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The Budget Control Act of 2011: Implications for Medicare

OVERVIEW

On August 2, 2011, President Obama signed the Budget Control Act of 2011 into law, which will reduce net federal spending by \$2.1 trillion over ten years and raise the debt ceiling by up to \$2.4 trillion. With the nation's debt nearly reaching the \$14.3 trillion debt ceiling, the Act was a bipartisan compromise negotiated between the Administration and Congressional leaders, just before the nation was to breach the debt ceiling.

Medicare could be a component of forthcoming efforts to reduce the national debt, although there is considerable uncertainty about the magnitude of potential savings and the scope of how they would be achieved. Federal spending for the Medicare program has continually been part of the deficit and debt ceiling discussions because Medicare accounted for 15 percent of the federal budget in 2010, and is projected to grow as a share of the economy due to rising health costs and a Medicare population expected to nearly double in size between now and 2055.¹ The Budget Control Act sets forth a process that could result in Medicare savings, if approved by the new Joint Select Committee on Deficit Reduction, known as the "Super Committee", and enacted into law, or if that fails, through a sequester that would reduce spending, beginning in 2013. Additional Medicare savings could be considered this year to avoid a 29.4 percent reduction in Medicare physician fees. These additional savings would come on top of the \$424 billion in net Medicare ten-year savings enacted last year in the Patient Protection and Affordable Care Act (ACA) of 2010.

This issue brief provides an overview of the new law, describing the timeline and process for raising the debt ceiling and lowering the federal deficit (**Exhibit 1**). It describes the role of the new Joint Select Committee on Deficit Reduction, examines how Medicare spending could be affected by changes proposed by the Committee, or if that process fails, by sequestration. The brief also summarizes prior laws that were designed to reduce the federal deficit through limits on federal spending and sequestrations affecting both discretionary and mandatory spending, including Medicare.

Exhibit 1

The Budget Control Act of 2011: Key Dates

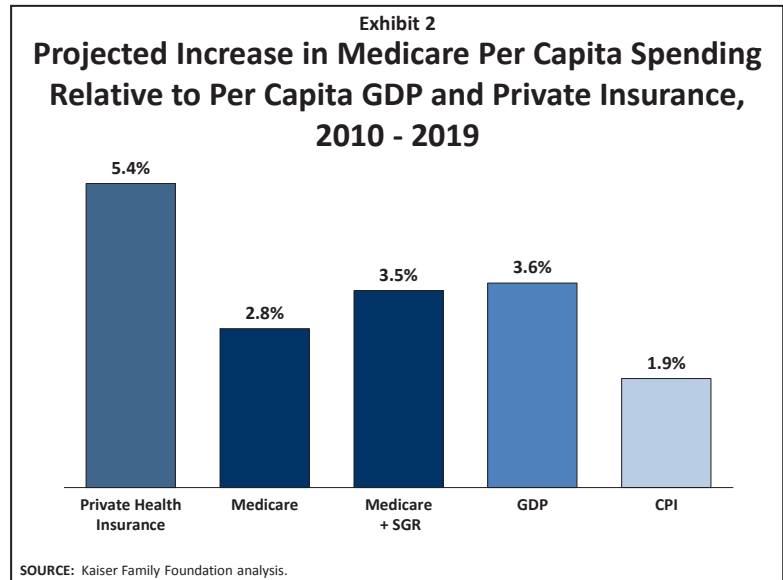
Date	Action/Deadline
2011:	
Sept. 16	Joint Select Committee meets
Sept. 21	Debt ceiling raised by additional \$500 billion unless Joint Resolution of Disapproval is enacted
Oct. 1 – Dec. 31	Congress required to vote on Balanced Budget Amendment
Oct. 14	Deadline for House and Senate committees to send suggestions to Joint Select Committee
Nov. 23	Deadline for Joint Select Committee to vote on proposal
Dec. 23	Deadline for Congress to vote on Joint Select Committee bill
Late 2011/2012 [Exact date to be determined]	Debt ceiling to increase by \$1.2 - \$1.5 trillion, unless Joint Resolution of Disapproval is enacted
FY 2013 – FY 2021	Sequester of \$1.2 trillion, less the amount saved by the Joint Select Committee

SOURCE: Kaiser Family Foundation analysis of Budget Control Act law.

BACKGROUND

Federal expenditures for the 48 million people covered by Medicare exceeded \$520 billion in 2010, and are projected to reach \$970 billion by 2021.² As a result, each of the major debt reduction proposals released in 2010 and 2011, including the Bowles-Simpson Plan, the Domenici-Rivlin Plan, and the House Budget Resolution, include Medicare savings as part of a broader package of proposed recommendations. Proposals vary in terms of the magnitude of Medicare savings to be achieved and the nature of the proposed reforms. Some would reduce Medicare spending by relatively substantial reforms such as transitioning to a premium support system,³ while others would keep the structure of the program intact and achieve savings through other means.

The debate over Medicare's role in deficit reduction discussions follows significant reductions in Medicare spending enacted last year in the Patient Protection and Affordable Care Act (ACA) of 2010. The law included more than \$424 billion in net Medicare savings (\$528 billion in gross Medicare savings) over a ten-year period, reducing annual payment updates to hospitals and other providers by \$196 billion and payments to Medicare Advantage plans by \$136 billion over ten years.⁴ Additionally, the law created the Independent Payment Advisory Board (IPAB) and charged it with developing proposals to reduce Medicare spending if the projected per capita growth rate exceeds target levels.⁵ The Medicare savings included in the health reform law were projected to reduce aggregate spending by 6 percent over the 10 year period.⁶ As a result of these changes and other factors, Medicare per capita spending is projected to grow on average by about 3.5 percent between 2010 and 2019, substantially less than the 5.4 percent per capita growth in private health insurance expenditures (**Exhibit 2**).



Many of the reductions in spending made by the ACA have not yet been implemented, and their long-term impact on Medicare remains to be seen. The Chief Actuary of the Centers for Medicare & Medicaid Services recently expressed his concern that reductions in payment to providers included in the ACA could make it difficult for certain providers to remain profitable, and could result in providers no longer participating in Medicare, possibly jeopardizing access to care for beneficiaries.⁷ Additionally, the Office of the Actuary projected that, by 2019, Medicare rates are projected to be lower than those currently paid for Medicaid, and that the update reductions would not be sustainable over the long term.⁸

Against this backdrop, The Budget Control Act of 2011 was enacted August 2, establishing a pathway to raise the debt ceiling and reduce the deficit, with potentially significant implications for Medicare.

THE BUDGET CONTROL ACT: PROCESS AND TIMELINE

The Budget Control Act of 2011 raises the debt ceiling by up to \$2.4 trillion in order to allow the federal government to continue to fund its obligations. The initial \$900 billion increase coincides with a round of spending reductions (caps in discretionary spending and changes to student loan programs), and an additional increase in the debt ceiling will be tied to further spending reductions and possibly also revenue increases. These actions will occur in multiple steps.

Increase in the Debt Ceiling

The Act raised the debt ceiling by \$400 billion on **August 2** and will increase it by an additional \$500 billion on **September 21**, unless a Joint Resolution of Disapproval is passed by the House and Senate and signed into law by President Obama by that date.

The initial increase in the debt ceiling coincides with the imposition of caps on discretionary spending and changes to the student loan programs, saving \$917 billion between fiscal year (FY) 2012 and FY2021.⁹ If discretionary spending exceeds the cap in a given year, the additional spending will be automatically reduced

through across-the-board reductions, known as a “sequestration,” in discretionary spending. The caps on discretionary spending do not apply to Medicare (or Medicaid or Social Security) because these are mandatory, rather than discretionary programs.¹⁰

In the future, the debt ceiling will need to be raised again to allow the government to continue to fund its obligations. At that point, the debt ceiling will be increased between \$1.2 trillion and \$1.5 trillion, if the President releases a certification of need, and a Joint Resolution of Disapproval is not enacted within 15 days thereafter. This increase in the debt ceiling will coincide with additional deficit-reduction measures—either spending reductions, possibly in conjunction with revenue increases, based on recommendations by the Joint Select Committee’s proposals, or automatic reductions in spending through sequestration.

New Joint Select Committee on Deficit Reduction

Congressional leaders are required to establish a new Joint Select Committee, also known informally as the “Super Committee,” which will be tasked with decreasing projected deficits by \$1.5 trillion between FY2012 and FY2021. The Committee has broad authority to propose changes to meet its target, including changes to Medicare, Social Security, Medicaid, defense, taxes, and any other element of the budget. Thus, the Committee may consider a number of Medicare savings proposals that have been discussed over the past year, including, for example, transforming the program from a defined benefit to a defined contribution plan, raising the age of Medicare eligibility, increasing beneficiaries’ premiums and cost sharing, reducing payments to providers, strengthening the role of the IPAB, and requiring pharmaceutical manufacturers to provide larger rebates on prescription drugs.¹¹

The 12-member Committee includes six members from the Senate, selected by the Senate Majority and Minority Leaders, and six members from the House, selected by the Speaker of the House and the House Minority Leader. Congressional leaders have appointed Representative Jeb Hensarling and Senator Patty Murray as co-chairs. Others appointed to the Committee are Senators Max Baucus, John Kerry, Jon Kyl, Pat Toomey, and Rob Portman and Representatives Xavier Becerra, Dave Camp, James Clyburn, Fred Upton, and Chris Van Hollen.

The Joint Select Committee is required to have its first meeting no later than **September 16** and is required to draft and vote on a proposal for decreasing the debt a little more than two months later, by **November 23**. The Senate and House Committees have until October 14, 2011 to send their recommendations for spending reductions or revenue increases to the Joint Select Committee for consideration. If a majority of the Joint Select Committee votes to approve the proposal, Congress will consider the Committee’s proposal under expedited rules with a simple majority vote.¹² Congress cannot amend or change the proposal, and must vote on it by **December 23**—just one month after the deadline for the Committee to vote on its proposal. The proposal must be enacted into law by **January 15, 2012** to avoid automatic, across-the-board reductions in government spending through sequestration.

Sequestration

If the Joint Select Committee’s proposal is not enacted by January 15, or if proposal is enacted but saves less than \$1.2 trillion over ten years, the Director of the Office of Management and Budget (OMB) would calculate the sequestered amounts that would be needed to ensure that savings total \$1.2 trillion for FY2013 to FY2021. For example, if the Joint Select Committee’s proposal were to be enacted but included only \$300 billion in savings and revenue increases, the sequestration process would reduce spending by an additional \$900 billion to achieve total savings of \$1.2 trillion. The sequestered spending would be divided equally amongst the fiscal years 2013 through 2021, and half of the sequestered spending each year would be drawn from defense functions, with the other half drawn from non-defense functions, including such things as Medicare, cost-sharing subsidies in the health reform exchanges beginning in 2014¹³, and farm price supports, vocational

rehabilitation basic state grants, and the Social Services block grant. In 2014 and thereafter, the discretionary savings would be achieved through reductions in the caps on discretionary spending.

The law limits the amount of savings that would be achieved through Medicare savings, capping reductions at 2 percent of payments to providers and plans per year of sequestration, and would apply to Medicare payments to Medicare Advantage plans, Part D (prescription drug) plans, and providers, including but not limited to hospitals and physicians. In 2013, 2 percent of payments to plans and providers would be approximately \$10 billion.¹⁴

The sequestration would not affect:

- Premiums under Parts B and D
- Cost-sharing for Medicare-covered services
- Medicare premium and cost-sharing subsidies under Part D; and
- Revenues to the Medicare Part A trust fund.

While sequestration would not directly raise beneficiaries' premiums and cost-sharing, it is possible that reductions in payments to plans and providers could indirectly affect beneficiaries' out-of-pocket costs, if, for example, Medicare Advantage plans shift costs to beneficiaries by raising premiums or cost-sharing. Reductions in payments to providers would come on top of savings enacted in the 2010 health reform law, potentially affecting access to and quality of care, and resulting in providers shifting costs to other health insurers or otherwise changing the mix of services they provide.

Balanced Budget Amendment

The Budget Control Act also requires Congress to vote on a Balanced Budget Amendment to the Constitution between **October 1** and **December 31, 2011**. The effect of a Balanced Budget Amendment on the Medicare program would depend upon the bill's legislative language.

PRIOR LAWS: SEQUESTRATION AND MEDICARE

The Budget Control Act of 2011 is not the first law to include a sequestration mechanism to constrain federal spending, with implications for Medicare.

Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman Hollings Act) established declining deficit targets, with the hope of achieving a balanced budget by FY1991. If Congress did not meet one of the targets, the law required a sequestration for both mandatory and discretionary spending. Medicare was not exempt, although reductions were capped annually at 2 percent of Medicare payments to providers.¹⁵ Medicaid was exempt from sequestration, as were other low-income programs and Social Security. In fact, a sequestration occurred in FY1986 and FY1990, but Congress avoided sequestration from FY1987 and FY1989, and reduced the sequestration in FY1990, through various means.¹⁶ For example, in 1987, Congress revised the Gramm-Rudman-Hollings Act by raising the deficit targets and setting FY1993 as the new target date for achieving a balanced budget.¹⁷ Some have criticized the Act for requiring Congress to take responsibility for deficits outside of its control, such as those due to poor economic conditions, rather than applying spending restrictions only to new legislation under the control of Congress.¹⁸

The Budget Enforcement Act of 1990 (BEA), enacted as part of the Omnibus Budget Reconciliation Act of 1990, effectively replaced the Gramm-Rudman-Hollings Act. It included a pay-as-you-go (PAYGO) rule, which required all new mandatory spending and revenue legislation in a given fiscal year to be offset and not increase the deficit, or reduce the surplus, for that year, and the OMB tracked spending and revenues on a scorecard. If Congress violated the PAYGO rule (i.e., the scorecard amount was greater than zero), sequestration of mandatory spending, including Medicare, would be triggered.¹⁹ The BEA raised the limits on sequestration of

Medicare spending from 2 percent to 4 percent of payments to providers, and continued to exempt Medicaid, other low-income programs, and Social Security from sequestration. The BEA included a separate process that set caps on discretionary spending, which were enforced by sequestration.²⁰

From FY1991 to FY1999, mandatory and discretionary spending mostly complied with the PAYGO rule and discretionary spending limits. However, beginning in FY2000, spending began to deviate substantially from these limits, and Congress used a variety of techniques to prevent large sequesters from occurring. For instance, Congress enacted the Defense Appropriations Act in FY2002, which required OMB to zero-out the PAYGO scorecard for FY2001 to FY2002 in order to avoid a sequestration of \$130 billion.²¹ Although Congress extended the BEA in 1993 and 1997, the law effectively expired in 2002 when Congress set the OMB scorecards for the remaining years of the law to zero.²²

The Statutory Pay-As-You-Go Act of 2010, established in February 2010, uses the same general PAYGO mechanism as the BEA, with some important differences. For example, the 2010 law allows Congress, until the end of 2011, to exclude the costs through December 31, 2014 of reforming the sustainable growth rate (SGR) formula to prevent automatic reductions in Medicare payments to physicians and does not require offsets for revenue loss associated with extending some tax cuts.²³ The Act continues to exempt Medicaid, other low-income programs, and Social Security from sequestration. It also allows up to 4 percent of Medicare payments to providers to be sequestered.

Congress complied with the PAYGO requirement in the first year of this Act, although about \$1 trillion over ten years was excluded because it was designated as emergency spending or adjustments to current policy.²⁴ This PAYGO mechanism is still in effect and is permanent unless overridden.²⁵

POLICY ISSUES FOR THE FUTURE

The Budget Control Act imposes caps on discretionary spending, raises the debt ceiling, and requires further reductions in federal spending that will be implemented either by enacting the recommendations of the Joint Select Committee on Deficit Reduction or by imposing across-the-board, automatic spending reductions through sequestration.

The Joint Committee's ability to recommend drastic changes may be constrained by politics and the desire to submit a proposal that could be passed by Congress; however, the Committee's scope of changes to programs is not legally constrained in any way. This lack of constraints provides an opening for substantial changes to be made to the Medicare program, but it also allows for the Committee to take a more nuanced approach towards reductions in spending.

If the Joint Committee's proposal is not enacted, or does not achieve sufficient savings, then Medicare spending will likely be reduced by a sequestration. Some may consider this to be a blunt approach to achieving savings, without regard to plans' and providers' operating margins. The reductions in Medicare spending through a sequestration could further encourage improvements in productivity, to the extent there is currently excess cost or waste in the health care system; however, these savings come on top of recently enacted productivity adjustments in the health reform law, and amidst concerns of their long-term effects on access to care. The reductions in Medicare payments to plans and providers could also coincide with spending cuts made by IPAB.

Additionally, Congress may look for more Medicare savings to offset costs associated with preventing a reduction in Medicare payments to physicians, even though those costs are exempt from PAYGO through the end of 2014 and would not be required to be offset under current law. Many deficit and debt reduction proposals, including Bowles-Simpson, Domenici-Rivlin, and the Senate "Gang of Six," recommended reforming or replacing the SGR with a new payment system.²⁶ According to the CBO, reforming the formula would cost \$297.6 billion dollars for 2012 to 2021, assuming a freeze in payments without an update over the next

decade.²⁷ This spending to reform the SGR formula would be in addition to any other Medicare savings needed to help reduce the deficit and debt.

As in all budget decisions, there is a very delicate balancing act to be achieved between reducing federal spending to improve the overall financial health of the country, and not causing harm to the people served by federally funded programs.

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¹ The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2011 Annual Report*.

² Congressional Budget Office, *Medicare Baseline*, March 2011.

³ For more information about issues to consider in transitioning to a premium support system, see Kaiser Family Foundation, *The Nuts and Bolts of Medicare Premium Support Proposals*, June 8, 2011; available at <http://www.kff.org/medicare/8191.cfm>. See also Kaiser Family Foundation, *Proposed Changes to Medicare in "Path to Prosperity": Overview and Key Questions*, April 14, 2011; available at <http://www.kff.org/medicare/8179.cfm>

⁴ See Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009-2010*, December 2010.

⁵ For more information, see Kaiser Family Foundation, *The Independent Payment Advisory Board: A New Approach to Controlling Medicare Spending*, April 13, 2011; available at <http://www.kff.org/medicare/upload/8150.cfm>

⁶ See Kaiser Family Foundation, *Medicare Spending and Financing: A Primer*, 2011.

⁷ See Foster, R.S., "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.

⁸ See Centers for Medicare and Medicaid Services, Office of the Actuary, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," May 13, 2011.

⁹ Congressional Budget Office, *CBO Analysis of August 1 Budget Control Act*, August 1, 2011.

¹⁰ Depending on how much Congress spends on two program integrity initiatives (Social Security Administration program integrity and Health Care Fraud and Abuse Control), a portion of such spending may be exempt from the discretionary caps. See Congressional Budget Office, *CBO Analysis of August 1 Budget Control Act*, August 1, 2011.

¹¹ For more information about the Medicare provisions in the major deficit and debt reduction proposals, see Kaiser Family Foundation, *Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals*, July 22, 2011; available at <http://www.kff.org/medicare/8124.cfm>

¹² Center on Budget and Policy Priorities, *Statement: Robert Greenstein, President, on New Debt Ceiling Agreement*, August 2, 2011; available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3555>.

¹³ See Kaiser Family Foundation, *The Budget Trigger and Health Reform*, August 4, 2011; available at <http://healthreform.kff.org/notes-on-health-insurance-and-reform/2011/august/the-budget-trigger-and-health-reform.aspx>

¹⁴ Center on Budget and Policy Priorities, *How the Potential Across-the-Board Cuts in the Debt Limit Deal Would Occur*, August 8, 2011; available at <http://www.cbpp.org/cms/index.cfm?fa=view&id=3557>

¹⁵ Congressional Research Service, *Statutory Budget Controls in Effect Between 1985 and 2002*, July 1, 2011; Congressional Budget Office, *Final Sequestration Report for Fiscal Year 1990*, October 11, 1989; and Paul Van de Water, *Budget Enforcement Mechanisms*, Testimony Before the Committee on Finance United States Senate, May 4, 2011.

¹⁶ Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2004 – 2013*, January 2003; Congressional Research Service, *Sequestration Procedures Under the 1985 Balanced Budget Act*, September 27, 2001.

¹⁷ Reischauer, R. "Taxes and Spending Under Gramm-Rudman-Hollings," September 1990 and Congressional Research Service, *Statutory Budget Controls in Effect Between 1985 and 2002*, July 1, 2011.

¹⁸ See Congressional Budget Office, *Mandatory Spending Control Mechanisms*, February 1996; see also Government Accountability Office, *Budget Process: Enforcing Fiscal Choices*, Testimony before the Senate Committee on Finance, May 4, 2011.

¹⁹ Congressional Research Service, *Techniques for Preventing a Budget Sequester*, March 8, 2002.

²⁰ Congressional Research Service, *Statutory Budget Controls in Effect Between 1985 and 2002*, July 1, 2011.

²¹ Congressional Research Service, *Techniques for Preventing a Budget Sequester*, March 8, 2002.

²² Congressional Research Service, *Statutory Budget Controls in Effect Between 1985 and 2002*, July 1, 2011.

²³ Congressional Research Service, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, April 2, 2010.

²⁴ Office of Management and Budget, *2010 PAYGO Report*, January 13, 2011.

²⁵ Congressional Research Service, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, April 2, 2010. The Senate also has procedural PAYGO rules, and the House of Representatives established CutGo rules in January 2011. For more information, see Bradford E. and Scogin M., *PAYGO Rules and Sequestration Procedures*, March 31, 2008 and Committee for a Responsible Federal Budget, *Understanding the New House Rules*, January 5, 2011.

²⁶ Kaiser Family Foundation, *Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals*.

²⁷ Congressional Budget Office, *Medicare's Payments to Physicians: The Budgetary Impact of Alternative Policies*, June 16, 2011.

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