



Perspective

Fallback Cuts or Super-Committee Concoction — Choosing Health Care's Policy Poison

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When the compromise on extending the debt limit was struck and enacted into Public Law 112-25 in early August, both President Barack Obama and the Republican congressional leadership stated that the

law's painful fallback budget cuts would probably not be triggered. They asserted that their very existence would motivate lawmakers (through the newly established congressional joint committee, better known as the super committee) to compromise on a thoughtful, policy-oriented deficit- and debt-reducing alternative to meet the law's required second round of cuts. The theory was that the \$1.2 trillion in automatic cuts to popular programs such as the military and Medicare outlined in the law's fallback "sequester" provision would be so damaging that all sides would produce a budget com-

promise to avoid the need for such cuts. Now, reflecting on the implications of likely alternatives, many health care stakeholders are concluding that the automatic cuts would be the lesser of the possible evils. How can that be?

First, Washington's governing precept is that the devil you know is preferable to the one you don't. Knowledgeable stakeholders — including consumer advocates, states, businesses, most health care providers, and pharmaceutical manufacturers — have a good sense of the implications and the liability exposure of policies that would emanate from the automatic cuts;

in contrast, they have no idea what specific policies would emerge from the super committee. And particularly when it comes to the health care community, ignorance is not bliss; rather, it evokes fear.

Second, when they study the possible scenarios, health care stakeholders are beginning to conclude that any plan agreed on by the super committee would result in larger aggregate cuts and would have a greater negative impact. More specifically, they know that such a plan would almost inevitably include new and damaging Medicaid cuts (Medicaid is exempted from the automatic cuts) and more extensive Medicare cuts (beyond the \$130 billion to \$150 billion that would be cut through the fallback 2% cap on total Medicare spending). They are quite aware that Republicans would insist on

much greater reductions to entitlements than the automatic cuts require, and they know that the Obama administration would have to spend health care negotiating chips to fulfill the President's desire for an up-front middle-income tax cut and investment initiative designed to help jump-start the economy.

And third, although there might and should be some revenues (from the closure of tax loopholes) on the table to help allay the need for extremely large Medicare and Medicaid cuts, few insiders believe that those revenues will be substantial enough to limit the required health care savings to a tolerable level. Indeed, most observers are willing to take Republicans at their word that they will continue to reject all or virtually all options that raise net revenues.

Thus, a "strange bedfellow" health care coalition has plenty of reasons to prefer that the automatic cuts take effect. Patient groups have virtually no reason to want the super committee to act, since the automatic cuts explicitly exempt seniors and the lowest-income Americans from any increases in cost sharing. These groups are highly skeptical that an alternative "big" deal would be balanced and fair, believing that the elderly and the poor would be exposed to painful increases in out-of-pocket costs in an agreement that probably would not include higher taxes on the highest-income Americans. They do not understand the strategy of agreeing to such cuts and thereby removing any leverage with which to secure revenues in the future.

At a time of increasing needs and decreasing or limited revenue, the states also wonder why they should accept large Medicare cuts and even some Medicare

cuts that shift — rather than contain — costs in ways that harm their budgets, their citizens, and their economies. Accepting those cuts in addition to the expected and disproportionately large cuts in appropriations and grants to the states called for by the debt-limit law would send many to the brink of budgetary calamity. And businesses ask why they should sanction large Medicare and Medicaid cuts that arguably shift costs to the private sector through even higher insurance premiums, particularly if the deal emerging from Congress ends up being a stopgap measure rather than a comprehensive agreement.

The analysis is not much different for health care providers and pharmaceutical manufacturers. Virtually all hospitals and home health care providers would rather not risk being exposed to greater Medicare and Medicaid cuts if they can limit their liability to the automatic 2% Medicare cut. (For physicians, the analysis is complicated by the ever-present need to more thoughtfully address Medicare reimbursement reforms, which might well be best handled in the context of a super-committee agreement.) As for pharmaceutical manufacturers, if their vulnerability to a large payment reduction (through the expansion of the Medicaid drug rebate) is almost eliminated by the automatic cuts and virtually ensured in a big deal, they can't really be expected to advocate for the latter.

To be clear, a well-constructed compromise — which would include an array of policies to spur job growth and boost the economy, a thoughtful collection of payment and cost-sharing reforms to sustain and strengthen Medicare and Medicaid over the long term, a long-overdue fix for physician

payment, and a reasonable deal on tax reform that closes loopholes and raises revenue — would almost inevitably be the better course of action for the economy and the nation. The question is whether such a balanced approach is possible in our polarized political environment. For the moment, most seasoned political and policy analysts are concluding that it is not.

The truth is that most health care stakeholders and their representatives trust neither the President nor the Republican leadership to pull off a balanced compromise that is sensitive to them and the populations they serve. They fear that the President is too willing to throw more and more health care savings onto the table to pursue an ever-elusive goal of a meaningful economic growth package. Moreover, even if his ongoing effort fails, they believe that having the President on record as proposing deep cuts will set a precedent and create a floor for cuts that can be "cherry-picked" in any future debate. Conversely, these stakeholders also believe that the Republicans will continue to oppose placing sufficient revenues on the table — a position that will, over time, necessitate excessive cuts to Medicare, Medicaid, and the implementation of the Affordable Care Act in order to achieve stated targets for deficit and debt reduction.

From the current vantage point of these stakeholders, the choice is therefore not a close call; the automatic cuts are by far the best poison to be forced to take, particularly in comparison to the concoction they fear the super committee could produce. It would meet the requirement of the law, protect against unknown and much larger cuts, and preserve resources and bargaining chips

for the next big deal, which will probably take place in 2013 after the presidential election.

Although health care stakeholders have substantial influence and will have an impact on congressional deliberations, they obviously don't have a vote in the decisions of the super committee, the rest of the Congress, and the President. Yet the concern over any

major agreement by the super committee — combined with the committee's difficult political challenge of attracting the majority required to pass an agreement — will most likely result in the triggering of some or all of the law's automatic health care cuts. The irony is that such an outcome would most likely be a welcome relief to most major players in the health care debate.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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