



Health Care on the Hill — Democrats Set the Agenda

John K. Iglehart

Democratic legislators, energized by their new (if slim) majorities in the 110th Congress, now face the daunting challenge of enacting an ambitious policy agenda while fulfilling their

pledge to restore “pay-as-you-go” rules to new legislation. Since 2002, when the Republican-controlled Congress let these rules expire, GOP-approved measures have been fueling large annual budget deficits — the three largest in U.S. history in 2003 (\$378 billion), 2004 (\$413 billion), and 2005 (\$318 billion). Restoration of the rules, which House Speaker Nancy Pelosi (D-CA) said she planned to accomplish in the first 100 hours of the new session, will mean that any legislation that increases federal spending or reduces taxes must be offset by equivalent revenue.

This commitment, plus potential Republican efforts to block

measures through Senate filibusters and presidential vetoes, will limit Democrats’ ability to advance their agenda rapidly. Nevertheless, there is no question that a new day has arrived on Capitol Hill, as Democrats assume committee chairmanships that have been held by Republicans for most of the past 12 years, initiate an aggressive series of oversight hearings to examine the impact of GOP policies, and establish a longer workweek of Monday evening through Friday afternoon rather than Tuesday through Thursday.

Democrats aim to pursue a legislative agenda that reflects the interests of middle-class and working-class Americans. Although

health care issues are an important component, many other matters deemed more pressing will largely consume Congress in 2007. Nevertheless, Democratic leaders included two health issues in their “Six for ’06” agenda, which they planned to address quickly in the new Congress: empowering Medicare to negotiate prices of prescription drugs directly with manufacturers rather than through private health plans and expanding federal support for embryonic stem-cell research. Authorizing greater federal support for such research will remain difficult, since its advocates may be unable to muster enough votes to override another presidential veto. The other four Democratic priorities are increasing the minimum wage; overhauling U.S. policy in the war against terrorism, including a phased withdrawal from Iraq; making college tuition tax deduct-



Senators Enzi and Kennedy

ible; and eliminating tax policies that benefit large oil companies and encourage the shifting of jobs overseas.

The call for the direct negotiation of drug prices served Democrats well as a proposal appealing to elderly voters, but fashioning it into Medicare policy will be difficult, for various reasons. Several recent surveys (conducted by J.D. Power and Associates and the Henry J. Kaiser Family Foundation) have found the drug benefit to be very popular among seniors, although another recent Kaiser survey reported that 85% of beneficiaries favored direct government negotiations to establish drug prices.¹ The program cost about \$30 billion in 2006, as compared with a projected \$43 billion, which will reduce the willingness of some legislators to reopen the law. In addition, the administration strongly opposes direct negotiations, suggesting that President Bush may veto any such legislation. The idea, Health and Human Services Secretary Michael O. Leavitt said in November, “really isn’t about the government negotiating drug prices. It’s a surro-

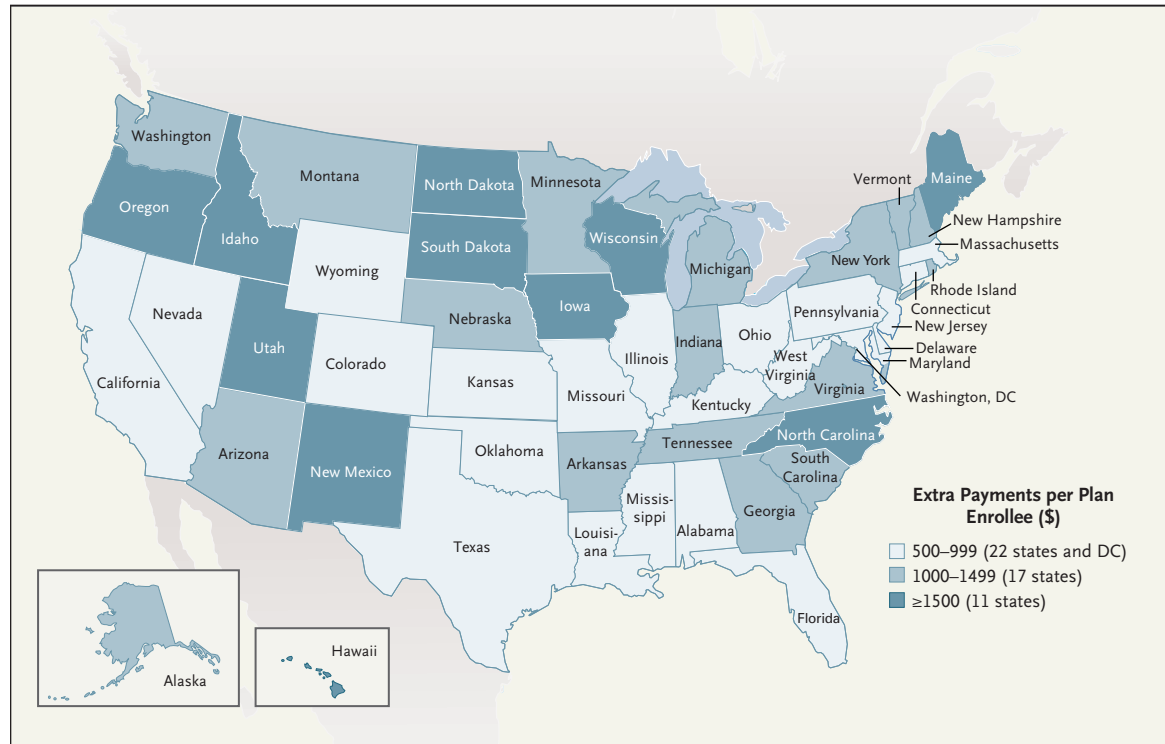
gate for a much larger issue, which is really government-run health care.”² The legislators who chair committees with jurisdiction over Medicare, particularly Senator Max Baucus (D-MT) and Representative Charles Rangel (D-NY), are also cool to the idea, largely because they have higher priorities over which they would prefer to do battle with the administration. In short, Democrats may have enough votes to remove the “no negotiation” clause from the law, but they have little leverage to compel the administration to deal directly with drug manufacturers on prices.

Another controversial policy that Democrats and some Republicans will seek to overturn provides larger payments to private plans that contract with Medicare — now called Medicare Advantage plans — than to providers who treat similar patients under Medicare’s traditional fee-for-service component. This policy, embedded in the legislation authorizing the drug benefit, is based on a Republican belief that an initial investment would stabilize participation in the plan and in-

crease enrollment, bolstering competition among private plans and slowing the growth of Medicare expenditures. A recent study published by the Commonwealth Fund, which confirmed earlier projections by the Congressional Budget Office and others, found that in 2005, payments to such plans exceeded average local fee-for-service costs by 12.4%, or \$922 per enrollee, for a national total of about \$5.2 billion.³ These payments vary greatly from state to state (see map), because the rates for Medicare Advantage plans factor in such variables as costliness of care and use of teaching hospitals.

In the waning hours of the last session, Congress reduced another form of support to health plans that was designed by Republicans to encourage enrollment of Medicare beneficiaries in regional preferred provider organizations. This “stabilization fund,” which authorized expenditures of up to \$10 billion over the period 2007 to 2013, was reduced to \$3.5 billion, and the savings were used to help finance the cost of repealing the scheduled cut of 5% in Medicare payments to physicians, which would have taken effect on January 1, 2007. Congress also made provision for a Medicare payment bonus of 1.5% for physicians who agreed to submit data to the program as part of its effort to improve the quality of care.

One of the perpetual calling cards of Democrats is extending health insurance to people who cannot afford coverage. In 2005, there were 46.6 million uninsured people in the United States, including 8.3 million children. With the enactment of universal coverage out of reach, many Democrats will focus on expanding insurance



Extra Medicare Payments per Enrollee in Medicare Advantage Plans, According to State (2005).

Data are from Biles et al.³

to as many children of low-income families as Republicans will allow. But the Blue Dog Democrats, a coalition of 44 members whose overriding priority is balancing the budget, may have enough votes to quash any major expansion of coverage unless savings can be found elsewhere. Pelosi has said repeatedly that she will take up her gavel “on behalf of America’s children.” The success of such an effort may turn on whether Congress decides to expand the State Children’s Health Insurance Program (SCHIP), which it authorized in 1997 with strong bipartisan support but which expires September 30, 2007. SCHIP offers states federal funds to expand coverage for children in families whose income puts them over the eligibility limits for Medicaid but who cannot afford private insurance. Every state took advantage of SCHIP in

some form, and the program now covers some 4 million children, while Medicaid covered an additional 22 million in 2005.

Congress in committee is Congress at work, so the priorities of legislators who chair the relevant panels will largely form the new health agenda. One tool that Republicans used sparingly was Congress’s authority to investigate the policies and performance of executive-branch agencies. Democrats will certainly increase oversight of executive agencies, including the Food and Drug Administration (FDA), which has lacked a permanent commissioner for most of George W. Bush’s presidency and has been embroiled in controversy over its delay of over-the-counter status for emergency contraceptives and its handling of drug-safety issues. In a last-minute surprise on December 7, the Senate

voted 80 to 11 to confirm Andrew C. von Eschenbach as FDA commissioner, after his nomination had been placed on hold for months by senators protesting various aspects of the agency’s performance. Von Eschenbach will be spending many hours in front of at least three congressional committees, chaired by Senator Edward M. Kennedy (D-MA) and Representatives John Dingell (D-MI) and Henry A. Waxman (D-CA), who plan to convene hearings on the FDA, addressing such matters as drug and food safety and the politicization of science. Kennedy, the new chair of the Senate Health, Education, Labor and Pensions Committee, and his predecessor, Senator Michael B. Enzi (R-WY), are cosponsors of a drug-safety bill that Waxman has characterized as “a good starting point” for deliberations in the new session.

After 12 years of Republican rule on Capitol Hill, one might expect Democrats to be itching to take political revenge on their rivals. But senior Democrats, including Kennedy, Dingell, and Rangel, who have long labored in Congresses that failed to make progress on major issues, have counseled junior colleagues to resist this temptation and seek bipartisan cooperation whenever possible. Even in the polarized environment of the last Congress, legislators who worked to bridge the party divide demonstrated that bipartisanship is the only real ticket to success. For years, Kennedy has been an exemplar in this regard, and these efforts have paid many dividends, including the Health Insurance Portability and Accountability Act negotiated with Representative Bill Archer (R-TX), the SCHIP law cosponsored with Senator Orrin Hatch (R-UT), and

now his cosponsorship of drug-safety legislation with Enzi.

When Congress adjourned on December 8, it left key tasks undone, forcing the issues onto the new session's agenda; these include 9 of the 11 appropriation bills for financing government activities, including those of the Department of Health and Human Services. Congress therefore adopted a continuing resolution that, until February 15, funds the agency's operations at 2006 levels, which are lower than what it anticipates receiving when the 2007 measure is enacted. Congress also left hanging bipartisan legislation approved by the Senate to accelerate the adoption of information technology by health care providers but, in the last few hours, reauthorized the National Institutes of Health. As the new Congress opens, partisan politics is certain to play a central role, but the de-

gree to which solutions to pressing problems can be found may depend less on how legislators from the two parties interact than on how Republicans relate to President Bush. Should enmity dominate those relations, progress on many fronts may be a long and painful time coming.

An interview with Representative Jim Cooper (D-TN) can be heard at www.nejm.org.

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3. Biles B, Nicholas LH, Cooper BS, Adrion E, Guterman S. The cost of privatization: extra payments to Medicare advantage plans — updated and revised. 2006: the Commonwealth Fund. (Accessed December 15, 2006, at <http://www.cmf.org>.)

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Medicare and Erythropoietin

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Since Medicare coverage of care for end-stage renal disease (ESRD) was implemented in 1973, dialysis treatments paid for by the federal government have extended the lives of hundreds of thousands of people. For nearly two decades, one of the most important services has been the administration of recombinant human erythropoietin, or epoetin, the mainstay of the treatment of anemia associated with chronic renal failure. In 2005, the ESRD program covered about 390,000 beneficiaries and spent \$7.9 billion for dialysis services, including \$2.9 billion for medications that are reimbursed separately. Epoetin alfa accounted for \$2 billion of this spending and was the

highest-expenditure drug in all of Medicare Part B.¹

Dialysis facilities can make more money from administering epoetin than from dialysis and related routine services, which Medicare has reimbursed at a composite rate since 1983.^{1,2} Monthly spending per patient for epoetin has soared to about half that for dialysis, which has remained relatively flat (see graph).³ Expenditures for injectable iron and vitamin D are increasing rapidly as well. In 2007, Congress may consider whether to eliminate financial incentives that may lead to the overuse of epoetin and other separately billable drugs by establishing a combined payment system for all ESRD services, as

was recently recommended by the Government Accountability Office (GAO)¹ and discussed at a December 2006 hearing of the House Committee on Ways and Means. In a November 2006 letter to the Centers for Medicare and Medicaid Services (CMS), Representative Bill Thomas (R-CA), then the committee chairman, and Representative Pete Stark (D-CA), then the ranking member of the subcommittee on health, wrote, "We are deeply concerned that the current CMS policy is not aggressive enough to stem the systemic abuse of [epoetin alfa], resulting in costs to taxpayers and potential health dangers to patients." At the hearing, Thomas told CMS officials, "You seriously need to