; President's Budget Out of Touch with Americans' Health Anxieties According to New Poll,” February 6, 2006, Shelley A. Hearne, Ph.D., Executive Director,
(<http://releases.usnewswire.com/GetRelease.asp?id=60552>)

“The dramatic cuts proposed to programs aimed at preventing cancer, diabetes, heart disease, and birth defects will come at a serious cost to our country's health. It is an unfortunate choice given that chronic diseases are now the major source of illness and health cost in the U.S.”

“TFAH's budget review also determined the proposed funds for bioterrorism preparedness remain virtually level from FY 2006, yet represent a cut of over 10 percent compared to FY 2005. The President called for \$2.65 billion in FY 2007 to be allocated to support pandemic flu preparedness activities across the Department of Health and Human Services. These funds are essential to fill gaps in vaccine development and production capacity, stockpiling antiviral medication and other medical supplies, contingency planning, risk communications, surge capacity, and diagnostics and reagents.”

Statement of U.S. Conference of Mayors on President Bush's Proposed FY'07 Budget, February 7, 2006, President Long Beach Mayor Beverly O'Neill.
(http://www.usmayors.org/uscm/news/press_releases/documents/bushbudget_020706.pdf)

“We remain concerned that this budget also cuts funding for key first responder programs by 30 percent from just two years ago. It puts those on the front line in jeopardy by slashing the largest first responder grant programs by almost \$400 million, cutting the funding for fire assistance grants in half, and cutting COPS funding by more than half.”

National Women's Law Center, "President Bush's Budget Hurts Already Struggling Families One Week after the House Significantly Cuts Programs for Low- and Middle-income Americans, President Bush Proposes Even More Cuts," February 6, 2006, Nancy Duff Campbell, Co-President,
(<http://www.nwlc.org/details.cfm?id=2629§ion=newsroom>)

“President Bush's FY2007 budget proposal further erodes funding for programs that help women and families.”

“The President said that the '2007 budget will ensure that future generations of Americans have the opportunity to live in a Nation that is more prosperous and secure,' but in reality his budget undermines the services that help more Americans realize that dream.”

“The President's health care proposals are bad news for anyone who isn't in perfect health and can stay that way.”

“Once again, the President released a budget that calls on women, children and families to make real sacrifices but provides more tax breaks for powerful special interests and the wealthy. The proposals haven't worked for ordinary Americans for the last five years, and they certainly won't help them this year.”

“amfAR Says President's Budget Slight's AIDS Research, Calls For Funds For Studies Leading to Improved Treatment, Prevention,” February 6, 2006, Judy Auerbach, Vice President, Public Policy and Program Development, (<http://releases.usnewswire.com/GetRelease.asp?id=60520>)

“This budget has grave implications for scientific research to combat HIV and AIDS. Bluntly put, this level of funding means less scientific research will get done by fewer scientists, with fewer new minds entering the field.”

“Congress was wise in doubling the NIH budget between 1998 and 2003. During this time, the agency was able to support many new investigators while continuing to fund those multiyear studies to which it had committed in previous years. Since 2003 however, funding for the NIH -- including its AIDS research portfolio--has failed to keep up with the Biomedical Research and Development Price Index, damaging the success rate of approved grants that receive funding and leaving very little money to fund promising new research. Since 2003, the success rate has fallen from 25.3 percent to a projected 19.5 percent in 2006. The President's current budget request means fewer than one in five of the grants with the highest scores under peer review will be funded.”

“Given the complexity of HIV/AIDS and the devastation it continues to cause around the world, we cannot afford to discourage the new scientists with new ideas from working in this field.”

Children's Defense Fund Responds: "President's Budget Full of Woes for Children," February 8, 2006, (<http://releases.usnewswire.com/GetRelease.asp?id=60693>)

"If the nation's children were counting on the president to make sure they succeed so they can make sure America succeeds - the equation he trumpeted at last week's State of the Union address - President Bush's new budget has made a mockery of that hope. Once again, the president is hacking away at the safety net that keeps millions of poor and low income children healthy, safe and sound even as he claims to care for our young and calls upon them to secure the nation's prosperity."

Catholic Charities USA, "Catholic Charities USA Troubled by President's Budget Impact on Nation's Poor and Vulnerable," February 7, 2006, Rev. Larry Snyder, President, (<http://releases.usnewswire.com/GetRelease.asp?id=60614>)

"A troubling pattern of cutting programs that support our nation's most poor and vulnerable continues. Instead of proposing a budget that would protect funding for critical services that help millions of seniors, the disabled, families, and others struggling to achieve stability and self-sufficiency, the president has sent to Congress a plan that threatens an already fragile safety net."

"We appreciate the president's ongoing commitment to support the faith community by providing important funding opportunities to enhance our efforts to support low-income families. Unfortunately, these increases come at the same time that other programs that serve our nation's poor and vulnerable are being slashed."

American Heart Association, February 6, 2006, Robert Eckel, M.D., President, (<http://www.americanheart.org/presenter.jhtml?identifier=3037310>)

"On behalf of the more than 71 million Americans who suffer from some from heart disease, stroke, or other cardiovascular disease we are disappointed that the President's budget has placed funding for programs that help prevent, treat and cure these diseases on the back burner of his domestic agenda. Cardiovascular disease is the No. 1 killer of Americans and is projected to cost this nation \$403 billion in 2006 – an amount roughly equivalent to this year's projected budget deficit. As the population ages, the prevalence and costs of these conditions will escalate, producing a cardiovascular time bomb with staggering implications for health care costs and quality of care. With deaths from heart disease alone projected to increase by nearly 130 percent by 2050, it's a terrible mistake to make cardiovascular research, prevention and treatment a mere afterthought in the proposed budget."

"Funding for the National Institutes of Health is reduced below last year's levels, and spending on medical research has eroded in inflation-adjusted terms by nearly 10 percent since 2003. The Centers for Disease Control and Prevention's Heart Disease and Stroke Prevention program is reduced even though the program currently funds efforts to prevent disease in only 14 states. The Health Resources and Services Administration's Rural and Community Access to Emergency Devices (AED) Program has been terminated even though communities with aggressive AED placement plans have achieved survival rates from sudden cardiac arrest as high as 40 percent."

"If we hope to contain soaring healthcare costs, we must attack the problem at its core by funding programs that prevent and find cures for chronic diseases, not placing them on the chopping block. A sound investment in medical research and disease prevention will create a healthier future for all Americans and diffuse a looming cardiovascular disease crisis."

American Cancer Society, February 7, 2006, Daniel E. Smith, National Vice President, Federal and State Government Relations, (<http://www.cancer.org/docroot/homel/index.asp>)

“The American Cancer Society is deeply disappointed that the President proposed a cut in funding for the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC) in his budget for Fiscal Year 2007. At a time when we are reaping the return on our sustained investments in the fight against cancer with continuing decline in death rates, we should be accelerating our investments and progress, not retreating from our commitment. The President himself has said, ‘in order to win the war against cancer we must fund the war against cancer,’ and in proclaiming National Cancer Control month last April said, ‘aggressive funding will lead scientists to earlier diagnoses and improved treatments for lung, colorectal and other cancers.’ The budget he has proposed is far from adequate to fulfill the pledge for ‘aggressive funding.’”

“We understand the financial problems facing this country. However, turning our attention to a growing deficit does not require that we turn our backs on cancer patients, survivors and their families. Cancer costs this nation an estimated \$210 billion a year in direct medical costs, lost wages and lost productivity.”

“Despite advancements made from past investments and extraordinary opportunities that now exist to make exponential progress in this fight against American’s most feared disease, policymakers are inexplicably changing their tune as exemplified by the President’s budget proposal and Congress’ vote this past December to cut NIH funding for the first time in 35 years. The diminished funding to NIH and NCI comes just as we have begun to witness the return on these investments. From 1991-2002, the death rates for cancer declined nearly 10 percent, saving around 321,000 lives—a direct result of this nation’s investment in preventing, detecting and treating the disease.”

“The government’s commitment is also critical outside the laboratory. Since 1991, nearly 2.5 million uninsured and low-income women have received lifesaving breast and cervical cancer screening exams through the CDC’s National Breast and Cervical Cancer Early Detection Program, resulting in the diagnoses of nearly 23,000 breast cancer cases and more than 75,000 cases of pre-cancerous cervical lesions. Despite the success of this program, only 20 percent of eligible American women have access to it, and the budget announced yesterday provides no new dollars for the program.”

The Generic Pharmaceutical Association, “Administration’s Inadequate Funding for FDA’s Office of Generic Drugs Is ‘Penny-wise and Pound-foolish,’” February 6, 2006, Kathleen Jaeger, President and CEO, (<http://www.pharmalive.com/News/index.cfm?articleid=312640&categoryid=24#>)

“The Generic Pharmaceutical Association (GPhA) today expressed extreme disappointment over the Bush Administration FY 2007 budget’s inadequate funding for the Office of Generic Drugs (OGD), an agency within the Food and Drug Administration (FDA) that is responsible for the review and approval of affordable generic medicines. Generics save consumers and public and private health care purchasers billions of dollars each year, and OGD’s scarce funds could substantially delay consumers’ timely access to these affordable medicines.”

“The Administration’s budget proposal is penny-wise and pound-foolish. Generic medicines provide billions of dollars in savings to state and federal programs, employers, insurers and consumers. This budget proposal jeopardizes those savings.”

“Instead, the Administration should realize that the return on investment from increased OGD accountability and de minimus funding -- even in the amount of \$15 million -- would pay substantial and long-lasting dividends for all Americans. For example, additional OGD funding could yield tremendous financial benefits for several of the Administration's health care priorities, such as Medicare, Medicaid and programs to improve children's health care, assist the chronically ill, and fight AIDS. Delaying access to affordable generics, whether it's days, months or years, hurts the health of this nation.”

“We certainly agree with the Administration's budget reference about the need to eliminate unintended loopholes in bringing cost-effective generic drugs to the marketplace. However, it is deeply disappointing that this year's lack of investment in OGD undermines the very goal the Bush Administration rightly extols.”

National Association of Social Workers, “Budget Proposal Harmful to Nation's Disadvantaged: Social Workers Oppose Cuts and Reductions That Hurt Their Clients,” February 9, 2006, Ikeita Cantu Hinojosa, Associate Counsel for Legislative Affairs, (<http://www.ascr.org/cgi-bin/behold.pl?ascrleid=20060209.075958&time=08%2009%20PST&year=2006&public=1>)

“Just as the nation's most vulnerable populations will suffer from the FY 2006 budget bill that President George W. Bush signed Wednesday, such families and communities will face even greater obstacles to care and services if President Bush's FY 2007 budget is passed. With 37 million people in the United States living in poverty, the proposed budget severely reduces or cuts essential services to those who need them the most.”

“With the nation facing the aging of the largest generation of Americans, President Bush has proposed a \$28 million cut to the Administration on Aging budget, limiting their reach to older Americans.”

“For the fifth year in a row, President Bush has requested no funding for the Elementary and Secondary School Counseling Program. This grant program provides desperately needed counseling and mental health services for students.”

“NASW is speaking out on behalf of social workers and our clients to oppose proposals that cut funding to some of the most essential services available - education, protection for our children, and health care for our nation's poor, elderly and disabled.”

National League of Cities, February 6, 2006, James C. Hunt, President, (http://www.nlc.org/Newsroom/Nation_s_Cities_Weekly/Weekly_NCW/2006/02/13/8247.cfm)

“... we are disappointed that once again the Community Development Block Grant Program has been significantly reduced. Funding for this program, which is one of the most flexible and successful programs we use to bolster the economic vitality of our communities, has been cut by more than \$1 billion.”

*Friends of Cancer Research, February 7, 2006,
(<http://www.focr.org/news/newsletter/archive/2006/2006-2.htm>)*

“Overall, the \$2.77 trillion spending plan calls for increased spending on military and homeland security programs, while recommending cuts in many domestic discretionary programs in healthcare, education, and agriculture. The President’s proposal for the National Institutes of Health (NIH) calls for \$28.59 billion, the same funding level as FY 2006. With NIH projecting medical inflation to increase by 3.5 percent for FY 2007, the President’s budget proposal amounts to a real cut in biomedical research funding at NIH.”

“Within the President’s Budget proposal for NIH, NCI is slated to receive \$4.75 billion – a \$40 million cut over the Institute’s FY 2006 funding level. Every entity within NIH receives a cut or level funding from FY 2006 under the President’s plan except for the National Institute of Allergy and Infectious Diseases (which receives a \$12 million increase) and the NIH Director’s Office (which receives a \$140 million increase).”

*Ad Hoc Group for Medical Research, February 6, 2006, David Moore, Executive Director,
(<http://www.aamc.org/research/adhocgp/020805.pdf>)*

“Once you adjust the NIH budget for inflation, it won’t be long before we reach the point where the NIH five-year doubling might as well have never happened.”

*HIV Medicine Association, February 7, 2006, Daniel R. Kuritzkes, Chairman of the Board,
(http://www.idsociety.org/HIVMA_Template.cfm)*

“This is the first increase in HIV prevention in a number of years. While we strongly support the expansion of HIV testing, including rapid testing, we are concerned that even with the modest increases proposed for the Ryan White program (an important source of federal funding for HIV care), we will not have adequate capacity to provide medical care and treatment to those newly identified.”

“The \$70 million in additional funding for state drug assistance programs is sorely needed to get people with HIV/AIDS off waiting lists for life-saving drugs. However, in light of current waiting lists and program restrictions, it is unlikely that this funding level will be adequate to address the needs of individuals who might be newly identified through CDC testing initiatives.”

“We are very concerned about the president’s proposal to flat-fund NIH. Scientists need new resources to keep pace with potential breakthroughs in biomedical research, particularly AIDS research. While we support the president’s call for increased funding for research related to pandemic influenza, in a zero-sum budget environment this effectively translates into a \$15 million decrease in funding for AIDS research. We need to do better to maintain the quality of health and life enjoyed by most Americans living with HIV/AIDS and to respond to the needs of millions of persons in the developing world for more effective treatments and diagnostics.”

“At a time when biomedical research programs and STD prevention and treatment are being held at current levels, it is discouraging to see an increase in abstinence education. There is no scientific evidence that such programs are effective in delaying sexual activity or in decreasing sexually transmitted infections, including HIV/AIDS. We hope Congress will see fit to eliminate this program and transfer this funding to comprehensive sexuality education programs and STI prevention programs.”

AIDS Action, February 6, 2006, (<http://www.aidsaction.org/>)

“President Bush’s budget proposal for fiscal year 2007 calls for \$188 million in new funding for domestic HIV programs, but it falls short of what is needed to respond effectively to this country’s growing and changing epidemic. Since 2001, the domestic HIV funding portfolio has shrunk by 2.5% while the number of new AIDS cases has grown 7.6%. Given the growing number of people living with HIV in the United States, this loss of funding has been especially hard to absorb.”

*San Francisco AIDS Foundation, February 7, 2006, Mark Cloutier, Executive Director,
(http://www.sfaf.org/aboutsfaf/newsroom/bush_increases.html)*

“While the President’s targeted funding initiatives are welcomed, they are insufficient given the more than one million Americans living with HIV/AIDS today.”

*AIDS Project Los Angeles, February 7, 2006, Craig Thompson, Executive Director,
(http://www.apla.org/news/press_releases/2006/020606_bush_aids_budget_insufficient.html)*

“We’ve got people all around the country waiting in line for lifesaving HIV drugs and other services, and while we appreciate this call for new funding we will need much more, or we’ll just keep playing catch-up with a growing epidemic.”