

*HAVE RECENT BUDGET
POLICIES CONTRIBUTED TO
LONG-RUN FISCAL STABILITY?*



John L. Palmer and Rudolph G. Penner



*HAVE RECENT BUDGET
POLICIES CONTRIBUTED TO
LONG-RUN FISCAL STABILITY?*



John L. Palmer and Rudolph G. Penner

Copyright © October 2010. The Urban Institute. All rights reserved. Permission is granted for reproduction of this file, with attribution to the Urban Institute.

John L. Palmer is a university professor at the Maxwell School of Syracuse University, and Rudolph G. Penner is an institute fellow at the Urban Institute. The authors are grateful to Leonard Burman and Paul Van de Water for their useful comments and to the John D. and Catherine T. MacArthur Foundation for financial support.

The Urban Institute is a nonprofit nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

Contents

The President's 2011 Budget	3
Stimulus versus Long-Run Sustainability	3
Tax Policies	4
Spending Policies	5
Pay as You Go	5
Fiscal Commission	6
Congressional Reaction to the President's Budget	6
Health Reform	7
CBO Estimates	8
Reliability of the CBO Estimates	11
Concluding Observations	14
Conclusion	15
Notes	16
References	18

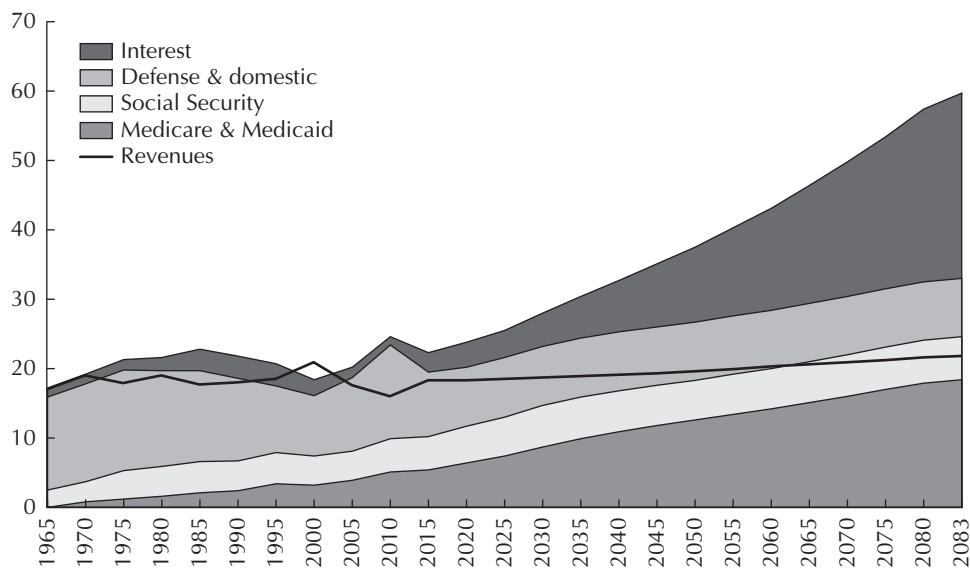
Have Recent Budget Policies Contributed to Long-Run Fiscal Stability?

In January 2010, the National Research Council and the National Academy of Public Administration (NRC-NAPA) released *Choosing the Nation's Fiscal Future*,¹ which clearly showed the United States on a disastrous fiscal path. If current policies continue the national debt will grow at an accelerating rate and eventually explode. On the spending side of the budget, the problems lie in just two areas: Social Security and health care. In 2007, before the surge in spending related to the Great Recession, Social Security, Medicare, and Medicaid accounted for almost 50 percent of noninterest spending. Those three entitlement programs are growing faster than the economy and tax revenues. Meanwhile, the tax burden has been remarkably constant, varying between 17 and 19 percent of the gross domestic product (GDP) for all but 11 of the past 50 years.

The single most important reason for the unsustainability of fiscal policy is the rapid rise in health costs. It is caused by two factors. First, the population is aging, with a surge in the second and third decades of the 21st century as large cohorts of baby boomers reach retirement age and become eligible for Medicare. As baby boomers age, they are also more likely to require Medicaid to pay for long-term care. Second, age- and sex-adjusted health costs per capita are projected to rise annually by about 2 percentage points more than income per capita in the decades ahead, as they have over the past four decades. The recently passed health reform legislation is unlikely to dampen this trend. As described in detail below, it will add to Medicaid spending, create a new subsidy for the purchase of health insurance, and reduce the growth of Medicare spending. Although elements of health reform may somewhat dampen cost growth, health spending will almost certainly continue to constitute the biggest long-run budget problem.²

Social Security is the largest federal program. Although its outlays do not present as large a long-run problem as health costs, it will create very significant upward pressures on spending, especially over the next 20 years as baby boomers retire in large numbers, drawing benefits for decades.

If Social Security and our health programs are not significantly reformed, other programs grow at the same rate as GDP, and the tax burden remains at its average level of the past 50 years, the national debt will soar. The NRC-NAPA committee projected that the debt will reach 100 percent of GDP in 2027 and 200 percent in 2040, compared with an average ratio of 42 percent over the past 20 years (figure 1). As the debt grows

Figure 1 The Long-Run Budget Outlook (percent of GDP)

Source: Congressional Budget Office (2010b), table B-2.

relative to GDP, the interest on the debt becomes a very large budget problem.

It is very unlikely that we shall ever see a debt as high as 200 percent of GDP. Long before that happens, domestic and foreign investors will become nervous about lending money to the U.S. government, interest rates will soar, and the foreign exchange value of the dollar may plummet. At that point, we shall have no choice but to radically reform spending and tax policy. Hopefully, it will be done as the result of a timely deliberative process and not as a panicked reaction to a financial crisis. In the worst of all possible worlds, countries try to inflate their way out of budget crises. That works for a time, but the hyperinflation that follows wrecks havoc on the economy and on individuals owning assets denominated in money terms.

Since the NRC-NAPA committee report, the Congressional Budget Office has updated its own long-run budget projections (CBO 2010b). The underlying economic assumptions differ slightly from those used by NRC-NAPA, and CBO makes slightly different assumptions about future policies. But the basic message does not change: we are on an unsustainable path, and we shall have to do something about it.

The long-run budget problem has been apparent for decades, but the need to confront it has been intensified by the Great Recession of 2008–09. The economic downturn slashed revenues and raised spending on unemployment insurance and other safety-net programs. It also provoked the passage of a huge stimulus package, now estimated to

cost \$862 billion, and required bailouts of the financial and automobile sectors that were designed to prevent a collapse from becoming a calamity. As a result, the national debt in the hands of the public soared from 40 percent of GDP at the end of fiscal year 2008 to a forecasted 63 percent at the end of 2010.

By some measures, the Great Recession was the most severe economic downturn since World War II, and it is not surprising that it caused the budget deficit to explode. Normally, after a severe recession, revenues revive, safety-net spending declines, any stimulus package expires, and the budget deficit shrinks rapidly. In fact, under the president's budget policies, the budget deficit is expected to decline from 10 percent of GDP in 2010—a post-World War II record—to a little under 4 percent in 2014 (Office of Management and Budget 2010). That decline is not enough, however, to prevent the national debt from rising faster than our incomes; by the end of 2014, it will be over 70 percent of GDP.

Ominously, the deficit is expected to rise after 2014, even though the economic recovery is expected to continue. The increase accelerates after 2018, and by the end of 2020, the debt is expected to be 77 percent of GDP under the economic and technical assumptions in the president's budget and about 90 percent according to estimates of the president's budget using Congressional Budget Office assumptions (CBO 2010a). Not surprisingly, the main culprits are health costs, interest, and Social Security in that order of importance. Interest costs are expected to rise by 4½ times

between 2010 and 2020 because of the large increase in the debt and an assumed relatively small increase in interest rates.

It is particularly disturbing that under the president's budget the deficit rises between 2014 and 2020, even though spending other than Social Security, Medicare, Medicaid, and interest falls by 1.0 percent and receipts rise by 0.6 percent of GDP. The relative fall in other spending is partly the result of reduced growth in safety-net programs as the economic recovery is assumed to continue and the administration's proposed three-year freeze on nonsecurity discretionary spending. On the receipts side, individual income taxes are expected to grow especially rapidly as the recovery restores incomes and growth pushes people into higher tax brackets.

The NRC-NAPA committee suggested that the debt-GDP ratio be stabilized at 60 percent by 2022. Its report shows that there will have to be substantial and painful changes in tax and/or spending policies to achieve that goal. The choice of 60 percent was a matter of judgment. There is no scientifically proven correct ratio, but the committee noted that the choice of a higher ratio would imply larger deficits in the long run and a greater erosion of national wealth. It would also increase the risk of a fiscal crisis. The choice of a lower ratio would imply even more painful policy choices—perhaps more painful than the political system can endure.

This paper reviews significant events related to budget policy since January 2010. It asks whether anything in the president's budget or in recent congressional actions gives some hope that the long-run budget outlook has improved significantly. It also examines health reform and discusses the risks that it creates for the fiscal outlook.

Although Congress had remarkable success in passing significant health and financial regulatory reform, it has fumbled in dealing with the budget. The budget policy-making machinery of Congress is broken. That leaves the nation less able to deal with long-run budget problems in the future. The one thin hope is that the president has appointed a National Commission on Fiscal Responsibility and Reform. It is supposed to recommend policies that would eliminate the budget deficit, excluding interest costs, by 2015 and meaningfully improve the budget outlook thereafter. The commission's prospects, however, are doubtful.

The President's 2011 Budget

Stimulus versus Long-Run Sustainability

The president's budget reflects a struggle between the desire to pay some attention to the long-run budget problem and

the worry that if the deficit is lowered too quickly, the current unsteady recovery from the trough of the Great Recession will be extremely slow and high unemployment will persist or perhaps worsen. The worry that the stimulus might be withdrawn too quickly has much influence within the budget document. But as this report is written, it is unclear that it will win the struggle in the halls of Congress, where worries regarding the deficit are growing rapidly.

The president's budget lists more than 50 initiatives in a section entitled "Reviving Job Creation and Laying a New Foundation for Economic Growth." Kris Cox (2010) of the Center for Budget Policies and Priorities has identified \$266 billion of spending that either temporarily extends programs from the first stimulus program or is otherwise aimed at temporary job creation. (The administration only classifies \$147 as "temporary recovery measures.") Of this amount, \$98 billion would be spent in fiscal 2010 and \$169 billion in fiscal 2011–20. Some tax cuts in the initial stimulus are continued, unemployment insurance is extended, special tax breaks are introduced for small businesses, various investments are proposed for infrastructure and research and development, and certain types of aid to states are continued, along with a host of other measures.

Although the president's budget is expansive relative to what it would be if all components of the original stimulus plan were allowed to expire as scheduled, the implied increase in the deficit for 2011 is only \$120 billion, far lower than if the whole stimulus program were extended. In 2012 and beyond, the president's policies would modestly reduce the deficit.

Since the budget was released, the stimulus extensions have been cut back considerably in an effort to garner congressional support. But Republicans and conservative Democrats have resisted any expansion, in response to growing public concern over the deficit and national debt. Many opponents argue that the measures have merit, but they should be paid for with future cuts in spending. Some conservative Democrats are willing to contemplate paying for new spending with future tax increases, but they have not been joined by any Republicans. An extension of unemployment insurance costing \$34 billion was barely passed after a lengthy struggle. It was not paid for with other spending cuts or tax increases. A \$26 billion aid package for states—about half the amount requested by the president—appears near passage. It looks as if it will be paid for, in part by reducing foreign tax credits for multinational corporations.

Although the president's budget includes considerable rhetoric about the long-run budget problem and a small reduction of future deficits, it does not include any meaningful tax or spending policy initiatives that would move

us toward fiscal sustainability. The main specific policy in his budget associated with the long run would freeze nonsecurity, discretionary spending in nominal terms for three years. Compared with increasing those programs with inflation, the proposal saves \$11 billion in 2011 and \$25 billion in 2013. By comparison, total spending on Social Security, Medicare, and Medicaid, as estimated before health reform, increases \$64 billion in 2011 and \$105 billion in 2013. Unless the three programs that are causing the long-run spending problem are reformed, fiscal stability cannot conceivably be achieved without raising tax burdens far beyond those ever experienced in the United States.

Much of the recent commentary on fiscal policy discusses the difficulty of avoiding highly contractionary policies in the short run while addressing budget problems in the long run. But there is really no conflict between these goals. We could easily continue some short-run stimulus while immediately announcing reforms in Social Security or in health programs that would be phased in slowly beginning in, say, 2012 or 2013. Indeed, spending on the retired is causing the bulk of the long-run budget problem, and when reforming such programs, it is important to phase in the reforms gradually so people approaching retirement have a chance to adjust their plans accordingly.

Long-run revenue increases could also be put in place to begin to take effect in 2012 or 2013. That might even be stimulative in the short run if people rush to engage in economic activity before taxes increase. More important, enacting long-run reforms now would give domestic and foreign buyers of U.S. debt confidence that we were serious about our long-run problems, presuming that they had confidence that we would follow through with the scheduled reforms. This could assuage concerns about the risk of higher interest rates and inflation in the future.

It might be argued that any announcement of future budget austerity would immediately dampen consumption and business investment. But future budget austerity is a certainty regardless of whether it is put in legislation now. Some believe that uncertainty over future tax and spending policies is a factor in slowing the current recovery. Providing a detailed description of the policies to come may in fact reduce uncertainty and immediately benefit the economy.

Tax Policies

The president's budget contains important tax policy recommendations. The president proposes continuing the Bush tax cuts for all but the rich—defined as couples with incomes greater than \$250,000 a year and individuals with incomes above \$200,000. The tax rate on capital gains and

dividends would rise from 15 to 20 percent for the rich. Under current law, the top tax rate on capital gains rises to 20 percent after 2010; the president does not alter that, but his proposal regarding dividends lowers future marginal tax rates that otherwise could go as high as 39.6 percent.³ The president also proposes to index the alternative minimum tax for inflation and to maintain the basic estate tax exemption and tax rates at their 2009 levels. The latter would result in an estate tax exemption of \$3.5 million for individuals (\$7 million for couples) and a 45 percent tax rate on amounts above that level. The president would also extend numerous temporary tax advantages such as those provided by the research and experimentation tax credit.

CBO (2010b) has analyzed the economic impact of President Obama's policies in detail using several different economic models with different assumptions. But CBO compares the Obama policies to a continuation of current law in which all Bush tax cuts expire, as do all other temporary tax cuts in the tax code. Under that comparison, Obama's policies cut taxes considerably and increase the budget deficit. To analyze how Obama's policies affect the strength of the recovery, however, they must be compared to the policies in effect for 2009 and 2010. As noted earlier, relative to those policies, Obama's policies increase the deficit in 2011 and reduce it thereafter.

CBO places great emphasis on policy-induced changes in the deficit. In the short run, CBO analysts say that Obama's increased deficit in 2011 will increase aggregate demand and strengthen the recovery. However, they are reluctant to carry that effect too far out into the future because they believe that the effect becomes more uncertain as the recovery proceeds. In the longer run, a higher deficit dampens economic growth because it absorbs saving that could otherwise be used to finance productivity-enhancing investment. Consequently, one would presume that CBO would judge that Obama's longer-run deficit reductions would enhance growth relative to simply continuing the policies of 2009 and 2010. This is despite the fact that Obama's policies increase marginal tax rates on the rich and the rate paid on capital gains and dividends. CBO estimates that the effects of Obama's policies on the marginal tax rate applied to capital and labor income are quite small compared with current law, and one would expect them to be even smaller relative to current policy because the Obama budget is very much closer to current policy than to current law. In summary, in CBO's analysis, the main impact of the president's budget on the long-run growth of the capital stock and the economy comes not from changes in marginal tax rates, but from the effects on national saving caused by changes in the budget deficit.

But the budget and the CBO analysis did not consider the effects of health reform. The reform increases the Medicare payroll tax rate applied to the rich and brings investment income into the Medicare tax base. It implicitly increases marginal tax rates on previously uninsured lower-income groups and the middle class by rapidly reducing the subsidy for purchases of health insurance from exchanges as their incomes grow. It also relates Medicare Part D premiums to income and subjects a larger portion of the Medicare beneficiary population to higher (income related) Part B premiums.

Even abstracting from the effect of income relating Medicare Part B and Part D premiums, the top marginal tax rate will increase to worrisome levels under Obama's recommendations when the new payroll tax rate becomes effective in 2013. The new payroll tax rate of 3.8 percent for high-income individuals will be added to the top regular income tax rate of 39.6 percent. The top rate can be increased further by the phaseout of exemptions and itemized deductions at high income levels. If the effect of income taxes in many states and some localities is added, the top marginal rate can approach 50 percent. Such a high rate not only creates disincentives for working, saving, and investing, it also intensifies the pursuit of tax avoidance strategies and increases illegal tax evasion.

Such a situation cries out for tax reform. Reform would allow us to decide on the fate of the Bush tax cuts, the alternative minimum tax (AMT), and the many temporary tax provisions more rationally. If the tax base can be broadened significantly by eliminating or reducing special deductions, more revenues can be raised—even with lower marginal tax rates (NRC-NAPA 2010, chapter 8). The provision that excludes the value of employer-provided health insurance from taxable income is especially important, because the associated revenue loss grows rapidly with health costs. If it could be capped, a system of basic exemptions and low rates could be designed that would cause income tax revenues to grow rapidly in the future in a way that would help stabilize the long-run fiscal situation.

Spending Policies

The most important policies on the spending side of the budget have already been described. They involve the temporary spending increases aimed at accelerating the economic recovery and the freeze on nonsecurity discretionary spending that makes an extremely modest contribution to lowering long-run deficits.

In contrast to the stringency applied to nonsecurity discretionary spending, most programs related to national

security are unconstrained. Budget authority for homeland security is raised 10.7 percent between 2010 and 2011; the security portion for state and international (almost entirely international operations, including foreign aid) is up a whopping 15.8 percent, and the portion for veterans is up 7.3 percent. The Defense Department receives a relatively modest increase of 3.8 percent. The cost of the Iraq and Afghanistan wars is expected to be about \$150 billion in fiscal 2011.

Some agencies will face a cold shower once the stimulus disappears. For example, the normal appropriation for education was \$41.4 billion in 2009. In addition, it received \$81.1 billion of stimulus funding! In 2011, the requested budget authority falls to \$49.7 billion. The situation in the Department of Energy is even more extreme. The normal appropriation in 2009 was \$16.9 billion. The stimulus program added \$36.7 billion. Its requested budget authority falls to \$17.1 billion in 2011. The effects of stimulus on the departments of Health and Human Services and Housing and Urban Development are less extreme but still dramatic. Each received stimulus funds equal to about one-third their normal 2009 appropriation, and both will be cut back dramatically in 2011.

All the above numbers refer to budget authority. The actual activity and outlays related to the stimulus program will be spread out over a number of years. In agencies like Energy, actual spending was undoubtedly delayed and made less effective by the sheer magnitude of the task of administering and allocating a budget more than three times its normal size.

The most important development in entitlement programs occurred after publication of the president's budget. That was the enactment of fundamental health reform. No changes were recommended for Social Security. Reforms enacted for the future might have offset the cost of extending elements of the stimulus program that the president so badly wanted. On the other hand, in today's contentious political climate, that might have made stimulus extensions even more difficult to pass.

Pay as You Go

The Budget Enforcement Act of 1990 created a pay-as-you-go (PAYGO) rule that required that any tax cut or entitlement increase compared to current law had to be paid for by some other tax increase or entitlement cut. The rule was used to ensure that the hard-won deficit-reducing agreement of 1990 would not be eroded by subsequent legislation. The rule did not improve the budget outlook; it simply prevented it from getting worse. PAYGO was

complemented by a rule that placed a cap on discretionary spending. PAYGO worked very well until a budget surplus appeared in 1998. After that, it was routinely violated, even though it did not officially expire until the end of fiscal year 2002.

PAYGO has recently appeared in various forms, but the original PAYGO that used current law as its base simply is not viable. The problem is, a growing gap has evolved between current law and current policy, given that current law would have all Bush tax cuts disappear along with the one-year fix for the AMT and many other temporary tax and spending provisions. All extensions would have to be paid for under the 1990 PAYGO, and that would imply a very large and unrealistic tax increase or equally unrealistic entitlement cuts.

President Obama's budget supports the PAYGO concept but modifies the baseline to which it would be applied. With the budget's proposed baseline, Congress would not have to pay for extending the Bush tax cuts, maintaining the estate tax at 2009 levels, indexing the AMT, or waiving the scheduled 21 percent cut in physicians' fees under Medicare. The budget implies that ending the tax cuts for the rich is a "saving." Consequently, the proceeds can be used to pay for other tax cuts or entitlement increases. However, many other temporary tax cuts are not assumed to be extended; in that way, the president's baseline departs from current policy.

Congress passed a PAYGO law in February 2010 with a baseline similar to the president's except that extending the tax cuts for the rich—not those for the middle class—would have to be paid for. If the law is violated, spending will be sequestered to make up for anything that is not paid for. However, certain spending, such as that for Social Security and federal retirement benefits, is exempt from any sequester; in other cases, such as Medicare, the amount of the sequester is limited. Ironically, Social Security and Medicare are exempted from the full force of the sequester when those programs are mainly responsible for the long-run budget problem.

Many deficit hawks deplore the leniency of the president's and Congress's baselines and complain that the PAYGO provisions are filled with "loopholes." However the real question is whether it is preferable to have a loose baseline that has some hope of bringing discipline to the process or an extremely strict baseline that is too politically painful to enforce. In the best of all possible worlds, a bipartisan agreement would create a path for the debt-GDP ratio that implied fiscal stability. The policies implied by the path would constitute a new baseline and PAYGO could return to its original purpose—ensuring that the agreement is not eroded.

Fiscal Commission

The president's budget favored a congressional initiative to create a bipartisan fiscal commission that would recommend policies to restore fiscal sustainability and have the policies considered by Congress using fast-track procedures. When the initiative reached the Senate floor, several Republicans who had cosponsored the initiative voted against it, and the idea was defeated.

The president then decided to create a bipartisan commission by executive order. He appointed two co-chairmen and four other members; Democratic Senate and House leaders appointed three members each, and Republican Senate and House leaders did the same. The commission was given the precisely defined, but modest, goal of eliminating the noninterest deficit by 2015. At that point, the deficit will be near its medium-run low without any policy changes, assuming that the economic recovery continues. Vague language gives the commission responsibility for "meaningfully" improving the long-run budget outlook. The commission is to report December 1 after the midterm elections. Fourteen of the 18 members must agree to any recommendations; this requirement ensures that successful recommendations have the support of some elected members of both parties.

Few believe that the commission has much chance of success. The odds were low to begin with, but the congressional leadership made them lower still by appointing some members from the extreme wings of their parties.

Although few forecast success, the members of the commission and their staffs are taking their responsibilities very seriously and are working hard to come up with something. While we are unlikely to see a significant package supported by 14 members, the co-chairmen may come up with something that gains the support of several members of the commission. It remains to be seen how the president and Congress will react to such a package.

Congressional Reaction to the President's Budget

Congress will not have a budget this year. Although there have been other times that the Senate failed to pass a budget resolution and still other times when both houses of Congress passed differing resolutions but failed to compromise, this is the first time since the congressional budget process started in 1974 that the House failed to pass a budget.

A cynic may argue that it does not matter much. A budget resolution simply sets targets for aggregate spending, receipts, and the deficit, and those targets have often been

violated. However, the resolution gives a sense of congressional priorities: aggregate spending is divided between mandatory and discretionary spending, and the resolution further apportions the latter to spending committees. The Appropriations Committee then apportions its allotment among its various subcommittees. Budget rules are enforced by various points of order that bring some discipline to the process, although it must be admitted that the House Rules Committee almost invariably waives all budget points of order when setting the rules for consideration of legislation.

The Senate Budget Committee did pass a resolution out of committee on a party-line vote, but the leadership chose not to take it to the Senate floor. The Committee-passed resolution cut discretionary spending \$10 billion or 0.9 percent more than proposed by President Obama. It did not, however, take any significant action toward Social Security or the health programs that are at the heart of the long-run budget problem.

The failure of Congress to pass a budget provides just one more indication that the congressional process is broken. In addition, Congress has allowed the estate tax to expire as if by accident, it cannot provide a permanent solution to the problems posed by the AMT, it has not been able to deal permanently with an unrealistic provision of Medicare law that would cut physician reimbursement 21 percent, and no one expects passage of 2011 appropriations before the beginning of the fiscal year.

As if to atone for its inability to pass a regular budget resolution, the House passed a Budget Enforcement Resolution that is supposed to cap discretionary spending. The House bragged that it came out even lower than the Senate Committee-passed resolution, but the difference was only \$3 billion (Delisle 2010).

It is interesting that actions in the Senate and House that attempted to show a modicum of restraint focused their efforts on discretionary spending. This illustrates a profound flaw in our budget processes. The budget game is played on a very uneven playing field. Almost all discretionary programs must be acted on every year, while the Social Security and health programs that are causing our budget problems go on and on if Congress does nothing. As a result, discretionary programs are scrutinized more intensely than entitlements and are much more vulnerable to being cut.

Although Congress finds it extremely difficult to take action on budget issues, it did pass a huge stimulus bill, a fundamental health reform, and a financial reform. It is ironic that Congress could do so much on health and financial issues but utterly fail to follow regular procedure for the budget.

The financial reform largely concerns regulation and has little impact on spending or revenues. It does, however, contain one initiative that creates a very bad precedent for budget policy. Its consumer financial protection agency is to be housed in the Federal Reserve System and financed out of the Fed budget. Its costs, expected to approach \$500 million, will not appear directly in the nation's official budget. But the agency will add to the deficit since the Fed, which normally transfers its profits to the Treasury, will be turning over a smaller amount. We could finance health policy in this manner and its costs would be similarly obscured.

Housing the consumer agency in the Federal Reserve makes the Fed a fiscal agent. During the recent financial crisis, it was understandable for the Fed to provide assistance to specific sectors of the economy because it had the flexibility to move quickly. However, the practice outlasted the emergency. As various short-term securities acquired by the Fed during the crisis expired, the Fed used the proceeds to buy longer-term mortgage-backed securities. The purchases have now ended, but they could be resumed. While the policy was in effect, assistance was being provided to the housing sector without it showing up in the official budget. The proper way to proceed would have been for the Fed to use the proceeds of maturing assets to buy Treasury securities and to have the Treasury or the Department of Housing and Urban Development (HUD) buy the mortgage-backed securities. The cost of the transaction would then have been transparently reflected in the budget, it would have been reviewed by OMB budget examiners, and the benefits of the program could have been compared with the benefits of spending on other activities. However, Congress showed no interest in providing the necessary authority to HUD or Treasury.

Putting government activities off budget has a long history. The practice was once more common, but in recent decades, reforms have brought almost all government activities back into the budget. As a result, it is a more valuable document. It would be a shame if we begin to use the Fed as a device for again moving public activities off budget.

Health Reform

Once fully implemented, the new health reform legislation is expected to extend public or private health insurance coverage to 32–34 million otherwise uninsured Americans,⁵ and to provide important protections to tens of millions of others whose insurance coverage otherwise would have critical gaps. The added public coverage, which will account for half or more of the newly insured, results from expanding Medicaid to all eligible individuals with incomes up to 133 percent of the federal poverty level (FPL) and

continuing the Children’s Health Insurance Program (CHIP). The added private coverage results from the requirement that most U.S. citizens and legal residents have health insurance (reinforced by the requirement that employers with more than 50 employees offer coverage), the creation of state-based health insurance exchanges through which individuals and small businesses can purchase coverage, and the provision of federal subsidies to help defray the costs to moderate-income individuals and families and small employers that purchase coverage through these exchanges and meet certain other conditions. The law also imposes regulations on health plans in the exchanges and in the individual and small-group markets to enhance consumer protections, among other purposes.

These expansions in coverage are accompanied by myriad other legislative provisions. The most important are aimed at containing health care costs (to lower the general rate of health care cost inflation and finance the expansions in coverage), raising revenues through various means (also to finance the expansions in coverage), improving the quality and performance of the health care system, promoting prevention and wellness activities, strengthening the Medicare program, and establishing a new voluntary long-term care insurance program for purchasing community living assistance services and supports (CLASS program).

The final legislation was expressly designed by the White House and congressional Democratic leadership to be deficit-neutral over the near term and deficit-reducing over the longer term. This goal was officially achieved, as CBO estimated the legislation to reduce deficits over 2010–19 by \$143 billion (a trivial sum in comparison with projected federal outlays and revenues—or even projected federal deficits absent health reform—over the same period and by an average of 0.5 percent of GDP over the subsequent decade.⁶ CBO also anticipated that the legislation would “probably continue to reduce budget deficits relative to those under current law in subsequent decades, assuming that all of its provisions continued to be fully implemented.”⁷

However, as anyone who has followed the debate about the reliability of these estimates knows, they should be taken with a large dose of salt. CBO does an admirable job of consistently employing the best data and economic tools available to make as reliable as possible projections of the likely impact of hundreds of proposed policy changes each year. But doing so for legislation as complex as the health reform bill—that will affect so many aspects of the entire health care system and larger economy, often in ways for which there is little evidence on which to simulate the consequences—is a particularly daunting task, stretch-

ing even CBO’s capabilities. Questionable, also, is the assumption that several specific provisions of the health reform legislation will be fully implemented as written and subsequently sustained (as CBO is required to assume). In the remainder of this section, we first provide more detail on the impact that CBO estimates various major components of the health reform legislation will have on future federal finances. We then discuss the most important concerns surrounding these estimates before offering some concluding observations. As we shall elaborate, there is ample justification for arguing that the CBO estimates either considerably overstate, or considerably understate, the positive consequences of the health reform legislation on federal finances. The only certainty is that the level of uncertainty surrounding these particular estimates is extremely high, and it will be many years before any better reading of the tea leaves is possible.

CBO Estimates

The CBO projection of 10-year deficit savings of \$143 billion reflects the net effect of the gross cost of expansion in health coverage of well over \$900 billion and the larger amount of savings from additional revenues and from Medicare, Medicaid, and other programs. The health reform law contains literally hundreds of provisions, and CBO provides individual (year-by-year) estimates of the impact on the budget for each of them. The most important contributors to the costs of health coverage expansion; the savings from Medicare, Medicaid, and other programs; and the additional revenues are briefly described below. Their projected fiscal impacts are noted in table 1

Expanding health coverage

The gross costs of expanding health coverage are attributable to three major initiatives prescribed by the legislation.

- Once the state-based exchanges are fully operational in 2014, the federal government will provide premium credits offsetting a portion of the costs to eligible individuals and families with incomes between 133 and 400 percent FPL who purchase health insurance through the exchanges. The premium credits will be set on a sliding scale related to income and adjusted upward over time. Subsidies to offset a portion of individual and family out-of-pocket costs under the exchange plans will also be provided on a sliding scale.
- Effective 2014, states will be required to extend Medicaid coverage to all non-Medicare eligible individuals

Table 1 CBO Estimates of the Effect on the Deficit of the Health Reform Legislation 2010–19 (billions of dollars)

Gross Cost of Expanding Health Coverage	
Subsidies to participants in health insurance exchanges	464
Medicaid expansion/CHIP	434
Small-employer tax credits	40
Subtotal	938
Less: Medicare, Medicaid, and Other Program Savings	
Curb Medicare Advantage overpayments	136
Adjust payments to Medicare providers	196
Reduce Medicaid prescription drug costs	38
Reduce subsidies for hospitals serving the uninsured	36
Increase Medicare premiums for the affluent	36
CLASS	70
Other outlay changes (net)	-1
Subtotal	511
Less: Additional Revenues	
Medicare tax on high-income people	210
Health industry fees	107
Penalty payments by employers and uninsured individuals	69
Excise tax on high-cost insurance plans	32
Other revenue changes	152
Subtotal	570
Net Deficit Effect	-143

Source: Van de Water (2010).

under age 65 with incomes up to 133 percent FPL, with the federal government covering 100 percent of the added costs for the first three years, modestly declining shares in 2017–19, and a 90 percent share in 2020 and thereafter.

- Federal funding for CHIP is also extended through 2015.
- Small employers with 25 or fewer employees and average wages of less than \$25,000 will be provided temporary tax credits to defray a portion of their contribution toward their employees’ health insurance if they meet certain criteria. The full credit will be available to employers with 10 or fewer employees and average annual wages of less than \$25,000, with the credit phasing out as firm size and average wage increase

Medicare, Medicaid, and other program changes⁸

Program savings account for just under half of the projected deficit savings measures in the health reform legislation. The majority of these savings come from Medicare,

although there are also substantial deficit savings from Medicaid and from the new CLASS program, as well as numerous other less important provisions that essentially net to approximately zero cost.

- The Medicare Advantage program combines hospital, physician, and outpatient services and prescription drug coverage within a wide range of individual plans offered to Medicare beneficiaries through private insurers, in lieu of traditional Medicare. Medicare currently pays those insurers an average of about 13 percent more per beneficiary than it would cost to cover them through traditional Medicare. The health reform legislation scales back these higher payments over the next three to six years.
- The health reform legislation reduces Medicare’s annual payment updates to hospitals, skilled nursing facilities, and several other types of providers (though not physicians’ fees, which are being addressed in other legislative action), in part to account for economy-wide increases in productivity. It also reduces payments to home health agencies and inpatient rehabilitation facilities, as recommended by the Medicare Payment Advisory Commission (an expert advisory board to Congress).
- Drug manufacturers that participate in Medicaid must pay rebates to the state and federal governments for prescription drugs provided to beneficiaries. The health reform legislation will increase those rebates to ensure that Medicaid pays no more than private purchasers for the same drugs.
- Because the health reform legislation will greatly reduce the ranks of the uninsured, it will also reduce the disproportionate share hospital (DSH) payments that Medicare and Medicaid provide to hospitals across the country to offset the uncompensated care costs incurred from treating individuals without insurance.
- Medicare beneficiaries who enroll in Part B or Part D pay monthly premiums whose levels are adjusted upward at the beginning of each year to cover 25 percent of the expected average annual costs per beneficiary. (The remaining 75 percent of parts B and D is largely financed by general revenues.) The vast majority of enrollees pay the same basic-level premium. However, Part B beneficiaries with incomes exceeding certain thresholds (currently \$85,000 for individuals and \$170,000 for couples) are charged higher premiums that are indexed annually to the general rate of inflation by prior law. The health reform legislation introduces a similar income-related premium charge into Part D effective 2011 and suspends the indexing of the income thresholds for parts B and D for 2011–19.⁹ As a result, many higher-income participants will experience larger premium

- increases over time than they would have were indexing of the thresholds continued during this period.
- The CLASS Act provision in the health reform legislation establishes a national, voluntary insurance program for purchasing community living assistance services and supports. The program will provide enrolled individuals with functional limitations a cash benefit of at least an average of \$50 a day to purchase nonmedical services and supports necessary to maintain community residence. It is effective at the beginning of 2011 and designed to be self-financing over time through voluntary payroll deductions (and interest earnings) by working adults, who will be eligible to receive benefits following a five-year vesting period. The program yields sizeable deficit savings in the short run, since premium collections will substantially exceed benefit payments during its startup period.
 - The residual category of other program changes contains more than a hundred disparate provisions not easy to summarize. Most affect Medicare or Medicaid and are aimed at “transparency and program integrity”⁷⁰ and “improving the quality and efficiency of health care,” with many of the latter intended to contain costs by contributing over time to the modernization of the health care system by changing the information available to patients and providers and the incentives facing the latter. Of particular note is the creation of an independent Payment Advisory Board charged with recommending changes to certain Medicare payment categories to prevent per-beneficiary Medicare costs from increasing faster than the average of the consumer price index (CPI) and medical component of the CPI in years 2015–19 and the increase in per capita GDP plus 1 percentage point in years thereafter. The Board’s recommendations would automatically go into effect unless overridden by new legislation. Other provisions are aimed at “prevention of chronic disease and improving public health” and expanding and strengthening the “health care workforce.” Among the provisions with the greatest estimated fiscal impact are ones increasing subsidies under the Medicare Part D drug benefit to enrollees with high out-of-pocket expenses and ones yielding savings in connection with reforms to the Higher Education Act also included in the final amendments to health reform legislation
 - All earnings are currently subject to a 2.9 percent Medicare Hospital Insurance (HI) payroll tax (paid 50-50 by employers and employees and in full by the self-employed). Effective 2013, the health reform legislation adds a 0.9 percentage point HI tax on the earnings of individuals with incomes above \$200,000 and families with incomes above \$250,000. It also introduces, at the same time, a new “unearned income Medicare contribution” of 3.8 percent on income from interest, dividends, capital gains, and other sources of unearned income for individuals and families with incomes above the same thresholds.¹¹ The two income thresholds are fixed in nominal terms and not indexed, so these surtaxes will be paid by individuals and families with more modest real (inflation-adjusted) incomes over time
 - Pharmaceutical companies, medical device manufacturers, and health insurance companies will gain millions of new customers as a result of the expansion in coverage. The health reform legislation imposes various fees on these industries to contribute to the financing of the coverage expansions.
 - The requirement that most U.S. citizens and legal residents have health insurance starting in 2014 is enforced by imposing substantial financial penalties on large firms that employ full-time workers who purchase subsidized health insurance in the new insurance exchanges, rather than through their employers (to encourage those employers to provide insurance to their employees), and modest penalties on individuals who have no health insurance coverage at all, unless coverage would not be affordable for them.
 - To help finance the expansion in coverage and contribute to restraint in the growth of health care costs over time, the health reform legislation imposes an excise tax on very high cost health insurance plans (so-called “Cadillac” plans) offered through employers, effective in 2018. The law establishes plan value thresholds, above which the tax will apply, for the first year and then indexes to the CPI thereafter.
 - Another 20 revenue items beyond those noted above have a substantial deficit-reducing impact on balance. Many reflect various changes to the income tax code that reduce the generosity with which it treats medical-related expenses. Others reflect the larger share of corporate and individual incomes CBO projects will be subjected to income and payroll taxes as a result of various health reform provisions, such as those reducing the overhead costs of insurance companies and the employer-provided

Additional revenues

New revenues from a variety of sources account for the remainder of the deficit savings under health reform.

subsidies for very high cost plans.¹² Still others entail changes in specific provisions of the tax code entirely unrelated to health care.

Because of how Congress requires CBO to “score” legislation, the 10-year aggregate fiscal impact measures of health reform are the ones most often reported. But it is more instructive to consider year-by-year estimates if one is concerned about the course of the fiscal impacts over time. These are shown in figure 2 for the effects of the net change resulting from the insurance coverage provisions,¹³ the changes in other spending, and the changes in other revenues, respectively—as well as for the overall effect on the deficit. Note that virtually all the \$143 billion in 10-year deficit savings occurs in 2012–15, as many deficit-reducing measures begin to phase in before costs are incurred for the expanded coverage. This back-loading of costs has led many critics of the reform to claim the CBO 10-year estimate of overall deficit savings is a misleading indicator of the longer-term consequences. However, as noted at the outset of this section, CBO projects a substantially more positive effect for the legislation on deficits over the second decade (and beyond) than over the first. This longer-term projection is foreshadowed in figure 2 by the downward trend of the “Net effect on the deficit” line beginning in 2018–19, driven largely by the Medicare savings result-

ing from the payment adjustments to providers (including DSH) and the revenues from the excise tax on Cadillac health plans growing faster than the costs associated with the expanded coverage. But the realism of assuming these new policies will be fully implemented and then sustained also has been strongly challenged.

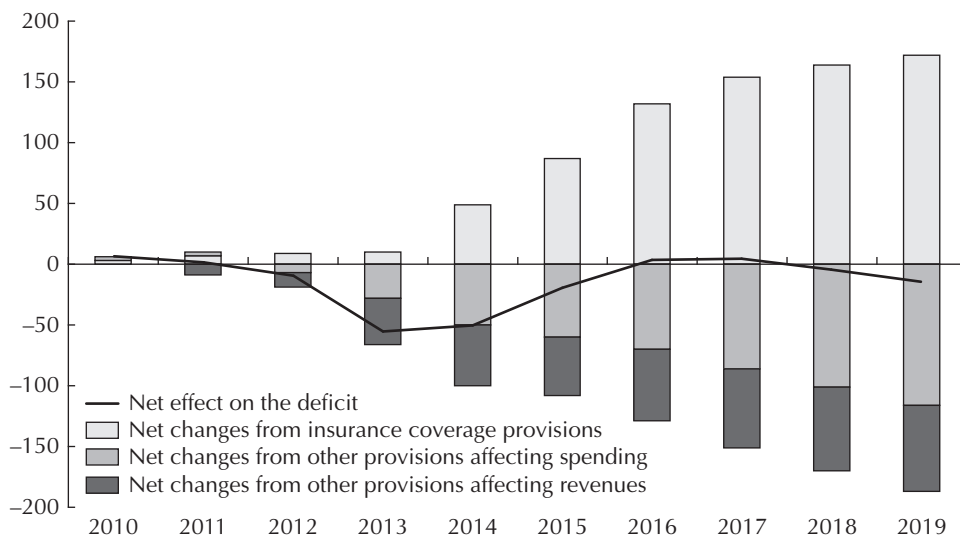
Reliability of the CBO Estimates

Indeed, the reliability of these CBO estimates on the likely budgetary impact of the health reform legislation can be, and has been, challenged on three broad fronts: that they misestimate the effects of the changes in law, that they misrepresent certain effects of the law, and that they fail to account for likely future changes in the law.¹⁴

Misestimating the effects

Numerous observers have criticized CBO for misestimating the budgetary impact of various major provisions of the law. Concerns have been expressed that they are both too optimistic and too pessimistic: for example, that the estimated costs of the subsidies to participants in the health exchanges are too low, and that some Medicare reforms will yield more deficit savings than projected. This is not surprising in light of the range of uncertainty surrounding

Figure 2 Effect of the Health Reform Legislation on the Deficit (billions of dollars)



Source: Douglas W. Elmendorf, letter to Speaker of the House Nancy Pelosi, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>, table 1.

many of these estimates. As Director Doug Elmendorf states in an April 12, 2010, posting on CBO's blog:

Our estimates reflect the middle of the distribution of possible outcomes based on our careful analysis and professional judgment, drawing on relevant research by other experts. Nevertheless, estimates of the effects of comprehensive reforms are clearly very uncertain, and the actual outcomes will surely differ from our estimates in one direction or another.

This observation concerning the high degree of inherent uncertainty is reinforced by a comparison of the estimates of the budgetary impact of the various provisions of the health reform legislation made by the actuarial office (OACT) of the Centers for Medicare and Medicaid Services (CMS) to those of CBO. While the two institutions arrived at similar results for numerous provisions they estimated, for many other provisions—some of very considerable importance to the bottom line—the differences were pronounced. For example, CMS-OACT estimated the 10-year deficit savings from the DSH payments, the penalty payments by employers and uninsured individuals, and the CLASS Act at \$64 billion, \$120 billion, and \$38 billion, respectively (as opposed to CBO's \$36 billion, \$69 billion, and \$70 billion), and the 10-year cost of the subsidies to individual participants in the health insurance exchanges and of the tax credits to small employers at \$507 billion and \$31 billion, respectively (as opposed to \$464 billion and \$40 billion).¹⁵

When making public the CMS-OACT estimates, Chief Actuary Richard Foster also went to some length to emphasize the uncertainty surrounding them, noting "In particular, the responses of individuals, employers, insurance companies, and Exchange administrators . . . could differ significantly from the assumptions underlying the estimates presented here." He then, with CBO clearly in mind, pointed out that "Due to the very substantial challenges inherent in modeling national health reform legislation, our estimates will vary from those of other experts and agencies" and that "Indeed . . . effects could lie outside the range of estimates provided by the various estimators."¹⁶

Perhaps the most compelling case for CBO "misestimation" is that made by many health care economists who believe the legislation will have a much larger positive effect on the deficit in both the short and long run than do either CBO or CMS-OACT by more immediately and more substantially slowing the rate of growth of per capita and overall health care expenditures. In health care economists' more optimistic view, the numerous provisions in the law

aimed at changing the incentives faced by, and information available to, health care consumers and providers will transform payment and delivery systems and greatly increase the efficiency of the overall health care system—and, thus, substantially "bend the cost curve" (the growth path of national health care expenditures relative to GDP).¹⁷ In contrast, the conservative estimating methodologies used by CBO and CMS-OACT attribute essentially no deficit savings to such "modernization" of the health system. One study that did conclude that—relative to CBO's projections—the deficit savings of the health reform bill under consideration in the Senate last December (which was similar to the final legislation in relevant respects) would be at least \$279 billion more in the first 10 years and continue thereafter to grow much faster annually (Cutler et al. 2009).¹⁸

Misrepresenting the effects

Federal budgetary conventions require CBO to present budgetary estimates for the health reform legislation in a way that many commentators find misleading, if not flat-out wrong. Chief concerns here have to do with discretionary costs associated with the legislation and accounting for the CLASS Act and the Medicare (Part A) Hospital Insurance trust fund.

The CBO estimates cited above include only direct or mandatory spending, such as for Medicare and Medicaid, whose amount is determined by the initial authorizing law and continues from year to year unless altered by new legislation. The estimates do not include discretionary spending associated with the health reform legislation, because any such amounts are subject to annual appropriation by Congress, with the law setting only an upper limit on what is permissible or simply specifying "such sums as may be necessary." After issuing the projections for direct spending under the legislation, CBO identified roughly \$105 billion more in authorized discretionary spending over the initial 10 years associated with various provisions for grants and other program activities; CBO also estimated that the costs for various federal agencies (most notably the Department of Health and Human Services and the Internal Revenue Service) to administer the new arrangements for expanded coverage and premium and cost-sharing subsidies would fall within the range of \$10–\$20 billion over the same period.¹⁹ This led many commentators to conclude that the initial CBO estimates for the legislation overstated the 10-year deficit savings by \$125 billion or more.

But the truth is more complicated. CBO also concluded that the vast majority of the \$105 billion in authorized discretionary spending reflected items previously funded or authorized and already accounted for in its baseline. In

addition, it noted that a number of the other items could overlap somewhat with current law activities, again already in its baseline.²⁰ Finally, since Congress operates in most years under a limit on the amount of total discretionary funding that can be appropriated for the fiscal year, whatever greater discretionary spending for associated purposes does finally result from the legislation may well be partially or fully, offset by reductions in other discretionary spending. All things considered, it would seem safe to assume that any deficit-increasing impact of discretionary spending associated with health reform will be minimal relative to the larger picture.

In contrast, the CLASS Act and HI trust fund accounting conventions pose more problematic concerns. As noted above, the CLASS Act is expected to generate a substantial positive cash flow in 2011–19, which CBO must credit to deficit savings by congressional federal budgetary accounting conventions. But the fact that the program is designed to be self-financing over the long term means it will experience equivalent (in present-value terms) negative cash flow and be deficit-increasing on balance, in the years beyond 2019. Thus, the 10-year deficit savings of \$70 billion attributed to CLASS by CBO is a misleading indicator of the program's long-term budgetary consequences.

Nevertheless, CBO's projection of growing deficit saving from the overall health reform legislation in the decades beyond 2010–19 takes into account the projected negative cash flow of CLASS over this period, assuming the program is sustained as designed. The more troubling aspect of CLASS from a budgetary perspective lies in this assumption. As noted by CMS-OACT, because of how the program is designed, "there is a very serious risk that [CLASS will] become [fiscally] unsustainable as a result of adverse risk selection by participants."²¹ Should this prove the case, CLASS could eventually prove a substantial fiscal liability, rather than neutral, to federal finances. In any event, it would seem more appropriate to account for a presumably self-financed program like CLASS in the budget on a present-value, rather than cash-flow, basis, as is currently done for federal credit programs.²²

The Medicare (Part A) Hospital Insurance trust fund has been running sizeable cash-flow deficits for the past several years, with its modest level of remaining assets previously expected to be depleted within the next 10 years because of a rapidly growing gap between annual HI revenues and costs. By increasing HI revenues and decreasing HI costs, the health reform legislation markedly improves the projected cash flow of the HI trust fund. By federal budget accounting conventions, this improvement has two important consequences: it yields very sizeable deficit sav-

ings (more than \$400 billion over the first 10 years), most of which is being used to help pay for the expanded coverage and other new health reform activities; and it bolsters the financial outlook for HI by an equal amount, in the process postponing the depletion of HI trust fund assets for more than a decade.²³ This result has been characterized as double-counting by some commentators; again, the reality is more complex. As noted by CBO Director Elmendorf, the higher balances in the HI trust fund, in fact, give Treasury the *legal authority* to pay Medicare benefit longer; however, as they do not result in an improvement in overall federal finances, they do not enhance the government's *economic ability* to pay these benefits.²⁴ Thus, it would be more appropriate to characterize the consequences of the legislation for HI as a missed opportunity than as double-counting. Reductions in HI payments and increases in HI taxes that could have been applied to overall deficit reduction were instead used to support an expansion of other federal outlays.

Failing to account for likely future changes in the law

CBO is required to do its "scorekeeping" assuming no future changes in the law governing the provisions being estimated. This engenders little or no controversy in most cases. But critics of the health reform legislation have argued that, in addition to CLASS, several other provisions with major cost or savings implications are unlikely to survive very long as written, potentially resulting in far more unfavorable fiscal consequences than currently projected. Moreover, critics have received support for this view from both CBO and CMS-OACT.

CBO Director Elmendorf singled out three particular concerns when noting that "the legislation maintains and puts into effect a number of policies that might be difficult to sustain over a long period of time."²⁵ The first of these had to do with the post-2018 indexing of the premium subsidies provided to low- and moderate-income purchasers of health insurance through the exchanges. For the first five years (2014–18), these subsidies are indexed to keep pace with the rising premium costs, which in turn will reflect the increasing costs of medical care. Thereafter, the subsidies will increase at a lower rate. The actual rate will depend upon how some ambiguous provisions of the law are interpreted and defined in regulations yet to be developed, but it could be as slow as the rate of growth of the CPI, which has been several percentage points lower on average than medical cost inflation. Whether political support for whatever lower rate of indexing eventuates will be sustainable is questionable.

Elmendorf's second concern was the excise tax effective 2018 on the very high cost plans offered by employers. In the health care bill passed by Congress, this was to take effect in 2014, at the same time as the coverage provisions in the bill, with the plan value thresholds indexed to the CPI+1 thereafter. However, the tax proved so controversial that the reconciliation amendments pushed back its effective date to 2018; to compensate for the delay, the indexing for the thresholds was reduced to the CPI-only for 2020 and thereafter. (CPI+1 indexing still applies for 2019.) Whether the excise tax will ever take effect and, if so, be maintained subsequently with CPI-only indexing over time is questionable.

The third—and most important—concern singled out by Elmendorf involved the provisions constraining Medicare payment rates, particularly those introducing annual productivity adjustments to price updates for most providers. These adjustments assume the providers can improve their own productivity to the degree achieved by the broader private, nonfarm sector of the economy and will result in ongoing payment rate increases for many of them less than even the CPI. Both Elmendorf and CMS Chief Actuary Foster point out that these provisions slow the rate of growth of Medicare payments to an unprecedented degree that may jeopardize the access to, and quality of, care for Medicare beneficiaries.²⁶ For this reason, the full deficit savings attributable to these provisions (to quote Foster) “may be unrealistic,” since future changes in the law to loosen these constraints on Medicare payments rates is possible.

A related concern applies to the savings attributed to the assumed implementation of the Independent Payment Advisory Board's recommendations to reduce Medicare payments if average Medicare costs per beneficiary are increasing above the target growth rate. CMS-OACT estimates that this provision will require further reductions in Medicare payments in 2015–19 beyond the already-substantial savings to Medicare it projects from other provisions, including the productivity adjustments. But, as Foster points out, the Advisory Board's target growth rate is actually a bit below the target rate for the physician fee sustainable growth rate (SGR) payment system; and Congress has overridden the SGR-based payment reductions for each of the past seven years and once again this year (temporarily). The Advisory Board's recommendations could likely meet the same fate, unless the optimistic view of the modernization of the health care system on “bending the cost curve” proves correct.

There are several other provisions for which it also might prove difficult to maintain political support over time. Tw

that strike us as potentially particularly vulnerable are the lack of indexing of the \$200,000/\$250,000 income thresholds for the Medicare-related surtaxes and the state cost-sharing for the expanded Medicaid coverage. If the experience with the AMT is any guide, political pressure to index the thresholds for the former provision will mount once the surtaxes begin to affect middle-income families, as they eventually will. And, unless the economy grows much more robustly over the next five years than now seems likely, the states will surely fight hard to delay or rescind the phasing in of their 1 percent cost-sharing for the expanded Medicaid coverage.

Concluding Observations

Several things seem worth briefly emphasizing in concluding our discussion on the effects of health reform on the budget. First, as we noted at the outset, the level of uncertainty surrounding the CBO estimates is extremely high. This stems not only from the inherent problems of predicting the consequences of many provisions of the legislation as written, but from the distinct possibility that maintaining political support for several key provisions in their current form will prove impossible. Further, while the likelihood of misestimation could mean the bottom line for federal finances is appreciably better or worse than now projected by CBO, the risks from failure to implement or sustain key provisions are largely on the downside and could easily lead to health reform becoming deficit-increasing on balance in the longer run.²⁷

Second, the avoidance of just such a negative fiscal outcome may depend upon the optimists' prediction that health reform will substantially bend the cost curve being borne out, CBO and CMS-OACT skepticism to the contrary. That is, if the changes aimed at modernizing health care do not promote efficiencies and contain costs systemwide far more successfully than given credit for by CBO and CMS-OACT scoring, maintaining political support for the full implementation and continuance of the more controversial direct cost-saving provisions of the legislation is much more likely to prove impossible.

Third, while the expanded coverage promulgated by health reform has great merit, it comes at potentially great opportunity cost to overall federal finances. We noted earlier that reductions in HI payments and increased in HI taxes could have been applied to general deficit reduction instead supporting an expansion of other federal outlays, and the same is true of other sources of deficit savings in the legislation. Substantial low-hanging fruit, which otherwise would be available to contribute to future long-term deficit

reduction efforts, has now been consumed—although to just what fiscal end remains to be seen

All in all, the health reform legislation appears to be a huge fiscal gamble, the outcome of which will not be clear for many years.

Conclusion

Little has happened so far in 2010 that improves the long-run budget outlook. Indeed, it can be argued that we have stepped backward, since Congress has not been able to pass any budget at all. Given that Congress has not been disciplined by its own rules, it is hard to imagine making any progress unless spurred by a full-blown financial crisis

The biggest budget and social event of the year was the passage of fundamental health reform. It is a fiscal riverboat gamble in that its complexity makes it extremely difficult to estimate its spending and revenue implications with any confidence. Moreover, the reform will certainly be modified over time as unintended consequences are discovered and various provisions cost much more or much less than originally estimated.

It is most unfortunate that so little progress has been made this year. Every day of delay means that necessary reforms will be more abrupt and more painful. The one remaining hope for some meaningful action this year rests with the fiscal commission. We shall analyze its findings in a subsequent paper.

Notes

1. The report was prepared by a committee whose members were experts in different areas of spending and tax policy. The members represented a wide range of ideologies, and many had served at the Office of Management and Budget or the Congressional Budget Office. The effort was financed by the John D. and Catherine T. MacArthur Foundation. The authors of this paper co-chaired the committee.
2. As discussed later, the long-run budget impact of health reform is extremely uncertain.
3. Although the top statutory marginal rate would be 39.6 percent, the effect of phasing out itemized deductions for higher-income groups can raise their effective marginal rate to 44 percent.
4. Unless otherwise noted in the text, all references to health reform or health reform legislation refer to P.L. 111-148, the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.
5. The lower end of this range is the CBO estimate of the added coverage in 2019, and the upper end is the estimate of the Chief Actuary of the Centers for Medicaid and Medicare (CMS). See Douglas W. Elmendorf, letter to Speaker of the House Nancy Pelosi, March 20, 2010, <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>, for CBO coverage and budgetary estimates of the legislation. For the same from CMS, see Richard S. Foster, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” memo, April 22, 2010, http://burgess.house.gov/UploadedFiles/4-22-2010_-_OACT_Memorandum_on_Financial_Impact_of_PPACA_as_Enacted.pdf.
6. All deficit impact numbers in this section refer to the unified budget deficit, which includes several types of outlays and revenues—most notably those associated with Social Security—formally classified as off budget.
7. Elmendorf, letter to Pelosi, p. 13.
8. The descriptions of the changes made by the health reform law for each major component to follow under this heading and the next (“Additional revenues”) draw heavily upon those in Van de Water (2010).
9. Part B and D premium charges are classified as negative outlays, rather than revenues, and offset against the gross costs of benefits by CBO budget accounting conventions.
10. All phrases in quotes in this paragraph are headings of various titles of The Patient Protection and Affordable Care Act.
11. Although labeled a Medicare contribution in the law, the yield from this new tax will not flow into any Medicare trust funds; rather, it will contribute to general revenues.
12. For example, the existence of the exchanges is expected to reduce the administrative and marketing costs of insurance companies.
13. These include the penalty payments by employers and uninsured individuals, the excise tax on high-cost insurance plans, and a portion of the “Other revenue changes” shown in table 1.
14. CBO Director Elmendorf uses this framework for categorizing the challenges in his April 12, 2010, blog posting “The Effects of Health Reform on the Federal Budget,” at <http://cboblog.cbo.gov>.
15. See Foster, “Estimated Financial Effects,” table 1 for the CMS-OACT estimates.
16. Foster, “Estimated Financial Effects,” p. 19.
17. For two representative examples of this view and discussion of the relevant provisions, see Feder (2010) and Cutler, Davis, and Stremikis (2009).
18. The difference between Cutler and colleagues’ estimates and CBO’s estimates are attributable primarily to the various provisions Cutler and colleagues consider important to health system modernization—such as those that promulgate payment innovations, increase funding for comparative effectiveness research, profile medical care providers on the basis of cost and quality, increase emphasis on wellness and prevention, and lay out the role of the new Independent Payment Advisory Board—and secondarily to the reduction in overhead costs in the administration of insurance due to the competition and transparency engendered by the new exchanges. Cutler and colleagues also discuss what they term the “imperative” to “cast a wider net than traditional evidence standards” (by which CBO and CMS-OACT are bound) in estimating the effects of such large policy changes, which accounts for the more inclusive analytic underpinnings of their much larger deficit-savings projections. In a subsequent commentary on the final legislation, Cutler (2010) argues it is reasonable to expect an even greater bending of the cost curve, and consequent deficit savings, than projected in his earlier analysis of the Senate bill.
19. Douglas W. Elmendorf, letter to Appropriations Committee Ranking Member Jerry Lewis on the potential effects of H.R. 3590, May 11, 2010, http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf.

20. Douglas W. Elmendorf, "More on Discretionary Spending in the Final Health Care Legislation," May 13, 2010, <http://cboblog.cbo.gov/?m=201005&paged=2>.
21. Foster, "Estimated Financial Effects," p. 21.
22. Present-value accounting is not now used for government insurance programs, such as veterans' life insurance, but many budget experts believe that it should be.
23. The \$400+ billion estimate is CBO's (Elmendorf, "The Effects of Health Reform on the Federal Budget," <http://cboblog.cbo.gov>), but it does not estimate for how long depletion of the HI trust fund assets will be postponed. CMS-OACT has put the latter at 12 years, from 2017 to 2029 (Foster, "Estimated Financial Effects," p. 9), but has not yet issued an updated accounting of the long-term financial outlook for HI (This will be done in the next Medicare Trustees' report, normally issued each April but delayed this year so the effects of the health reform legislation can be included.)
24. Elmendorf, "The Effects of Health Reform." By law, annual HI cash flow surpluses are invested in special issue Treasury bonds earning market rates of interest (interest is similarly invested as it accrues unless needed to pay current benefits). The actual cash is used by Treasury to pay for other current government obligations, thereby reducing commensurately the borrowing from the public necessary to finance the annual deficit. When the HI reserves are drawn down to offset negative cash flow in the trust fund, the process operates in reverse: the bonds are redeemed and the cash to do so has to then be borrowed from the public, unless the government is running a sufficiently large annual surplus on balance in all other government accounts. Once the reserves are depleted, Treasury has no legal authority to expend any more on annual benefits for HI than can be paid for by annual trust fund income.
25. Ibid.
26. See Foster, "Estimated Financial Effects," pp. 9–11, for discussion of this issue and the related concern involving the Independent Advisory Board. Foster notes that private, nonfarm sector productivity gains reflect relatively modest improvements in the service sector together with much larger ones in manufacturing, and, since the provision of most health care tends to be very labor intensive, the medical community is unlikely to achieve productivity improvements equal to those of the overall economy. Thus, providers who rely heavily upon Medicare for their income could find it difficult to remain profitable and might even end their participation in the program, absent legislative intervention.
27. Any future bills entailing changes in such provisions that are deficit-increasing, as scored by CBO, would be subject to the new PAYGO law, so they could result in accompanying offsetting deficit-savings measures (related or not to health care). Alternatively, Congress could vote to waive the PAYGO requirement for this purpose, as it has frequently done for other purposes in the past.

References

- Congressional Budget Office. 2010a. *A Preliminary Analysis of the President's Budget and an Update of CBO's Budget and Economic Outlook*. Washington, DC: Congressional Budget Office
- . 2010b. *The Long-Term Budget Outlook*. Washington, DC: Congressional Budget Office.
- Cox, Kris. 2010. *President's Budget Requests \$266 Billion to Support Economic Recovery: Proposal Is Appropriate Size and Well-Targeted*. Washington, DC: Center on Budget and Policy Priorities.
- Cutler, David. 2010. "How Health Care Reform Must Bend the Cost Curve." *Health Affairs* 29(6): 1131–35.
- Cutler, David M., Karen Davis, and Kristof Stremikis. 2009. *Why Health Reform Will Bend the Cost Curve*. New York: The Commonwealth Fund.
- Delisle, Jason. 2010. *Congressional Budget Action for Fiscal Year 2011 and Its Impact on Education Funding*. Washington, DC: New America Foundation.
- Feder, Judy. 2010. *Cost Containment Is the Key: Health Care Reform Will Bring Costs under Control*. Washington, DC: Center for American Progress.
- National Research Council and National Academy of Public Administration. 2010. *Choosing the Nation's Fiscal Future*. Committee on the Fiscal Future of the United States. Washington, DC: National Academics Press.
- Office of Management and Budget. 2010. *Mid-session Review: Budget of the U.S. Government, Fiscal Year 2011*. Washington, DC: Office of Management and Budget
- Van de Water, Paul N. 2010. *How Health Reform Helps Reduce the Deficit*. Washington, DC: Center on Budget and Policy Priorities.



2100 M Street, N.W.
Washington, D.C. 20037

Phone: 202.833.7200
Fax: 202.467.5775
<http://www.urban.org>