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The United States faces a daunting long-term federal debt problem. According to the Congressional Budget Office, the federal budget deficit in Fiscal Year (FY) 2012 will total $1.1 trillion, marking the fourth year in a row with a deficit of more than $1 trillion (Congressional Budget Office, An Update to the Budget and Economic Outlook: Fiscal Years 2012 to 2022, at III, August 2012). This deficit is rapidly inflating the federal debt, which now equals 73 percent of the gross domestic product—the highest level since 1950.

It is widely appreciated that the growing deficit and debt are strangling federal budgets and creating a drag on the economy. Compounding the outlook and complicating solutions are a number of revenue and spending changes scheduled to take effect at the end of 2012 (collectively referred to as the “fiscal cliff”) that will lead to economic contraction if unaddressed.

On the revenue side, the Bush-era tax cuts—provisions related to income, estate, gift and alternative minimum taxes—a temporary payroll tax deduction and a number of temporary tax provisions are set to expire at the end of 2012 and produce roughly $400 billion of additional revenue in FY2013 (Mindy R. Levit et al., Congressional Research Service, Major Fiscal Issues Before Congress in FY2013, at 2, August 2012). While the additional revenue would address the deficit favorably, most economists and lawmakers agree that allowing all of these provisions to lapse at once would stall economic recovery and potentially send the country into a double-dip recession.

On the spending side, the expiration of temporary unemployment insurance benefits, the lapse of the “doc fix” to the Medicare physician payment sustainable growth rate formula and an automatic sequestration of federal spending required by the Budget Control Act of 2011 are scheduled to reduce federal spending by more than $100 billion in FY2013. Policy- and lawmakers likewise foresee these federal spending cuts as beneficial to the deficit, but as a net detriment to the economy.

In light of these threats to the fragile economic recovery, President Obama and Congress are expected to address these matters either in the forthcoming “lame duck” congressional session later this month or early in 2013. The Medicare and Medicaid programs will undoubtedly figure prominently into these discussions.

In order to defer expiration of most of the pending tax changes and avoid the Medicare physician payment cut and sequestration for one year without further adding to the deficit, Congress and the President will need to increase other revenues or reduce federal spending by at least $500 billion. Given that Medicare and Medicaid account for nearly 25 percent of total mandatory federal spending, these programs will necessarily contribute substantially to the solution (CBO, Budget and Economic Outlook, at 7).

If President Obama and Congress choose to seek long-term solutions (i.e., those enduring more than a year), the cost will increase dramatically. If they also choose to begin tackling the deficit in earnest, the Medicare and Medicaid programs could face historic cuts.

The President is on record supporting $4 trillion in deficit reduction over 10 years, including $321 billion in Medicare and Medicaid spending reduction. (See, e.g., Office of Management and Budget, Living Within Our Means and Investing in the Future: The President’s Plan for Economic Growth and Deficit Reduction, at 35-43, September
However, $4 trillion in deficit reduction may be the opening gambit. U.S. House of Representatives Republicans may demand more progress on the deficit, and more cuts coming from entitlement programs than the President has previously been willing to concede. Combined with the need to address the threats presented by the fiscal cliff, the health care community could be confronting as much as $550 billion in Medicare and Medicaid spending reductions over 10 years.

By comparison, the **Patient Protection and Affordable Care Act** was projected to cut $575 billion from Medicare over 10 years, but the President and lawmakers persuaded stakeholders to accept these cuts on the promise that 34 million uninsured Americans would gain health insurance (Memorandum of Richard Foster, Chief Actuary, Centers for Medicare & Medicaid Services, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” April 22, 2010). Despite all the hand-wringing, the sequestration mandated by the Budget Control Act of 2011 would cut only $120 billion from Medicare over a 10-year period, and cut nothing from Medicaid (C. Stephan Redhead, Congressional Research Service, Budget Control Act: Potential Impact of Sequestration on Health Reform Spending, at 10–11, October 2012).

A look at deficit reduction measures previously advanced by both the President and congressional Republicans, as well as by the National Commission on Fiscal Responsibility and Reform (otherwise known as the “Simpson-Bowles Commission”), among others, provides a glimpse of where specifically cuts are most likely to be made.

- Hospitals could be targeted with changes that reduce Medicare outpatient and graduate medical education payments and bad debt reimbursement, reduce the number of Critical Access Hospitals and their reimbursement, implement a host of new fraud and abuse enforcement tools, and lower thresholds triggering intervention by the Independent Payment Advisory Board.
- Post-acute providers, like skilled nursing facilities, home health agencies and rehabilitation facilities, could see reduced inflation adjustments or across-the-board spending reductions, increased beneficiary cost sharing, an accelerated transition to quality-oriented programs, like readmissions penalties and value-based purchasing, and capped benefits.
- Laboratories also could face across-the-board spending reductions (beyond those built into current law) and new beneficiary cost sharing, while ambulatory surgery centers could see reduced inflation updates and a faster track to value-based purchasing payments.
- Physician payments could be altered by provisions requiring pre-payment validation for high-cost service orders and prior authorization for advanced imaging services.
- Pharmaceutical and medical products interests could confront pressure to allow government negotiation on drug reimbursement under Part D, expanding durable medical equipment competitive bidding, capping Medicaid DME reimbursement at Medicare levels, revising Part D low-income subsidies to encourage more product substitution, and extension of Medicaid drug rebates to dual eligible beneficiaries enrolled in Part D or application of rebates to all of Part D.
- Payors could be affected by changes restricting first-dollar Medigap coverage, applying an excise tax on Medigap plans or modifications to the Medicare Advantage quality bonus demonstration.
- The President may also support changes to the Affordable Care Act as part of a larger debt reduction deal. For instance, the President may agree to scale back the Affordable Care Act’s subsidies designed to help low-income residents afford health insurance coverage or change the age rating band to enable insurers to charge older citizens more and younger citizens less for health insurance.

For a health sector striving to make sense of the election and predict how the Medicare and Medicaid programs may be altered in 2013, the analysis must be more specific than can be offered here. The general policy changes discussed above will impact stakeholders differently. Understanding how these programs might be altered, and how these changes will affect you will be essential to charting new strategic directions.

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