KAISER FAMILY FOUNDATION
Medicare Policy

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE BRIEF

The Budget Control Act of 2011: Implications for Medicare

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OVERVIEW

Beginning January 2013, Medicare spending will be subject to automatic, across-the-board reductions, known as "sequestration," which is slated to reduce Medicare payments to plans and providers by up to 2 percent. This sequestration results from provisions in the Budget Control Act of 2011, signed by President Obama on August 2, 2011. The Act raised the debt ceiling and will reduce net federal spending by $2.1 trillion over ten years. This Act was a bipartisan compromise negotiated between the Administration and Congressional leaders, just before the nation was to breach the debt ceiling.

The Budget Control Act set forth a process to reduce federal spending and established a Joint Select Committee on Deficit Reduction, known as the "Super Committee", which failed to reach a bipartisan agreement. As a result, the Act required automatic reductions in spending, beginning in 2013. This sequestration is projected to reduce Medicare spending by $11 billion in FY2013. This reduction in Medicare spending will come on top of the $716 billion in net ten-year Medicare savings enacted in the Patient Protection and Affordable Care Act (ACA) of 2010.

This issue brief provides an overview of the Budget Control Act of 2011, describing the timeline and process for raising the debt ceiling and lowering the federal deficit. It describes the role of the Joint Select Committee on Deficit Reduction, examines how Medicare spending could have been affected by changes proposed by the Committee, and how they could be affected 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. Finally, this issue brief puts the new reductions in spending into a broader context of Medicare spending projections and recent efforts to reduce the growth of Medicare spending.

THE BUDGET CONTROL ACT: PROCESS AND TIMELINE

The Budget Control Act of 2011 raised the debt ceiling by $2.1 trillion to allow the federal government to continue to fund its obligations, capped discretionary spending, changed the student loan program, and will reduce federal spending, beginning January 2, 2013, unless legislation is enacted to prevent it. The Act required multiple actions including: sequential increases in the debt ceiling, the establishment of the Joint Select Committee on Deficit Reduction, a vote by the House and Senate on a Balanced Budget Amendment, and sequestration.

Increases in the Debt Ceiling

Since the passage of the Act, the debt ceiling has been raised three times, by the following amounts: $400 billion upon passage of the Act on August 2, 2011; $500 billion on September 21, 2011; and $1.2 trillion on January 28, 2012.

The initial increase in the debt ceiling coincided 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.[1] The law requires that, if discretionary spending exceeds the cap in a given year, the additional spending will be automatically reduced through 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. The second and third increases in the debt ceiling could have been overridden if both the House and Senate had passed measures disapproving of the increases.

Congressional Joint Select Committee on Deficit Reduction

The Budget Control Act required Congressional leaders to establish a new Joint Select Committee, also known informally as the "Super Committee," which was tasked with decreasing projected deficits by $1.5 trillion between FY2012 and FY2021. The Committee had 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 was permitted to consider a number of Medicare savings proposals that have been recently discussed, 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.[2] The Senate and House Committees with jurisdiction were permitted to send their recommendations for spending reductions or revenue increases to the Joint Select Committee for consideration.

The 12-member Committee included 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 appointed Representative Jeb Hensarling and Senator Patty Murray as co-chairs. Others appointed to the Committee were 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 was required to have its first meeting no later than September 16 and draft and vote on a proposal for decreasing the debt, by November 23. On November 21, 2011, the Joint Select Committee announced that it was not able to reach a bipartisan agreement and could not advance legislation to full Congress.

Balanced Budget Amendment

The Budget Control Act also required Congress to vote on a Balanced Budget Amendment to the Constitution between October 1 and December 31, 2011. The House of Representatives voted on the Balanced Budget Amendment on November 18, 2011; the measure did not receive the two-thirds majority needed to advance a constitutional amendment. On December 14, 2011, two Balanced Budget Amendments failed in the Senate.

Sequestration

Sequestration is scheduled to occur beginning January 2, 2013,[i] since the Joint Select Committee did not develop legislation by the deadline set by the Budget Control Act, and Congress did not subsequently enact such legislation by January 15, 2012. The sequestered spending is required to be divided equally amongst the fiscal years 2013 through 2021, and half of the sequestered spending each year will 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 2014,[3] farm price supports, vocational rehabilitation basic state grants, and the Social Services block grant. Medicaid is exempt from sequestration, as are other low-income programs and Social Security. In 2014 and thereafter, the discretionary savings will be achieved through reductions in the caps on discretionary spending.

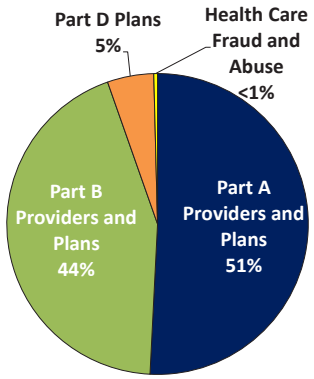
The law limits the amount of savings that would be achieved through Medicare, capping reductions at 2 percent of payments to providers and plans per year of sequestration, and would apply to Medicare payments to Medicare Advantage plans, Part D (prescription drug) plans, and providers, including but not limited to hospitals and physicians. The Budget Control Act prohibits sequestration from affecting:

- 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.

On August 7, 2012, President Obama signed into law the Sequestration Transparency Act of 2012 (P.L. 112-155), which required the Administration to report to Congress on the impact of the sequestration. On September 14, 2012, the Office of Management and Budget (OMB) released preliminary estimates of the sequestration's impact on the federal government, including Medicare (**Exhibit 1**).

Exhibit 1

Estimated Impact of Sequestration on Medicare Spending for FY2013



Total Sequestered Spending, FY2013 = $11.085 billion

NOTE: Total sequestered amounts shown include Medicare non-administrative spending only.
SOURCE: Office of Management and Budget Report Pursuant to the Sequestration Transparency Act of 2012, September 2012.

OMB estimates that Medicare non-administrative spending would be reduced by $11.085 billion for FY2013, including $5.607 billion from the Federal Hospital Insurance Trust Fund (Medicare Part A), $4.903 billion from the Federal Supplementary Medical Insurance Trust Fund (Medicare Part B), $559 million from the Prescription Drug Account (Medicare Part D), and $16 million from the Health Care Fraud and Abuse Control Account.[4]

[i] Reduced payments to providers will go into effect February 1, 2012.

While sequestration will 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. Sequestration of Part B spending would lower beneficiaries' Part B premiums from what the premiums would have been otherwise, since Part B premiums are set to cover approximately 25 percent of projected Part B spending.

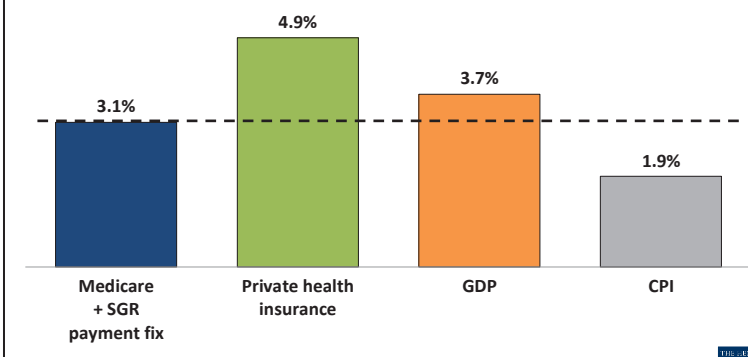
SEQUESTRATION IN THE CONTEXT OF MEDICARE SPENDING

Federal expenditures for the 50 million people covered by Medicare will exceed $550 billion in 2012, and are projected to exceed $1 trillion by 2022.[5] As a result, many of the major debt reduction proposals released in the past several years 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,[6] 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 in the ACA of 2010. The 2010 law included more than $716 billion in net Medicare savings between 2013 and 2022, reducing annual payment updates to hospitals and other providers by $415 billion and payments to Medicare Advantage plans by $156 billion over ten years.[7] Additionally, the law authorized a new Independent Payment Advisory Board (IPAB) and charged it with developing recommendations to reduce Medicare spending if the projected per capita growth rate exceeds target levels.[8] As a result of these changes and other factors, Medicare per capita spending is projected to grow on average by about 3.1 percent between 2011 and 2020, substantially less than the 4.9 percent per capita growth in private health insurance expenditures, and grow at a slightly slower rate than the overall economy, as measured by the growth in the gross domestic product (GDP) (**Exhibit 2**).

Exhibit 2

Projected Increase in Medicare Per Capita Spending Relative to Per Capita GDP and Private Insurance, 2011-2020



SOURCE: Kaiser Family Foundation

The reductions in spending made by the ACA are being phased-in, 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.[9] Additionally, the Office of the Actuary projected that, by 2019, roughly 15 percent of Medicare Part A providers would become unprofitable as a result of the provider productivity adjustments, and that the update reductions would not be sustainable over the long term.

POLICY ISSUES FOR THE FUTURE

The Budget Control Act imposed caps on discretionary spending, raised the debt ceiling, and requires further automatic spending reductions through sequestration. Some may consider the impending sequestration of payments to providers and plans 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 lead to 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 enacted productivity adjustments in the health reform law, and amidst concerns of their long-term effects on access to care. The President and Congressional leaders are set to negotiate a proposal that would repeal, modify, or replace the automatic spending reductions with alternatives measures to reduce the deficit. 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 maintaining health coverage for the people served by federally funded programs.

This brief was prepared by Gretchen Jacobson, Zachary Levinson, and Tricia Neuman of the Kaiser Family Foundation.

[1] Congressional Budget Office, *CBO Analysis of August 1 Budget Control Act*, August 1, 2011.
[2] 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
[3] 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
[4] Office of Management and Budget, *OMB Report Pursuant to the Sequestration Transparency Act of 2012 (P.L. 112-155)*, September 14, 2012.
[5] Congressional Budget Office, *Medicare Baseline*, March 2012.
[6] For more information about issues to consider in transitioning to a premium support system, see Kaiser Family Foundation, *Transforming Medicare into a Premium Support System: Implications for Beneficiary* Premiums, October 2012; available at http://www.kff.org/medicare/8373.cfm. See also Kaiser Family Foundation, *Comparison of Medicare Premium Support* Proposals, July 2012; available at http://www.kff.org/medicare/8284.cfm. Also 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.
[7] Congressional Budget Office, *Letter to the Honorable John Boehner Providing an Estimate for H.R. 6079, the Repeal of Obamacare Act*, July 24, 2012.
[8] 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.
[9] See Foster, R.S., "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010.

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.[1] 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 in FY1987 and FY1989, and reduced the sequestration in FY1990, through various means.[2] 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.[3] 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.[4]

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.[5] 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.[6]

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 sequestrations. 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.[7] 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.[8]

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.[9] 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.

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[1] 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.
[2] 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.
[3] 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.
[4] 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.
[5] Congressional Research Service, *Techniques for Preventing a Budget Sequester*, March 8, 2002.
[6] Congressional Research Service, *Statutory Budget Controls in Effect Between 1985 and 2002*, July 1, 2011.
[7] Congressional Research Service, *Techniques for Preventing a Budget Sequester*, March 8, 2002.
[8] Congressional Research Service, *Statutory Budget controls in Effect Between 1985 and 2002*, July 1, 2011.
[9] Congressional Research Service, *The Statutory Pay-As-You-Go Act of 2010: Summary and Legislative History*, April 2, 2010.

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