THE COMMITTEE ON ENERGY AND COMMERCE

INTERNAL MEMORANDUM

February 28, 2012

To: Members, Subcommittee on Health

From: Committee Staff

Re: Hearing on "The FY 2013 HHS Budget"

On March 1, 2012, at 10:00 a.m. the Energy and Commerce Committee Subcommittee on Health will hold a hearing in room 2123 of the Rayburn House Office Building to examine the President's Proposed Fiscal Year (FY) 2013 Budget for the Department of Health and Human Services (HHS).

I. WITNESS

The sole witness will be the Honorable Kathleen Sebelius, Secretary of HHS.

II. BACKGROUND

Health Care Law Implementation – Selected Issues

The President's Budget includes several requests for implementation of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA).

The budget requests an additional $1 billion in discretionary funding for the implementation of PPACA through the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid Services (CMS). This request is in addition to the $1 billion implementation fund included in HCERA that is expected to be exhausted by the end of FY 2012. This request to double the appropriation has raised concerns and questions given the claims that moving PPACA implementation to CMS would provide operational "efficiencies." The inability of CCIIO to produce basic information about obligations and outlays incurred by that office also underscores the need to examine this request thoroughly.

HHS also has continuously underestimated the cost of State exchange grants. In the President's FY 2012 budget, HHS estimated that the Department would spend $400 million on State exchange grants. Yet the HHS FY 2013 budget indicates that HHS will spend nearly $906 million in FY 2012 – meaning HHS outlay projections were off by 127 percent. In addition, HHS estimates over $1 billion in additional State grants will be obligated for FY 2013. This is highly troubling given statements from the CMS Administrator that the majority of the additional

$1 billion request for PPACA implementation will be spent on the creation of a federal exchange.

Despite the availability of resources, CCIIO has yet to produce many of the proposed or final rules that are necessary for States to establish and implement the exchanges required by PPACA. For example, CCIIO Center has yet to produce a proposed rule for the benefit mandates and cost-sharing requirements that will apply to health plans inside and outside of PPACA exchanges. Rulemaking related to the basic structure and design of PPACA exchanges has yet to be finalized. The lack of clarity from HHS regarding basic information and rules already has led to compressed and unworkable timelines for States, health plans, and providers – jeopardizing the integrity of the $1 trillion exchange subsidy entitlement created by PPACA and the availability of quality health coverage options for consumers.

Medicare

The President's FY 2013 Budget includes an adjustment totaling $429 billion over 10 years (FY 2013-FY 2022) to reflect the Administration's best estimate of the cost of future congressional actions effecting Medicare based on what Congress has done in recent years regarding physician payments and points out that "this adjustment does not signal a specific Administration policy." The Administration failed to include meaningful reform of the physician payment system in PPACA and has not offered any suggestion on how to reform the Medicare Physician Payment system.

The President's Budget proposes lowering the Independent Payment Advisory Board (IPAB) spending target rate in 2018 and thereafter from gross domestic product (GDP) per capita growth plus 1 percent to GDP per capita growth plus 0.5 percent. This would increase the likelihood that the IPAB trigger will be reached and that a 15-member panel of unelected, unaccountable experts will make major health policy decisions regarding Medicare that will be implemented without going through the usual legislative process.

Medicaid

In its March 2011 baseline, the Congressional Budget Office (CBO) estimated federal Medicaid spending would rise to $4.6 trillion over 10 years. As the National Governors Association (NGA) noted in November 2011, "spending on Medicaid is expected to consume an increasing share of state budgets and grow much more rapidly than state revenue growth, resulting in slow or no growth in education, transportation or public safety."[1]

The President's Budget notes the federal share of Medicaid outlays is expected to be $283 billion in FY 2013— or a $28 billion (approximately 11 percent) increase over the estimates for FY 2012. In his budget, the President outlines $56 billion of savings over ten years (approximately a 1 percent reduction). Specifically, the President includes a proposal applying a single Blended Matching Rate to Medicaid and the Children's Health Insurance Program

[1] http://www.nga.org/cms/home/news-room/news-releases/page_2011/col2-content/main-content-list/nga-nasbo-say-states-facing-big.html

(CHIP). Under the President's proposal, States could receive a lower Federal Matching Rate for the PPACA-mandated beneficiaries than originally promised in PPACA.

Food and Drug Administration

The FY 2013 Budget calls for a total of $4.5 billion for the Food and Drug Administration (FDA). This amount constitutes a $654 billion (17 percent) increase over the total FDA budget for FY 2012.

The budget request would reduce the period of exclusivity for follow-on biologics to seven years from the current 12 years. Some Members have voiced concerns that this proposal would reduce the necessary incentives to develop new biologics in the United States, jeopardizing domestic medical innovation and job creation while reducing access for patients to new therapies.

The budget request also would prohibit routine settlements of drug patent litigation. By barring these common types of settlements, the President's Budget would remove current incentives for generic drug companies to challenge patents by prohibiting a generic drug company from accepting anything of value from the patent holder in a settlement other than an "early entry date" for the marketing of a generic drug. This could have the opposite of the intended effect of the proposed policy and delay the entry of generic drugs into the market.

Public Health

The FY 2013 Budget for public health includes funding for the Healthcare Resources and Services Administration (HRSA), the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Agency for Healthcare Research and Quality (AHRQ), the Administration on Aging (AoA), the Indian Health Service (IHS), the Public Health and Social Services Emergency Fund (PHSSEF), and the Office of the Assistant Secretary for Health (OASH). With the exception of SAMHSA and NIH, the budget for these agencies overall is an increase from FY 2012 of $532 million. The budget for SAMHSA was decreased by $142 million, while the NIH budget remained at the FY 2012 level.

One of the goals of this increased spending is to increase the primary care workforce. The HRSA budget is increased in FY 2013 by $49 million to "improve the training and distribution of primary care, dental, and pediatric health providers". Yet, funding for the Children's Hospitals Graduate Medical Education Payment Program that supported the training of 6,000 pediatricians is reduced by $177 million from FY 2012 levels.

Focused and coordinated research is critical to setting priorities and finding solutions that will improve health care and reduce costs. Yet, the Administration randomly funds health economics research across its agencies. AHRQ, whose mission is to improve the quality, effectiveness, and efficiency of the health care system, is tasked with health economics research and funded at $409 million in the FY 2013 budget. Instead of consolidating research in one agency, health economics research also is funded at NIH and the Center for Medicare and

Medicaid Innovation (CMMI). At NIH, the Administration is requesting that $13 million from the Common Fund be used for health economics research. Diverting biomedical research funds to pay for health economics research is not only a significant departure for NIH, but also duplicative of the health economics research conducted at AHRQ.

III. CONCLUSION

This hearing will provide Members of the Subcommittee an opportunity to question Secretary Sebelius about the Administration's budget, health policy priorities, and implementation of the new health law.

IV. STAFF CONTACTS

If you have any questions about this hearing, please contact Ryan Long or Howard Cohen at extension (202) 225-2927.