CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

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Honorable Max Baucus
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Current proposals to reform the health care and health insurance systems would affect the federal budget and the nation's spending for health care in many ways, and those effects can be summarized using a variety of different measures. This letter aims to clarify the measures being used by the Congressional Budget Office (CBO) in its analysis of such proposals—in particular, the effects of proposals on federal budget deficits and on the magnitude of the federal budgetary commitment to health care. As concrete examples, the letter discusses the preliminary analyses recently completed by CBO and the staff of the Joint Committee on Taxation (JCT) of the proposal put forward by the Chairman of the Senate Committee on Finance, as amended by the committee, and of H.R. 3962, the Affordable Health Care for America Act, which was introduced yesterday in the House of Representatives.[1]

The effects of health care reform proposals on the federal budget and national spending for health care are only some of the criteria that might be used in evaluating such proposals. Their impact on the market for health insurance, sources of insurance coverage, the cost of insurance before and after accounting for subsidies, the number of people with health insurance, the organization and delivery of health care, the quality and cost-effectiveness of health care, and many other factors are likely to weigh on policymakers as they make decisions about proposals. Although CBO has analyzed a number of those issues, this letter—in response to questions the agency has received—addresses only the impact on the federal budget.

[1] See Congressional Budget Office, letter to the Honorable Max Baucus providing a preliminary analysis of the Chairman's mark for the America's Healthy Future Act, as amended (October 7, 2009), and letter to the Honorable Charles B. Rangel providing a preliminary analysis of H.R. 3962 (October 29, 2009).

Effects on Federal Budget Deficits

CBO and JCT's analysis of a health care reform proposal focuses on its net impact on federal budget deficits during the 10-year budget window from 2010 through 2019. This "bottom line" reflects all of the effects of a proposal on spending and revenues, regardless of whether or how they are related to the provision of health care. For example, if an increase in spending on health programs was fully offset by the imposition of a new tax that was related to health care, or by cuts in federal spending unrelated to health care, the net impact of the proposal on deficits would be zero in either case. CBO and JCT estimated that the proposal approved by the Committee on Finance would result in a net reduction in federal budget deficits of $81 billion over the 2010–2019 period, and that H.R. 3962 would result in a net reduction in federal budget deficits of $104 billion over the same period.

The analyses of those proposals also included an assessment of their long-term effect on budget deficits, as requested by many Members. However, detailed year-by-year projections, like those that CBO prepares for the 10-year budget window, would not have been meaningful because the uncertainties involved are simply too great. CBO therefore developed an approach for providing a rough outlook for the decade following the 10-year budget window; that approach involved grouping the elements of each proposal into broad categories, assessing the rate at which the budgetary impact of each of those broad categories is likely to increase over time, and summing those impacts.

For the decade following 2019, CBO concluded that the proposal approved by the Senate Committee on Finance would reduce federal budget deficits relative to those projected under current law—with a total effect during that decade that is in a broad range between one-quarter and one-half percent of gross domestic product (GDP). For that same decade, CBO concluded that H.R. 3962 would slightly reduce federal budget deficits relative to those projected under current law—with a total effect during that decade that is in a broad range between zero and one-quarter percent of GDP. The imprecision of those calculations reflects the even greater degree of uncertainty that attends to them compared with CBO's 10-year budget estimates, and the effects of each proposal could fall outside of those ranges.

Following CBO's standard procedures for estimating the costs of legislation, those longer-term projections assumed that the proposals were enacted and remained unchanged throughout the next two decades, which is often not the case for major legislation. (For example, the sustainable growth rate mechanism governing Medicare's payments to physicians has frequently been modified to avoid reductions in those payments, and legislation to do the same again is currently being discussed in the Congress.) These proposals would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time. In particular, they would allow Medicare's payment rates for physicians' services to drop sharply for

much of the coming decade, and they aim to achieve substantial long-term savings through constraints on the payment rates for other providers of Medicare services.

Effects on the Federal Budgetary Commitment to Health Care

CBO's letters providing preliminary analyses of the proposal approved by the Senate Committee on Finance and H.R. 3962 also addressed the effects of the proposals on "the federal budgetary commitment to health care." CBO used that phrase in a letter earlier this year to describe the sum of net federal outlays for health programs and tax preferences for health care.[2] The letter noted that this sum would be greater than $1 trillion in fiscal year 2009: Net federal outlays for Medicare and Medicaid would be about $700 billion; tax preferences for health care—commonly called tax expenditures—would amount to more than $250 billion (primarily through the exclusion of premiums for employment-based health insurance from income and payroll taxes); and the federal government would also pay for veterans' health care, public health initiatives, and other health programs.[3]

CBO has used this measure because some Members have expressed interest in the federal government's overall role in the financing of health care—both under current law and under alternative reform proposals. (Whether the federal role should be expanded, contracted, or held the same is a policy choice, and CBO, as always, makes no policy recommendations.) Federal outlays for health programs are not an adequate gauge of that overall role because tax expenditures for health care are substantial under current law and because new tax credits to help purchase health insurance are a significant part of some reform proposals. Similarly, federal tax expenditures for health care do not, by themselves, capture this overall role because federal spending on health care is also substantial under current law and because such spending would increase significantly under some reform proposals. By including both the federal government's spending for health care and the subsidies for health care that are conveyed through reductions in federal taxes, the "federal budgetary commitment to health care" represents a broad measure of the resources allocated by the federal government in this area—and a measure that is independent of the extent to which outlays or tax provisions are used to channel those resources.

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[2] See Congressional Budget Office, "Health Care Reform and the Federal Budget," attachment to a letter to the Honorable Kent Conrad and the Honorable Judd Gregg (June 16, 2009).

[3] Net federal outlays for Medicare include both spending and offsetting receipts for that program. The latter consist of: premiums for Part A (which are paid only by individuals who, on the basis of their work history or the work history of a spouse, are not entitled to coverage); premiums for Part B (which cover about 25 percent of the cost of Part B); premiums for Part D that are withheld from Social Security benefits (but not premiums that enrollees pay directly to their Part D plans); Part D payments by states (based on the costs that were transferred from Medicaid to Medicare when Part D was established); and amounts paid to providers and subsequently recovered.

Proposal Approved by the Senate Committee on Finance. How would the proposal approved by the Senate Finance Committee affect the federal budgetary commitment to health care? (The attached table provides a summary for the 2010–2019 period.) In assessing that proposal, CBO reported that the gross cost of the coverage expansions (including increases in both outlays and tax expenditures) would be about $829 billion during the 10-year budget window. That figure includes the credits and subsidies provided through new insurance exchanges, increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers.[4] The proposal also includes the following other significant changes to federal policies that would tend to offset that cost and thereby reduce its effect on the sum of net federal outlays and tax preferences for health care:

- Reductions in net spending for Medicare, Medicaid, CHIP, and other federal health programs other than the changes associated directly with expanded insurance coverage (roughly $404 billion);[5]

- Revenues generated by the excise tax on high-premium insurance plans, which is effectively a reduction in existing tax expenditures for health insurance premiums (roughly $201 billion); and

- Changes to existing law regarding tax expenditures for health care and effects of other provisions on those tax expenditures (roughly $138 billion).[6]

Accounting for all of those changes, CBO and JCT's estimates imply that the proposal would increase the federal budgetary commitment to health care by about $85 billion over the 2010–2019 period.

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[4] Under the Finance Committee's proposal, many of the subsidies for insurance coverage would be provided in the form of refundable tax credits. To the extent that those credits would reduce enrollees' tax liability, they would represent tax expenditures; any amounts in excess of that liability (that is, the portion that is refundable) would be treated as outlays for budgetary purposes. JCT has indicated that roughly three-quarters of the total amount of credits under this plan would be outlays.

[5] The reductions in net spending for those programs could themselves be divided into provisions that would increase spending (and thus the federal budgetary commitment to health care) and provisions that would decrease spending (and thus that commitment). However, even some individual provisions of the proposal have elements that raise costs and elements that lower costs. Tabulating all of the aspects of the proposal that would, in isolation, increase federal outlays would be complicated and would require somewhat arbitrary judgments about how to allocate interactions among different elements of individual provisions and interactions among provisions.

[6] That figure is the sum of roughly $86 billion (the revenue component of the line labeled "Other Effects on Tax Revenues and Outlays" in the table "Preliminary Analysis of the Insurance Coverage Provisions" enclosed with the October 7 letter to the Honorable Max Baucus); roughly $41 billion (the sum of provisions related to tax expenditures for health care estimated by JCT and shown in JCX-41-09); and roughly $12 billion (the sum of provisions labeled "Effect on Revenues of Changes in Health Insurance Premiums" on page 8 of the table "Preliminary Estimate for Title I, Subtitle F, Through Title V of the Chairman's Mark, as Amended" enclosed with the October 7 letter to the Honorable Max Baucus).

The proposal includes still other provisions that would not affect the government's outlays or tax expenditures for health care—and thus not affect the federal budgetary commitment to health care—but that would reduce budget deficits by about $167 billion over the next 10 years. Most of that amount would result from penalty payments by employers and uninsured individuals and from new fees imposed on providers of health insurance and on manufacturers and importers of brand-name drugs and certain medical devices. Although those types of revenues are related to health care, they do not represent tax preferences for health care and therefore do not affect the federal budgetary commitment to health care as CBO uses the term; rather, they are means of paying for an expanded commitment. Putting together the roughly $85 billion increase in the budgetary commitment to health care and the roughly $167 billion in deficit reduction from other provisions yields an estimated net reduction of roughly $81 billion in budget deficits between 2010 and 2019, as noted above.

By CBO's estimate, the Finance Committee's proposal would increase the federal budgetary commitment to health care by about $11 billion in 2019; but in subsequent years, the effects of the proposal that would tend to reduce that commitment would grow faster than those that would increase it. As a result, the net increase in the government's commitment to health care near the end of the 10-year budget window would turn into a net decrease during the subsequent decade, when the proposal would reduce the sum of net federal outlays and tax expenditures for health care (relative to the amounts anticipated under current law). CBO's October 7 letter describing the preliminary analysis of the proposal approved by the Committee on Finance presented that conclusion about the longer-term impact along with CBO's overall assessment of the proposal's effects on budget deficits during that decade.

The approach taken here to categorizing and displaying the effects of provisions in the Finance Committee's proposal differs from the presentation used in CBO and JCT's preliminary analysis of October 7. In that earlier analysis, the agencies grouped the provisions directly related to the expansions of insurance coverage, the provisions making other changes to direct spending (primarily to the Medicare program), and the provisions generating other changes in revenues. That approach seemed useful in describing the overall contours of the proposal; however, it did not separate the aspects of the proposal affecting federal expenditures and tax expenditures for health care from the aspects of the proposal making other changes in federal policy, which is the objective of this letter. Of course, the way in which the budgetary effects of various provisions are combined and displayed has no effect on the estimated net impact of the proposal on budget deficits.

H.R. 3962. In assessing the bill introduced yesterday in the House, CBO reported that the gross cost of the coverage expansions (including increases in both outlays and tax expenditures) would be about $1,055 billion during the 2010–2019 period. As with the

proposal approved by the Senate Finance Committee, that figure includes the subsidies provided through new insurance exchanges, increased net outlays for Medicaid and CHIP, and tax credits for small employers. The bill also includes the following other significant changes to federal policies that would tend to offset that cost and thereby reduce the effect of the proposal on the sum of net federal outlays and tax expenditures for health care:

- Reductions in net spending for Medicare, Medicaid, CHIP, and other federal health programs other than the changes associated directly with expanded insurance coverage (about $426 billion); and

- Changes to existing law regarding tax expenditures for health care and effects of other provisions on those tax expenditures (roughly $32 billion).[7]

Accounting for all of those changes, CBO and JCT's estimates indicate that H.R. 3962 would increase the federal budgetary commitment to health care by about $598 billion over the 2010–2019 period (see the attached table).

The proposal would nevertheless reduce budget deficits over the next 10 years because it includes other provisions that would not affect the government's outlays or tax expenditures for health care—and thus would not affect the federal budgetary commitment to health care—but that would diminish deficits by about $701 billion. Most of that amount would result from an income tax surcharge on high-income individuals, from penalty payments by employers and uninsured individuals, and from other revenue provisions. Although some of those revenues are related to health care, they do not represent tax preferences for health care, so CBO treats them instead as means of paying for an expanded federal budgetary commitment to health care. In combination, the increase of about $598 billion in the budgetary commitment to health care and the deficit reduction of about $701 billion from other provisions yield the estimated net reduction of about $104 billion in budget deficits between 2010 and 2019 noted above.

By CBO's estimate, H.R. 3962 would increase the federal budgetary commitment to health care by about $104 billion in 2019. The legislation would also increase the federal budgetary commitment to health care (relative to that under current law) in the decade after 2019, as explained in CBO's October 29 letter describing the preliminary analysis of the bill.

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[7] That figure is the sum of -$4 billion (the revenue component of the line labeled "Other Effects on Tax Revenues and Outlays" in Table 2, "Preliminary Analysis of the Insurance Coverage Provisions," in the October 29 letter to the Honorable Charles B. Rangel); $21 billion (the sum of provisions related to tax expenditures for health care estimated by JCT and shown in JCX-43-09); and $14 billion (all but the first provision on page 10 of Table 3, "Preliminary Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962," in the October 29 letter to the Honorable Charles B. Rangel).

"Bending the Curve"

The question often arises: How does CBO evaluate whether health care reform proposals "bend the curve"? But that question raises another one: Which curve? Several cost trends are of interest to policymakers, and even though they are related, proposals might not have the same effects on each one. One such curve is the federal budget deficit as a whole, and another is the federal budgetary commitment to health care. A third is the trajectory of national health expenditures (NHE), and a fourth might be the premiums charged for health insurance.

Moreover, what does it mean to "bend the curve"? If a proposal makes the expected budget deficit 20 years from now smaller than it is expected to be without any policy changes, then the deficit curve is clearly being bent downward, on average, during the next 20 years; that is, the average growth rate of the deficit during those two decades would be lower. On the other hand, if the expected deficit is larger, then the deficit curve is being bent upward, and the average growth rate of the deficit in that period would be higher. Would that slower or faster growth rate continue indefinitely? That sort of extrapolation might seem natural, but it may not be appropriate. Distinguishing between a series of shifts in the level of the deficit and permanent changes in the growth rate of the deficit is difficult. Although CBO can provide a rough indication of a proposal's effect on the level of the budget deficit 20 years ahead, the agency does not have an analytic basis for projecting the proposal's effect on the growth rate of the deficit at that point, much less for evaluating whether that growth rate will continue in future years. Those same considerations apply to the agency's analysis of the federal budgetary commitment to health care. Therefore, CBO has concluded that it is more appropriate to talk about whether proposals would "lower" or "raise" the curve of the federal budget deficit or budgetary commitment to health care 10 to 20 years from now than to discuss those proposals' effects on the shape of the curve in that time period or the level or slope of the curve beyond that period.

Major proposals to reform health care would affect not only the federal budget but also spending for health care by individuals, firms, and other levels of government. A broad measure encompassing those effects would be the impact on total national health expenditures. However, CBO does not analyze NHE as closely as it does the federal budget, and at this point CBO has not assessed the net effect of health care reform proposals on those expenditures, either within the 10-year budget window or for the subsequent decade.[8] That is, CBO has not evaluated whether reform proposals would lower or raise—or bend down or up—the "curve" of national health expenditures.

[8] Projections of NHE are produced annually by the Office of the Actuary in the Centers for Medicare & Medicaid Services.

Finally, the question of what impact proposals might have on health insurance premiums is also of considerable interest. CBO intends to address that issue in the near future.

I hope this discussion is helpful in your consideration of proposals for broad changes in the nation's health care and health insurance systems.

Sincerely,

Douglas W. Elmendorf
Director

Enclosure

cc: Honorable Chuck Grassley
Ranking Member

Honorable Kent Conrad
Chairman
Committee on the Budget

Honorable Judd Gregg
Ranking Member

Identical letters sent to the Honorable Tom Harkin, the Honorable George Miller, the Honorable Henry A. Waxman, and the Honorable Charles B. Rangel.

CBO'S ESTIMATE OF THE CHANGE IN THE FEDERAL GOVERNMENT'S BUDGETARY COMMITMENT TO HEALTH CARE UNDER TWO PROPOSALS, FISCAL YEARS 2010-2019
(Billions of dollars)

	Senate Finance Committee's Proposal [a]	H.R. 3962 [b]
Changes in the Federal Budgetary Commitment to Health Care		
Gross Cost of Expanded Insurance Coverage	829	1,055
Changes in Net Spending for Medicare, Medicaid, and Other Programs	-404	-426
Changes in Revenues from Tax on High-Premium Insurance Plans	-201	0
Other Changes in Existing Tax Expenditures	-138	-32
Net Change in the Federal Budgetary Commitment to Health Care	**85**	**598**
Other Budgetary Effects		
Penalty Payments by Firms and Individuals	-27	-167
Revenues from Other Changes to Tax Law	-139	-536
Miscellaneous Other Budgetary Effects	-1	2
Net Impact on Federal Budget Deficits	**-81**	**-104**

Source: Congressional Budget Office.

a. The Chairman's mark for the America's Healthy Future Act, as amended by the Senate Committee on Finance.

b. The Affordable Health Care for America Act, as introduced on October 29, 2009.

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

Components may not sum to totals because of rounding.

For further details, see Congressional Budget Office, letter to the Honorable Max Baucus providing a preliminary analysis of the Chairman's mark for the America's Healthy Future Act, as amended (October 7, 2009), and letter to the Honorable Charles B. Rangel providing a preliminary analysis of H.R. 3962 (October 29, 2009).