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The American Taxpayer Relief Act of 2012 and Anticipated Medicare and Medicaid Payment Reforms

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On January 1, 2013, the U.S. Congress approved the American Taxpayer Relief Act of 2012 (the Act), concluding a protracted debate on how to prevent the United States from falling over the proverbial "fiscal cliff." President Obama signed the legislation into law on January 2, 2013.

The legislation extends a number of individual and business taxes and unemployment insurance, but is more noteworthy for the health care community for the more than 40 Medicare and Medicaid changes, many of which will significantly affect payment for and regulation of health care items and services. The legislation also is notable for what it does not include: numerous Medicare and Medicaid changes that would have more dramatically altered the payment and regulatory landscape, and which the health care industry feared would be part of this legislation. While some in the health care industry may be breathing a sigh of relief over bullets dodged, the reprieve may be short-lived, as the Act sets Congress on a course to again consider substantial changes to Medicare, Medicaid and other entitlement programs as soon as February 2013.

This *White Paper* summarizes the Medicare, Medicaid and health reform provisions included within the Act, and looks ahead to the next wave of legislation that may be swelling offshore.

Medicare Extensions

MEDICARE PHYSICIAN PAYMENT UPDATE

One of the most significant and prominent portions of this legislation is the prevention of substantial cuts to Medicare payments to physicians. The Act directs the U.S. Centers for Medicare and Medicaid Services (CMS) to continue to pay physicians at 2012 levels through 2013. Without this fix to the payment formula, physician payments would have been cut 26.5 percent. While this intervention is welcome relief for physicians who were fearing substantial cuts in payments, 2013 will be the second consecutive year with no inflation increase to physician payments. In other words, except for other non-inflationary adjustments, Medicare payments to physicians in 2013 will be the same as they were in 2011.

The Act also adds a provision to the Social Security Act that revises the reporting requirements under the Physician Quality Reporting System. This program provides incentive payments (and payment adjustments beginning in 2015) for eligible professionals who report data on quality measures. Under the new provision, a professional will be deemed to meet data submission requirements for the program if he or she "satisfactorily participates" in a qualified clinical data registry. The Secretary of the Department of Health and Human Services (Secretary) must define a "qualified clinical data registry" and clarify how reporting requirements are to be met. The Act also directs the Comptroller General (the U.S. Government Accountability Office (GAO)) to conduct a study—due November 15, 2013—on how to utilize clinical data registries to improve the quality and efficiency of Medicare beneficiary care, as well as potential uses of these data by private health insurers.

PHYSICIAN WORK GEOGRAPHIC ADJUSTMENT

The Act also preserves payment rates for physicians' services by keeping the Geographic Practice Cost Index (GPCI) floor of "1.0" for the work component of physician payment rates. Medicare adjusts payments to physicians through the GPCI to reflect the varying cost of delivering physician services in different locations. These GPCIs are applied to the three components used to calculate a procedure's relative value unit: work, practice expense, and malpractice. In 2003, Congress created a "floor" of 1.0 for the work component of the formula so that physician payments would not be reduced in a geographic area just because the relative cost of physician work fell below the national average. The Act continues this floor through 2013.

OUTPATIENT THERAPY SERVICES

Legislation enacted in 1997 created an annual per-Medicare-beneficiary cap of $1,500 for outpatient therapy services, except when received from a hospital outpatient department. The annual cap applied to physical and speech therapy combined, and separately to occupational therapy. From 1997 through the end of 2005, the caps were never imposed because Congress enacted a series of bills temporarily suspending the caps.

In 2005 legislation, Congress allowed the caps to go into effect in 2006, but established an exceptions process whereby Medicare beneficiaries can request and be granted an exception to the caps, and receive an unlimited amount of therapy services to the extent deemed medically necessary by Medicare. The 2005 law authorized the exceptions process for only one year, but Congress has also repeatedly extended the exceptions process. The Act extends this exceptions process, which effectively suspends the cap, for an additional year, through December 31, 2013.

Prior to 2012, the limits on annual payments for therapy services did not apply to therapy services furnished by hospitals. The Middle Class Tax Relief and Job Creation Act (Public Law 112-96) applied the caps to therapy services furnished by hospitals in outpatient settings. The American Taxpayer Relief Act broadens the scope of the caps further, now applying the caps to therapy services furnished on an outpatient basis by critical access hospitals.

The Act also provides additional protection to beneficiaries affected by this cap by incorporating the beneficiary rights provisions of Section 1879 of the Social Security Act. Section 1879 protects Medicare beneficiaries from liability for items and services furnished to them if the Medicare beneficiary and the provider did not know, and could not have been reasonably expected to know, that the item or service would be non-covered.

AMBULANCE ADD-ON PAYMENTS

Beginning July 1, 2008, Medicare increased the base Medicare reimbursement rate for ground ambulance trips originating in rural areas by 3 percent, and for ground ambulance trips originating in urban areas by 2 percent. Both payment enhancements were set to expire December 31, 2012. The Act extends these payment increases for another 12 months through December 31, 2013.

The Act also extends special treatment for certain air ambulance services originating in rural areas. Legislation enacted in 2008 continued rural status for certain areas previously deemed to be rural but subsequently reclassified as urban for purposes of qualifying air ambulance services for more favorable payment. This special treatment was continued by the Act, but only until July 1, 2013.

The Medicare statute also provides a "super" add-on payment for ambulance services in the "lowest population density" areas. CMS has set this add-on payment at 22.6 percent. The Act extends the add-on for ambulance service in these "super rural" areas through 2013.

Notably, the Act signals that Congress is considering potential payment reforms for ambulance services by directing the Secretary to conduct two studies. The first study will analyze cost report data for ambulance services furnished by hospitals and critical access hospitals—including any variation among these providers. This report is due to Congress by October 1, 2013. The second study must examine the potential to reform the payment system for ambulance services by determining the feasibility of collecting cost report data from all ambulance providers and suppliers, and a corresponding report must be completed no later than July 1, 2014.

LOW-VOLUME HOSPITAL ADJUSTMENT

The Medicare Program provides a percentage increase for each payment to certain qualifying low-volume hospitals. The Affordable Care Act substantially broadened the eligibility criteria, enabling many more hospitals to qualify for these additional payments. The Act continues the broader eligibility criteria for low-volume hospitals—as well as the Affordable Care Act methodology for calculating such payments—through 2013.

MEDICARE-DEPENDENT HOSPITAL PROGRAM

The Medicare Program has a special reimbursement methodology that increases Medicare payments for certain hospitals that qualify as Medicare-Dependent Hospitals (MDHs). This program is designed to support small rural hospitals with a substantial Medicare patient population that rely significantly on Medicare payments. This program expired October 1, 2012. The Act extends the MDH program through October 1, 2013. CMS has indicated that it will issue instructions to hospitals that forfeited or lost this status effective October 1, 2012, on how to regain MDH status.

EXTENSION FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS AND EXTENSION OF MEDICARE REASONABLE COST CONTRACTS

The Act extends authorization for Special Needs Plans (SNPs) through the end of the CY 2014 benefit year. Although not a permanent authorization for these types of Medicare Advantage Plans, the extension enables existing SNPs to continue to service Medicare beneficiaries and also enables entities to move forward with plans to apply to offer SNPs or expand the service area of existing SNPs for CY 2014. The legislation does not, however, address any of the payment issues raised by sponsors of SNPs, such as recognition of frailty or co-morbidities among the SNP population, beyond those already in place for all Medicare Advantage Plans.

Congress also permits reasonable cost reimbursement contracts to be extended or renewed for a service area even if there are two or more Medicare Advantage regional plans or two or more Medicare Advantage local plans in the contract's service area. This provision is effective until January 1, 2014.

PERFORMANCE IMPROVEMENT

In the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), Congress instructed the Secretary to hire a consensus-based entity to collect and synthesize evidence and to meet with relevant stakeholders in order to make recommendations on national strategies and priorities for developing health care performance measurement in all care settings. Funding for this program ended September 30, 2012. The Act continues funding for this consensus-based entity through fiscal year 2013.

In an expansion of this initiative, Congress now instructs the Secretary to develop a strategy to allow "applicable providers" (physicians, hospitals, critical access hospitals, and any other provider selected by the Secretary) to receive performance improvement data (e.g., utilization data, feedback on quality data). The Secretary must publish this strategy on the publicly available CMS website and must seek feedback from relevant stakeholders.

Congress demonstrates an interest in conducting analyses on the potential uses of performance data. Accordingly, in conjunction with CMS's activities, the Comptroller General must study and submit a report on how both the Medicare Program and private sector entities share data with providers. The study and resulting report will help evaluate information-sharing processes in public and private industries, and will identify opportunities to make future improvements.

EXTENSION OF FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS

Under legislation enacted in 2008, Congress created additional funding for state health insurance assistance programs designed to provide information and counseling services. These programs are designed to make available information regarding eligibility, benefits, payments and appeals under the Medicare Program, as well as to provide guidance on connections between Medicare and a state's Medicaid Program. The Affordable Care Act increased the funding for this program from $7.5 million to $15 million for fiscal years 2010 through 2012; the American Taxpayer Relief Act reduces funding back to $7.5 million for fiscal year 2013.

Congress also extends funding to states for three other low-income programs: area agencies on aging, aging and disability resource centers, and initiatives implemented by the National Center for Benefits and Outreach. Area agencies on aging were first developed under the Older Americans Act, which required states to develop public or nonprofit organizations that plan, develop, coordinate and arrange for a broad range of services for older adults. The Act decreases funding for these programs from $15 million in fiscal years 2010–2012 to $7.5 million in fiscal year 2013.

Similarly, the Act continues funding for Aging and Disability Resource Centers, which are administered by the Administration on Aging in collaboration with CMS to facilitate access to and increase information about long-term care options available to the elderly. The Act reduces by half the amount of funding for these centers ($5 million) as compared to that provided in the Affordable Care Act ($10 million). Finally, the Act maintains the same level of funding ($5 million) for the ongoing contract with the National Center for Benefits Outreach and Enrollment, which assists seniors and younger adults with disabilities in signing up for benefits programs for which they qualify.

Other Health Extensions

EXTENSION OF THE QUALIFYING INDIVIDUAL AND TRANSITIONAL MEDICAL ASSISTANCE PROGRAMS

Two programs specifically for low-income Medicaid beneficiaries have also been extended. First, federal Medicaid law requires state plans to provide assistance to dual eligibles in the form of premium support for Part B services for qualifying Medicare beneficiaries that have incomes between 120 percent and 135 percent of the poverty level. Separately, the Transitional Medical Assistance Program provides low-income families with the ability to continue Medicaid coverage on a temporary basis once they become employed and collect earnings that otherwise disqualify them from eligibility.

The Act extends both programs through 2013. For the Qualifying Individual (QI) Program, the Act also increases the amount allocated to the program in 2013 as compared to 2012, with $485 million available for the period from January 1, 2013, to September 30, 2013, and $300 million available for the period from October 1, 2013, to December 31, 2013.

EXTENSION OF MEDICAID AND CHIP EXPRESS LANE OPTION

The Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3) created the Express Lane option to help facilitate determinations regarding Medicaid and Children's Health Insurance Program (CHIP) coverage for children. This program permits a state to rely on the eligibility determinations of certain Express Lane agencies (e.g., Head Start agencies, agencies administering the temporary assistance for needy families program) instead of requiring the state Medicaid and/or CHIP agency to conduct a separate eligibility analysis. This program is now reauthorized through September 30, 2014.

EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS

The Act extends the Family-to-Family Health Information Center program through fiscal year 2013. This program was originally created in the Deficit Reduction Act of 2005 (Public Law 109-171) and provides grants to centers that help families with children who have disabilities or special health care needs. The program provides information, education, training and referral services, and facilitates interaction among families who have children with disabilities.

EXTENSION OF SPECIAL DIABETES PROGRAM FOR TYPE I DIABETES AND FOR INDIANS

Congress established two diabetes-related funding programs under the Balanced Budget Act of 1997 (Public Law 105-33): the Special Diabetes Program (SDP-type 1) and the Special Diabetes Program for Indians (SDPI). The SDP-type 1 program is administered through the National Institute of Diabetes and Digestive and Kidney Diseases and focuses on research for the prevention and treatment of type 1 diabetes. The SDPI program is designed specifically for Indian health programs and provides funding for resources and tools to prevent and treat diabetes in the Indian population. Both programs have been reauthorized several times; the Act now reauthorizes these programs again, this time through fiscal year 2014.

Other Health Provisions

IPPS DOCUMENTATION AND CODING ADJUSTMENT FOR IMPLEMENTATION OF MS-DRGS

Under the TMA, Abstinence Education, and QI Programs Extension Act of 2007 (Public Law 110-90), Congress required CMS to adjust hospital payments in fiscal years 2010 through 2012 to offset payment increases believed to have resulted in fiscal years 2008 and 2009 from the transition to a new coding classification system and not from actual changes in hospitals' case mix. The Act now revises the 2007 legislation to require an offset for fiscal year 2010 too. The Act also directs the Secretary to apply an additional prospective adjustment in fiscal years 2014 through 2017 to further offset an $11 billion increase in aggregate payments from 2008 through 2013 that also resulted from implementation of the new coding classification system.

ESRD BUNDLED PAYMENTS AND NON-EMERGENCY AMBULANCE TRANSPORTS FOR ESRD BENEFICIARIES

The Act includes a provision that re-bases end-stage renal disease (ESRD) payments. In a December 2012 report by the GAO regarding ESRD services and payments, the GAO found that utilization of ESRD drugs in 2011 was approximately 23 percent lower than utilization in 2007. Insofar as 2011 ESRD bundled payment rates are based on 2007 utilization data, the report concluded that Medicare could have saved as much as $880 million by re-basing the 2011 payment rates to reflect 2011 drug

utilization. Congress took this advice to heart, requiring the Secretary to compare 2007 and 2012 utilization data and make reductions to bundled payment rates accordingly for renal dialysis services furnished on or after January 1, 2014.

The Act also delays incorporation of oral-only ESRD-related drugs into the bundled payment for renal dialysis services from January 1, 2014, until January 1, 2016. Currently, the Medicare program only provides payment for ESRD-related oral medications if the beneficiary has prescription drug coverage under Part D. Until this provision is incorporated, Congress instructs the Secretary to monitor bone and mineral metabolism of individuals with ESRD, conduct an analysis of necessary case mix payment adjustments, and issue a report by December 31, 2015, to update previous reports regarding the incorporation of oral-only ESRD-related drugs into the bundled payment.

As a cost-saving mechanism, the Act reduces reimbursement for non-emergency ambulance services provided to ESRD beneficiaries. Specifically, the Act reduces by 10 percent the amount paid for non-emergency basic life support ambulance services furnished to an individual with ESRD as part of transport for renal dialysis services. This provision is effective for services furnished on or after October 1, 2013.

MULTIPLE SERVICE PAYMENT POLICIES FOR THERAPY SERVICES

CMS has a number of policies that limit payment when multiple procedures are furnished on the same day. CMS originally created a 25 percent multiple procedure payment reduction by regulation in November 2010. In response to these regulations, Congress passed The Physician Payment and Therapy Relief Act of 2010 (Public Law 111-286), which, among other things, decreased the payment reduction to 20 percent. Under the American Taxpayer Relief Act, Congress mandates that the multiple procedure payment reduction be increased to 50 percent for therapy services furnished on or after April 1, 2013.

RADIOLOGY SERVICES

In the Act, Congress took the unusual step of requiring the same payment rate to be set for stereotactic radiosurgery described by Healthcare Common Procedure Coding System (HCPCS) code 77371 ("Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cerebral lesion[s] consisting of 1 session; multi-source Cobalt 60 based") and HCPCS code G0173 ("Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session"). This provision does not apply to hospitals located in rural areas, hospitals classified as rural referral centers, and sole community hospitals. Although highly unusual, this reflects a willingness by Congress to step in legislatively to adjust payment rates otherwise set by CMS through the rulemaking process.

In addition, the Act increases the assumed equipment utilization rate for certain expensive diagnostic imaging equipment to 90 percent. The equipment utilization rate is one component of the overall calculation of a physician's practice expense, which reflects the costs incurred in operating his or her practice and directly influences the calculation of payment for the physician's services. Raising the assumed equipment utilization rate changes the calculation in such a way that overall payments for each service are decreased. In regulations promulgated in November 2009, CMS set the utilization rate at 90 percent for expensive diagnostic equipment, but through the Affordable Care Act, Congress changed the utilization rate to 75 percent for fee schedules established for 2011 and subsequent years. Congress is now restoring the assumed equipment utilization rate to 90 percent beginning in 2014.

MEDICARE PAYMENT OF COMPETITIVE PRICES FOR DIABETIC SUPPLIES AND ELIMINATION OF OVERPAYMENT FOR DIABETIC SUPPLIES

CMS began implementing a Competitive Bidding Program (CBP) for diabetes testing supplies purchased through mail order suppliers in 2011. For the first two years, the payment amounts established under the CBP applied only in nine areas where the CBP was conducted. CMS is now conducting a second round of bidding, and in July 2013, the payment amount for all diabetes testing supplies purchased through mail order suppliers throughout the United States will be set through the competitive bidding program. Meanwhile, payment amounts for diabetes testing supplies purchased through non-mail-order suppliers (e.g., retail pharmacies) continue to be set by fee schedule. As a result, through much of 2012, CMS paid three different amounts for diabetes testing supplies: approximately $38 if purchased from a non-mail-order supplier, approximately $34 if purchased from a mail order supplier outside of a competitive bidding area, and approximately $14 if purchased from a mail order supplier in a competitive bidding area.

The Act begins to bring parity to those payment amounts, providing that effective April 1, 2013, Medicare will pay approximately $34 for all diabetes testing supplies, and then effective with implementation of the national competitive bidding program (expected to be July 1, 2013), Medicare will pay one rate (i.e., the rate determined through the CBP) regardless of where the supplies are purchased.

OVERPAYMENTS

The Act amends Section 1870 to lengthen the timeframe in which CMS may recoup overpayments made for items and services. Under this provision, providers are deemed to be "without fault" for any overpayments "subsequent to the fifth year following the year in which notice was sent" as to the amount paid. Prior to this change, providers would be deemed "without fault" after the third year. For providers that are determined to be "without fault," CMS and its contractors may not recoup overpayments for claims as long as there is no fraud. This revision to the de facto statute of limitations for overpayments will have a significant impact on simple recoupments made by CMS and its contractors. In particular, this provision may raise substantial issues for providers that have a pattern of improper payments over many years, as CMS would now be able to seek recoupment for a five-year period rather than three.

MEDICARE ADVANTAGE CODING INTENSITY ADJUSTMENT

The Act modifies the coding intensity adjustment that CMS is required to make to all Medicare Advantage Plan member risk scores to account for differences in coding practices and patterns between Fee-For-Service Medicare and Medicare Advantage, which are viewed as affecting Medicare Advantage Plan payments. The Affordable Care Act mandated a coding intensity adjustment for 2014 equal to the prior year's adjustment plus 1.3 percentage points, and the new legislation increases the percentage to 1.5 percent. For CY 2014, this means the CY 2013 adjustment of 3.41 percent will be increased by 1.5 percent, to 4.91 percent. The legislation also increases the minimum percentage for the coding intensity adjustment applicable to CY 2019 and subsequent years from the 5.7 percent adopted under the Affordable Care Act to 5.9 percent. These coding intensity adjustments are required until CMS implements risk adjustment using Medicare Advantage diagnostic, cost and use data.

ELIMINATION OF ALL FUNDING FOR THE MEDICARE IMPROVEMENT FUND

The Medicare Improvement Fund was created by 2008 legislation to provide funding for CMS to make improvements to the administration of the Part A and B programs. Congress decreased funding for this program through the Department of Defense Appropriations Act of 2010 (Public Law 111-118), and subsequently all funding for fiscal year 2014 was deleted under the Affordable Care Act. The American Taxpayer Relief Act now eliminates funding for fiscal year 2015 and removes a provision that would have provided funding in fiscal year 2020 and each year thereafter, effectively terminating this program.

STATE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The Affordable Care Act established a new methodology to determine Medicaid disproportionate share hospital (DSH) payments and reduce overall spending. Under the methodology, DSH payments will be reduced most in states that have the lowest percentage of uninsured and where DSH payments are least connected with hospitals' Medicaid or uncompensated care volumes. Under the ACA, Medicaid DSH allotments were reduced for fiscal years 2014–2021. The Act extends the ACA Medicaid DSH reductions for an additional year, 2022.

CLASS PROGRAM

The Affordable Care Act established the Community Living Assistance Services and Supports (CLASS) program to provide voluntary long-term care insurance options for U.S. workers to help prepare for long-term services and support that might be needed in the future. In October 2011, the Secretary halted implementation of the CLASS program, saying there was not a viable path forward" for the program. The Act now formally eliminates the CLASS program.

COMMISSION ON LONG-TERM CARE

Most likely as a result of the elimination of the CLASS program, Congress now creates a 15-person Commission on Long-Term Care tasked with developing a plan for the "establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system" for long-term care services. The Commission must consider how a new long-term services and support system would interact with current coverage under the Medicare and Medicaid programs, as well as any improvements that should be made to these programs in light of various long-term care issues. In addition, the Commission must address potential

needs for implementing such a support system (e.g., increased workforce development, new care delivery systems). Six months after appointment of its members, the Commission must vote on its long-term care plan, which, if approved by a majority of the Commission's members, must be submitted to the president, vice president, speaker of the House, and the majority and minority leaders of each House.

CONSUMER OPERATED AND ORIENTED PLAN PROGRAM CONTINGENCY FUND

The Affordable Care Act originally created the Consumer Operated and Oriented Plan program to create nonprofit health insurance issuers for the individual and small group markets. Congress now establishes a fund to provide assistance and oversight to qualifying issuers developed under this program. Funding for this assistance is gained by taking 10 percent of the current unobligated balance of funds first delegated for this initiative under the Affordable Care Act. Notably, however, the Act otherwise rescinds all funds for this program that are unobligated as of January 2, 2013.

Conclusions

The American Taxpayer Relief Act is not only notable for the provisions it includes, but also for the provisions that it does not contain. While the law extended a number of expiring Medicare programs, it did not extend a number of others, continuing a trend begun earlier in 2012 with the Middle Class Tax Relief and Job Creation Act of 2012, in which Congress started to bring to an end various payment enhancement programs. For example, Congress allowed a program that provided special Medicare payment protections to small rural hospitals to expire.

While physicians appreciate the one-year reprieve from drastic reimbursement cuts, organized medicine had hoped for a permanent solution that would end the annual ritual of seeking relief from payment cuts.

The medical device community is lamenting the fact that the Act was not able to include relief from a tax on device sales created under the Affordable Care Act. The device industry has been seeking such relief since 2010 and hoped that this legislation would accomplish that goal.

While the hospital community is bemoaning $10.5 billion in hospital payment reductions, it also is quietly celebrating the fact that the law did not include additional spending reductions that many observers expected to be included. For example, the hospital community has been vigorously fighting payment cuts for certain outpatient services, graduate medical education programs, bad debt losses and critical access hospitals. None of those cuts materialized in this new law.

The American Taxpayer Relief Act also is notable for setting up the next big legislative battle. The Act prevented the United States from "going over the fiscal cliff," a term first coined by the chairman of the U.S. Federal Reserve Bank, Ben Bernanke, when referring to the coincidental expiration of dozens of individual and business taxes on December 31, 2012, and a mandated sequestration of federal spending that was scheduled to be implemented on January 2, 2013. According to Chairman Bernanke and dozens of economists, not addressing the dual issues of the fiscal cliff likely would have plunged the U.S. economy back into recession.

While the Act resolved these issues in time to prevent economic catastrophe, it resolved the sequestration threat for only two months. Specifically, the Act delays the day of reckoning on the sequestration from January 2, 2013, to March 1, 2013. As such, Congress and the White House will be forced to confront this matter again in only two short months, at the same time that Congress and the White House also must negotiate an extension of the government's borrowing authority.

The U.S. Treasury predicts that the federal government will once again hit the "debt ceiling," the statutory restriction on how much the federal government may borrow, sometime in the next two months. On December 26, 2012, U.S. Treasury Secretary Timothy Geithner sent a letter to congressional leaders saying that the U.S. government would reach the debt limit on December 31, 2012, although the Secretary also indicated that the Treasury could take steps to forestall reaching the debt limit for approximately two months. Therefore, the president is expected to need to request additional borrowing authority sometime between mid-February and mid-March 2013.

If past debates are any indication, congressional Republicans will demand substantial reductions in federal spending in exchange for raising the federal debt limit. If congressional Republicans get their way, and Congress simultaneously re-orders the sequestration mandated under the Budget Control Act of 2011 (Public Law 112-25), the law that emerges from these debates would likely include substantial reductions in Medicare and Medicaid spending, perhaps on the order of $400 billion and $175 billion, respectively. Cuts of that magnitude would impose significant hardships on all aspects of the health care industry directly or indirectly reliant on payments from these federal programs.

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