Budget Sequester: Potential Impact on Health Care Providers

M.J. Ferrara

ABBREVIATIONS: FY = fiscal year; NIH = National Institutes of Health

I present an overview of the potential impact on health care providers due to blanket federal spending cuts (the Sequester) triggered by the Budget Control Act of 2011, highlighting specific areas of impact to both academic and private practice physicians.[1] The aim is to provide some clarity and context to the health care component of the Sequester and, consequently, defuse some of the hype and hyperbole that can accompany a discussion of such complexity, rife with so many impassioned stakeholders.

The Budget Control Act of 2011 was enacted to avert a looming debt-ceiling crisis, which could have resulted in the United States defaulting on its sovereign debt for the first time in the history of the country. The impact of this would be analogous to a private citizen defaulting on his mortgage, restricting his ability to borrow more money in the future. Among other mandates, the law requires $1.2 trillion in federal spending cuts during 9 years, for FY 2013 through 2021.[2] These cuts are split evenly between defense (military) and nondefense spending. The initial start date of January 1, 2013, was postponed through additional legislation (American Taxpayer Relief Act)[3] to March 1.

Medicare Cuts

Health care spending is impacted in 2 major ways. First, physician reimbursements through Medicare absorbed a 2% across-the-board cut, effective April 1, 2013, resulting in aggregate cuts of a projected $122 billion during the 9 years. Additionally, decreases in Medicare Part B premiums will produce an additional $31 billion in reductions.[4] For 2013, the total spending reduction is expected to be $10.84 billion.[4] Total Medicare spending in 2012 was $551 billion.[5] The dollar amount attached to the 2% cut will scale up as Medicare spending trends upward. The Congressional Budget Office projects 2015 Medicare spending to breach $600 billion ($12 billion cut) and, by 2019, to exceed $800 billion ($16 billion).[6]

Ancillary Department Cuts

Second, federal spending cuts in research dollars face even deeper reductions than Medicare. For FY 2013, the National Institutes of Health must cut 5.5% ($1.71 billion) across all Programs, Projects, and Activities.[7] This would reduce by 703 (7.8% drop) the number of competing research grants awarded.[8] The NIH budget funds the work of >300,000 research personnel.[9] The National Science Foundation faces 5% in cuts, projecting 1000 fewer grants awarded for 2013.[10]

The FDA will see $218 million (8% across the board) in cuts, including $39 million to Human Drugs, $17 million to Biologics, and $26.5 million to Devices.[11] Industries regulated by the FDA pay upward of $83 million a year in user fees, in part to fund drug approvals. Even though these dollars are not generated by tax revenue, they are nonetheless still subject to Sequestration cuts, a contentious point within the industry.[12]

The Centers for Disease Control and Prevention will see budget cuts of $285 million (5%) for FY 2013 from the Sequester. Combine these with additional, non-Sequester-related cuts and the Centers for Disease Control and Prevention for FY 2013 will have $580 million fewer dollars available than in the previous year.[13] Medicaid is on a list of programs protected from the Budget Control Act of 2011 and thus is insulated from related cuts.

Demographics

Health care professionals often see Medicare as a government liability with harrowing prospects because it is a "pay-as-you-go" program with worrisome demographic trending. Retirees today have the brunt of Medicare costs covered by the payroll taxes of active workers. As baby boomers continue to age, the ratio of active workers paying into the system (payroll taxes) to retirees pulling out (Medicare recipients) is worsening: 3.0:1 in 2009 sliding to 2.1:1 by 2035.[14] For context, the ratio of workers to Social Security beneficiaries in 1955 was 8.6:1.[15] The strength of that

Received June 15, 2013; accepted after revision July 24.

From Northwestern Mutual/The Miami Group, Miami, Florida.

Please address correspondence to Matthew J. Ferrara, Financial Advisor, Northwestern Mutual/The Miami Group, 2 S. Biscayne Blvd, Suite 220, Miami FL, 33131; e-mail: matthew.ferrara@nm.com

http://dx.doi.org/10.3174/ajnr.A3726

1955 ratio is, in part, bolstered by the fact that Social Security did not start writing checks to retirees until 1940. As of 2012, there were 50 million people covered by Medicare, 85% of whom were elderly (as opposed to disabled beneficiaries).[16] Ten thousand Americans will turn 65, every day, through 2030.[17]

Analytic Challenges

In evaluating the Sequester as it relates to private practice physicians, it is sensible to focus on Medicare reimbursements because these rates set the benchmark for both government and private insurance reimbursement rates. When it comes to how physicians are compensated for the care they provide, Medicare rates are the straw that stirs the drink.

Less than 6 months into the 2% cuts of the Budget Control Act of 2011, there are few compelling empiric data available that could lead one to any definitive diagnosis of the impact on the day-to-day lives of physicians, especially because these cuts fall close on the heels of a series of previous cuts in recent years. One cannot place the latest cuts in a vacuum to analyze the direct impact nor can 3–6 months be considered a representative sample size worthy of analysis.

In that light, it seems that the more edifying discourse lies in placing the Sequester cuts of the Budget Control Act of 2011 in the context of the broad trends in third-party reimbursement and the effects they are having on physicians. Viewed from 30,000 feet up, are the Sequester cuts a tipping point leading to the demise of the independent private practice physician?—all signs point to no. However, is it another layer of ice on the glacial expansion that erodes the independent physician's ability to maintain the status quo of his or her business model—that seems the prevailing sentiment.

Private Practice

The slow pace of the ebb may actually be part of the problem. In the same way that a lobster sitting in a pot heating a single degree per hour may be unaware of the long-term peril he finds himself in, these incremental cuts viewed in isolation can appear much ado about nothing. Dr Joshua Lenchus (President of the Jackson Health System Medical Staff, Associate Professor, Clinical Medicine and Anesthesiology at the University of Miami Miller School of Medicine) illuminates this concern (written communication; June 6, 2013): "We are not feeling any direct effects from sequestration aside from the 2% cut (but)…. My biggest fear is that, due to the lack of meaningful negative effect on a physician's daily life or the practice of medicine, we will become complacent, emboldening the Federal Government to do something like this again."

Alfred A. Caminos, Chief Operating Officer of Med Health Services (a multispecialty group, serving >200 regional, physician-based health care facilities) in Pittsburgh, Pennsylvania, feels a mounting pressure on the sustainability of the private practice testing model, akin to an assault by 1000 paper cuts (written communication; June13, 2013): "The 2% across the board Medicare Sequester cut is not a game changer in and of itself, but catastrophic for outpatient, independent physician clinics when added to the 35%–40% reimbursement cuts already experienced in Echocardiography and Cardiac Nuclear SPECT imaging, 50% cuts in electromyogram test and nerve conduction velocity testing and 25% reduction in technical component payment for additional imaging procedures (when more than one procedure is performed on the same day). Couple the reimbursement cuts with rising uncollected debt as a result of increased patient deductibles and an onerous preauthorization process for many medical imaging procedures and one finds that many practices today are experiencing significant drops in revenues while their operating costs continue [to] rise. As industry revenues continue to dip, we have seen sequential 15% and 25% annual hikes the last two years in our own health insurance premiums."

Academia

The Sequester cuts in academic settings are less pervasive but far more impactful for those directly affected. Grant dollars often comprise the entirety of a research team's salary source. Principal Investigators and their associated teams (fellows, technicians, and so forth) who experience a decrease or outright loss of funding can see dramatic reductions in their base compensation, including the elimination of positions altogether. Unlike the Medicare cut, which is 2% across the board and thus incrementally more manageable, the Sequester will manifest itself largely in the research arena through the reduction and elimination of entire grants or limiting the scope of new ones. Dr Jose Pizarro (Section Chief of Neuroradiology, Chairman of Radiology, Mount Sinai Medical Center) reflects (written communication; June 13, 2013): "We are now doing research projects that are simpler and of a smaller scale than what we did in the past."

Beyond 2013

The arithmetic is challenging because the spending reductions are tied to the moving target of Medicare spending; it will always be 2 cents of every dollar, but how many dollars? The delta between low- and high-end estimates of Medicare spending plots an expansive pendulum swing. In 2010, the Congressional Budget Office estimated cumulative Medicare spending between 2013 and 2020 at $6.6 trillion. Conversely, the 2013 estimate of the Congressional Budget Office for that same period has been revised down to $5.6 trillion, a net drop of $1.0 trillion.[18] In economies of this scale within a model so sensitive to human behavior, even slight shifts in the delivery of health care (or the calculus used to project it) can deliver dramatic swings in the cumulative numbers. Either way, a physician should be concerned less by the aggregate number and more focused on further action that trims individual rates. The shrinking margin on the cost of delivering care and what one can charge is the pivotal metric.

If the law stands in its current form, annual cuts affecting research funding and Medicare reimbursements will continue through 2021. However, what if Congress acts? Handicapping the next move of Washington is never easy, but urgency seems to be waning. The "cash flow" situation of the federal government is slightly less dire than it was this time last year: We are seeing slower growth in Medicare spending and, at the same time, increasing tax revenues coming into the Treasury. Policy battles such as immigration reform are on the front burner. Couple that with the murky political ramifications (neither party is sure if renegotiating the Sequester is to their political gain) and the pre-

vailing view of the moment is that any serious discussion will be pushed back until after the 2014 midterm elections.[19]

Disclosures: Matthew J. Ferrara—*OTHER RELATIONSHIPS:* I work as a financial advisor serving primarily physician clients. I lecture at hospitals but receive no compensation or special access of any kind.

REFERENCES

1. Public Law 112-25 S. 365 The Budget Control Act of 2011. 112th Congress. Superintendent of Documents. United States Government Printing Office. January 5th, 2011 http://www.gpo.gov/fdsys/pkg/BILLS-112s365enr/pdf/BILLS-112s365enr.pdf
2. Labonte M, Levit MR. The Budget Control Act of 2011: effects on spending levels and the budget deficit. Congressional Research Service. November 19, 2011. http://www.fas.org/sgp/crs/misc/R42013.pdf. Accessed April 16, 2013
3. President Obama signs the American Taxpayer Relief Act of 2012. Centers for Medicare & Medicaid Services. January 2, 2013. http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-01-03-Standalone.pdf. Accessed May 12, 2013
4. Estimated impact of automatic budget enforcement procedures specified in the Budget Control Act. Congressional Budget Office. September 12, 2011. http://www.cbo.gov/publication/42523. Accessed June 13, 2013
5. Gottlieb S. Medicare's temporary reprieve. *Forbes Online*. February 13, 2013. Accessed June 12, 2013
6. CBO Medicare Baseline, March 2009; CRS analysis of CBO Cost Estimates for the PPACA as amended by the Reconciliation Act, March 20, 2010. http://www.ncsl.org/documents/health/mcprov.pdf Accessed June 5, 2013
7. The National Institutes of Health current operating year, fiscal year 2013. National Institutes of Health Office of Budget. http://officeofbudget.od.nih.gov/cy.html. Accessed June 13, 2013
8. Kaiser J. NIH details impact of 2013 sequester cuts. *Science Insider* May 8, 2013. http://news.sciencemag.org/people-events/2013/05/nih-details-impact-2013-sequester-cuts. Accessed June 12, 2013
9. Fact sheet: impact of sequestration on the National Institutes of Health. National Institutes of Health. June 3, 2013. http://www.nih.gov/news/health/jun2013/nih-03.htm. Accessed June 13, 2013
10. Important Notice to Presidents of Universities and Colleges and Heads of Other National Science Foundation Awardee Organizations. Notice No. 133. National Science Foundation Office of the Director. February 27, 2013. http://www.nsf.gov/pubs/2013/in133/in133.pdf. Accessed June 12, 2013
11. Alliance for a Stronger FDA. FDA: sequesterable funding by center/user free. http://fdaalliance.files.wordpress.com/2009/11/sequesterable-fda-funding-by-center-10–17-12-doc-doc.pdf. Accessed June 13, 2013
12. Ethridge E. Sequester withholding of FDA user fees irks industry. *Roll Call*. May 17, 2013. http://www.rollcall.com/news/sequester_withholding_of_fda_user_fees_irks_industry-224910–1.html?pos=hln. Accessed June 11, 2013
13. Fact sheet: impact of sequestration and other budget changes on the Centers for Disease Control and Prevention. CDC 24/7. http://www.cdc.gov/fmo/topic/budget%20information/appropriations_budget_form_pdf/Sequester_Impacts.pdf. Accessed June 13, 2013
14. Levit MR, Labonte M. The Budget Control Act of 2011: effects on spending levels and the budget deficit. Congressional Research Service 7–5700 2011. May 4, 2012. http://www.fas.org/sgp/crs/misc/R42506.pdf. Accessed April 16, 2013
15. Table II.F19: comparison of OASDI covered workers and beneficiaries by alternative, calendar years 1945–2070. Social Security Administration. http://www.ssa.gov/history/reports/trust/1995/tbiif19. Accessed June 13, 2013
16. The 2012 long-term budget outlook. Congressional Budget Office. June 5, 2012. http://www.cbo.gov/publication/43288. Accessed June 14, 2013
17. Cohn D, Taylor P. Baby boomers approach 65–glumly. *Pew Research Social & Demographic Trends*. December 20, 2010. http://www.pewsocialtrends.org/2010/12/20/baby-boomers-approach-65-glumly/. Accessed June 14, 2013
18. Thompson D. Don't look now, but our Medicare spending projections are plummeting. *The Atlantic*. May 14, 2013. http://www.theatlantic.com/business/archive/2013/05/dont-look-now-but-our-medicare-spending-projections-are-plummeting/275849/. Accessed June 12, 2013
19. Nicholas P, Hook J, Paletta D. Deficit deal even less likely. *The Wall Street Journal*. June 2, 2013. http://online.wsj.com/article/SB10001424127887324423904578521600404730028.html. Accessed June 11, 2013