



RSC Policy Brief: Health Care Proposals in FY09 Budget

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The RSC has prepared the following policy brief analyzing health care spending proposals in President Bush's Fiscal Year 2009 Budget.

Summary: In submitting his Fiscal Year 2009 Budget request to Congress, President Bush proposed a number of health-related changes that would achieve budgetary savings to both mandatory and discretionary spending. As part of this package, the Administration has proposed a package that would reduce the growth of Medicare spending from 7.2% to 5.0% to meet requirements under the Medicare Modernization Act.

Mandatory Spending—Medicaid/SCHIP:

The budget proposal includes \$1.8 billion in Medicaid savings in Fiscal Year 2009 and \$17.4 billion over the next five years. Budgetary savings would be achieved by realigning reimbursement rates for family planning services at the statutory Federal Medical Assistance Percentage (FMAP) rate (\$3.3 billion in savings over five years), and by aligning reimbursement rates for all administrative services and case management at 50% (total \$6.6 billion in savings over the five-year window). Additional savings over the next five years would be achieved through adjustments to pharmacy reimbursements (\$1.1 billion), asset verification (\$1.2 billion), and cost allocation (\$1.77 billion).

The budget proposes an additional \$2.2 billion in SCHIP spending for Fiscal Year 2009, and \$19.7 billion over the five year period. The budget includes outreach grants of \$50 million in 2009, and \$100 million annually in subsequent years, for state and local governments as well as community-based organizations to engage in activities designed to increase enrollment of eligible children. Lastly, the budget proposes to simplify SCHIP eligibility by clarifying the definition of income, eliminating the "income disregard" system that has been a source of concern among many conservatives.

Mandatory Spending—Medicare:

The budget includes several proposals to reduce the overall growth in Medicare spending. Overall, Medicare funding would fall \$178 billion below the baseline over the next five years. These proposals would not constitute overall “cuts” to the Medicare program, but would instead reduce its growth from 7.2% to 5.0%. Highlights of the budget submission include the following:

Provider Adjustments: The Administration proposal would freeze payment rates for hospitals, skilled nursing facilities, long-term care and outpatient hospitals, ambulatory surgical centers, inpatient rehabilitation facilities, and home health providers through Fiscal Year 2011, and provide a –0.65% annual market basket update thereafter, saving \$112.93 billion over five years. The savings derived from flat-level payments would not mean that providers would not continue to receive increased reimbursements from the federal government, as the level, number, and intensity of services provided would still continue to grow.

Disproportionate Share Hospital (DSH) Payments: Medicare DSH payments, which compensate hospitals that serve large numbers of low-income individuals, would be reduced by 30% over two years, saving \$20.7 billion over five years. This modest reduction in payments to hospitals would recognize the significantly enhanced benefits provided to seniors, particularly those with low incomes, as part of the Medicare Modernization Act.

Medical Education: The budget would eliminate duplicate Indirect Medical Education (IME) payments made to hospitals on behalf of Medicare Advantage beneficiaries, and would reduce the IME add-on by 60% over the next three years, saving a total of \$21.75 billion over five years.

Means Testing: The budget proposes to end annual indexing of income-related Part B premiums and establish an income-related Part D premium consistent with the Part B “means testing” included in Title VIII of the Medicare Modernization Act. The proposals would achieve total savings of \$5.75 billion over five years. The RSC has previously included similar proposals in its budget documents as one way to constrain costs and ensure consistency between a Part B benefit that is currently means-tested and a Part D benefit that is not.

Other Savings: Additional savings over the five year budget window would come from a reduction in the rental period for oxygen equipment (\$3 billion), extending Medicare Secondary Payor for the End-Stage Renal Disease (ESRD) program from 30 to 60 months (\$1.1 billion), eliminating bad debt payments over four years (\$8.5 billion), and other regulatory and administrative actions (\$4.7 billion).

Medicare Funding Trigger

Concurrent with the budget submission, the Medicare Modernization Act (MMA) requires the President to submit to Congress within 15 days a proposal to remedy the Medicare “excess general revenue Medicare funding” warning announced by the Medicare trustees last spring. In addition to the savings package described above, the opportunity afforded by the trigger could be used to advance more comprehensive proposals, which could include:

Premium Support: This model would convert Medicare into a system similar to the Federal Employees Benefit Health Plan (FEHBP), in which beneficiaries would receive a defined contribution from Medicare to purchase a health plan of their choosing. Previously incorporated into alternative RSC budget proposals, a premium support plan would provide a level playing field between traditional Medicare and private insurance plans, providing comprehensive reform, while confining the growth of Medicare spending to the annual statutory raise in the defined contribution limit, thus ensuring long-term fiscal stability.

Restructure Cost-Sharing Requirements: This concept would restructure the existing system of deductibles, co-payments, and shared costs, which currently can vary based on the type of service provided. Additionally, Medicare currently lacks a catastrophic cap on beneficiary cost-sharing, leading some seniors to purchase Medigap policies that insulate beneficiaries from deductibles and co-payments and therefore provide little incentive to contain health spending. Reforms in this area would rationalize the current system, generating budgetary savings and reducing the growth of health spending.

Increase Medicare Part B Premium: The RSC has previously proposed increasing the Part B premium from 25% to 50% of total Medicare Part B costs, consistent with the original goal of the program. This concept would not impact low-income seniors, as Medicaid pays Medicare premiums for individuals with incomes under 120% of the federal poverty level.

Medical Liability Reform: This proposal would help bring down health spending both within and outside Medicare by helping to eliminate frivolous lawsuits and providing reasonable levels of compensation to victims of medical malpractice. In 2003, the Congressional Budget Office scored a liability reform bill (H.R. 5) as lowering Medicare spending by \$11.2 billion over a ten-year period.

Bipartisan Commission: This proposal would provide an expedited mechanism requiring Congress to hold an up-or-down vote on the recommendations of a bipartisan commission examining ways to reform Medicare and other federal entitlements.

Value-based Purchasing: This concept, also known as “pay-for-performance,” would seek to adjust physician and provider reimbursement levels to reflect successful patient outcomes on a risk-adjusted basis. While advocates believe pay-for-performance can yet achieve the significant budgetary savings not present in existing Congressional Budget Office models, some conservatives may be concerned that this methodology would deepen the government’s role in health care by altering the fundamental doctor-patient relationship.

Sequestration Mechanism: This proposal would cap the growth of overall Medicare spending levels, and provide adjustments in benefit structures in the event that spending exceeded statutory levels. The budget submission to Congress did include the proposal that physician payments be reduced 0.4% for every year in which general tax revenues cover more than 45% of Medicare costs—the level at which the Medicare Modernization Act required that a funding warning be issued, and action taken by Congress. The Administration proposal is designed to provide Congress with an impetus to embrace comprehensive entitlement reform by requiring across-the-board cuts absent pre-emptive legislative action.

Discretionary Proposals: Overall, the President’s proposed discretionary budget for the Department of Health and Human Services (HHS) is \$68.5 billion, \$1.7 billion less than last year. Preliminary highlights of funding levels on health programs include the following:

Centers for Disease Control (CDC): The proposal reduces overall spending by \$412 million from current year levels. Significant reductions within the CDC account include a proposed \$111 million reduction for the Occupational Safety and Health Administration (OSHA), and an \$83 million reduction in the World Trade Center screening and treatment program.

Earmarks: The budget proposes \$451 million in savings by eliminating earmarked projects from the HHS budget.

Food and Drug Administration (FDA): The budget provides a \$130 million increase for FDA over Fiscal Year 2008 levels. More than half (\$68 million) of the proposed increase comes from additional resources for drug and biologic safety programs, with an additional \$33 million increase in the food safety budget.

Health Resources and Services Administration (HRSA): A total of nearly \$1 billion in reductions in the HRSA account comes from several proposed sources—grants to train nurses and health professionals (reduced by \$240 million); training doctors at children’s hospitals (eliminated, saving \$302 million); rural health programs (reduced by \$150 million); and public health buildings and projects (eliminated, saving \$304 million). Reductions in the rural health and health training accounts have previously been proposed in previous RSC budget documents. Since that time, reconciliation legislation passed last September (P.L. 110-84) provided student loan forgiveness to public health workers, raising additional questions about the duplicative nature of the HRSA-funded grant programs.

National Institutes of Health (NIH): The National Institutes of Health would receive flat-level funding from Fiscal Year 2008, \$29.5 billion in total, after years of substantial increases. Funding for most institutes within NIH would likewise remain at constant levels for the upcoming Fiscal Year.

Conclusion: The Administration's Fiscal Year 2009 budget includes several reasonable proposals to slow the growth of health spending and thereby help return federal entitlements to a more sustainable trajectory. Such measures are needed urgently, as Medicare faces \$34.1 trillion in unfunded liabilities over the next 75 years, according to the Government Accountability Office. The need for immediate action is great: the first Baby Boomer becomes eligible for Medicare in 2011, and every year that Congress does not address unfunded entitlement obligations, their size grows an additional \$2 trillion, according to Comptroller General David Walker. Some conservatives may believe that these measures proposed by the Administration to constrain reimbursements to providers, while helpful, can constitute the starting point for a comprehensive discussion about entitlement reform.

For further information on this issue see:

- [*RSC Policy Brief: Medicare Funding Warning*](#)

RSC Staff Contact: Chris Jacobs, christopher.jacobs@mail.house.gov, (202) 226-8585

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