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Obamacare and the Budget: Playing Games with Numbers

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The federal government's finances were dismal even before the Patient Protection and Affordable Care Act (PPACA) was enacted. That is why lawmakers who pushed for its passage felt compelled to try to calm worried Americans by claiming that the law would cut projected federal budget deficits in addition to covering the uninsured.[1]

And, in fact, the Congressional Budget Office's (CBO) official estimate shows that PPACA's health care provisions[2] would cut projected deficits by $124 billion over the period from 2010 to 2019.[3] But that cost estimate is not the whole story—not by a long shot. A close examination of what CBO said, as well as other evidence, makes it clear that the deficit reduction associated with PPACA is based on budget gimmicks, sleights of hand, accounting tricks, and completely implausible assumptions. A more honest accounting reveals the new law as a trillion-dollar budget buster.

Summary. CBO must assume that current law will be enacted as written, even in cases where this is improbable. For instance, PPACA makes $575 billion in projected cuts to Medicare, threatening seniors' access to care.[4] Regarding these and the existing planned cuts in payments to physicians under what is known as the "sustainable growth rate" formula, CBO Director Douglas Elmendorf wrote:

> [C]urrent law now includes a number of policies that might be difficult to sustain over a long period of time. For example, PPACA and the Reconciliation Act reduced payments to many Medicare providers relative to what the government would have paid under prior law. On the basis of those cuts in payment rates and the existing "sustainable growth rate" [SGR] mechanism that governs Medicare's payments to physicians, CBO projects that Medicare spending (per beneficiary, adjusted for overall inflation) will increase significantly more slowly during the next two decades than it has increased during the past two decades. If those provisions would have subsequently been modified or implemented incompletely, then the budgetary effects of repealing PPACA and the relevant provisions of the Reconciliation Act could be quite different—but CBO cannot forecast future changes in law or assume such changes in its estimates.[5]

Medicare's Chief Actuary echoed this concern in his own analysis.[6] If Medicare savings do not materialize, new spending under PPACA will be added to the deficit.

As noted by Elmendorf, Medicare's payments to physicians are scheduled to be cut as well under the SGR formula. There is bipartisan agreement to stop this from happening. But the "doc fix" costs billions, requiring Congress to scramble to find an offset.

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Without it, physicians would face a 25 percent (and growing) Medicare payment reduction, restricting seniors' access to care as more doctors become unable to serve Medicare patients. Congress has never allowed this to happen, even as it has insisted on paying for the "fix" with offsets.

While pushing PPACA through Congress, President Obama took the position that it was no longer necessary to pay for the "doc fix." He proposed to add its costs to the national debt, but he did not want those costs to count against PPACA, because they would explode the myth of deficit reduction. So his solution was to pass the "doc fix" in separate legislation. But it does not matter to taxpayers if the President's ideas are passed in one bill or many. All that matters is the total cost. And the President's total bill for health care—with an unfinanced "doc fix"—shows massive deficits, not deficit reduction.

CBO further assumes that all cuts to existing programs and new revenues created by PPACA are used to pay for new spending. In reality, this will not be the case. PPACA increases Medicare taxes and imposes cuts in Medicare that are double-counted as offsets for new programs, but are also pledged to extend Medicare's solvency.[7] They cannot do both.

Another source of double-counted savings is the CLASS Act, which creates a new, federally run long-term care insurance program. Beneficiaries will begin paying premiums in 2011 but will not receive benefits for five years. This frontloads revenue and creates the illusion of $70 billion to pay for new spending under PPACA. In reality, premium payments from CLASS will be used to pay out benefits in later years.[8] Senator Kent Conrad (D–ND) called this "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of."[9]

1. Congress cannot build sound market-based health care reform on the foundation of a flawed health care law. Therefore, the health care law must be repealed in its entirety.

   The House of Representatives has taken a major step towards full repeal of the Patient Protection and Affordable Care Act (PPACA—otherwise known as "Obamacare"). Until full repeal occurs, Congress must continue to focus on the core failures and consequences of PPACA and block its implementation to allow time to achieve repeal and lay the groundwork for a new market-based direction for health care reform.
2. Patient Protection and Affordable Care Act of 2010, Public Law 111–148, and Health Care and Education Reconciliation Act of 2010, Public Law 111–152.
3. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to Nancy Pelosi, Speaker, U.S. House of Representatives, March 20, 2010, at *http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf* (January 13, 2011).
4. Robert E. Moffit, "Obamacare and Medicare Provider Cuts: Jeopardizing Seniors' Access," Heritage Foundation *WebMemo* No. 3105, January 19, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Medicare-Provider-Cuts-Jeopardizing-Seniors-Access.*
5. Douglas W. Elmendorf, Director, Congressional Budget Office, letter to John Boehner, Speaker, U.S. House of Representatives, January 6, 2011, at *http://www.cbo.gov/ftpdocs/120xx/doc12040/01-06-PPACA_Repeal.pdf* (January 10, 2011).
6. See Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' As Amended," April 22, 2010, p. 9, at *http://www.politico.com/static/PPM130_oact_memorandum_on_financial_impact_of_ppaca_as_enacted.html* (January 13, 2011).
7. See U.S. Senate Budget Committee Republicans, "Budget Perspective: The Real Deficit Effect of the Democrats' Health Package," March 23, 2010, at *http://budget.senate.gov/republican/pressarchive/2010-03-23BudgetPerspective.pdf* (January 13, 2011); Centers for Medicare and Medicaid Services, "2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds," August 5, 2010, at *https://www.cms.gov/ReportsTrustFunds/downloads/tr2010.pdf* (January 13, 2011).
8. See Brian Blase, "No CLASS: How Congress Saddled Taxpayers with Another Costly Entitlement," Heritage Foundation *Backgrounder* No. 2444, July 29, 2010, at *http://www.heritage.org/Research/Reports/2010/07/No-CLASS-How-Congress-Saddled-Taxpayers-with-Another-Costly-Entitlement.*
9. Lori Montgomery, "Proposed Long-Term Insurance Program Raises Questions," *The Washington Post*, October 27, 2009, at *http://www.washingtonpost.com/wp-dyn/content/article/2009/10/27/AR2009102701417.html* (January 13, 2011).

Savings within Medicare and CLASS revenues can be spent only once. If they are used to increase Medicare's solvency and pay for the CLASS program, new spending in PPACA will be added to the deficit.

PPACA also creates a new subsidy program for low- and middle-income Americans to purchase insurance in the new health exchanges. CBO predicts that 19 million Americans will benefit from this generous new entitlement program at a cost of $460 billion by 2019. But the new law includes substantial incentives for employers to drop existing coverage and allow employees to instead purchase taxpayer-subsidized coverage.[10] Former CBO director Douglas Holtz-Eakin points out that many businesses could drop their employee health plan, raise wages to make up for the lost benefit, pay the employer penalty for not offering insurance, and still come out ahead.[11] These incentives, exacerbated by the various new insurance rules that will cause a faster rate of growth in employer plan premiums, will cause the cost of the subsidy program to greatly exceed initial projections.

Finally, the CBO scoring of PPACA looks only at the first 10 years of the law's enactment. This, however, includes just six years of full spending, as the costliest provisions do not go into effect until 2014. This also allows PPACA to meet the requirements of the pay-as-you-go (PAYGO) rule, which requires legislation to exhibit deficit neutrality over a 10-year window. In theory, PAYGO should maintain levels of deficit spending. In actuality, it has had little success at halting the addition of new spending to the deficit, since new programs can create savings in one decade but run trillions in deficits the next and still meet PAYGO requirements.

The CLASS program alone is an excellent example of how easy it is to create a new and completely insolvent program without violating PAYGO. Experts—including the CBO Director, Medicare's Chief Actuary, and the American Academy of Actuaries—have all concluded that CLASS is unsustainable and will go bankrupt. Despite this, Heritage budget expert Brian Riedl writes that, perversely, "repealing CLASS would violate the 'pay as you go' law against expanding budget deficits. This is because 'pay-go' focuses only on the 10-year $70 billion 'cost' of repeal and ignores the trillions of dollars that would be saved thereafter."[12]

The reality is that the new health care law will result in trillions in unaffordable deficit spending.

Impact:

It Will Increase the Federal Deficit. In 2010, the federal deficit was $1.3 trillion. While the average historical deficit is 2.9 percent of gross domestic product (GDP), by 2050, the budget gap is projected to exceed 20 percent of GDP.[13] This trend is set to continue as the population ages and the baby boomer generation retires, causing the cost of programs such as Medicare, Medicaid, and Social Security to soar.

Rising health care costs further add to growth in entitlement spending. Creating a new entitlement program and expanding an existing one will hasten the arrival of inevitable financial collapse.[14] The deficit-reducing provisions of PPACA are either unrealistic or unsustainable.

It Delays Progress to Repair Existing Unsustainable Entitlement Programs. Claims that the new health care law will reduce the deficit are irresponsible and delay meaningful action. To truly reduce

10. See Brian Blase and Paul Winfree, "Obamacare and Health Subsidies: Expanding Perverse Incentives for Employers and Employees," Heritage Foundation *WebMemo* No. 3112, January 20, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Health-Subsidies-Expanding-Perverse-Incentives-for-Employers-and-Employees*.
11. Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010, at *http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf* (January 13, 2011).
12. Brian Riedl, "CLASS Is the Next Huge Taxpayer Bailout," Heritage Foundation *Commentary*, July 26, 2010, at *http://www.heritage.org/Research/Commentary/2010/07/CLASS-is-the-Next-Huge-Taxpayer-Bailout* (January 13, 2011).
13. The Heritage Foundation, "Federal Budget Deficits Will Reach Levels Never Seen Before in the U.S.," 2010 Budget Chart Book, at http://www.heritage.org/budgetchartbook/federal-budget-deficits.
14. PPACA adds a total of 16 million Americans to Medicaid by 2019. See Elmendorf, letter to Pelosi, March 20, 2010.

deficit spending, Medicare, Medicaid, and Social Security must be reformed. The sooner a solution is adopted, the better: current beneficiaries would experience greater stability and future beneficiaries would have more time to adjust to change.

PPACA made significant cuts to Medicare, but these can either increase the program's solvency or pay for new spending—not both. Moreover, the new law increased Medicare payroll taxes and extended them to apply to investment income, but it will use the additional revenue to pay for non-Medicare spending. This sets a dangerous precedent that could further increase the insolvency of the program. The provisions create the illusion of Medicare reform, but the changes are the wrong ones and will only give lawmakers another excuse to further avoid addressing the long-term health of entitlement programs.

It Promises Future Increases in Taxes and Penalties. As mentioned earlier, PPACA creates enormous incentives for certain employers to drop their employer-sponsored coverage. The employer penalty included in the law ($2,000 per employee) is low enough to allow employers to drop coverage, pay the penalty, and come out ahead. John C. Goodman, President of the National Center for Policy Analysis, writes, "As more employers dump their employees onto the exchange and as the cost to taxpayers rises, the potential pressure to increase the fine will become inexorable."[15] Larger penalties would harm businesses' ability to create jobs, raise wages, or keep their current workers.

It Puts Future Generations on the Hook. Once Americans rely on the new subsidies in order to afford coverage, Congress will have a hard time walking back the generous program. To pay for it, Congress can either raise taxes or add to the deficit. Of course, deficit spending is not free; it merely delays paying for programs, requiring tomorrow's taxpayers—currently unable to vote—to pay for current citizens' benefits.[16]

A New Direction. If Congress is serious about reducing the deficit and controlling spending, lawmakers should set aside easily manipulated rules like PAYGO and require scoring that reveals the true long-term impact of legislation. This would make it more difficult for legislation like PPACA, which increases the size of government and creates unsustainable new spending, to become law. To reduce the deficit, PPACA must be repealed.

Budget process reform should enforce policy changes that reduce the size of the federal government, reduce out-of-control federal spending, and prohibit any tax increase on the American people.[17] Congress should prominently disclose long-term entitlement program obligations in the budget resolution to provide a more accurate picture of the federal government's commitments. Scoring of policy changes should also look at long-term effects on the government's total unfunded obligations to give lawmakers a more accurate understanding of the true cost of any piece of legislation. In so doing, the reality of PPACA's 10-year scoring would have been revealed.

Congress should also establish mechanisms to equitably assess and enforce changes in spending and revenues. CBO's current spending baseline assumes that laws that authorize spending will continue despite scheduled expiration dates. However, CBO assumes that laws relating to taxes will expire as scheduled. A new enforcement strategy must consider both spending and revenue on the same baseline in order to be effective.

Finally, mandatory spending on entitlements should be put on a long-term budget. Entitlement spending is currently on autopilot, allowing open-

15. John C. Goodman, "The $6-an-Hour Minimum Wage," John Goodman's Health Policy Blog, October 18, 2010, at *http://healthblog.ncpa.org/the-6-an-hour-min-wage/?utm_source=newsletter&utm_medium=email&utm_campaign=HA#more-13959* (January 13, 2011).
16. See James C. Capretta, "Obamacare: Impact on Future Generations," Heritage Foundation *WebMemo* No. 2921, June 1, 2010, at *http://www.heritage.org/Research/Reports/2010/06/ObamaCare-Impact-on-Future-Generations.*
17. See Alison Acosta Fraser, "Any Stimulus Legislation Must Include Budget Reforms to Address Long-Term Challenges," Heritage Foundation *WebMemo* No. 2199, January 9, 2009, at *http://www.heritage.org/Research/Reports/2009/01/Any-Stimulus-Legislation-Must-Include-Budget-Reforms-to-Address-Long-Term-Challenges.*

ended growth. Left unchecked, entitlement spending will eventually crowd-out other priorities. Instead, these programs should be put on a limited budget, and Congress should regularly examine their spending and take steps to keep the programs within their limits. Automatic adjustments or triggers should be put in place to reduce spending if Congress fails to act. This will force lawmakers to put these programs on stable financial footing. Medicare should be transformed to a limited, defined-contribution system that allows seniors to seek better value by purchasing a health care plan that suits their needs in the private market.[18] Medicaid reform should limit taxpayer funding but give states greater flexibility to administer their respective programs while also creating the opportunity for beneficiaries to receive better quality coverage in the private market.

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18. See Robert Moffit and James C. Capretta, "Medicare Reform: A New Vision for a Better Program," Heritage Foundation *Backgrounder* No. 2500, December 13, 2010, at *http://www.heritage.org/Research/Reports/2010/12/How-to-Fix-Medicare-A-New-Vision-for-a-Better-Program.*