



BUDGET COMMITTEE

Judd Gregg, Ranking Member
<http://budget.senate.gov/republican>

Contact: Betsy Holahan (202)224-6011

For Immediate Release

March 18, 2010

Budget Perspective: The Real Deficit Effect of the Health Bill

- **Deficit increase of \$582 billion over first ten years.**
- **Deficit increase of \$1.6 trillion over second ten years.**
- What do Democrats say about the Senate-passed health bill that the House is about to vote on? **They say that, according to CBO, their bill reduces the deficit by \$118 billion in the first ten years (and by \$812 billion from 2020-2029, although CBO does not actually estimate that figure; instead, CBO provides only a ballpark estimate that the net change in the deficit would be from 0.25-0.50 percent of GDP over those 10 years).**
- CBO says a lot of other important things in its 28-page cost estimate. Boiling down the budgetary effect of this massive bill into just one number, as the Democrats do, is a misleading exercise.
- For example, CBO indicates that \$53 billion of the \$118 billion “lower” deficit over the next 10 years comes from Social Security payroll tax revenues that result from the increase in wages that employers will offer employees instead of health insurance.
- But when Social Security revenues increase, it is only because future Social Security benefits are also going to increase. Social Security is already promising to pay benefits that the program cannot afford – there is a large unfunded liability. So the increased Social Security revenues resulting from this bill are already spoken for – they will be collected to pay for increased future benefits. They cannot be available for both paying for the related future increases in Social Security benefits and for offsetting the increases in health spending in this bill.
- **Therefore, we should not count \$53 billion of the “lower” deficit that comes from increased Social Security payroll tax revenues.**
- A similar situation applies in the case of the new voluntary federal program of long-term care insurance – the CLASS Act. Because it would work like an insurance program – premiums would

be collected in the near term from all who purchase a policy, and insurance benefits would be paid out only to those who end up needing long term care later.

- As a result, CBO estimates net premium income of \$70 billion over the next 10 years. This premium income is not available to offset other spending in the bill – it would be collected to pay for future long-term care insurance benefits. So the deficit effect of the other health spending in this bill over the next 10 years is not decreased by the amount of CLASS insurance premiums.
- **Therefore, we should not count \$70 billion net premium income from the CLASS Act.**
- After adjusting for the fact that Social Security revenues and CLASS premium income are being collected not to pay for other unrelated spending in this bill but to pay for future benefits in those two programs, the deficit picture changes from the deficit reduction claimed by the supporters of this bill to essentially no change in the deficit outlook at all. But even that understates the budgetary damage that this bill will do.
- The bill also includes both implicit and explicit authorizations of discretionary spending that would be essential for the proper implementation of the bill’s provisions. Because this new discretionary spending would be subject to future appropriations, these costs are not included in CBO’s direct spending estimate and, thus, are not included in the Democrats’ deficit impact estimate.
- The implicit discretionary costs include the amounts that would need to be appropriated to federal agencies in order to finance the administrative costs of implementing the bill’s provisions. Although the legislation does not contain specific provisions that would authorize this new spending, CBO concludes that funding these activities would be “essential for implementing the legislation in the intended time frame.” Over 2011-2019, CBO estimates that the major implicit discretionary costs include \$9 billion for the Internal Revenue Service (IRS), to develop the processes to determine and verify premium and cost sharing credits, and \$9 billion for the Department of Health and Human Services (HHS), to implement changes to existing programs and reforms to the private insurance market.
- The explicit discretionary costs include amounts that would need to be appropriated in order to fund a variety of grant and other programs that are authorized in the legislation. Some of these new programs are provided a broad, undefined authorization level; CBO has provided no cost estimate for these programs. CBO has only been able to provide a discretionary cost estimate for those authorizations that include specified funding levels for possible future appropriations that are set in the bill for one or more years. Additionally, CBO is restricted to estimating the cost of new discretionary spending for only the period of authorization detailed in the bill’s provisions, which gives the impression that these new programs are temporary in nature, and would lose funding at the end of their authorization window. However, experience suggests that discretionary spending for programs with specified authorization periods often continues well past the expiration of the

authorization. Accordingly, it is appropriate to extrapolate the costs of such programs beyond their explicit authorization periods to get a better sense of what the true budgetary impact that enactment of these programs would be. After extrapolating CBO's discretionary spending estimate from Fiscal Year (FY) 2011 through FY 2019, explicit discretionary costs would total approximately \$96 billion.

- **Therefore, we should count \$114 billion in new discretionary spending over the next ten years as part of the cost of the legislation.**
- The bill includes \$463 billion in Medicare cuts over the next 10 years. Medicare has an unfunded liability of \$38 trillion. The cost of Medicare is growing much faster than the rate of growth in the economy.
- What this means is that, on our current path, the federal government will not have sufficient resources to make the payments that Medicare beneficiaries might be expecting for their health care. If a liability does not have a funding source, then it does not get paid. We already know this will start happening in Medicare in 2016.
- One way to reduce the unsustainability of Medicare is to plan ahead and make some reductions now in future promises so that our remaining promises are more likely to be fulfilled in an orderly way, rather than the federal government telling beneficiaries: "Sorry, we ran out of money so you're on your own."
- The Medicare reductions in this bill, by themselves, would have been an important step to extending the life of that program. But instead of using the savings to make Medicare healthier, this bill uses those savings to pay for other new spending programs in the bill.
- But savings can't be used twice – to both extend the life of Medicare and to pay for other spending. Yet the supporters of this bill have the nerve to claim they are extending Medicare's solvency past 2016 and reducing the deficit at the same time.
- **Therefore, we should not count \$463 billion in Medicare cuts.**
- The real result is that the government is not reducing its exposure to future claims on its resources and the resources of the American economy at all. Instead, future Medicare claims are still out there, and we are adding a whole new set of future claims with other new spending in this bill.
- If you take out the \$463 billion in Medicare savings –because the first claim on them is from the program itself and the need to make it more sustainable for the future – then the result is that this bill really **increases the deficit** by \$582 billion over the next 10 years, a far cry from the deficit reduction claimed by the bill's supporters.

Bottom Line: What is the Real Deficit Impact of This Bill?

- Deficit increase of \$582 billion over first ten years.
- Deficit increase of \$1.6 trillion over second ten years.

Real Effect on the Federal Deficit of the Senate-Passed Health Care Bill

(By fiscal year in billions of dollars)

	<u>2010-</u> <u>2019</u>	<u>2020-</u> <u>2029</u>
CBO Estimate of Reid II - Unified Deficit Impact (- = reduction in the deficit)	-118	-812
Remove Off-Budget Effect of Social Security	-53	-228
Remove CLASS ACT	-70	-29
Add discretionary spending	114	151
Remove Medicare Cuts	-463	-2051
Total	582	1647

H.R. 3590 as Passed by the Senate

(billions)	2010-14	2010-19	2014-23	2020-29	2010-29
Spending Increases					
Discretionary spending	44	114	142	151	265
Medicaid/CHIP (coverage)	18	386	814	1,346	1,734
CLASS Act spending	1	13	42	105	118
Exchange subsidies	21	344	758	1,346	1,691
Risk Adjustment Payments	11	106	207	329	434
Other Medicare/Medicaid spending	50	134	193	300	432
Small employer tax credits	21	37	41	63	102
Exchange Premium credits	5	106	233	407	513
Total Spending	170	1,240	2,429	4,046	5,288
Offsets					
Medicare/Medicaid cuts	-111	-542	-1,122	-2,387	-2,928
CLASS ACT premiums	-25	-83	-119	-134	-218
Risk Adjustment collections	-12	-106	-212	-344	-449
Other revenues	-2	-14	-27	-38	-53
Individual mandate penalties	0	-15	-34	-59	-74
Employer mandate penalties	-2	-24	-55	-89	-115
Other Tax increases	-80	-459	-899	-1,655	-2,114
Total Offsets	-232	-1,244	-2,468	-4,706	-5,951
GRAND TOTAL	-104	-118	-39	-661	-663

H.R. 3590 as Passed by the Senate

(billions)	2010-14	2010-19	2014-23	2020-29	2010-29
Spending	144	1,097	2,155	3,577	4,674
Spending Cuts	-111	-542	-1,122	-2,387	-2,928
Taxes/Receipts	-95	-558	-1,072	-1,850	-2,408
TOTAL	-104	-118	-39	-661	-663

NOTES

*Details may not add to totals due to rounding

*2014-23 - programs are fully implemented

*Spending = Medicaid/CHIP coverage, exchange subsidies and other Medicare/Medicaid spending

*Spending cuts = Medicare/Medicaid cuts

*Other Tax increases= taxes estimated by JCT and associated effects on revenues and outlays per CBO

*Tax Increase = Small employer tax credits, tax impact of coverage policies, penalties and tax increases