FACT SHEET
HEALTH PROPOSALS IN PRESIDENT BUSH'S FY 2008 BUDGET

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President Bush's FY 2008 Budget Cuts Health Funding Without Needed Reform

Overview

A year ago, the President signed into law the *Deficit Reduction Act* (DRA), P.L. 109-171, which reduced Medicare and Medicaid spending by $50.7 billion over ten years. The President's Fiscal Year 2008 budget includes a second round of mandatory health reductions with Medicare and Medicaid cuts of $280.4 billion over ten years – more than five times the size of the original DRA cuts. The savings from this new round of legislative and regulatory spending cuts in Medicare and Medicaid would be more than wiped out by the $2.0 trillion cost of the President's tax cuts over the next ten years.

In addition, the President's health budget proposes deep cuts in important discretionary spending programs, including preventive health care, health research, rural health programs, substance abuse and mental health treatment, and energy assistance.

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

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

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

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

- Shifts costs to health care consumers, by eroding employer-sponsored health care coverage, forcing more consumers into the individual market (including older and disabled workers with chronic conditions) where insurance is far more expensive, further fragmenting risk pools, and providing little help to low-income workers to gain affordable health care coverage.

Medicare

President's Budget Includes $252 billion in Legislative Medicare Cuts Over Ten Years
The President's budget cuts Medicare spending by $66.0 billion over five years and $252.4 billion over ten years. These proposals would achieve savings primarily through cuts in payments to fee-for-service (FFS) providers, like hospitals and skilled nursing facilities. Yet, the President's budget includes no proposals to eliminate Medicare overpayments to private managed care plans in the Medicare Advantage program (MA). Separately, the President's budget also provides for additional arbitrary across-the-board provider payment cuts if general-revenue financing exceeds 45 percent of Medicare costs in the future. It also fails to address steep projected cuts in physician reimbursement that threaten to force doctors out of the Medicare program.

Most of these proposals will do little to address the underlying causes of health care cost growth in the overall health care system. Budget experts have urged Congress to focus legislative efforts on approaches that will tackle unsustainable cost growth in the health sector as a whole. For example, GAO Comptroller General David Walker pointed out in a House Budget Committee hearing that "federal health spending trends should not be viewed in isolation from the health care system as a whole . . . Rather, in order to address the long-term fiscal challenge, it will be necessary to find approaches that deal with health care cost growth in the overall health care system". In recent testimony before the Senate Budget Committee, CBO Director Peter Orszag stated, "[I]t's a mistake to look at containing costs just within the federal programs themselves, Medicare and Medicaid. The underlying driver of that cost growth . . . is the underlying rate of cost growth in the health sector as a whole. Tackling that problem is perhaps the fundamental fiscal challenge and an important economic challenge facing the nation." Ignoring this challenge, the President's budget offers a series of Medicare proposals narrowly focused on shifting costs to other entities.

Shifting costs to providers – Most of the savings in the President's Medicare proposals are achieved by cutting, freezing, or slowing the growth in payments to fee-for-service providers, like doctors, home health agencies, hospitals, and nursing homes. The administration asserts that its proposals simply "slow" Medicare spending growth. In addition, the administration asserts that these proposals will not affect the quality of Medicare beneficiaries' health care. However, without reforms in the overall health care sector, cuts of this magnitude will eventually cause more and more providers to stop providing services to Medicare beneficiaries or to deliver a lower quality of service. The greatest impact of these cuts may be felt in rural areas and other underserved or underpriveleged areas, where Medicare payments do not currently cover providers' costs and where Medicare accounts for a disproportionately large share of revenue.

Shifting costs to beneficiaries – In addition to cutting fee-for-service provider payments, the President's budget also proposes to push a greater share of Medicare Part B and Part D costs onto upper-middle income beneficiaries. Under current law, starting this year, beneficiaries with incomes over $80,000 ($160,000/couple) will be subject to higher Part B premiums. The income thresholds for income-related Part B premiums are indexed to annual increases in inflation. The President's budget proposes to eliminate annual inflation indexing for these income thresholds, starting in 2008. As a result, over time, more and more seniors will be subject to higher, income-related Part B premiums. By 2017, 1.7 million more seniors will be subject to higher premiums, compared to current law. The administration estimates this provision would save $26.8 billion over ten years – $14.7 billion from higher Part B premiums and $12.1 billion from lower Part B spending due to beneficiaries who drop out or decide not to enroll.

Separately, the President's budget proposes to establish income-related premiums under Part D, saving $11.0 billion over ten years. As under Part B, beneficiaries with incomes greater than

$80,000 ($160,000 per couple) would pay a larger share of Part D premium costs, on a graduated basis. The income thresholds for the Part D income-related premium proposal would not be indexed for inflation. This means that, over time, more and more middle class beneficiaries would be subjected to these increased premiums. By 2017, the administration estimates that 2.6 million beneficiaries would pay higher premiums as a result of this provision.

Table 1 – Proposed Medicare Cuts in President's FY08 Budget ($ in billions)

Cuts to Providers	**2008-12**	**2008-17**
Permanently reduce annual market basket update by 0.65% for hospitals, hospices, and the ambulance fee schedule in 2008 and beyond	-18.7	-91.1
Freeze payments to Skilled Nursing Facilities (SNFs) and Inpatient Rehabilitation Facilities (IRFs) in 2008 and permanently reduce annual market basket update by 0.65% in 2009 and beyond	-11.1	-36.4
Freeze payments to home health agencies every year through 2012, then provide a market basket update, minus 0.65%, in 2013 and beyond	-9.7	-35.9
Eliminate Bad Debt Payments (Medicare currently covers a portion of payments owed by Medicare beneficiaries to providers, but not paid)	-7.2	-26.5
Eliminate IME payments to hospitals for MA enrollees	-4.4	-18.2
Adjust payments in five post-acute conditions treated in SNFs and IRFs so that payments are more equitable	-2.9	-7.1
Expand competitive bidding to include lab services	-2.4	-6.7
Limit Oxygen Rental to 13 Months for older oxygen technologies and eliminate title transfer (note: the DRA capped the oxygen rental period at 36 months)	-2.4	-6.0
Extend the Medicare Secondary-Payer Program to End-State Renal Disease (ESRD) payments from 30 to 60 months and establish a federal MSP data-sharing clearinghouse to ensure Medicare does not make inappropriate payments	-1.7	-4.1
Capped rental for Power Wheelchairs	-0.5	-1.4
Permanently reduce annual CPI update by 0.65% for ambulatory surgical centers (ASCs) in 2011 and beyond	-0.1	-0.8
Eliminate payments for "never" events	-0.2	-0.4
Limit mandamus jurisdiction	-0.1	-0.2
New Costs for Beneficiaries	**2008-12**	**2008-17**
Part B Indexing Proposal	-7.1	-26.8
Part D Indexing Proposal	-3.2	-11.0
Interactions with Part B Premiums	5.6	19.8
TOTAL, Net Medicare Legislative Cuts	*-66.0*	*-252.4*

Ignoring automatic cuts to physician payments in 2008 – The *Tax Relief and Health Care Act of 2006* froze physician payments at 2006 levels, preventing an automatic cut of five percent that was scheduled to go into effect in 2007. In addition, physicians who meet certain reporting requirements will get a 1.5 percent bonus payment for the last six months of the year. Without further action, an automatic across-the-board cut of ten percent in physician payments will go into effect in 2008. The President's budget does not propose to prevent this cut and provides no budgetary resources to address this significant payment cut to doctors. If no adjustment is made, over time, more and more doctors will refuse to provide services to Medicare patients, reducing seniors' access to care.

President's Budget Includes $27 billion in Regulatory Medicare Cuts Over Ten Years

In addition to the $252 billion in proposed legislative Medicare cuts, the President's budget includes regulatory proposals that would cut net Medicare spending by $10.2 billion over five years and $27.3 billion over ten years. The President's new regulatory proposals include:

- Various upcoding adjustments in home health and inpatient psychiatric facilities *(net ten-year savings: $11.8 billion)*
- Program Integrity efforts *(net ten-year savings: $7.0 billion)*
- Reduction in Capital add-ons *(net ten-year savings: $6.6 billion)*
- Extend 25% rule to freestanding LTCHs *(net ten-year savings: $1.1 billion)*
- Targeted medical review for hospices *(net ten-year savings: $0.7 billion)*

President's Budget Calls for Arbitrary Across-the-Board Cuts in Future Medicare Payments

The Medicare Modernization Act (MMA) requires Medicare's trustees to measure the portion of Medicare funding that comes from general revenues. If the trustees report that general revenue financing is projected to exceed 45 percent within seven years in two consecutive annual reports, the President must submit legislation to Congress to address the shortfall. Congress is required to consider the proposal on an expedited basis. The President's budget includes a budget reform proposal that would automatically trigger across-the-board cuts of 0.4 percent to all Medicare provider payments, if the 45 percent threshold is breached. The cuts would grow by 0.4 percent every year the shortfall continued to occur. According to the administration, these automatic cuts would not be triggered in the ten-year budget window, assuming the other Medicare cuts in the President's budget are adopted.

Medicaid

The administration proposes legislative and regulatory cuts to Medicaid of $24.7 billion over five years and $60.5 billion over ten years. These savings generally result from shifting costs to beneficiaries and the states or cutting payments to providers. The administration's budget also calls for new Medicaid spending of $1.1 billion over five years and ten years. As a result, the net impact of the administration's proposals on Medicaid will cut Medicaid spending by $23.6 billion over five years and $59.4 billion over ten years.

Legislative Medicaid Cuts – The administration proposes policy changes resulting in $10.9 billion in net Medicaid cuts over five years and $28 billion over ten years. This net total includes gross Medicaid cuts of $12 billion over five years and $29.1 billion over ten years and new Medicaid spending of $1.1 billion over five years and ten years. The President's proposals include:

- Reducing Administrative Match Rates *(ten-year savings: $12.3 billion).* The budget proposes to reduce administrative reimbursement rates in Medicaid to 50 percent.
- Cutting Medicaid Payments for Administrative Costs *(ten-year savings: $3.7 billion)*. The

budget proposes cutting federal reimbursement for Medicaid administrative costs to reflect the shared costs of Medicaid and the TANF program.

- Reducing Targeted Case Management (TCM) Match *(ten-year savings: $2.9 billion)*. The budget proposes changing the TCM reimbursement level from the FMAP, which currently varies by state from 50 percent to 83 percent, to a flat rate of 50 percent for all states. It reduces the federal reimbursement for TCM services for the 38 states that have FMAPs higher than 50 percent.
- Restructuring Pharmacy Reimbursement *(ten-year savings: $3 billion)*. The budget proposes limiting Medicaid payments for multi-source drugs to 150 percent of the average manufacturer's price.
- Optional Managed Formulary for Prescription Drugs *(ten-year savings: $2.1 billion)*. The budget proposes permitting states to close their Medicaid formularies and allowing states to negotiate with drug manufacturers for better discounts. Allowing states to restrict their Medicaid formularies would be a major departure from current law, which requires states to provide exceptions to the formulary where medically necessary and could result in Medicaid beneficiaries losing all access to drugs they need.
- Delaying Payment of Prenatal and Pediatric Care *(ten-year savings: $300 million)*. The budget proposes allowing states to avoid payments of 1) prenatal and pediatric care if there is a potentially liable third party (e.g., private insurer), and 2) medical care for a child where a non-custodial parent may be liable for payment for at least 90 days. Under current law, states must pay the provider first, then seek reimbursement from the liable party.
- Link Medicaid Reimbursement to State Reporting *(ten-year savings: $1.4 billion)*. The budget proposes to require states to report on Medicaid performance measures and link performance to Federal Medicaid grants.
- Require Tamper-Resistant Prescription Pads *(ten-year savings: $510 million)*.The budget proposes to require all states where providers use hand-written prescription pads to use tamper-resistant pads. According to HHS, 13 states have utilized tamper-resistant pads resulting in savings and decreases in drug diversion.
- Expand Asset Verification Demonstration *(ten-year savings: $1.8 billion)*. The budget proposes to expand a Social Security Administration (SSA) pilot using electronic financial records for verifying an applicant's assets to appropriate HHS programs. State Medicaid agencies would be required to establish pilots in locations where SSA is operating such a pilot. Currently New York and New Jersey have SSA pilots.
- Cap Excluded Home Equity at $500,000 *(ten-year savings: $1.1 billion)*. The budget proposes to limit to $500,000 the amount of equity an individual may have in a home in order to still qualify for medical assistance payments for Medicaid nursing facility services or other long-term care. This reverses a provision in the DRA which allowed States the option to substitute an amount exceeding $500,000 but not in excess of $750,000.

Regulatory Changes – In addition, the President's budget baseline assumes Medicaid cuts of $12.7 billion over five years, and $31.4 billion over ten years, from proposed regulatory changes. The President's regulatory Medicaid cut proposals include:

- Capping Government Providers *(ten-year savings: $11.9 billion)*. The budget proposes cutting payments to providers by prohibiting states from paying government-owned providers more than "cost."
- Limiting Reimbursement of Rehabilitation Services *(ten-year savings: $6.2 billion)*. The budget proposes limiting what services may be claimed as Medicaid rehabilitation services. These are Medicaid services typically offered to individuals with special needs or disabilities to help improve their health and quality of life.
- Eliminate Medicaid GME Payments *(ten-year savings: $4.3 billion)*. The budget proposes

to prohibit the use of Medicaid funds to pay for Graduate Medical Education (GME). Under current law, Medicare provides funds in support of GME nationwide. Some states also use Medicaid to pay for these physician training programs.

- Eliminate Reimbursement of School-Based Administration *(ten-year savings: $9 billion)*. The budget prohibits federal Medicaid reimbursement for IDEA-related school-based administration and transportation costs related to Medicaid services provided in schools.

Program Extensions – The budget proposes $1.1 billion over ten years for the extension of Transitional Medical Assistance (through Sept. 2008), premium assistance for certain Medicare beneficiaries (through Sept. 2008), and the extension of Supplemental Security Income (SSI) and SSI-related Medicaid eligibility for refugees and asylees from seven to eight years.

Table 2 – Proposed Medicaid Cuts in President's FY08 Budget ($ in billions)

Proposal	**FY2008 - 2012**	**FY2008-2017**
Legislative Cuts:		
Reduce Administrative Match Rates	-5.3	-12.3
Cut Payments for Administrative Costs (TANF)	-1.8	-3.7
Reduce Targeted Case Management	-1.2	-2.9
Restructure Pharmacy Reimbursement	-1.2	-3.0
Optional Managed Formulary	-0.9	-2.1
Delay Payment of Prenatal and Pediatric Care	-0.1	-0.3
Medicaid State Reporting	-0.3	-1.4
Tamper Resistant Prescription Pads	-0.2	-0.5
Asset Verification Demonstration	-0.6	-1.8
Cap Excluded Home Equity at $500,000	-0.4	-1.1
Total Legislative Cuts	*-12.0*	*-29.1*
Regulatory Cuts:		
Cap Government Providers	-5.0	-11.9
Limit Reimbursement of Rehabilitation Services	-2.3	-6.2
Eliminate Medicaid GME Payments	-1.8	-4.3
Eliminate IDEA Related School Costs	-3.6	-9.0
Total Regulatory Cuts	*-12.7*	*-31.4*
Total Legislative and Regulatory Cuts	**-24.7**	**-60.5**
Program Extensions	1.1	1.1
Total Net Legislative Cut	***-10.9***	***-28.0***
TOTAL, Net Legislative and Regulatory Cut	**-23.6**	**-59.4**

State Children's Health Insurance Program (SCHIP) Reauthorization

The budget proposes to provide a net increase of $4.2 billion over five years and $9.7 billion over ten years for SCHIP reauthorization ($5.9 billion over five years and $12.6 billion over ten years, excluding Medicaid interactions). However, this proposed funding level will not cover the funding shortfalls facing the SCHIP program. Instead the budget proposes to pay states Federal SCHIP funds at the enhanced FMAP only for enrolled children or pregnant adults with family income at or below 200 percent of poverty. States would receive SCHIP funds at the regular Medicaid FMAP level for all other enrollees, i.e., non-pregnant adults and children with family income above 200 percent of poverty. The budget also proposes to prohibit any further expansion of coverage to parents or, in states already covering them, childless adults.

Department of Veterans' Affairs (VA) Medical Care

As in previous years, the administration proposes new and increased fees to be assessed on Priority 7 and Priority 8 veterans for health care totaling $4.9 billion over ten years. These are veterans without compensable service-connected disabilities who have incomes as low as $27,790. The administration assumes ten-year savings of $3.4 billion from an increase in the pharmacy co-payment from $8 to $15 and assumes ten year savings of $1.1 billion by creating a tiered annual enrollment fee based on a veteran's family income. The administration also assumes ten-year savings of $421 million by billing veterans for treatment of non-service connected disabilities for their entire co-payments. VA estimates that if the enrollment fee and the increase in pharmacy co-payments are enacted in 2008, over 111,000 veterans would leave the VA healthcare system. Congress has repeatedly rejected similar proposals in the past.

Discretionary Health Programs

Overall, the President's budget provides $67.6 billion for discretionary spending programs at the Department of Health and Human Services (DHHS), which funds agencies such as the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). This funding level assumes cuts to NIH, CDC, HRSA, SAMHSA, and the Administration for Children and Families.

- *Cut for National Institutes of Health (NIH)* – The budget provides $28.7 billion for the NIH, a $743 million (2.5 percent) cut from what is needed to maintain NIH funding at the 2007 Continuing Resolution (CR) level adjusted for inflation.

- *Cut for Centers for Disease Control and Prevention (CDC)* – The budget provides $5.8 billion for the CDC, a $165 million (2.8 percent) cut from what is needed to maintain CDC funding at the 2007 CR level adjusted for inflation. As part of this cut, $99 million reflects the elimination of the Preventive Health Services Block grant.

- *Cut for Health Resources and Services Administration (HRSA) Programs* – The budget proposes $17 million for Rural Health activities, a $146 million (90 percent) cut from what is needed to maintain the funding at the 2007 CR level adjusted for inflation. This cut includes the elimination of the Rural Access to Emergency Devices and Public Access Defibrillation Demonstration projects ($1.5 million), Rural Hospital Flexibility grants ($64.8 million), Rural Outreach grants ($39.7 million), and the Denali Commission ($40 million). Other cuts include Children's Hospitals Graduate Medical Education ($193 million); Health Professions

($138 million), and Poison Control Centers ($14 million). The HRSA budget also eliminates a number of programs including Traumatic Brain Injury ($9 million); Universal Newborn Screening ($10 million) and Emergency Medical Services for Children ($20 million).

- *Cut Urban Indian Health* – The budget eliminates funding ($34 million) for the Urban Indian Health program in the Indian Health Service. The budget proposes that urban Indians receive health care through other federal, state, and local providers.

- *Cut for the Substance Abuse and Mental Health Services Administration (SAMHSA)* – The budget provides $3 billion for SAMHSA, a $221 million (7 percent) cut from what is needed to maintain the funding level at the 2007 CR level adjusted for inflation.

- *Cut for Low-Income Home Energy Assistance Program (LIHEAP)* – The budget provides $1.8 billion for LIHEAP, a $420 million (19 percent) cut from what is needed to maintain LIHEAP funding at the 2007 CR level adjusted for inflation.

Health Tax Proposals

Health Insurance Deduction

The President proposes a new standard deduction for health insurance of $15,000 for families ($7,500 for singles) to replace the current exclusion for employer-provided health insurance. Under the proposal, if a taxpayer has health insurance, either employer-provided or purchased individually in the non-group health insurance market, the taxpayer is entitled to the new deduction, which would be applicable to both income and payroll taxes. Employees would now include the value of employer-provided health coverage in gross income. The proposal would eliminate certain existing health tax subsidies, such as Flexible Spending Accounts, the premium deduction for the self-employed, and the medical expense itemized deduction (for taxpayers not enrolled in Medicare). The proposal would lose revenues in the first few years and then raise revenues in the out-years. Over ten years, the proposal raises $5.2 billion. If the outlay effect on EITC is factored in, the total cost of the proposal is $32.7 billion over ten years. Starting in 2014, the proposal begins to raise revenue, as health care costs grow faster than the value of the deduction (which is increased by inflation). According to the administration, 3 to 5 million of the 47 million uninsured may gain health coverage under this proposal.

The proposal also provides incentives to states to encourage changes in the non-group insurance market (such as risk pooling) and to provide premium subsidies for those below 200% of the poverty level to purchase “affordable, basic” health insurance. However, the proposal does not mandate that states use tools, such as pooling, and does not define what affordable, basic health insurance must include.

Some analysts have raised concerns that this proposal may encourage small and mid-size employers to drop coverage altogether, force more individuals and families (particularly older workers, disabled workers, and those with chronic conditions) into the more expensive individual insurance market, further fragment the risk pool and insurance, and do little to help low income workers obtain affordable health care.

In addition, the President’s proposal would affect individuals with chronic conditions, such as diabetes, heart disease, cancer, kidney disease, liver disease, and severe disabilities like, cerebral palsy, multiple sclerosis, Lou Gehrig’s disease (ALS), Alzheimer’s, and other neurological diseases. Families with children or other family members with disabilities or chronic conditions

may be forced into the individual insurance market where insurers deny coverage or charge higher rates to individuals with chronic conditions, making private insurance unaffordable.

Expanding Health Savings Accounts (HSAs)

The President's budget would expand HSAs by making more types of health plans eligible for HSA status, expanding the scope of qualified medical expenses under HSAs, allowing larger HSA contributions by employers, and making it easier for families to get HSA coverage. The most significant proposal, which accounts for $8.9 billion of the total HSA expansion package, would allow HSA-eligibility for plans that do not meet the current law minimum deductible requirement. Health plans with at least a 50 percent coinsurance requirement would qualify. Together, the HSA expansion proposals would reduce revenues by $10.4 billion over ten years.

Table 3 – Health Tax Reform Proposal ($ in billions)

Proposal	2008-12	2008-17
Revenue effect of health insurance deduction proposal	-121.2	5.2
Outlay effect of insurance deduction proposal	-14.3	-37.9
TOTAL Budget Impact (Including Outlay Impact)	*-135.5*	*-32.7*
Health Savings Account (HSA) expansion proposals	-3.7	-10.4

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