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M E M O R A N D U M

To: Association of Academic Physiatrists

From: Peter Thomas, Jim Pyles, and Adam Chrisney

Date: August 15, 2011

Re: **Analysis of the Final Federal Debt Limit Agreement and Implications for Medicare and Medicaid Providers**

The deal the White House and top lawmakers reached on July 31 that was signed into law on August 2, 2011 averted the first default of the federal government in history. However, as volatility of the U.S. and other financial markets demonstrates, the deal has created tremendous uncertainly for the future, both with respect to fiscal policy as well as political viability. This memorandum reviews the final agreement and next steps in the budget process and analyzes the effect on various health care constituencies, particularly providers of health services. In addition, the Center on Budget and Policy Priorities has created a timeline outlining the steps to the impending budget process which is attached to this memo.

As background context for this budget analysis, federal spending is implemented through two different types of spending legislation, discretionary and mandatory. Discretionary spending requires passage of annual appropriations bills and is typically for a fixed period (usually a year). Examples would be housing programs, military procurement programs, or NIH research programs. Mandatory spending (sometimes referred to as “direct” spending) refers to spending enacted by an authorized law but not dependent on an annual or periodic appropriations bill. Most mandatory spending consists of entitlement programs such as Social Security benefits, Medicare and Medicaid but also includes much smaller budget items such as the salaries of Federal judges.

Summary of Debt Ceiling Agreement

Stage One: The deal to raise the U.S. debt ceiling includes a multi-stage approach that would authorize President Obama to immediately raise the debt ceiling by $400 billion. The next $500 billion would be subject to Congressional resolutions of disapproval that could be vetoed by the President. Such a procedural set-up makes it less likely that such a vote would fail or be blocked. Politically, it makes the President look more responsible for raising the debt ceiling than

Congress because he would be in the position of vetoing something the Congress has voted to disapprove. This provision was a major goal of fiscal conservatives in the negotiations.

This $900 billion increase in the existing $14.3 trillion debt limit would allow the government to cover debt liabilities through 2011. The proposal would also create mechanisms for raising the debt limit to cover liabilities through 2012. Achieving a deal that essentially postpones another debt ceiling standoff until after the next election was an important goal of the President.

The proposal would cap total discretionary spending over the next ten years. This is simply said but has major implications on federal spending over the next decade. If appropriations in the next ten years are equal to the caps in discretionary spending and the maximum amount of funding is provided for the program integrity initiatives, the Congressional Budget Office estimates the caps would decrease the federal budget deficit by $917 billion between 2012 and 2021.

More specifically, in fiscal year ("FY") 2012, the Act would impose a cap of $1.043 trillion, about $7 billion below current funding levels, and those levels were reduced earlier this year by $38.5 billion from last year's levels. In FY 2013, the Act would impose a cap of $1.047 trillion, about $3 billion below current levels. For FY 2012 and FY 2013, separate caps for security and non-security budgetary authority would be in effect. The security savings would represent roughly $5 billion of the total $10 billion in reductions over this two-year period. From FY 2014 on, only one cap would apply to total discretionary funding.

The Medicare and Medicaid programs are entitlement programs and are protected in the first round of cuts. However, other programs within the Department of Health and Human Services are subject to reductions in funding through the appropriations process. The National Institutes of Health and the Centers for Disease Control and Prevention are particularly vulnerable to cuts of this nature.

Stage Two: The second stage of the budget process would involve a newly created bipartisan, joint congressional committee which would recommend changes in law to reduce the federal debt by $1.5 trillion (through entitlement reform and/or tax revenues) over the next ten years. This figure, coupled with the $900 billion from stage one of the budget process, is designed to ensure that every dollar of increase in the debt limit is offset by spending cuts or revenue raisers, but the total figure is a shadow of the $4 trillion+ proposals being negotiated by the President and Congressional leaders throughout July.

Nonetheless, the debt limit deal requires a vote by November 23, 2011 by the joint committee on the proposals to achieve $1.5 trillion in savings. Congress is then required to vote on these proposals, without amendment, by December 23rd of this year.

If the joint committee agrees to a proposal worth $1.5 trillion (subject to another congressional vote of disapproval), then the plan would raise the debt ceiling by $1.5 trillion. If Congress fails to enact a bill, the debt limit would be raised by only $1.2 trillion. The President could also seek a $1.5 trillion increase in the debt limit if Congress adopts a balanced-budget amendment and sends it to the states for ratification.

The "Teeth" in the Agreement: If the committee fails to reach a compromise by January 15, 2012 that would decrease the federal debt by at least $1.2 trillion over ten years, or Congress fails to enact it, the Act includes a budget enforcement mechanism (known as "sequestration") that will implement automatic spending cuts to both discretionary and direct spending over 2013 through 2021. The across-the-board cuts to discretionary spending would be in addition to the spending cuts necessitated by the ten-year spending caps discussed above. Half of the sequestration cuts would come from defense spending and the other half from nondefense programs. The idea behind this "trigger" is that both Republican and Democratic priorities are at risk under it, meaning both sides have an incentive to act on the joint committee's proposal.

The amount of the cut would be based on the difference between the savings reached by the joint committee and $1.2 trillion in the debt limit increase. (In other words, if the Joint Committee only achieves consensus on $600 billion in deficit reduction and Congress approves that, sequestration would require an across-the-board cut to achieve another $600 billion in deficit reduction over the next ten-year period.) Some analysts have suggested that sequestration in discretionary programs could result in across-the-board cuts as high as 6% or even 9% from existing spending levels. The reductions in direct spending (i.e., mandatory programs) would be imposed by applying a uniform percentage cut.

However, there are very significant exceptions to the sequestration provision that protect Medicare, Medicaid, and Social Security. Under sequestration, across-the-board spending cuts to Medicare would be limited to 2% of the program's cost. These cuts would come out of payments to providers and insurance plans, not benefits or beneficiary cost sharing. Medicaid and Social Security are completely exempt from across-the-board cuts under sequestration. In a relative sense, this is a huge victory for health care advocates that collectively sought protections for Medicare and Medicaid under this budget agreement.

The Act also includes numerous changes to the federal student loan program, including eliminating the ability of most graduate students to take out subsidized student loans. Finally, the measure requires the House and Senate to vote on a balanced-budget amendment to the U.S. Constitution between September 30 and December 31, 2011.

Political Reaction & Next Steps

The agreement was passed by both houses of Congress and signed by the President on August 2, 2011, averting a federal default by authorizing an immediate increase in the debt limit. However, both Democrats and Republicans have objected to the measure. GOP conservatives have protested that the agreement does not cut spending deeply enough and fails to require congressional passage of a balanced-budget amendment before the debt limit is raised. Liberal Democrats have complained that the measure requires no new taxes or revenues and may lead to unwarranted cuts in entitlement programs as the joint committee tries to achieve consensus.

The Obama administration, which negotiated the final version with congressional leaders, supports the measure but was willing to go much farther in terms of spending reductions and increases in tax revenues. A $4 trillion package was the subject of intense negotiations throughout the month of July but a final deal could not be reached.

Prospects for Compromise: The political polarization in Washington does not bode well for the success of the joint committee. A key indicator of the joint committee's potential to reach agreement is selection of the 12 legislators who are tasked with this responsibility and by law must meet face-to-face for the first time before September 16th. In order for proposals to move toward the Congressional approval process, seven out of 12 votes must be secured. This means that at least one Democrat will have to vote with all of the Republicans, or one Republican will have to vote with all of the Democrats, or some combination thereof. There are many in Washington who believe consensus in this environment is highly doubtful, but there are glimmers of hope that at least a number of joint committee members are willing to try. Recent statements by several appointees suggest a new willingness to compromise in the wake of what, by all accounts, was seen as an ugly and unnecessarily partisan negotiation of the debt ceiling increase.

Joint Committee Appointees: Senate Majority Leader Harry Reid recently announced the Senate Democratic members of the joint committee are Patty Murray (WA), John Kerry of (MA) and Max Baucus of (MT). Senator Murray will be the Democratic co-chair of the committee. Senate Minority Leader Mitch McConnell selected the following Republicans to serve on the joint committee: Senators Jon Kyl (AZ), Pat Toomey (PA) and Rob Portman (OH). The Senate appointees are interesting in that both Republicans and Democrats selected a mix of party faithful and those willing to reach across party lines. While the entire panel of 12 legislators holds a total of 138 years of experience in the House or Senate, the Senate Republicans selected two freshman Senators.

House Speaker John Boehner appointed Ways and Means Committee Chairman Dave Camp (R-MI), Energy and Commerce Committee Chairman Fred Upton (R-MI), and Republican Conference Chairman Jeb Hensarling (R-TX) as the House GOP members of the joint committee. Congressman Hensarling will be the Republican co-chair of the panel. Finally, House Minority Leader Nancy Pelosi selected Jim Clyburn (D-SC) part of the Democratic leadership team in the House, Henry Becerra (D-CA), and Chris Van Hollen (D-MD), ranking member on the House Budget Committee. The House appointees appear to be more aligned with party priorities. Jeb Hensarling, for instance, the Republican co-chair of the panel, is a Tea Party favorite, while Jim Clyburn will do everything he can not to include Medicare reforms in any compromise package, with the clear goal of preserving Medicare as a political issue for Democrats in the upcoming election.

Impact on Medicare Providers: Medicare providers should be very concerned with the debt deal when it comes to cutting health care costs. The joint committee will have many proposals to draw upon that have been put forth during the debt limit discussions as well as those suggested by the President's deficit reduction commission last December. However, it is unclear whether the joint committee will have the capacity and time to pursue a comprehensive overhaul of the program, let alone the political support to do so. The timeline for the joint committee to agree on at least $1.2 trillion in savings is very tight. As such, structural changes to the program that will impact the trajectory of growing health costs will be difficult to negotiate.

This suggests that the quickest and easiest options for negotiators will be cutting payments to doctors, hospitals, and other providers, or asking Medicare beneficiaries to pay more for their care. If the joint committee fails to produce a bipartisan plan that Congress then passes, across-the-board spending cuts will be triggered to begin in 2013. These across-the-board cuts would include Medicare to a limited extent (i.e., 2% reduction in spending levels over a ten-year period) but would not include Medicaid.

Because of this, there is good reason to believe that some consumer organizations and provider groups will be more inclined to support sequestration rather than a more comprehensive deal that could heavily impact Medicare and Medicaid spending in the future. For instance, those stakeholder groups expected to be hit harder if a deficit reduction package is passed such as managed care plans, pharmaceutical companies, and home health care, may view a 2% cut as the better option. Add to this the fact that sequestration would not begin until 2013, giving these providers another year without additional payment cuts and additional time to lessen the impact of harmful proposals.

Additional Health Sector Implications

Notably, the deal does not include a permanent fix for the sustainable growth rate formula (SGR) for physician reimbursement under Medicare. Under the SGR, physicians face a 29.5 percent cut in reimbursement at the end of 2011, unless Congress once again steps in to provide relief. Because of this threat, the American Medical Association has stated that it anticipates the joint committee will consider the SGR in its negotiations, but there are no guarantees that a permanent fix of the SGR will be addressed as such a fix will cost over $300 billion over 10 years which conflicts with the cost-cutting or savings goals of the joint committee. A further one to two year SGR patch could be more likely.

Physicians and hospitals will also be concerned with cuts to graduate medical education programs. During the debt ceiling negotiations, an early document outlining items under consideration included a section identifying $14 billion in “reform to DGME and IME payments” over a ten-year period. No further details were forthcoming but teaching hospitals and the providers they generate are on edge in anticipation of potentially catastrophic cuts to these programs.

Other than the DGME/IME (direct graduate medical education/indirect medical education) cuts, hospitals are concerned with how payment cuts will affect emergency rooms and trauma services as well as policies generating savings from eliminating bad debt, reforming rural hospital programs, and rebasing disproportionate share hospital (DSH) payments. Health insurers are worried about the Medicare Advantage program, supplemental coverage and Medicaid managed care while pharmaceutical companies are focused on mandatory drug rebates and cuts to the Medicare Part D program. However, these insurers and pharmaceutical companies know that such changes would not generate enough savings as compared to cuts to hospital and physician services and medical equipment.

Finally, documents released during the debt ceiling negotiations which summarized proposals under consideration contained a provision to generate $50 billion from co-payments or payment reductions in “post-acute care payments / cost sharing for SNFs [skilled nursing facilities] and

home health." In addition, there was a general proposal to reduce "Medicare DME Payments" by $5 billion which were interpreted to be payments related to durable medical equipment, not direct medical education. However, no further details on either proposal were forthcoming at the time.

In short, the next four months are expected to be extraordinarily busy for policymakers, lobbyists, trade associations, and myriad interest groups with much to gain or lose in this debate.

DEBT DEAL TIMETABLE FOR 2011-2013

Debt Deal/Budget Calendar	
August 2011	*August 4* – Debt ceiling raised $400 billion (out of the $900 billion in first portion of the debt ceiling increase). *August 16* – Deadline to appoint supercommittee members.
Sept 2011	*Sept 16* – Deadline for supercommittee to hold first meeting (agenda provided 48 hours in advance; any hearings to have 7 days advance notice). No specified number of meetings. *Sept 30* – Last day of FY2011: current CR expires.
October 2011	*Oct. 1* – FY12 begins. *Oct 14* – Deadline for House and Senate committees to submit recommendations to supercommittee, if they choose to do so.
November 2011	*Nov 23* – Deadline for supercommittee to vote on plan with at least $1.5 trillion in savings (CBO estimates must be available at least 48 hours before vote).
December 2011	*Dec 2* – If supercommittee approves plan, deadline to submit report and legislative language to President and Congress. *Dec. 9* – If legislation is approved by the supercommittee, each committee receiving a referral of the supercommittee bill must report that bill without amendment by this deadline. *Dec. 23* – Deadline for House and Senate votes on supercommittee plan. *Dec. 31* – Deadline for House and Senate to vote on a balanced budget amendment to the constitution (cannot vote sooner than Oct.1).
January 2012	*Jan 1* – If Congress has not passed a joint resolution of disapproval, Secretary of Treasury is authorized to raise the debt limit by an additional $500 billion (i.e., the remainder of $900 billion in first portion of debt ceiling increase). *Jan 15* – If supercommittee's plan fails or falls short of $1.2 trillion in savings, sequestration would be triggered and start in 2013. Any agreed upon deficit savings from the supercommittee would be credited against the $1.2 trillion sequestration, i.e. across the board cuts in non-exempt programs. The president's third and final debt-increase is likely to come sometime in early 2012. (The request could be $1.2 trillion without Congress taking any other action. Congress could submit a $1.5 trillion balanced budget constitutional amendment to the states. If, as a result of the joint committee's work, the president signs a bill reducing the deficit by at least $1.2 trillion, the debt ceiling will be raised by an amount equal to those savings, but no more than $1.5 trillion, even if the savings achieved by the joint committee exceeds that amount.)
April/May 2012	*April 15* – Deadline for chair of Senate Budget committee to report allocations for FY12 and FY13 to Approps Cmte based on new discretionary caps. (No House deadlines with respect to the new caps, but under the Congressional Budget Act, Congress is supposed to agree to a budget resolution by April 15 and presumably it will not exceed the cap.)
January 2013	*Jan 2* – If the supercommittee plan is not passed by Congress, sequestration will occur.

	Early 2013 - Potential new debt limit debate after exhaustion of extraordinary measures.