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Health Policy on a Budget

By Joseph Antos

With an unusually ambitious second-term agenda focused on a few other key policy areas, the Bush administration has largely ducked pressing health policy issues in its proposed budget. Nevertheless, Congress should take action to move Medicare toward a sound, long-term financial footing; to eliminate abuses in Medicaid payments; and to change the tax treatment of health insurance.

If you believe the news stories, the biggest surprise in the president's 2006 budget is the Medicare prescription drug benefit—which Congress passed more than two years ago. The *Washington Post* headline proclaimed that the benefit might cost \$1.2 trillion over the next decade, a figure that raises eyebrows even in a town accustomed to speaking in terms of billions of dollars. The resulting torrent of outrage from politicians and pundits alike dominated the news for a week, until everyone finally realized that this was old news.

The media frenzy overshadowed the new challenges contained in the Bush health budget. The president sidestepped the debate over Medicare's long-term fiscal instability by emphasizing the importance of the Medicare drug benefit and the reintroduction of competing private plans. The immediate problems facing Medicare, including the intense pressure to roll back an automatic payment-cut facing physicians next year, are barely acknowledged. Instead, the budget focuses on cutbacks in Medicaid, which are wildly unpopular with state governors. It also touts tax breaks for the uninsured, even though there will be stiff competition for that money in a tight budget year.

Joseph Antos (jantos@aei.org) is the Wilson H. Taylor Scholar in Health Care and Retirement Policy at AEI.

The hot potato has landed squarely in the lap of Congress, and we can only hope that it does not drop it. The president's major objectives—to cut the deficit in half over the next four years, reduce taxes, and reform Social Security—require an extraordinary degree of political cooperation on Capitol Hill and willingness to make hard calls on where to reduce federal outlays. His budget lays out a fiscal path that is very steep, made more difficult by failing to consider more aggressive cuts in health programs. It is now Congress's turn to decide what it can accomplish, and how. It has an opportunity to begin to address structural defects in the Medicaid program that promote unnecessary spending, and it is unlikely to adjourn without addressing at least the pressing near-term problems with Medicare.

The \$1.2 Trillion Flap

A bombshell was buried in one of the technical appendices to the 2006 budget. The numbers seemed to indicate that the Medicare drug benefit was much larger than Congress thought when it passed the Medicare Modernization Act (MMA) in 2003. Instead of \$400 billion in federal outlays over ten years expected by the Congressional Budget Office (CBO), the cost had soared to \$724 billion or perhaps \$1.2 trillion.

Here was a program truly out of control, tripling in cost even before it had begun in earnest.

That conclusion is a simple misreading of the facts. The original cost estimate covered the ten-year budget window from 2004 through 2013. The full drug benefit available to all Medicare beneficiaries does not begin until January 2006, however. Until then, a temporary discount card and subsidy program targeted only to the neediest people has been in place.

The new estimate covers a later period, 2006 through 2015. The two relatively cheap years, 2004 and 2005, have been replaced by two years when the full benefit is in place, 2014 and 2015. It is not surprising that the bottom line is higher—\$724 billion over the next decade, accounting for both increased outlays and savings built into the program. The bandied-about figure of \$1.2 trillion ignores those savings and overstates how much the taxpayers will spend for the drug benefit over the decade.

Adding to the confusion is a long-standing disagreement between CBO and the administration's actuaries about the full cost of the drug benefit.¹ At the time MMA was enacted, the administration believed that the net federal cost of the drug benefit between 2004 and 2013 would come to \$511 billion, about 25 percent higher than the CBO estimate. Although neither group has significantly changed its estimates, they are now in close agreement about the cost of the benefit over the new budget window. Some arithmetic and a simple extrapolation suggest that CBO's estimate of the drug benefit's net impact is about \$735 billion between 2006 and 2015.²

Although gallons of ink have been spilled trying to divine new meaning in the numbers, we know no more about the cost of the Medicare drug benefit than we did three years ago. The program's rules have only recently been finalized, and we will not know until next fall what plans seniors will be able to choose from. The only certainty is that, whatever the cost of the program, taxpayers will be expected to cover it—and the payments will continue well past 2015.

Bad News Drives Bad Policy

The reaction from some quarters of Congress was immediate and completely predictable. Expressing shock at the cost of the drug benefit, Senator Edward Kennedy (D-Mass.), Representative Nancy Pelosi (D-Calif.), Representative Henry Waxman (D-Calif.), and others renewed their demand for a repeal of the

“noninterference” clause, allowing the government to directly negotiate prices with pharmaceutical manufacturers. From the crowd that would have been happy to spend a trillion dollars on the benefit, this is a call for government controls, not fiscal prudence.

If noninterference is dropped, the government will control prices, not negotiate them. Certainly, the government has considerable market power under a drug benefit with 40 million participants. But the government also sets the rules for the Medicare program and determines the business climate for the entire health sector. If the government is unhappy with its deal, it can send in federal auditors, the IRS, and the Justice Department. Such powers far exceed the scope of a mere commercial transaction.

If the government were to grant itself the power to set drug prices under the Medicare drug benefit, there is no guarantee that taxpayers would save money or that seniors would continue to have access to new and better medicines. The Centers for Medicare and Medicaid Services (CMS) would have to set the prices of tens of thousands of drugs in a variety of strengths, preparations, and packaging, distributed by a multitude of retail and mail-order outlets. Inevitably, some prices would be too high and some too low.

Drugs that have been on the market have a pricing history that could guide the government's regulators. Innovative new drugs, however, would pose a much more difficult problem. How would CMS evaluate the investment risks necessary to bring such a drug on the market or the potential improvement in health that such a drug could offer patients? These are inherently difficult questions that are best sorted out by markets, which adjust with remarkable speed to pricing that is either too high or too low.

Medicare already has a track record in setting pharmaceutical prices, and the results have been dismal. Some drugs administered by physicians on an outpatient basis are currently covered under Medicare Part B. Until recently CMS reimbursed physicians for those drugs 5 percent below the average wholesale price (AWP)—a price well above what the drugs actually sold for. In 2001, the Government Accountability Office (GAO) found that Medicare overpayments for most physician-administered drugs ranged from 8 to 29 percent of the AWP.³ Overpayment topped 80 percent of AWP for one such drug.

Such overpayments, once recognized, are an obvious target for budget cutters. In the case of Part B drugs,

Congress changed the payment method to better reflect market prices. Under the new drug benefit, we are more likely to see across-the-board reductions rather than finely tuned price adjustments. Cutting all drug prices indiscriminately might yield short-term savings for the government, but only at the cost of discouraging the development of future cures and treatments.⁴

In fact, prices will be vigorously negotiated under the Medicare drug benefit by private firms that have both the means and incentives to get the best deal. Pharmacy benefits managers (PBMs) and drug benefit sponsors will take the lead. Some of the firms that are likely to participate in the Medicare drug benefit already represent tens of millions more people than the entire Medicare population. Caremark, the largest PBM in the United States, negotiates drug prices on behalf of 100 million people. The three largest PBMs nationally already have more than 50 million covered lives each. Such companies have formidable market power that results in substantial savings for their customers. Adding Medicare beneficiaries to the mix should strengthen their ability to negotiate prices with manufacturers.

Medicare's Real Problem

We are still trying to get over the sticker shock of the Medicare drug benefit. The ten-year costs estimated by CBO and the Medicare actuaries are large by anyone's standards. However, those numbers do not take into account the much larger obligation that looms beyond 2015, perhaps more than \$16 trillion worth according to the Medicare trustees.⁵

That is only part of the story. Even without the drug benefit, Medicare would face a \$45 trillion obligation that would have to be paid over and above the revenues that are specifically earmarked for the program.⁶ Consequently, the political focus on setting drug prices misses a larger point: Medicare's fiscal crisis is a product of its own design, not solely the result of adding an expensive new benefit. Until we come to grips with the defects of a program that rewards providers for more services, not more results, we will see unnecessary costs mount inexorably.

Those stupendous cost estimates will not drive this year's congressional debate, just as they failed to drive the legislative process in 2003. Instead, one simple number is likely to turn the debate on its head: \$35.

That is the average monthly premium that seniors can expect to pay for their Medicare drug benefit, on top of their Part B premium.

Seniors do not like to see their premiums increase. Last fall's announcement that the Part B premium for 2005 would increase by \$11.20 a month, or about 17 percent, to \$78.20 was greeted with criticism but Congress allowed it to stand. Next fall's announcement will be more traumatic. The combined drug and Part B premiums will increase seniors' payments by another \$35 a month for the drug benefit plus at least \$5 for Part B—a jump of 50 percent or more. That is sure to bring a storm of protest and serious efforts to hold down the increases. The fact that a new benefit is being added will do little to ease the political pain of higher premiums, or the threat of precipitous action that could make matters worse.

More Medicare Budget Problems

Despite all the attention on the prescription drug benefit, some of the biggest fights in Congress will be waged over how much to pay providers in Medicare. The 2006 budget does not specifically recommend how much to increase payments for physicians, hospitals, and other providers. That might mean the president endorses the increases—and decreases—already hard-coded into the law. More likely, the president is hoping Congress will find its own way out of a very tight fiscal box.

The biggest problem of this sort is the 5 percent payment-cut scheduled to hit physicians next year. Unless the payment formula is modified, physician fees could be slashed 30 percent over the next few years. By any standard, that is untenable.

Congress previously delayed the formula-driven cuts, but the cost of permanently eliminating them is high and growing every year. Legislation to roll back the "sustainable growth rate" formula permanently would increase federal spending by \$140 billion over the next ten years.⁷ In this year's tight budget, the money simply is not there.

Some analysts believe that CMS could modify the formula to provide some partial relief without new legislative authority. If CMS acted without direction from Capitol Hill, CBO would not score a cost to that action. In the past, however, CMS has interpreted the formula strictly and would not make changes without a congressional mandate.

One other partial solution has been suggested thus far. CMS administrator Mark McClellan supports tying physician payments to their performance on objective quality measures. This pay-for-performance idea could promote more effective care, at least over the long term. CMS recently initiated a demonstration project with large physician group practices to test the idea, but we are far from having a proven workable model. Moreover, even when this approach becomes operational, any additional spending will count against Congress's budget.

Congress is unlikely to permanently solve the physician payment problem this year. Absent a big new idea that somehow does not cost much, Congress likely will delay the payment cut again despite the fact that this will dig its budget hole even deeper next year.

What about hospitals, nursing homes, and other Medicare providers? The administration is proposing a series of administrative reforms that would reduce provider payments somewhat. Congress is likely to give the providers an even shorter budget haircut. Hospitals, for example, might see a smaller increase than implicitly endorsed by the president as Congress looks for funds. The Medicare Payment Advisory Commission (MedPAC) recommended that hospital payments increase by less than the amount built into current law, giving some political cover for such a move.

More drastic Medicare payment reductions may be in the offing if Congress runs into serious funding problems. We are facing a much worse deficit than in 1997, when Congress cut nearly \$400 billion out of Medicare. Although that action helped turn the budget deficit into a surplus (temporarily), it also helped to drive private health plans out of Medicare and stymied efforts to promote competition that could have encouraged greater program efficiency. We could see a replay of draconian budget reductions for Medicare, possibly this year but more likely in 2006 or 2007.

The Rest of the Health Budget

The last time Medicaid sustained a substantial cut in federal outlays was 1997, when payments were reduced by \$48 billion over the ten-year budget window as part of a larger deficit reduction package. The impact on states was greatly reduced, however, since Congress created a new state-run health insurance program at the same time. The State Children's Health Insurance Pro-

gram (SCHIP) represented a \$46 billion expansion of federal outlays, largely offsetting the Medicaid cuts.

This year's budget is less benign to the states. The administration proposes to cut some \$60 billion out of Medicaid over the next ten years, offset by \$16.5 billion in additional federal spending on Medicaid and SCHIP. That will not sit well with the nation's governors. The governors have made it clear that they want the federal government to take more responsibility, rather than less, for the cost of that program. The National Governors Association (NGA) is on the record against any budget strategy that in their view shifts Medicaid costs to the states.⁸

The particulars of the Bush Medicaid package constitute a strategic political statement rather than a reform of the program. The package does not break with the basic structure of Medicaid, in which the federal and state governments share the cost of health services. It nibbles away at some long-standing problems, and it provides some additional flexibility to states wishing to innovate. In that context, these major provisions are sensible:

- New rules would limit the ability of states to reap windfalls using "creative" financing schemes in which the federal government reimburses states for inflated charges for health services.
- Overpayments to pharmacies would be reduced by using the average sales price of drugs as the basis of reimbursement. Pharmacy markups paid by Medicaid currently are based on the average wholesale price, which is often much higher than actual sales price. According to a recent CBO report, that triples the markup for some categories of drugs, even though the pharmacist's cost of filling a prescription is unrelated to the cost of the drug itself.⁹
- A flat percentage rebate would replace the "best price" provision that now determines the size of rebates that drug manufacturers must pay to states. "Best price" requires that drug manufacturers charge states no more than their best customers. That requirement limits the ability of even large private purchasers, including hospitals and health plans, to bargain with manufacturers since any price reduction would have to be granted to Medicaid as well.

- People would be required to spend more of their assets for their own long-term care needs before becoming eligible for Medicaid.
- Home- and community-based services would be more accessible to people who otherwise would have to move to a nursing home.

While the budget avoids the controversy over turning Medicaid into a block grant, suspicions linger. An NGA analysis, for example, has raised concerns that lower Medicaid spending levels projected by CBO over the next ten years might be enforced through a budget cap of some sort.¹⁰ At least on this point, NGA has little to fear. Congress is not eager to enact budget cuts if they can be avoided. When the baseline (CBO's projection of future federal spending) yields unexpected savings without the trouble of passing legislation, smart politicians accept those savings without question.

Even though the president's Medicaid agenda seems modest, Congress is likely to have trouble with it. Any cuts will meet with stiff resistance back home. Governors do not want to see federal Medicaid payments threatened. Local providers do not want to see their reimbursements reduced. The middle class does not want to see new restrictions on their ability to preserve their assets should they need long-term care. Greater state flexibility for managing Medicaid and wider access to home-based long-term care services would be popular, but they might increase both federal and state outlays.

Nonetheless, Congress can send a message back to the states that business as usual in Medicaid is unacceptable. Some states have exploited the inherent weakness of Medicaid's shared financing system for decades, resulting in hundreds of millions of dollars inappropriately siphoned away. Congress should take action to change the incentives that lead to these financial abuses, although that will not happen overnight. Ultimately, we must revamp the way Medicaid services are financed and revisit which level of government should be responsible for what costs. Experience proves that shared financial responsibility inevitably leads to bad behavior that eventually cannot be tolerated.

What about the uninsured, who put pressure on community health systems because they cannot pay for the care they receive? The budget includes tax credits to help people buy health insurance, tax breaks to promote the purchase of high-deductible insurance

and health savings accounts (HSAs), and money for community health centers. Combined with expansions in Medicaid and SCHIP, the administration proposes over \$140 billion in new insurance coverage initiatives through 2015. In addition, the president supports several insurance market reforms with little or no impact on federal spending. Those proposals include allowing people to buy insurance coverage offered in any state and permitting the creation of association health plans.

Prospects for passage of the administration's proposals for the uninsured seem dim without a strong push from the White House. Health insurance tax credits have been part of the Bush agenda for the past four years, but they have taken a political backseat to the Medicare drug benefit.¹¹ Budget pressures and opposition from congressional critics (who believe that individual purchase of health insurance could disrupt the employment-based system that covers most people) could keep tax credits on the back burner this year as well.

Walking the Health Budget Tightrope

Every year, Congress finds a way to balance competing policy and budgetary demands, albeit not to everyone's liking. Although the president's budget clearly has an influence, Congress rarely feels constrained by the details of it. This year will be no exception.

The 2006 budget, backed up by the president's recent veto threat, clearly expresses the administration's intention to implement the Medicare drug benefit without interruption. It reminds us that Medicaid continues to have problems, and offers modest proposals to address them. It reiterates the president's support for private insurance instead of expanding government insurance programs. This is not a year for major health policy changes, according to the budget.

Adding up the numbers, the president's budget allows about \$90 billion in new health spending over the next decade. That will not even cover the cost of a permanent resolution to the Medicare physician payment problem, much less address many other demands for federal health dollars. It is now Congress's turn to become creative.

Here is a suggestion. If Congress wants to find some new money and improve the way our health system functions as well, it should cast an eye toward the tax treatment of health insurance. The tax system generously subsidizes employer-sponsored health insurance,

amounting to some \$760 billion that will not be collected over the next five years in income taxes.¹² That is the largest tax preference by far, outstripping even mortgage interest deductibility. It is also the third largest federal program supporting the health sector.

More importantly, that subsidy has bred inefficiency into our health sector—a point made recently by my colleague Bob Helms.¹³ That means there will be more people without coverage and higher costs for those who do have it. In a year in which Congress is likely to focus on tax reform, the tax treatment of health insurance should be on the table.

Notes

1. On February 9, 2005, the Office of the Actuary in the Centers for Medicare and Medicaid Services issued an explanation comparing its original estimates with the new ones; see www.aei.org/MedCostResources. (Although widely circulated, this paper has not been posted yet on a government website. CBO also issued an explanation in a letter to Rep. Bill Thomas (R-Calif.), chairman of the House Ways and Means Committee, on the same day; see www.cbo.gov/showdoc.cfm?index=6076&sequence=0).

2. Based on the February 9, 2005 letter from CBO to Chairman Thomas. Savings to Medicaid and federal programs other than Medicare were extrapolated to 2015 using CBO's original estimates reported through 2013.

3. GAO, *Medicare Payments for Covered Outpatient Drugs Exceed Providers' Cost*, GAO-01-1118, September 2001, 4. Medicare received a discount of 5 percent off AWP; typical discounts to physicians ranged from 13 to 34 percent.

4. The risks of government price setting are discussed in greater detail by Joseph Antos and John E. Calfee in "Of Sausage-Making and Medicare," *AEI Health Policy Outlook*, January–February 2004 (available at www.aei.org/publications/filter.,pubID.19765/pub_detail.asp).

5. Boards of Trustees, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table II.C22, 108. Funds from general revenues must be shifted into the drug benefit amounting to \$16.6 trillion in present value, through the infinite horizon.

6. Boards of Trustees, *2004 Annual Report*, Table II.B11, 60 (unfunded obligations through the infinite horizon); and

Table II.C16, 99 (general revenue contributions through the infinite horizon).

7. CBO, *Budget Options*, February 2005, 202 (available at <http://www.cbo.gov/showdoc.cfm?index=6075&sequence=0>).

8. National Governors Association letter to Senator Frist, Senator Reid, Speaker Hastert, and Representative Pelosi, December 22, 2004 (available at http://www.nga.org/nga/legislativeUpdate/1,1169,C_LETTER^D_7695,00.html), and NGA Statement on Medicaid in the FY 2006 Budget, February 7, 2005 (available at http://www.nga.org/nga/newsRoom/1,1169,C_PRESS_RELEASE^D_7923,00.html).

9. CBO, *Medicaid's Reimbursement to Pharmacies for Prescription Drugs*, December 2004, Table 1, 2 (available at <http://www.cbo.gov/showdoc.cfm?index=6038&sequence=0>).

10. NGA, *The President's Proposed Fiscal Year Budget*, February 7, 2005, 2 (available at <http://www.nga.org/cda/files/FY06BUDGET.pdf>).

11. The Health Care Tax Credit (HCTC) was created in the 2002 Trade Act as a result of hard negotiations by the White House. The HCTC is restricted primarily to workers in trade-affected industries who lost their health insurance, and is consequently a very limited application of the tax credit approach to promoting private insurance. More information is available from the U.S. Treasury at www.irs.gov/individuals/article/0,,id=109960,00.html.

12. Office of Management and Budget, *Analytical Perspectives: Fiscal Year 2006 Budget of the U.S. Government*, Table 19-1, 318; and Table 19-3, 324 (available at www.whitehouse.gov/omb/budget/fy2006/). Those tables account for forgone revenue from federal income taxes only. A recent study estimates the full amount of forgone federal and state revenue resulting from tax preferences for health care, including the loss of payroll tax revenue, at \$210 billion in 2004; see John Sheils and Randall Haight, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs—Web Exclusive*, February 25, 2004 (available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1>). That estimate includes forgone revenues by exempting from federal income and Social Security taxes the following: contributions by employers to health benefits, health benefit deductions for the self-employed, health spending under flexible spending plans, and the tax deduction for health expenses.

13. Robert B. Helms, "Tax Reform and Health Insurance," *AEI Health Policy Outlook*, January–February 2005 (available at http://www.aei.org/publications/pubID.21921/pub_detail.asp).