PUBLICATION

President's Budget on Health Care: Entitlement Reform, Opioid Funding, and Cuts to Health Programs

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Note: All fiscal estimates cited over a ten-year budget window refer to the Fiscal Year 2019 – 2028 budget window.

The President's fiscal year 2019 (FY19) budget proposal for the Department of Health and Human Services (HHS) reflects the Trump Administration's priorities to repeal and replace the Affordable Care Act (ACA) and implement significant reductions in federal spending for health care entitlements and domestic health programs. The budget assumes Congress will replace the ACA's Medicaid expansion funding and insurance exchange subsidies with market-based block grants to the states (citing the Graham-Cassidy-Johnson-Heller proposal), generating $679 billion in net savings over the ten-year budget window. Like last year, the budget includes a proposed restructuring of Medicaid from an open-ended federal and state entitlement program to a per capita cap or block grant system beginning in FY20, projected to save approximately $1.4 trillion over ten years. However, unlike last year's budget proposal, this year's budget calls for substantial reforms and cuts in Medicare, producing $532 billion in total savings over ten years. The budget proposes reductions in Medicare reimbursements to post-acute care providers, graduate medical education programs, hospitals providing uncompensated care, and hospital-owned physician practices. The budget also proposes savings through efforts to lower Medicare payments and beneficiary out-of-pocket cost sharing for prescription drugs.

The FY19 budget request for HHS includes $95.4 billion in discretionary funding and $1.1 trillion in mandatory funding. Initially, the Administration planned to propose a 21 percent reduction in discretionary HHS spending and later amended the proposal as part of the Addendum to the President's FY19 budget that accounts for passage of the Bipartisan Budget Act of 2018 (BBA) last week. The budget's request for $95.4 billion in discretionary spending represents an $8.7 billion increase from the FY17 enacted level, directed primarily towards the Administration's efforts to combat the opioid abuse problem. Even with this discretionary funding increase, other public health areas such as HIV/AIDS, cancer research, and emergency preparedness have significant funding reductions proposed.

The budget proposal serves to outline the Trump Administration's key priorities for health care for the coming year and will likely serve as a framework for the upcoming debates in Congress.

Background and Analysis

Major health care policies within the President's FY19 budget proposal are outlined below. The funding amounts listed incorporate the updated numbers provided in the addendum to the President's FY19 budget.

Affordable Care Act (Page 57, HHS Budget in Brief)

Although overarching federal reform of the ACA appears unlikely to advance in Congress in the near-term, the President's FY19 budget once again seeks to repeal and replace the ACA. Specifically, the Administration supports passage of the Graham-Cassidy-Heller-Johnson legislation to repeal the ACA's Medicaid expansion

and insurance exchange subsidies and institute market-based health care block grants to the states. In addition, the Administration supports restructuring the Medicaid program by instituting per capita caps or block grants beginning in FY20. These reforms are intended to provide states with greater flexibility to administer their Medicaid programs and refocus the program on traditional Medicaid populations. To restrain the long-term growth of program spending, the Administration calls for aligning the growth rate of the market-based health care block grants and Medicaid per capita caps with the Consumer Price Index for all Urban Consumers (CPI-U).

Altogether, the Administration projects that the Medicaid reforms related to ACA repeal and replace will save $1.4 trillion, the market-based health care grants included in the Graham-Cassidy-Heller-Johnson legislation will cost approximately $1.2 trillion, and the overall impact of these policies (including other provisions and non-HHS impacts) will generate $679.7 billion in total government net savings over the ten-year budget window.

Of note, the budget calls for the following interim policies to support the ACA's insurance exchanges in transition while Congress works on broader health care reforms:

- Provide mandatory appropriations for the Cost-Sharing Reduction (CSR) payments for FY18 through the end of calendar year 2019 (the same payments that the Trump Administration ended last year);
- Provide mandatory appropriations to fully fund the Risk Corridors Program, including exempting the program from sequestration;
- Reduce the grace period for individuals enrolled in exchange plans to make premium payments from 90 days to 30 days; and
- Permit federally-facilitated exchange states to certify Qualified Health Plans in place of the Centers for Medicare & Medicaid Services (CMS).

Medicare (Page 62, HHS Budget in Brief)

The proposed budget estimates that FY19 spending for Medicare will total $768.6 billion (compared to $704.6 billion in last year's budget), including $209.4 billion for Part A, $210.1 billion for Part B, $247.6 billion for Part C, and $101.5 billion for Part D.

The budget proposes substantial legislative changes to Medicare to improve drug pricing and payment, address opioids, reform payment and delivery systems, reduce provider burdens, address fraud waste and abuse, and reform the Medicare appeals process. The budget estimates that the Medicare legislative changes alone will result in $272 billion in net savings over the ten-year budget window. In addition, when including Medicare interactions from multi-agency proposals, the budget's overall proposed policies are projected to yield $493.7 billion in net Medicare savings over the ten-year budget window, extending the solvency of the Hospital Insurance Trust Fund by approximately eight years.

The budget's Medicare legislative proposals and their estimated budget impacts are outlined in the linked table at the top of this page. Key areas of legislative proposals for Medicare are outlined below.

Graduate Medical Education: The budget proposes significant reforms to graduate medical education (GME) spending. The budget calls for consolidating federal GME spending from Medicare, Medicaid, and the Children's Hospital Graduate Medical Education programs into a single grant program for teaching hospitals, operated jointly by CMS and the Health Resources and Services Administration (HRSA). The creation of this separate, consolidated grant program would pull out direct GME funding from Medicare and Medicaid. The budget notes that this shift of funds would result in an estimated $195 billion reduction in Medicare expenditures and $21.2 billion in Medicaid expenditures over the ten-year budget window. Total funds in the new GME program in FY19 would equal the sum of Medicare and Medicaid's 2016 payments for GME, plus

2016 spending on Children's Hospitals Graduate Medical Education, adjusted for inflation. This amount would grow at CPI-U minus one percentage point each year. Funding would be prioritized for physician specialty and geographic shortages. Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The budget estimates that these reforms to GME funding would generate an overall $48.1 billion in total government net savings over the ten-year budget window.

Payment and Delivery Systems: The budget proposes significant changes in Medicare reimbursements affecting hospitals providing uncompensated care, post-acute care providers, coverage of bad debts, and hospital-owned physician practices. In total, the budget estimates that these payment and delivery systems reforms will result in $298.1 billion in net savings over the ten-year budget window. The major policies include:

1. Removing uncompensated care payments from the Inpatient Prospective Payment System and establishing a new process to distribute uncompensated care payments to hospitals based on share of charity care and non-Medicare bad debt, effective FY20. The total amount available for uncompensated care would be equal to FY18 funding levels, increasing annually by CPI-U.
2. Establishing a unified payment system based on patients' clinical needs rather than site of care for post-acute care providers. For FY19 – FY23, the four primary post-acute care settings (including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long term care hospitals) would receive a lower annual Medicare payment update. Starting FY24, this proposal would create a unified post-acute care payment system across these four settings, with payments based on episodes of care and patient characteristics rather than site-of-service. The first year would be required to be budget neutral relative to estimated payments that would have otherwise been paid in FY24 absent this change. Payment rates would be risk-adjusted and set prospectively on an annual basis, with episode grouping and pricing based on the average cost for providing post-acute care service for a diagnosis.
3. Reducing Medicare reimbursement of bad debt from 65 percent to 25 percent over three years. Rural hospitals with fewer than 50 beds, Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers would be exempt from this reduction.
4. Eliminating all exemptions for off-campus facilities, including grandfathered off-campus hospital outpatient departments that were billing or under construction as of November 2, 2015, emergency departments, and cancer hospitals, under Medicare's site neutral payment policy, effective 2019.

Drug Pricing: The budget aims to modernize the Medicare Part D drug benefit to improve plans' ability to deliver affordable drug coverage for seniors and reduce their costs at the pharmacy. The budget projects that these drug pricing proposals will result in $3.5 billion in net savings over the ten-year budget window. Specifically, the budget proposes the following major policies:

5. Requiring Part D sponsors to apply at least one-third of total rebates and price concessions at the point of sale.
6. Establishing a beneficiary out-of-pocket maximum in the Medicare Part D catastrophic phase by increasing Part D plan sponsors' risk in the catastrophic phase by increasing plan liability over four years from 15 percent to 80 percent and simultaneously decreasing Medicare's reinsurance liability from 80 percent to 20 percent. Beneficiary coinsurance would decrease from 5 percent to 0 percent over the same time period.
7. Restructuring the Part D coverage gap discount program to exclude manufacturer discounts from the calculation of true out-of-pocket costs.
8. Changing the Part D plan formulary standards to require a minimum of one drug per category or class rather than two.

9. Reducing the cost sharing for generics to $0, including biosimilars and preferred multiple source drugs, for low-income subsidy enrollees.

The proposed changes are intended to enhance Part D plans' negotiating power with manufacturers, encourage utilization of higher value drugs, discourage drug manufactures' price and rebate strategies that increase spending, and provide beneficiaries with more predictable annual drug expenses through the creation of a new out-of-pocket spending cap.

The budget also includes two notable proposals outside of Medicare Part D. First, the budget proposes authorizing the HHS Secretary to leverage Medicare Part D plans' negotiating power for certain drugs covered under Part B. Beginning in 2019, the HHS Secretary would have the authority to consolidate certain drugs currently covered under Part B into Part D, where there are savings to be gained from price competition. Second, starting in 2019, the budget would allow CMS to apply savings from the reduction in payment to hospitals for drugs purchased under the 340B program in a non-budget neutral manner. Under current regulations for 2018, hospital payment for 340B drugs was reduced from average sales price plus 6 percent to average sales price minus 22.5 percent, but statute requires these savings to be redistributed within the payment system in a budget-neutral manner.

Appeals Process: The budget includes several proposals to reform the Medicare appeals process across CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board. The budget proposes to provide $127 million per year in mandatory funding to invest in addressing the backlog of pending Medicare appeals. The HHS Secretary would be authorized to transfer this funding across levels 3 and 4 of the appeals system. The budget also proposes to establish a post-adjudication user fee for all unfavorable Medicare appeals, other than beneficiary appeals, at the Office of Medicare Hearings and Appeals (third level of appeals) and the Departmental Appeals Board (fourth level of appeals).

Finally, the budget includes several Medicare administrative proposals to reform the payment system for home health, utilize claims data from patient encounters in Medicare Advantage, base payments for employer group waiver plans on competitive individual market plan bids in Medicare Advantage, and to improve the valuation of physician services, estimated to save $38.5 billion over the ten-year budget window.

Medicaid (Page 84, HHS Budget in Brief)

In addition to the structural changes related to enactment of ACA repeal and replace (noted above), the budget includes legislative proposals for Medicaid that are intended to provide additional flexibilities to the states, improve Medicaid financing, and refocus Medicaid on traditional populations – the elderly, people with disabilities, children, and pregnant women. The budget estimates that these policy changes will result in $26.3 billion in net savings over the ten-year budget window.

The budget proposes to allow states to use state plan authority, instead of waivers, to charge copayments above the nominal statutory amounts for non-emergency use of the emergency department. The budget would also allow greater flexibility for states to expand asset tests to populations determined eligible by the Modified Adjusted Gross Income standard, such as able-bodied adults.

The budget calls for new statutory demonstration authority to allow up to five states more flexibility in negotiating prices directly with drug manufacturers, rather than participating in the Medicaid Drug Rebate Program. Participating states would be required to include an appeals process so that patients can access non-covered drugs based on medical need.

Finally, the budget includes a proposal to continue Medicaid Disproportionate Share Hospital (DSH) allotment reductions at $8 billion per year from FY26 – FY28. This policy change is estimated to generate $20.7 billion of the total $26.3 billion in net savings for the Medicaid legislative proposals over ten years.

Public Health Programs (Page 35, HHS Budget in Brief)

The budget highlights combating opioid misuse, abuse, and overdose as a key priority for the Trump Administration. The budget proposes $10 billion in new HHS funding for programs related to opioid abuse, varying by agency. The funding would be directed towards investments to advance HHS's five-part opioid strategy, which involves:

10. Improving access to prevention, treatment, and recovery services, including medication assisted therapies;
11. Targeting availability and distribution of overdose-reversing drugs;
12. Strengthening our understanding of the epidemic through better public health data and reporting;
13. Supporting cutting edge research on pain and addition; and
14. Advancing better practices for pain management.

The Centers for Disease Control and Prevention (CDC) would see $5.6 billion in discretionary funding under the budget, a decrease of $703 million relative to the FY18 Continuing Resolution (CR). This includes an initial allocation of $175 million to the CDC to combat the opioid abuse problem. However, the Administration proposes significant funding reductions to a number of other public health areas, including public health preparedness ($600 million), chronic disease prevention and health promotion ($138 million), occupational safety and health ($333 million), HIV/AIDS research and prevention efforts ($35 million), and cancer prevention and control ($17 million). The budget also includes last year's proposal for a new $500 million "America's Health Block Grant" to provide flexibility in FY19 for each state to implement specific interventions that address their population's unique public health issues, including interventions to spur improvements in physical activity and the nutrition of children and adolescents.

The budget includes $35.5 billion in total funding for the National Institutes of Health (NIH), a $1.4 billion increase over the FY18 CR and a reversal from last year's budget proposal to cut the NIH by $5.8 billion. Note that Congress included $1 billion in additional funding for the NIH for FY19 as part of last week's BBA. The budget provides an initial allocation of $750 million to the NIH to combat the opioid abuse problem. Like last year, the budget proposes reorganizing and consolidating certain HHS research programs into three new NIH institutes: 1) the National Institute for research on Safety and Quality (which would incorporate the Agency for Healthcare Research and Quality), 2) the National Institute for Occupational Safety and Health, and 3) the National Institute on Disability, Independent Living, and Rehabilitation Research.

The budget would provide $4.8 billion in total funding for the Substance Abuse and Mental Health Services Administration (SAMHSA), an increase of $552 million above the FY18 CR. The proposed funding includes a reduction of $688 million from SAMHSA's traditional substance abuse and mental health block grant programs and an additional $1.2 billion for expanded efforts to combat the opioid abuse problem. Of the $1.2 billion in new opioid funding, $1 billion is included to expand the State Targeted Response Grants established by the 21st Century Cures Act, an increase of $503 million over the FY18 CR for these activities.

Food and Drug Administration (Page 17, HHS Budget in Brief)

The budget proposes $5.8 billion in total funding for the Food and Drug Administration (FDA), an increase of $663 million or 13 percent above the FY18 CR. The budget provides an increase of $190 million in user fees and includes an initial allocation of $10 million to the FDA as part of the $10 billion Department-wide

investment to address the opioid abuse problem and serious mental illness. Key priorities for the FDA as outlined by the proposed budget include helping to speed innovations that make medical products more effective, safer, and affordable; establishing a risk-based food safety system; and supporting the government's preparedness infrastructure.

Health Resources and Services Administration (Page 23, HHS Budget in Brief)

HRSA would receive $9.6 billion under the proposed budget, a decrease of $953 million from the FY18 CR. The FY19 budget shifts mandatory funding for the following programs to discretionary funding: Health Centers, National Health Service Corps, Teaching Health Center Graduate Medical Education, Home Visiting, and Family-to-Family Health Information Centers. In addition, the budget provides HRSA an initial allocation of $550 million to combat the opioid abuse problem.

The budget also proposes reductions in discretionary funding for HRSA Health Workforce programs. Specifically, the budget proposes $447 million in funding for workforce programs, a reduction of $744 million from the FY18 CR enacted level. A significant portion of this reduction comes from nursing workforce development, where the budget proposes $83 million in FY19, a decrease of $145 million from the $229 million in the FY18 CR enacted level.

We will continue to monitor and report on budget updates as more information is made available.