WARNING:
Beware of Budget Gimmicks in Health Care Reform
July 20, 2009

President Obama has stated that any health care reform bill should be deficit-neutral over ten years. We see ten-year budget-neutrality as a bare minimum standard for legislation, and believe that, to be worth the costs, any comprehensive health care reform must significantly reduce deficits over the medium- and long-term as well (See http://www.crfb.org/documents/6-10-Principle1.pdf and http://www.crfb.org/documents/Health_Principle2_000.pdf).

Given the immense pressure to pass health care legislation, the difficult trade-offs that come with paying for it, and the general unwillingness of policymakers to make hard budget choices these days, the pressure to resort to "budget gimmicks" to make it appear a bill is fully paid for – when it is not – will be strong.

Below, we list a number of budget gimmicks that should be avoided:

Phony Phase-ins & Other Timing Gimmicks

While there are legitimate reasons for phasing in policies – for instance, it is likely that achieving near universal insurance would take a number of years – policymakers regularly use gradual phase-ins to make a bill appear cheaper than it truly is.

Excessively gradual phase-ins can limit the costs of a given policy during the budget window (in this case, ten years) while creating budget deficits at the end of the window and beyond. For example, the ten year gross cost of the Senate HELP bill has been estimated at around $700 billion, even though the bill costs more than $100 billion *per year* once fully phased in. The House Tri-Committee bill, meanwhile, is expected to increase the ten year deficit by $239 billion – but over a quarter of that deficit is produced in the last year alone, when there will be a single-year deficit of $65 billion.

This gimmick can be used to either reduce the size of the offsets needed to pay for a bill, or to reduce the overall cost to stay within an agreed-upon target. With healthcare, for example, an unofficial target is to keep the costs at around $1 trillion over ten years, so lawmakers might use excessively gradual phase-ins to hit this trillion dollar mark.

An alternative to a gradual phase-in is the "cliff effect" or the inclusion of an artificial sunset, where policies intended to be permanent are assumed to either disappear or not grow at intended rates. Recently, this gimmick has been used to make the costs of SCHIP, the farm bill, and the 2001/2003 tax cuts appear smaller than really intended.

Deficits Beyond the Budget Window (The Tenth Year is not Enough)

A bill can be structured to appear deficit-neutral in the first ten years while leading to large budget deficits thereafter. The administration has proposed that health care reform legislation not increase the deficit in the tenth year, as well as over ten years to help avoid this situation. This 'final year test' would deter the use of phase-in gimmicks since the phase-in of any costs would have to be accompanied by an increase in the size of offsets.

The final year test is not sufficient, however, to prevent new health care spending from exceeding offsets beyond the ten-year period. Differential growth rates between new spending and new offsets are particularly likely if the offsets are not health care related. For instance, revenues raised from sources other than the employer-sponsored tax exclusion are likely to grow far more slowly than health care spending; as are programmatic cuts outside of Medicare and Medicaid. Even if costs are aligned with offsets in the tenth year, they could easily diverge beyond this period.

One of the challenges in evaluating longer-term budget effects is that the Congressional Budget Office (CBO) does not score costs and savings in legislation's second decade. However, CBO has said that it will attempt to evaluate whether costs or savings grow faster. Policymakers should insist that any plan appear not to increase deficits beyond the tenth year. They should also introduce a mechanism wherein costs are evaluated annually, and should future deficits be projected, spending would be adjusted accordingly.

Multiple Scorekeepers

Both the CBO and the Office of Management and Budget (OMB) have the capacity to model the costs and savings of comprehensive health care reform bills. Policymakers, though, should not have the option of "shopping around" to find the estimate which best fits their agenda. The CBO has long been considered the neutral and non-partisan arbiter on budget scoring; their estimates should be the standard against which deficit-neutrality is measured. Legislation which does not meet this standard should be

modified, not re-estimated by the OMB. We would feel better if OMB Director Orszag's recent statement that health care reform will be deficit neutral "using real savings or revenue proposals ***that can be*** scored by the Congressional Budget Office" (emphasis added) had left out the "that can be," insisting that only CBO scoring be used.

Bogus Offsets

There will undoubtedly be the temptation to rely on offsets which artificially appear to reduce the deficit. The Senate HELP bill includes a recent example of this. The bill contains a new disability and long-term care program, the CLASS Act, which the CBO has estimated would reduce the deficit by $58 billion over ten years. This is not because the program would cut structural deficits, but rather because its premiums would be collected in advance of when benefits would be paid out. Over a longer period of time, in fact, CBO estimates the CLASS Act will increase budget deficits by drawing benefits from its trust fund. Although there may be logic to structuring certain provisions this way, authors of the bill should not be allowed to count these as offsets when judging deficit-neutrality.

Loopholes

Though the Administration has insisted any health care reform bill be at least deficit-neutral, some policy makers may interpret this criterion as only applying to coverage provisions of a given bill. Although the lion's share of any legislation's costs will be subsidies related to expanding health coverage, *all* costs, not just these, should be fully offset.

In particular, any efforts to reform or remove scheduled cuts in Medicare's physician payments (the "sustainable growth rate" or SGR) must be deficit-neutral over ten years and beyond. By reforming the SGR without offsets, the House Tri-Committee bill actually *increases* the deficit by $239 billion (with SGR reforms costing $245 billion). Updating physician payments beyond current law should be paid for in any case, but exempting this spending from the principle of budget neutrality would be particularly absurd, when other cuts in provider payments are being used to finance expanded health care coverage.

Relying on Hypothetical Long-Term Savings to Finance Coverage Expansion

From a fiscal perspective, the primary purpose of health care reform should be to implement policies to slow the growth of health care costs. Some of the most promising policies include: changing the way we pay health care providers through bundling and pay for performance, reducing insurance or government coverage of ineffective services and procedures, making consumers more price-sensitive, and changing the way we subsidize health insurance through the tax code. Though we do not know exactly how

much these policies might save, their savings are likely to grow over time compared to the current spending trajectories.

Sometimes referred to as "game changers," these policies are often scored by the CBO as having little or no savings, both because savings are expected to occur largely outside the ten-year budget window and because insufficient evidence exists to demonstrate the full impact advocates expect.

These game changers are a vital part of health care reform and overall fiscal reform. There may be pressure to assume savings even though they are not estimated by the CBO, or to not include them in a health care bill because they are not scoreable as offsets. Thus, there appears to be little reward for including them, and either approach is a mistake.

Policymakers should include as many policies as possible that would slow the growth of health care spending in health care reform legislation. The policies should not be assumed to generate more in savings than the CBO scores, but rather, savings which do materialize should be considered a down payment on slowing the growth of health care spending and closing the fiscal gap. Health care reform has been sold as fiscal reform; however, "bending the health care curve" just to put all the money back into government health care spending does nothing to reduce the long-term fiscal gap – especially when those savings are highly uncertain. Health care reform must include policies to slow the growth of health care spending, and those savings must contribute to abating the dismal fiscal situation ahead.