Testimony Presented to the House Budget Committee:

"Perspectives on Long-Term Deficits"

James C. Capretta
Fellow, Ethics and Public Policy Center

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Mr. Chairman, Mr. Ryan, and other members of the Committee, thank you for the opportunity to participate in this very important hearing on the nation's long-term budget outlook.

It is readily apparent that the federal budget is on an unsustainable path. From 1789 to 2008, the nation accumulated $5.8 trillion in debt. According to the Congressional Budget Office (CBO), President Obama's 2010 budget plan would push the nation's debt above $17 trillion by 2019 -- thus more than tripling what the government owes to lenders in just eleven years.

Moreover, this rapid run-up in debt would occur just as the nation is entering into a period of dramatic demographic transformation. Between 2010 and 2030, the population age 65 and older will rise from about 41 million to 71 million, which will drive up spending on the nation's three largest entitlement programs -- Social Security, Medicare, and Medicaid. In their latest long-run projections, CBO expects spending on just these three programs to rise from 9.8 percent of GDP in 2010 to 14.4 percent in 2030, or an increase of about 4.6 percent of GDP in twenty years. To put that in perspective,

that's like adding another program of the size of Social Security to the federal budget over a period of two decades without any additional revenue to pay for it.

The president has correctly argued that rising health-care costs, along with the aging of the population, is at the heart of the medium and long-term budget problem. And he has also said, repeatedly, that one of the primary objectives of the health-care legislation which has been under consideration in Congress for the last year is to slow the pace of rising health entitlement costs for the federal government.

It is also true that CBO has provided cost estimates which show modest deficit reduction from these bills -- as written -- over the period 2010 to 2019.

But these cost estimates are based on assumptions that are highly unlikely to hold up over time. Indeed, there are many reasons why those who are concerned about the nation's long-term finances should be very concerned about the budgetary implications of the health-care bills under consideration in Congress.

Let me outline just a few of these reasons.

Medicare Physician Fees

Both the President and Congressional leaders have signaled that they will not allow a scheduled 21 percent reduction in Medicare physician fees to go into effect in

2010 or later years. The original version of House health care legislation, released in July 2009, included a permanent repeal of the planned fee cuts, at a cost of $229 billion over ten years. However, after the president announced a $900 billion limit on total spending for health-care in September, House leaders decided to drop this provision from the larger health-care legislation and pass it as a separate bill. Senate leaders then followed a similar course.

Both the House and Senate bills are filled with provisions which would make changes in the Medicare program. It is hard to imagine what would justify taking this one change to the program and passing it separately from all the others. Of course, passing it separately does not change its cost. It's still $200 billion in spending that must either be offset or borrowed from lenders, and it doesn't matter if the health-care effort is passed in one or two bills. The total cost is the same either way. When a fix for Medicare physician fees is properly included in the total cost of what is being planned, neither the House nor the Senate version would reduce the federal budget deficit between 2010 and 2019. Indeed, if something like the House version of the fix is including in the accounting, both the House and Senate bills would flip from modestly reducing the federal budget deficit to increasing it by about $80 billion over a decade.

Substantial Non-Coverage Spending in the Bills

In September, the president said he wanted the bills to spend no more than $900 billion over ten years. He didn't say that was for a "net" number, with tax increases

offsetting part of the cost. Nor did he say it was a limit only for some of the spending in the health-care bill.

And, yet, when all of the spending is included in a proper rack up, both the House and the Senate passed bills would far exceed the $900 billion limit the president established for the initiative just a few months ago.

In the House bill, the gross cost of the Medicaid expansions and the entitlement to new premium subsidies in the exchange would cost $1.055 trillion over ten years, according to CBO. In addition, the House legislation includes scores of other spending provisions, for everything from increasing payments to primary care providers to special payments to U.S. territories. According to CBO, these provisions would cost about $230 billion more over a decade. With a $210 billion physician fee bill, the total cost of the House's health care effort reaches nearly $1.5 trillion between 2010 and 2019.

In the Senate legislation, the cost of the coverage expansion is $871 billion between 2010 an 2019. Other spending in the bill totals about $90 billion over ten years. With about $200 billion more for a permanent repeal of the Medicare physician fee cut, the Senate plan's total cost approaches $1.2 trillion.

Spending Provisions in the House and Senate Health Care Plans		
	House	**Senate**
Coverage Expansions	$1.055 trillion	$0.871 trillion

Other Spending	$0.230 trillion	$0.090 trillion
Physician Fee Fix	$0.210 trillion	$0.200 trillion
Total Spending	$1.495 trillion	$1.161 trillion

Unrealistic Medicare Cuts

There has been a great deal of discussion about reforming health-care delivery to painlessly root out unnecessary costs. But the bills as passed by the House and Senate do not achieve any substantial savings with these kinds of provisions. Instead they achieve the bulk of the Medicare savings, which totals $467 billion over ten years in the Senate bill, from across-the-board payment rate reductions, including an automatic yearly cut in the inflation updates for certain providers of care.

The Chief Actuary of the Medicare program has warned that these arbitrary reductions could have serious consequences for beneficiaries' access to care, as it would push about one out of every five hospital facilities into insolvency.

And, yet, despite this warning, the House and Senate bills assume these cuts would continue in perpetuity and provide the offsetting savings needed for a rapidly growing entitlement expansion.

The CLASS Act

Both the House and Senate passed bills would stand up an entirely new entitlement program for long-term care services, called the Community Living Assistance Services and Supports, or CLASS Act. Eligible participants would be required to pay premiums in advance of receiving any benefit payments. Consequently, starting this new program from scratch would produce one-time "savings" from premium collections before any cohort of beneficiaries starts drawing benefits. But the premiums collected in the early years would also be needed to liquidate entitlement obligations later, outside of the ten-year budget window.

So, in a very real sense, the CLASS Act premiums are being double-counted. They are being used to pay for the health-care bill, as well as deposited in an account to pay future long-term care benefits. If these premiums were only counted once, the ten year deficit increase associated with the House-passed bill would go up by more than $100 billion.

The True Ten-Year Window

Although the House and Senate sponsors of the health care bills argue that expeditious enactment is necessary to provide better services to the uninsured, none of the key provisions to expand coverage would go into effect until 2013 in the House bill and 2014 in the Senate bill. Meanwhile, many of the spending reductions, such as the cut

in Medicare Advantage payment rates, would kick in much earlier, as would the tax increases. Consequently, both bills have ten years worth of spending and revenue "offsets" paying for only six or seven years worth of spending.

Looking at these bills over a true ten year window of full implementation reveals much higher costs. The Senate bill's provisions, even excluding the Medicare physician fee fix, would total $2.3 trillion over the period 2014 to 2023, with the coverage provisions fully in place. The House bill's true ten-year cost would be of a comparable magnitude.

The Certainty of Future of Entitlement Expansions

Both the House and Senate bills assume the new entitlement spending for coverage expansion can be held down with provisions which lock workers into employer-sponsored plans. If an employer offers "qualified" insurance coverage to a worker, the employee really has no choice but to take it if he wants to avoid paying the penalty for going uninsured. They could not go into the so-called "exchanges" to get insurance subsidized with federal tax support.

These firewall rules would create large disparities in the federal subsidies made available to workers inside and outside the exchanges. According to Gene Steuerle of the Urban Institute, a family of four with an income of $60,000 with employer-sponsored health care would get about $4,000 less in federal support in the House bill outside of the

exchange than a similar family inside the exchange would get in 2016. And there would be many tens of millions more families outside the exchange than in it, according to CBO. Today, there are about 127 million Americans under the age of 65 with incomes between 100 and 400 percent of the federal poverty line, but CBO expects only about 18 million people will be getting exchange subsidies in 2016.

If enacted as currently written, pressure would build very quickly to treat all Americans fairly, regardless of where they get their insurance. One way or another, the subsidies provided to those in the exchanges would be made more widely available, driving the costs of reform much higher than estimates currently indicate.

Weak Cost-Control Mechanisms

It has been argued by some that the bills include strong cost-control mechanisms which will slow the pace of rising costs even more than CBO currently estimates. That seems highly unlikely however, given the compromises which have been made to get these provisions into the bills.

For instance, many point to the so-called "high-cost insurance tax" in the Senate bill as a potentially important cost-control provision. But in recent days, the White House announced an agreement with some of the nation's leading labor unions to exempt all collectively bargained plans and state and local government workers from the excise tax through 2017.

News reports indicate that this deal would reduce the revenue collected from this provision by 40 percent. But it seems much more likely that it would lead to a wholesale abandonment of the idea because of the inequities it would create. In effect, all non-union workers in the private sector would be potentially subject to the tax for a full five years before unionized workers were. That will strike many Americans as patently unfair. If enacted, pressure would build on Congress to make the exemption available to all workers, thus gutting the provision altogether.

Similarly, the Senate bill also includes an independent Medicare commission which could make recommendations to reduce Medicare payments to providers, and those recommendations would automatically go into effect if Congress did not act to pass provisions which would reduce spending by similar amounts. Sponsors of the legislation have argued that this commission would help bend the cost-curve system-wide.

But the commission's mandate would be very limited. It could not make any recommendations which altered any aspect of insurance coverage for beneficiaries, or reduced hospital or physician spending through 2019. That doesn't leave a lot of room to implement meaningful changes which have a large impact on costs. Moreover, pressure would build to extend indefinitely the exemptions for hospitals and physicians, and to make it available to other providers of Medicare-covered services as well.

Conclusion

The nation's long-term budget outlook is bleak in large part because our health-care entitlement commitments far exceed the revenues available to pay for them. By 2019, the House and Senate-passed health-care bills would add at least another $200 billion per year to those commitments, and unleash pressures for even more spending down the road. Meanwhile, the offsets used to pay this spending would be much less likely to occur, and the cost control provisions are not nearly robust enough to make a difference.

Congress would be well-advised to take a step back and rethink this entire approach. Instead of passing an expensive health-care bill that uses $1 trillion in offsets to pay for more spending, it would be better to craft a sensible, consensus long-term budget plan which has as one of its core elements an affordable, bipartisan health-care program, one that truly does the job on costs and expands coverage as well.