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HEALTH REFORM WILL REDUCE THE DEFICIT

Charges of Budgetary Gimmickry Are Unfounded

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Despite an official estimate by the Congressional Budget Office (CBO) to the contrary, some critics of the new health reform legislation — such as Rep. Paul Ryan and former CBO director and McCain campaign adviser Douglas Holtz-Eakin — charge that it will not reduce federal budget deficits because it relies on budgetary gimmicks or games.[1] Careful analysis of these charges shows them to be misleading or inaccurate. They do not withstand scrutiny.

CBO estimates the legislation will reduce the deficit by $143 billion over the ten years from 2010 through 2019.[2] In the following decade, 2020 through 2029, it estimates that the legislation will reduce the deficit by an estimated one-half of 1 percent of gross domestic product (GDP), or about $1.3 trillion. CBO also anticipates that health reform "would probably continue to reduce budget deficits relative to those under current law in subsequent decades, assuming that all of its provisions continue to be fully implemented."

We now examine the specific claims about budgetary gimmicks and games one by one.

Claim: Health reform covers up long-term deficit increases by front-loading revenues and back-loading spending.

Fact: Health reform will reduce deficits in the legislation's second ten years and in subsequent decades.

In claiming that health reform front-loads revenues and back-loads spending, critics selectively cite just a few provisions and fail to consider the legislation as a whole. The assertion that short-

[1] Douglas Holtz-Eakin, "The Real Arithmetic of Health Care Reform," *New York Times,* March 21, 2010; and Paul D. Ryan, "Dissecting the Real Cost of ObamaCare," *Wall Street Journal,* March 4, 2010.

[2] Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010. The estimate reflects the combined effects of H.R. 3590 (Public Law 111-148)), the Patient Protection and Affordable Care Act, and H.R. 4590, the Health Care and Education Reconciliation Act of 2010. The reconciliation bill also includes changes in federal education programs. Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf.

term gimmickry covers up long-term deficit increases is flatly contradicted by CBO's assessment that the legislation will reduce the deficit in its second ten years and in subsequent decades.

Claim: The legislation uses revenues from Social Security and premiums from long-term care insurance to offset the cost of health reform.

Fact: Health reform reduces the deficit even without counting long-term care insurance premiums and additional Social Security payroll tax collections.

CBO and the Joint Committee on Taxation have concluded that the health reform legislation will reduce employer spending on health insurance, in part because the new excise tax on high-cost insurance plans will lead employers to shift some employee compensation from health insurance to cash wages. Workers will pay Social Security payroll contributions and income taxes on the additional wages.

The legislation also establishes a new, voluntary program of long-term care insurance, called the CLASS Act. Benefit payments from CLASS will be fully financed by premiums that beneficiaries pay and interest earnings. In its early years, as the program starts up, premium collections will substantially exceed benefit payments.

Congressional leaders crafted the health reform bill so that it would be *fully paid for without relying on these additional Social Security payroll contributions or the CLASS Act premiums*. The CBO estimate clearly shows that if one excludes the net revenues of $29 billion from Social Security contributions and $70 billion from CLASS Act premiums, health reform still reduces the deficit by $44 billion over the first ten years.

Claim: Medicare savings are double-counted.

Fact: The Medicare savings in the legislation both reduce the budget deficit and extend the life of Medicare's Hospital Insurance trust fund. Recognizing that fact does not constitute double counting.

The health reform legislation contains provisions that slow the growth of Medicare spending — for example, by scaling back overpayments to private insurance plans that participate in Medicare, as Congress' expert advisory body on Medicare has recommended for years — and provisions that increase Medicare tax revenues. The provisions affecting the Hospital Insurance part of Medicare necessarily have two types of effects:

- Viewed from an overall federal budget perspective, they help pay for expanding health coverage for the uninsured and contribute to overall deficit reduction. CBO has estimated that the provisions in the health reform legislation, including the provisions affecting Medicare costs and revenues, will reduce the federal deficit both in the 2010-2019 period and thereafter.

- Viewed from the perspective of Medicare's Hospital Insurance (HI) trust fund, these

provisions reduce expenditures out of the fund, increase its income, increase the balances in the fund, and prolong the fund's life. The Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) has estimated that the Senate-passed bill (which has now been signed into law) will extend the solvency of the HI trust fund by ten years.[3]

Both of these results flow automatically from the nature of the federal budget and the trust funds, and the normal, longstanding accounting rules that apply to them. No double-counting occurs.

Deficit-reduction legislation has been accounted for in exactly the same way in previous Congresses under both political parties. For example, both the Balanced Budget Act of 1997 and the Deficit Reduction Act of 2005 (both of which were passed by Republican Congresses) included Medicare savings that reduced the federal deficit *and* improved the solvency of Medicare's HI trust fund. No claims of double-counting were raised when these bills were enacted.

Claim: Congress doesn't allow Medicare savings to go into effect.

Fact: The vast majority of the provisions enacted in the past 20 years to produce Medicare savings were successfully implemented.

A careful examination of the historical record demonstrates that Congress has repeatedly adopted measures to produce considerable savings in Medicare *and has let them take effect.*[4] In an earlier analysis, we examined every piece of major Medicare legislation enacted in the last 20 years. Four pieces of legislation included significant Medicare savings. Virtually all of the Medicare savings in three of these pieces of legislation — the 1990, 1993, and 2005 budget reconciliation bills — were successfully implemented. In addition, nearly *four-fifths* of the savings enacted in the fourth piece of legislation — the Balanced Budget Act of 1997 — were implemented despite the fact that a balanced budget was achieved in 1998 (four years earlier than the target date of the legislation) and Medicare spending slowed far more than had been projected when the legislation passed. In fact, for the first time in history, Medicare spending in 1999 was lower than it had been the year before.

In short, the claim that Congress does not allow Medicare savings to take effect is false. It is thoroughly refuted by the historical record.

The one significant exception to this pattern of Medicare savings taking effect is what happened to the badly designed "sustainable growth rate" (SGR) formula, which set payments to physicians and was enacted as part of the 1997 Balanced Budget Act. Contrary to common misconceptions, the SGR provision was originally expected to produce only a *small* amount of savings — less than 5 percent of the total Medicare savings in the Balanced Budget Act, or only $12 billion over ten

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[3] Solomon M. Mussey, Director, Medicare & Medicaid Cost Estimates Group, Centers for Medicare & Medicaid Services, *Estimated Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate, on the Year of Exhaustion for the Part A Trust Fund, Part B Premiums, and Part A and Part B Coinsurance Amounts,* January 8, 2010. Available at http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_Medicare_2010-01-08.pdf.

[4] James R. Horney and Paul N. Van de Water, *House-Passed and Senate Health Bills Reduce Deficit, Slow Health Care Costs, and Include Realistic Medicare Savings*, Center on Budget and Policy Priorities, December 4, 2009. Available at http://www.cbpp.org/files/12-4-09health.pdf.

years.[5] The SGR formula was subsequently blocked by Congress when it turned out that it would have had the unintended effect of cutting payments well below doctors' actual costs of providing services. And even though Congress has not allowed the *full* cuts required under the SGR formula to take effect, it has still cut the physician reimbursement rate substantially: the current reimbursement rate in 2010 is *17 percent below* the rate for 2001, adjusted for medical care inflation.[6]

Those who ignore all of the other Medicare savings provisions enacted over the past 20 years, single out the SGR experience, and cite it as evidence that Congress does not allow intended Medicare savings to materialize have jumped to a faulty conclusion inconsistent with the record.

It also should be noted that most of the Medicare savings provisions in the health reform legislation are similar to the types of Medicare provisions that Congress has enacted in the past that have indeed taken effect, and differ markedly from the blunt-instrument design of the SGR cut. Furthermore, as Goldman-Sachs has noted in a recent analysis of the health reform bill, there is little likelihood that the circumstances that prevailed in the late 1990s will recur. At that time, the achievement of a balanced budget and the projection of continued budget surpluses helped convince the President and Congress to undo a small portion of the Medicare savings enacted in 1997.[7]

Claim: The estimate for health reform should include the cost of fixing the sustainable growth rate (SGR) payment formula for physicians.

Fact: The cost of fixing the SGR formula is entirely unrelated to health reform; all of its cost would remain if health reform were repealed tomorrow.

Some critics complain that the CBO cost estimate for health reform is misleading because the legislation does not include a permanent fix to the broken SGR payment formula for physicians. Since Congress will likely continue to prevent the SGR from taking effect, they say, Congress should consider the cost of such action as part of the cost of health reform.

Indeed, Congress likely will never let the full SGR cuts take effect, and it probably won't offset the cost of scrapping them. But that cost is neither part of, nor in any way a result of, health reform. *The federal government will incur this cost regardless of health reform, not because of it.* This fact is undeniable: if health reform legislation had not been enacted, the full SGR cost would remain. To be sure, it would be better if Congress offset the cost of cancelling the SGR cuts. But that issue is separate from the question of how much health reform itself reduces the deficit.

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[5] Congressional Budget Office, *Budgetary Implications of the Balanced Budget Act of 1997,* December 1997.

[6] This figure does not include the further 21-percent reduction in physician payment rates that will occur on April 1 in the unlikely event that Congress and the President do not continue to prevent the SGR cuts from taking full effect.

[7] Alec Phillips, "Health Reform: Preliminary Thoughts on the Fiscal Implications," Goldman Sachs Global ECS US Research, US Daily, March 18, 2010.

Claim: Health reform doesn't "bend the cost curve" because it extends health coverage to 32 million uninsured, which increases health care costs.

Fact: Health reform includes an extensive array of provisions to slow the growth of health care costs.

This claim confuses the short-run and longer-run effects of health reform. Because people who lack health insurance use fewer health care services, expanding insurance coverage will, by itself, increase health care spending in the short term. It is therefore no surprise that the chief actuary of the Centers for Medicare & Medicaid Services has estimated that the health reform legislation — which will extend coverage to two-thirds of the uninsured — will increase national health expenditures by 1.7 percent in 2016, when its coverage expansions will be fully phased in.[8]

Although covering the uninsured will necessarily increase the *level* of national health expenditures at first, the key question is what will happen to the *rate of growth* of health expenditures thereafter. Even a modest slowdown in annual cost growth will more than offset the initial cost increase within a short period of time. The CMS actuary also finds that health reform will indeed slow the rate of growth of national health expenditures after an initial increase. Furthermore, CBO estimates that by the decade after 2019, the total federal budgetary commitment to health care — the sum of net federal outlays for health programs and tax preferences for health care — will be *lower* than it would have been if the health reform legislation were not enacted.[9]

The health reform legislation includes an extensive array of provisions that hold considerable potential for slowing the growth in health care costs even more over the long haul. The legislation begins to move in most areas that health policy experts consider promising avenues for reducing the growth of health care spending and where specific steps can be identified. Health care experts agree that slowing the growth of health care costs will require an ongoing process of testing, experimentation, and rapid implementation of what is found to work. Enactment of the health reform legislation, which includes an array of demonstration projects to identify further ways to contain costs, begins that process.

Claim: The CBO cost estimate is misleading because it does not include discretionary spending that may be provided in future annual appropriation bills.

Fact: Future discretionary appropriations related to health reform are uncertain and may be accommodated without adding to total discretionary spending.

CBO treats mandatory spending and discretionary spending separately in estimating the cost of legislation. It does so for good reason. Mandatory spending, such as Medicare and Medicaid, continues from year to year unless new legislation is passed to reduce it. In contrast, discretionary

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[8] Richard S. Foster, Chief Actuary, Centers for Medicare & Medicaid Services, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate,* January 8, 2010. Available at http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf.

[9] Elmendorf, Letter to the Honorable Nancy Pelosi, p. 15.

spending, which covers most of the day-to-day operations of federal agencies, is provided for a year at a time in annual appropriations bills and is provided only to the extent that those bills make funding available. The CBO cost estimate for health reform appropriately includes all mandatory spending costs in its calculation of the effects of the legislation on the deficit, and provides a separate tabulation of the possible discretionary spending that could — contingent on future appropriations legislation — result from enactment of health reform.

CBO does not include discretionary spending in its assessment of the effects of legislation on the deficit because it cannot estimate either how much future discretionary funding Congresses will actually appropriate for any program or purpose or how any such appropriations would affect total discretionary spending. Congress operates in most years under a limit, set in the congressional budget resolution, on the total amount of discretionary funding that can be appropriated for that year. As a result, any increases in discretionary funding related to health reform may be accompanied by decisions to provide less funding for some other discretionary accounts, since Congress will need to remain within the operative ceiling on discretionary appropriations

Discretionary spending for health reform falls into two categories. First is the cost to the Department of Health and Human Services, the Internal Revenue Service, and other federal agencies of *administering* the new arrangements to expand health insurance coverage and provide assistance to low- and moderate-income families. CBO estimates that these costs will be modest, totaling between $10 billion and $20 billion over the legislation's first ten years. This amount represents only a very small portion of the cost of the coverage expansions and could be easily accommodated by making offsetting reductions in other discretionary spending programs.

The second category of discretionary costs comprises authorizations for a variety of grant and other programs. CBO has reported that the health reform legislation includes $50 billion or more over ten years in authorizations with specified maximum funding levels, along with some other authorizations for which no level of funding is specified. But the effect of these authorizations on total spending is highly uncertain. Congress traditionally *authorizes* spending for many discretionary programs at much higher levels than are *actually appropriated*; indeed, many authorizations are never funded at all, because the Appropriations Committees cannot find room to fund them within the overall amount they are allowed to appropriate for the year. And unlike the administrative funding noted in the previous paragraph, these authorizations do not have to be funded; health reform is not at all contingent upon them. Finally, as with the administrative costs of health reform, any amounts that are eventually appropriated for these authorizations will need to fit within the overall discretionary spending ceilings Congress sets.