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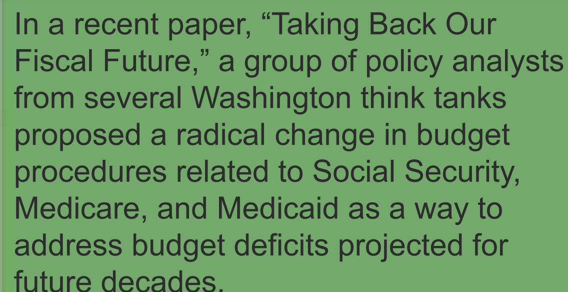
A BALANCED APPROACH TO RESTORING FISCAL RESPONSIBILITY



In a recent paper, “Taking Back Our Fiscal Future,” a group of policy analysts from several Washington think tanks proposed a radical change in budget procedures related to Social Security, Medicare, and Medicaid as a way to address budget deficits projected for future decades.

We agree that the nation faces large, persistent budget deficits that would ultimately risk significant damage to the economy. We also concur that policymakers should begin now to make the tough choices needed to avert such deficits.

But we believe the proposal set forth in “Taking Back Our Fiscal Future” is misguided. We believe there are better ways to begin tackling projected deficits, which we describe in this paper.

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Executive Summary

In a recent paper, "Taking Back Our Fiscal Future," a group of policy analysts from several Washington think tanks proposed a radical change in budget procedures related to Social Security, Medicare, and Medicaid as a way to address budget deficits projected for future decades. They urged Congress to establish 30-year budgets, or caps, for these programs. The White House would conduct a review every five years. If it projected that expenditures would exceed the caps, the programs would face automatic cuts or related tax increases.

We agree that the nation faces large, persistent budget deficits that would ultimately risk significant damage to the economy. We also concur that policymakers should begin now to make the tough choices needed to avert such deficits.

But we believe the proposal set forth in "Taking Back Our Fiscal Future" (hereafter referred to as TBOFF) is misguided. It could jeopardize the health and economic security of the poor, the elderly, and people with serious disabilities. For one thing, it does not focus adequate attention on the main driver of our fiscal problem — the relentless rise in health care costs throughout the U.S. health care system. Without measures to slow the growth of total (public and private) health care spending, no solution to the nation's fiscal challenges will prove sustainable. For another, it does not propose any action to restrain the hundreds of billions of dollars in entitlements that are delivered through the tax code and flow largely to more affluent Americans.

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This information is for identification purposes only. The material in this document represents the views solely of the individuals listed here, not of the institutions with which they are, or have been, affiliated.

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We believe there are better ways to begin tackling projected deficits, which we describe below.

In addition, TBOFF[1] would establish budget procedures that closely resemble failed approaches of the past. We believe that the proposal's formulaic budget caps backed by automatic cuts would fail to reduce projected deficits, just as when Congress tried such an approach under the 1985 Gramm-Rudman-Hollings law.

We believe the TBOFF proposal is ill-advised for three main reasons.

- **First, TBOFF is unbalanced**. It would subject Social Security, Medicare, and Medicaid to the threat of automatic cuts while giving a free pass to the open-ended entitlements (or "tax expenditures") enshrined in the tax code. These tax entitlements cost hundreds of billions of dollars a year, and their benefits flow largely to more affluent Americans. Nor would TBOFF place any obstacle in the way of deficit-financed tax cuts (or increases in other spending) even as Social Security, Medicare, and Medicaid faced potentially deep reductions based on projections of spending as much as three decades in the future. Yet over the next 75 years, the cost just of making permanent the 2001 and 2003 tax cuts is 3½ times the size of the entire Social Security shortfall. Thus, the plan departs from the "shared sacrifice" approach that has characterized the major, successful deficit-reduction laws of recent decades, such as those enacted in 1990 and 1993. Those agreements resulted when policymakers placed all parts of the budget "on the table" and developed balanced packages that combined reductions in major programs (particularly Medicare) with increases in taxes.

- **Second, TBOFF seeks to force action to substantially reduce projected expenditures for Medicare and Medicaid without requiring measures to restrain the growth of health care spending throughout the U.S. health care system**. The main driver of the high growth in projected expenditures for Medicare and Medicaid is the continued high growth in health care costs systemwide, not features unique to these two programs. For 30 years, per beneficiary spending in Medicare and Medicaid has grown at rates nearly identical to those for the health care system as a whole. As Congressional Budget Office director Peter Orszag recently noted, "Put simply, health care costs are the single most important factor influencing the federal government's budget trajectory."[2] Fundamental, systemwide reform of health care financing and delivery is the key to controlling Medicare and Medicaid expenditures — and reducing projected long-term deficits — without imposing draconian cuts that would harm the poor, the elderly, and people with serious disabilities.

- **Third, budget targets enforced by automatic cuts have proved ineffective in curbing past deficits, and there is no reason to think they will succeed in the future**. Under TBOFF, if the administration in office projected that expenditures for Medicare, Medicaid, or Social Security would exceed the caps that had been set for the next 30 years, automatic cuts would take effect. However, when policymakers previously tried to use budget targets backed by automatic cuts to force tough budget choices — under the 1985 and 1987 Gramm-Rudman-Hollings laws — the efforts failed. Policymakers first resorted to rosy assumptions to claim that the targets would be met and, when rosy scenarios proved insufficient, they resorted to accounting gimmicks and

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[1] The paper is available on the websites of the Brookings Institution (http://www.brookings.edu/~/media/Files/rc/papers/2008/04_fiscal_future/04_fiscal_future.pdf) and the Heritage Foundation (http://www.heritage.org/Research/Budget/upload/takingbackourfiscalfuture.pdf).

[2] Peter Orszag, "Health Care and Behavioral Economics: A Presentation to the National Academy of Social Insurance," May 29, 2008.

timing shifts in order to avert the automatic cuts. When such evasions were not enough, they waived or raised the budget targets. Ultimately, policymakers repealed the whole framework because it failed to produce the intended results. Opportunities for evasion under TBOFF would, if anything, be even greater. Projections of health care expenditures as much as three decades in the future — and hence of Medicare and Medicaid costs — vary widely among experts and involve considerable guesswork about future trends in medical technology and other matters. The potential for future administrations and Congresses to use rosy assumptions to avoid unpopular actions would be great.

In short, the TBOFF proposal is fundamentally flawed. If it worked, it could undermine the defined-benefit structure of Social Security, Medicare, and Medicaid, without adequately addressing the systemwide rise in health care spending that underlies our fiscal problems. And it would focus deficit-cutting attention on programs that serve needier members of our society without a comparable focus on tax breaks for the more economically secure. If TBOFF did not work, it could prove counterproductive — by encouraging policymakers who were beginning to feel pressure to address long-term deficits to substitute TBOFF's procedural change for tough budgetary choices, only to have TBOFF's easily-evaded budget procedures subsequently fail to produce meaningful results. In the interim, the existence of the TBOFF procedures could create an illusion of progress, giving policymakers a false sense of security and easing pressure on them to strike effective bipartisan deals for long-term deficit reduction.

Finally, TBOFF is exceedingly vague in critical respects. Would the caps for each of the three large programs be set in dollar terms, as a share of the Gross Domestic Product, as a function of other economic variables, or in some entirely different manner? At what levels would the caps be set and how would they be adjusted over time? Would the automatic cuts take the form of benefit reductions, cuts in provider payments, increases in beneficiary premiums or copayments, tax increases, or some combination thereof?[3] TBOFF is silent on all of these questions. While urging policymakers to make tough choices, TBOFF's authors skirted the tough choices needed to convert their proposal into a concrete plan.

Rather than spending time trying to hammer out complex budget procedures of dubious merit and effectiveness, policymakers should focus on actual steps they can start taking to reduce projected deficits by slowing the growth of health care spending throughout the U.S. health care system while also reforming Medicare, closing the Social Security shortfall, and raising more revenue. While policymakers may not yet be ready to address such matters fully, they can begin by seeking "grand bargains" involving changes in both the big spending programs and taxes, including the changes suggested below. To be sure, some of these changes will be difficult to enact on their own. But, in the spirit of "shared sacrifice" as exemplified by the deficit-reduction packages of 1990 and 1993, these measures may be achievable as part of overall deficit-reduction packages. (Note: Not all signatories to this statement favor all of the following measures, but all favor at least a majority of them.)

- Adopting recommendations of Congress' Medicare Payment Advisory Commission, which could generate substantial savings;
- Increasing the Medicare premiums that affluent beneficiaries pay;

[3] As another illustration of TBOFF's vagueness, the TBOFF document even suggests at one point that a projection that expenditures for these programs would exceed the caps could trigger the formation of a commission to make recommendations to Congress for "closing the gap," although TBOFF's primary focus clearly is on automatic spending reductions or comparable automatic mechanisms.

- Instituting vigorous research programs to determine the comparative effectiveness of different health care treatments and procedures as well as what is causing the huge differences in health care costs across the country, and using the results as the basis for new policies to restrain health care costs without compromising health care quality;

- Curbing or eliminating outdated or unproductive tax expenditures;

- Switching to the Bureau of Labor Statistics' alternative, more accurate Consumer Price Index in computing the annual cost-of-living adjustments in Social Security and other entitlement programs (while taking steps to shield low-income and other vulnerable beneficiaries) and the annual inflation adjustments in the tax code;

- Reforming farm price supports; and

- Adhering to Pay-As-You-Go rules for both increases in mandatory programs and tax cuts.

While, taken together, these proposals would have a substantial effect on future deficits, policymakers will need ultimately to enact more extensive measures to achieve long-term fiscal sustainability. But, they need to get started. Working to reach agreement on measures such as those listed here would be much more productive than spending the next several years haggling over the contentious issues that would have to be resolved to turn TBOFF into a concrete plan and implement it, especially since the TBOFF procedures are not likely to lead to significant deficit reduction anyway.

In the following pages, we explain in greater detail why procedural fixes like those proposed in TBOFF would likely do more harm than good, and we elaborate on specific measures to consider that would be more fruitful in helping the nation start to take back its fiscal future.

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A BALANCED APPROACH
TO RESTORING FISCAL RESPONSIBILITY

I. An Unbalanced Approach

Giving short shrift to the need for more revenues

By focusing exclusively on expenditures for Social Security, Medicare, and Medicaid, TBOFF understates how much recent tax cuts have exacerbated the nation's long-term fiscal problem and glosses over how important added revenues can be in helping address the problem.

Over the next 75 years, the costs of making the 2001 and 2003 tax cuts permanent is 3½ times the size of the Social Security shortfall. The Social Security trustees project that the Social Security imbalance will equal 0.56 percent of the Gross Domestic Product over the next 75 years. Based on Joint Tax Committee and Social Security Administration estimates, the costs of extending the tax cuts is approximately 1.95 percent of GDP over the same period.[4] Indeed, *just the cost of extending the tax cuts for the top 1 percent of Americans — those with incomes over $450,000 — exceeds the entire Social Security shortfall.*[5]

TBOFF includes a section on "myths and realities" that appropriately rejects as myths the assertions that we can grow our way out of our budget problem or solve the problem by eliminating "waste." But it also lists as a "myth" the statement that "we just need to raise taxes starting with rolling back some or all of the Bush tax cuts." This is a "straw man." Of course, one cannot solve the entire long-term budget problem just by undoing — or paying for the extension of — the 2001 and 2003 tax cuts, and no serious analyst suggests that. Nor should policymakers raise revenues so much that tax increases alone would close the projected long-term fiscal gap. But policymakers will face important decisions very soon with regard to revenues. They will have to decide whether to let the 2001 and 2003 tax cuts expire and whether to pay for the tax cuts they elect to extend. If they do either, *that alone would eliminate more than half of the projected fiscal gap through 2050.*[6] This and other revenue issues deserve more serious consideration than TBOFF accords them.

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[4] The cost of the tax cuts includes the cost of the portion of Alternative Minimum Tax (AMT) relief needed to prevent the AMT from taking back much of the tax cuts' value. For further explanation, see Aviva Aron-Dine and Robert Greenstein, "The AMT's Growth Was Not Unintended," Center on Budget and Policy Priorities, November 30, 2007, and Kris Cox and Richard Kogan, "Long-Term Social Security Shortfall Smaller Than Cost of Extending Tax Cuts For Top 1 Percent," Center on Budget and Policy Priorities, March 31, 2008.

[5] The cost of the tax cuts for the top 1 percent will equal approximately 0.60 percent of GDP over the 75-year period, compared to 0.56 percent of GDP for the Social Security shortfall. In dollar terms, the tax cuts for the top 1 percent of households would cost $4.6 trillion over the next 75 years, while the Social Security trustees project the Social Security shortfall at $4.3 trillion. (The $4.3 trillion figure represents the "unfunded obligations" of the trust fund. All these figures are measured in present value. Estimates of the present-value cost of the tax cuts are based on the trustees' economic assumptions.)

[6] The long-term cost of extending the 2001 and 2003 tax cuts is slightly less than 2 percent of GDP. The Center on Budget and Policy Priorities has estimated that the fiscal gap through 2050 equals 3.2 percent of GDP. The size of the fiscal gap is larger over periods that extend further into the future. Although the amount of revenue associated with the 2001 and 2003 tax cuts is much smaller than the anticipated growth over time in expenditures for federal health care programs, the fact that the decision on the fate of the tax cuts affects revenue levels by a full 2 percent of GDP starting in the next few years, rather than by an amount that is initially small and grows gradually, means that the added revenue would produce interest savings that would compound from an early date. See Richard Kogan, Matt Fiedler, Aviva Aron-Dine, and James Horney, "The Long-Term Fiscal Outlook Is Bleak: Restoring Fiscal Sustainability Will Require Major Changes to Programs, Revenues, and the Nation's Health Care System," Center on Budget and Policy Priorities, January 29, 2007, at http://www.cbpp.org/1-29-07bud.pdf.

Ignoring federal retirement and health subsidies that go disproportionately to the affluent

Social Security, Medicare, and Medicaid are not the only large, open-ended federal commitments for retirement and health care. Federal tax expenditures for retirement and health care (including tax breaks for 401(k)s, IRAs, Keogh plans, Health Savings Accounts, and employer contributions for health insurance) cost about $300 billion a year and are growing rapidly. (Tax expenditures as a whole cost about $900 billion a year.) Former Federal Reserve Board Chairman Alan Greenspan has termed these and other tax expenditures "tax entitlements."

Nevertheless, TBOFF proposes no limits on the growth of these tax expenditures, in contrast to the limits it would impose on Social Security, Medicare, and Medicaid.[7] It focuses on entitlements on the spending side of the budget without placing a comparable focus on entitlements on the tax side of the budget.

This imbalance is especially troubling because the tax entitlements go disproportionately to people at higher income levels. In a Tax Policy Center analysis, Leonard Burman, William Gale, Matthew Hall, and Peter Orszag found that two-thirds of federal tax expenditures for retirement saving go to households in the top fifth of the income distribution.[8] In contrast, Social Security and Medicare benefits are spread far more evenly. Medicaid is, of course, targeted on people with low incomes. Thus, TBOFF would limit federal expenditures for the retirement and health care programs that provide an economic foundation for low- and middle-income families, while leaving untouched the open-ended and costly federal retirement and health care subsidies delivered through the tax code, which provide their largest benefits to upper-middle- and upper-income people and serve no social insurance function.

Such an approach would not only be inequitable but also would weaken the effort to curb deficits. Capping Social Security, Medicare, and Medicaid *without* constraining tax expenditures for health care and retirement would create perverse incentives for policymakers. When TBOFF's automatic-reduction mechanism kicked in, policymakers would be pushed to cut Social Security and Medicare but could "compensate" by expanding retirement and health care tax breaks. That would lessen or eliminate the deficit reduction. Moreover, such an approach would reduce federal retirement and health care programs that pool risk and maintain a progressive benefit structure (and thereby protect people who become poor, sick, or disabled), while expanding tax-based mechanisms that, by their nature, cannot effectively pool risk or perform a social insurance function.[9]

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[7] The joint statement says that "ultimately" the signatories would like to extend the type of budget procedures proposed for Social Security, Medicare, and Medicaid to tax expenditures and to all other entitlement programs (including those targeted on poor families), and it acknowledges (on the last page) that "the tax code is also on autopilot." But the TBOFF proposal itself does *not* subject the tax code — or any tax expenditures — to new budget procedures or restraints (because the signatories could not agree on that). As a result, under the proposal, the entitlement status of Social Security, Medicare, and Medicaid would end while tax expenditures for retirement and health care retain their open-ended character.

[8] Leonard E. Burman, William G. Gale, Matthew Hall, and Peter R. Orszag, "Distributional Effects of Defined Contribution Plans and Individual Retirement Accounts," Tax Policy Center, revised August 2004.

[9] TBOFF's discussion of Social Security raises other concerns as well. TBOFF portrays Social Security as a program on auto-pilot that lacks mechanisms to prevent its costs from growing to unsustainable levels and greatly straining the federal budget. In fact, Social Security already has its own built-in automatic adjustment mechanism — once its trust fund is exhausted, Social Security must reduce benefit levels to stay within the income it receives each year. The Social Security trustees project that if no action is taken, benefits will be reduced 22 percent in 2041. Of course, relying on such an approach would be undesirable for a number of reasons.

Wall Street Journal economics editor David Wessel focused on this shortcoming in a recent commentary on TBOFF's inadequacies. "Force Congress to limit spending, and history demonstrates that it will create new, unimagined tax credits to avoid those constraints," Wessel wrote. "Moreover, to a substantial degree the bottom of the population gets its goodies through spending; the top gets them through tax breaks (for retirement savings, mortgage interest, capital gains and the like) that are most valuable to those in upper-income brackets. Tackling benefits without tackling the tax code isn't wise."[10]

II. A Flawed Way to Address Projected Increasesin Medicare and Medicaid Costs

Downplaying rising health care costs

TBOFF glosses over the critical role that systemwide increases in health care spending play in fueling our long-term budget problem. As a result, its recommended response to increases in Medicare and Medicaid spending would not solve the fundamental problem. Furthermore, it would threaten the central achievement of those programs — providing the elderly, the disabled, and the poor with access to the same kind of health care that other Americans receive.

TBOFF portrays projected increases in Medicare and Medicaid costs as the key driver of the nation's fiscal problems. But it fails to note that for more than 30 years, the rate of growth in Medicare and Medicaid spending per beneficiary has closely tracked that of health care spending throughout the U.S. health care system.[11] That the rates of growth in costs are nearly identical is not surprising. Both private- and public-sector financed health care is delivered largely by the same health care providers in the same settings and relies on the same procedures and medications. This basic truth has prompted leading experts from across the political spectrum, including Congressional Budget Office director Peter Orszag, then-Comptroller General David Walker, and Gail Wilensky, administrator of what is now the Centers for Medicare & Medicaid Services under the first President Bush, to warn that policymakers will not be able to slow Medicare and Medicaid cost growth substantially without larger health care cost reform that slows health care costs systemwide. (See the box on page 8.) Yet TBOFF portrays health care cost reform as a secondary matter. It dismisses — as a budget "myth" to dispel — the statement that we merely need to deliver health care more efficiently.

Rising health care spending accounts for virtually all of the projected long-term federal budget deficit.[12] That is, were health care expenditures per person growing no faster than the economy as a

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Also, in calling for some type of new "expenditure budget" to measure whether Social Security is remaining on course financially, TBOFF seems to overlook the eminently reasonable measure that Social Security already employs for that purpose — the projection that the Social Security actuaries and trustees make each year of whether the program will be in close actuarial balance in the decades ahead.

[10] David Wessel, "Deficit Hawks Try, Try Again," *Wall Street Journal*, April 3, 2008, p. A2.

[11] From 1970 to 2006, Medicare spending per beneficiary rose at an average rate of 8.7 percent per year, compared to 9.7 percent for private health insurance. Centers for Medicare and Medicaid Services, "NHE [National Health Expenditure] Web Tables," January 2008, table 13 available at [http://www.cms.hhs.gov/National HealthExpendData/downloads/tables.pdf](http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf). The cited figures refer to benefits commonly covered by Medicare and private health insurance.

[12] Henry J. Aaron, "Budget Crisis, Entitlement Crisis, Health Care Financing Problem — Which Is It?," Health Affairs, November/December 2007; 26(6): 1622-1633.

Experts Agree: Projected Medicare/Medicaid Costs Cannot Be Sharply Reduced Without Cost Reductions in the Overall Health Care System

"Many analysts believe that significantly constraining the growth of costs for Medicare and Medicaid over long periods of time, while maintaining broad access to health providers under those programs, can occur only in conjunction with slowing cost growth in the health care sector as a whole.

Ultimately, therefore, restraining costs in Medicare and Medicaid requires restraining overall health care costs."

— Peter Orszag, Director, Congressional Budget Office,
"Health Care and the Budget: Issues and Challenges for Reform,"
Testimony before the Committee on the Budget, U.S. Senate, June 21, 2007, p. 9.

"[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole. For example, Medicare and Medicaid cannot grow over the long term at a slower rate than cost in the rest of the health care system without resulting in a two-tier health care system."

— David Walker, then Comptroller General of the United States,
"Long-Term Fiscal Issues: The Need for Social Security Reform,"
Testimony before the Committee on the Budget, U.S. House of Representatives, February 9, 2005, page 18.

"Thus sustaining a lower rate of spending growth per capita in Medicare will only happen if there is a comparable rate of spending growth in the private sector."

— Gail Wilensky, Senior Fellow, Project Hope,
"The Challenge of Medicare," in *Restoring Fiscal Sanity 2007: The Health Spending Challenge*,
Alice Rivlin et. al. (ed.), Brookings Institution Press, 2007, p. 88.

whole, the nation would face little if any long-term budget problem. Having said that, the changes needed to limit health care expenditures to the rate of economic growth would be very difficult to achieve without depriving millions of Americans of access to new advances in technology and health care that cure disease and prolong life. Therefore, reforms in other programs as well as more revenues must be part of any effort to address the nation's daunting long-term fiscal problem. But systemwide health care cost reform must be the central component of any such effort. Downplaying its significance is unwise.

Furthermore, the TBOFF statement implies that policymakers should limit the annual growth rate of per-beneficiary Medicare and Medicaid expenditures to a rate significantly below that of health care expenditures nationwide.[13] Doing so would represent a radical change in U.S. health care that would

[13] The TBOFF statement declares the claim that the nation's budget problems can be solved by reducing projected health care costs is a myth, and that undoing the current entitlement nature of Medicare and Medicaid is necessary because "even if these efforts [to reduce health care costs systemwide] are successful, medical care spending is almost certain to grow faster than the economy, and federal health care spending will still grow faster than federal revenues" (p. 4). The statement also declares that "improving the efficiency of the health care delivery system — not just for Medicare and Medicaid patients, but for everyone — has the potential to slow the growth of health care spending. Nevertheless, spending will continue to rise faster than GDP as long as new procedures and drugs appear in profusion and the demand for the better health and longer lives that these innovations are believed to produce remains high" (p. 6). The implication of these statements is that Medicare and Medicaid costs should be held to the rate of growth of GDP or revenues even as private-sector health care costs continue to rise at a faster rate.

either prove impossible to sustain over time or exacerbate the gaps between the health care available to aged, blind, and disabled people who are not affluent — and to poor people generally — and the health care available to other Americans.

If Medicare and Medicaid beneficiaries continue to have access to the same treatments and medical advances as other Americans, holding Medicare and Medicaid costs to a lower rate of growth year after year than the growth in private-sector health care costs would either (1) require massive increases in premiums and cost-sharing charges to Medicare and Medicaid beneficiaries, many of whom could ill afford them, or (2) generate substantial cost-shifting from the public programs to private-sector health care, with little or no reduction in the overall burden that rising health care costs place on the U.S. economy.

Alternatively, policymakers could hold growth in Medicare and Medicaid spending per person below the growth of private-sector health care spending *without* substantial cost-shifting by denying some advances in medical treatment and technology to children, parents, the elderly, and people with disabilities who depend on these programs to cover most or all of their health care. Such an approach would exacerbate existing economic and racial disparities in health status and longevity. [14]

In his *Wall Street Journal* commentary, Wessel observed that "A rule to restrain Medicare and Medicaid alone won't do it" and added that "by setting up a system that looks only at the federal spending on Medicare and Medicaid, they [TBOFF's authors] may be making it less likely that Congress deals with the overall societal problem of health care costs going up very rapidly."[15]

Finally, the White House determination every five years on whether Medicare and Medicaid were meeting their spending targets — and thus whether automatic cuts would occur — would turn on 30-year projections that necessarily would be highly uncertain and subject to substantial error.[16] In 1994, for example, the Medicare actuaries projected that total Medicare costs would reach $499 billion in 2005; the actual 2005 figure was $338 billion. Under TBOFF, the large degree of uncertainty inherent in long-term projections for Medicare and Medicaid would give an administration considerable latitude to use projections to serve its policy and political agenda. Even an administration with no agenda could mistakenly trigger massive Medicare cuts — or *fail* to trigger any congressional action — based on estimates that later proved far off the mark.

Placing health care for low-income Americans at risk

TBOFF calls for restricting projected Medicaid expenditures as well. Costs in Medicaid are escalating mainly because health care expenditures are growing systemwide, and to a lesser degree because the population is aging and employer health care coverage is eroding. But policymakers have little room to cut Medicaid without causing significant hardship.

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[14] For a summary of disturbing new research that finds "large and growing" disparities in life expectancy between richer and poorer Americans that appear related in part to differences in the health care these individuals receive, see Robert Pear, "Gap in Life Expectancy Widens for the Nation," *New York Times*, March 23, 2008.

[15] David Wessel, "Deficit Hawks Try, Try Again"; brief analysis by David Wessel, Video: "Budget Wonks Tackle Federal Deficit," *Wall Street Journal*, April 3, 2008, http://link.brightcove.com/services/link/bcpid452319854/bctid1473784569.

[16] Under the Constitution, only the Executive Branch can make a determination that a budget trigger generating automatic changes has been pulled. A law requiring the use of Congressional Budget Office estimates to make such a determination would be unconstitutional.

Medicaid already pays doctors, hospitals, and other health care providers much less than Medicare and private-sector health care do, and many physicians already refuse Medicaid patients because fees are too low. Cutting fees further could prompt more physicians and some hospitals to refuse to serve Medicaid patients. Moreover, Medicaid beneficiaries are poor and cannot pay much more in co-payments, deductibles, and premiums. Where would the reductions come from? TBOFF devotes one sentence to this dilemma, simply saying that Medicaid reforms "would have to focus primarily on [the long-term care] portion of the program." In the 2005 Deficit Reduction Act, the President and Congress enacted cuts in Medicaid's long-term care component. Are additional large savings achievable in the absence of systemwide health care reform? If so, what might they be? The TBOFF statement is silent on these matters.[17]

Furthermore, Medicaid expenditures will necessarily *increase* if employer coverage continues to erode and Medicaid is the only coverage available to a growing number of low-wage workers and their families. Expenditures will rise further if states reach and enroll the several million low-income children who are eligible for Medicaid but are now uninsured, something both Democrats and Republicans say they favor. Under TBOFF, the higher outlays from these developments could trigger automatic cuts in Medicaid. (The proposal calls for limiting Medicaid growth to "sustainable" levels, and parts of the TBOFF document imply that a sustainable growth rate is one that does not exceed the growth rate of the economy. Under such a scenario, Medicaid would face the threat of severe cuts. If Medicaid needed to help fill coverage gaps created by further erosion of employer-based coverage, or if it reached currently uninsured poor children, the cuts would have to be still deeper.)

III. A Focus on Budget Procedures That Will Likely Prove Ineffective

Giving Policymakers a Justification for Postponing Action

Although TBOFF is intended to induce policymakers to act, it could delay action.

Past deficit-reduction efforts have succeeded when policymakers put all parts of the budget — including taxes — on the table. The landmark 1990 bipartisan deficit reduction agreement is a striking example. It generated a sense of shared sacrifice. Lawmakers who defended particular programs were willing to let Congress reduce them because their colleagues also were cutting other programs. Lawmakers who generally opposed tax increases were willing to accept some because other lawmakers had agreed to cut spending as well. Policymakers should return to this type of approach, putting all parts of the budget on the table and taking major deficit-reduction steps in both spending programs and revenues.

TBOFF would likely make it harder to achieve that sort of cooperation. If anti-tax conservatives believe they can end the entitlement character of Social Security, Medicare, and Medicaid and likely secure reductions in those programs' benefits *without* having to entertain the need for tax increases or even allow any portion of the 2001 and 2003 tax cuts to expire, why would they negotiate a balanced deficit-reduction package that encompasses both spending and revenues? By essentially defining the long-term problem as purely an expenditure problem, the TBOFF paper is already encouraging some

[17] A substantial share of the costs of Medicaid's long-term care component is for housing and custodial and other non-health care services. As a result, increases in health care costs generally will likely play a somewhat smaller role, and demographic changes a somewhat larger role, in driving future cost increases in Medicaid long-term care than in Medicare and the rest of Medicaid.

leading conservatives to adhere to a one-sided approach[18] and to resist negotiating a "grand bargain" in which all parts of the budget, including taxes, are on the table.

TBOFF also could give policymakers a convenient rationale for postponing hard choices for five years, and possibly for subsequent five-year periods through the imaginative use of budget projection gimmicks. After the 2008 election, policymakers could face pressure to begin addressing the nation's long-term fiscal problems. Instead of recommending specific measures to cut specific government expenditures, raise specific taxes, and slow the systemic increase of health care spending, however, policymakers could advance something like the TBOFF proposal and thereby put off actual hard policy choices for at least five years.

Moreover, TBOFF provides no assurance that policymakers would make hard choices even after five years. In the past, budget procedures that have sought to compel policymakers to make substantive choices by threatening painful automatic cuts if they fail to act have not achieved major deficit reduction. The 1985 and 1987 Gramm-Rudman-Hollings laws set annual deficit targets and mandated annual automatic spending cuts if the targets were expected to be missed. When substantial automatic cuts loomed, the White House produced extremely rosy budget estimates to make the shortfall "disappear" on paper or to reduce the size of the required cuts. Then the Administration and Congress either enacted gimmicks — such as asset sales, timing shifts in program spending, and moving entities "off budget" — to address much of the remaining shortfall or they raised the deficit target. Congress repealed the Gramm-Rudman-Hollings law in 1990 because it had failed.[19] As Congressional Budget Office Director June E. O'Neill testified in 1995:

> "Instead of enacting the changes in laws governing revenues and spending necessary to reduce the deficit, the President and the Congress were able to avoid the intent of the act by changing the deficit targets or by basing budget estimates on overly optimistic forecasts. For example, the original deficit target for 1990, the last year the Gramm-Rudman-Hollings procedures were fully in place, was $36 billion. The revised 1990 target, established in 1987, was $100 billion. The reported deficit for that year was $220 billion. The deficit for 1993 (the year in which the revised targets were to require a balanced budget) was $255 billion."[20]

As numerous budget experts have counseled for many years about large budget deficits, "the process isn't the problem; the problem is the problem." TBOFF is the latest in a long series of proposals that seek to change the budget *process* in the hope that this will induce the President and Congress to

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[18] For example, Rep. Paul Ryan, the ranking Republican member of the House Budget Committee, recently introduced legislation (H.R. 6110) that includes a tax cut that the Urban Institute-Brookings Institution Tax Policy Center estimates would cost $5 trillion to $6 trillion over ten years even when dynamic scoring assumptions are used and, thus, would constitute "by far the largest tax cut in **[U.S.]** history." To address long-term deficits, as greatly magnified by this tax cut, Ryan's bill also would cut Medicaid 73 percent, and Medicare 68 percent, below the budget baseline by 2082. In explaining the rationale for the legislation, Rep. Ryan cited TBOFF extensively. He also included the TBOFF proposal itself in the legislation.

[19] During the Gramm-Rudman-Hollings era, the invariable use of overly optimistic budget estimates to substitute for action had a second undesirable effect: it exacerbated public cynicism about official budget numbers. Many in the media and the public began to believe that virtually all budget figures were fictions and all budget plans were illusions, to the detriment of substantive debate. For a more detailed discussion of the failings of and lessons to be drawn from Gramm-Rudman-Hollings, see Congressional Budget Office, "The Budget Process and Deficit Reduction," Chapter 6, *The Economic and Budget Outlook: Fiscal Years 1994-1998*, January 1993.

[20] Congressional Budget Office director June E. O'Neill, testimony before the Subcommittee on Legislative and Budget Process and the Subcommittee on Rules and Organization of the House of the House Committee on Rules, July 13, 1995, p. 4.

make tough decisions on policies and programs. But as the Congressional Budget Office concluded after Congress repealed Gramm-Rudman-Hollings: "The experience under Gramm-Rudman-Hollings demonstrated that if the President and the Congress are unwilling to agree on a painful deficit reduction package, it is unlikely that any budget procedure can force them to agree. Instead, budgetary legerdemain is likely to be used to meet the letter of the law, and the hard decisions that would achieve real, permanent deficit reduction will be avoided."[21]

IV. What To Do Now

Take immediate policy steps to start addressing the long-term fiscal crisis

The President and Congress may not yet be ready to address such matters as systemwide health care cost reform — although they should start educating the public about the need to do so — but they can start taking important steps now to reduce projected deficits. Rather than spending time trying to hammer out budget procedures of dubious merit and effectiveness, policymakers should focus on real policy choices and begin the process of seeking bipartisan support for legislative packages that make specific changes both to curb spending and to raise revenue. Policymakers could consider a number of measures, including the following: (Note: Not all signatories to this statement favor all of the following measures, but all favor at least a majority of these options.)

1. Adopt the MedPAC recommendations. Congress has established the Medicare Payment Advisory Commission (or MedPAC) — an expert, bipartisan commission to advise it on Medicare. MedPAC conducts high quality research and provides extensive policy recommendations to Congress each year. Unfortunately, policymakers have not acted on some key MedPAC recommendations.

MedPAC's most significant recommendation is to halt the large overpayments to private insurance companies in the Medicare Advantage (MA) program.[22] Medicare now pays private insurance companies more than it costs to treat the same patients in traditional Medicare. MedPAC has unanimously recommended that policymakers end these excess payments. This one change would save up to $150 billion over ten years. Other MedPAC recommendations would save smaller but significant sums. (For example, eliminating duplicate medical education payments to teaching hospitals for Medicare Advantage enrollees would save $16 billion over ten years.) Although, as noted above, larger Medicare savings will require systemwide health care reform, that is no justification for failing to act on the MedPAC recommendations now.

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[21] Congressional Budget Office, "The Budget Process and Deficit Reduction," Chapter 6, *The Economic and Budget Outlook: Fiscal Years 1994-1998*, January 1993, p. 87. In fact, then-Congressional Budget Office director Robert Reischauer, writing about budget gimmickry, reported in 1990 that "In the pre-GRH era, these gimmicks occurred so infrequently that CBO did not keep systematic track of them. In the GRH era, fully half of the apparent deficit reduction has been achieved by such devices." See Robert Reischauer, "Taxes and Spending Under Gramm-Rudman-Hollings, *National Tax Journal*, vol. 43, #3, September, 1990, p. 232. The 1994 CBO report found that, in contrast to GRH, the pay-as-you-go rules and discretionary spending caps enacted to enforce the 1990 deficit reduction package were effective because "budget procedures are much better at enforcing deficit reduction agreements than at forcing such agreements to be reached....if the President and the Congress agree on and enact a painful package of spending cuts and tax increases to reduce the deficit, budget procedures that highlight and penalize deviations from that agreement can be effective." (pp. 86 - 87)

[22] Medicare Payment Advisory Commission, *Report to the Congress: Issues in a Modernized Medicare Program*, June 2005, chapter 3.

2. Consider increases in Medicare premiums for affluent beneficiaries. Currently, affluent beneficiaries pay higher premiums than do other enrollees for Medicare Part B, which covers physician and outpatient services. In contrast, all beneficiaries pay the same premiums for Medicare Part D, which covers the new prescription drug benefit.[23] Given Medicare's financial problems, targeted premium increases for those who can afford them make sense, as long as they are designed not to drive affluent beneficiaries from the program (and are not extended over time to beneficiaries of modest means who cannot afford them).[24] Congress can secure some modest savings here without undermining Medicare's universal social-insurance nature. (Note: The increased premiums could be collected most efficiently through the tax system.)

3. Establish an adequately funded research institution to evaluate such matters as the comparative effectiveness of different health care treatments and procedures and the sharp divergence in health care expenditures in various parts of the country — and thereby build knowledge about how to slow health care spending growth without compromising health care quality by curbing care that is not worth what it costs. Without such information, decisionmakers in both the public and private sectors are limited in their ability to design effective expenditure-reducing measures. Congressional Budget Office director Peter Orszag and other experts have highlighted the importance of such work in addressing our nation's daunting fiscal problems.[25] While the impact of such research on future health care spending is extremely difficult to estimate, the Congressional Budget Office has concluded that "Generating additional information about comparative effectiveness and making corresponding changes in incentives would seem likely to reduce health care spending over time--potentially to a significant degree."[26] (Note: The Children's Health and Medicare Protection Act of 2007, which the House of Representatives passed in August 2007, would have established a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality).

4. Close tax loopholes and eliminate or limit unwarranted or outdated tax expenditures. The Joint Tax Committee and the Congressional Budget Office have each issued reports outlining options for limiting or eliminating tax expenditures and closing tax loopholes. [27] While many of these options are highly controversial, some that may be less controversial could still produce significant savings. For example, simply taking steps to prevent corporations from simultaneously claiming U.S. tax deductions for their foreign business expenses *and* avoiding U.S. tax on their foreign earnings could save about $100 billion over ten years.

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[23] Subsidies are provided to cover the cost of premiums for beneficiaries with very low incomes.

[24] The President's fiscal 2009 budget proposed to extend income-related premiums (as the higher premiums on affluent Medicare beneficiaries are known) to Medicare Part D, as well. The budget also proposed, however, to eliminate the annual indexing of income levels above which the higher premiums apply (both for Part B and Part D), so that the higher premiums would increasingly apply over time to beneficiaries with relatively modest incomes. The Congressional Budget Office estimated the President's proposals would save about $30 billion over the next ten years.

[25] Peter R. Orszag and Philip Ellis, "Addressing Rising Health Care Costs—A View from the Congressional Budget Office," *New England Journal of Medicine*, November 6, 2007, pp. 1885-7; Institute of Medicine, *Knowing What Works in Health Care: A Roadmap for the Nation*. Washington: National Academies Press, 2008; Medicare Payment Advisory Commission, *Promoting Greater Efficiency in* Medicare, Washington, Washington, June 2007, chapter 2; Peter J. Neumann, *Getting Better Value for Our Health Care* Spending, Washington: NIHCM Foundation, July 2007; John E. Wennberg *et al.*, *Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008*, Lebanon, NH: Dartmouth Institute for Health Policy and Clinical Practice, 2008, pp. 94-97.

[26] Congressional Budget Office, Research on the Comparative Effectiveness of Medical Treatments, December 2007.

[27] Joint Committee on Taxation, "Options to Improve Tax Compliance and Reform Tax Expenditures, " JCS-02-05, January 27, 2005, and Congressional Budget Office, "Budget Options," February 2007.

5. In computing annual cost-of-living adjustments in Social Security and other entitlement programs and the annual indexing of income-tax brackets and other features of the tax code, adopt the changes that the Bureau of Labor Statistics has developed to improve the accuracy of the consumer price index. Experts generally agree that the alternative CPI (sometimes called the "superlative CPI" or "chained CPI") measures inflation more accurately than does the official version now in use. The Social Security actuaries estimate that this step alone would close more than one-quarter of the projected Social Security shortfall over the next 75 years. Analysis from several years ago indicated that this policy change would reduce deficits by more than $200 billion over the succeeding decade from reduced spending on Social Security and other indexed entitlements and from increased revenues, and the savings would grow larger in subsequent decades. Policymakers should use a portion of the resulting Social Security savings to shield vulnerable beneficiaries from hardship that could occur as a result of this change.

6. Reform farm subsidy programs. Most independent policy analysts agree that a significant portion of the approximately $15 billion a year spent on farm income stabilization does not produce significant public benefits. Many analysts also believe that U.S. farm policies reduce the earnings of very poor farmers in developing nations because U.S. subsidies drive down world prices by artificially inflating U.S. farm production. Proponents of the farm subsidies argue the subsidies are needed to sustain small family farms. But a substantial portion of the benefits goes to very large, profitable farm operations. Reforms in the farm programs, such as eliminating subsidies to high-income farm owners, would produce budget savings and reduce market distortions, while still allowing the programs to meet the stabilization needs of the agricultural sector.

7. Adhere to Pay-As-You-Go rules for mandatory spending and tax cuts. Offsetting the cost of extending temporary tax cuts and entitlement increases that are slated to expire, as well as of new tax cuts and entitlement expansions, would make a significant contribution to addressing the long-term fiscal problem.[28]

[28] Support for Pay-As-You-Go rules does not suggest that net savings achieved in deficit-reduction legislation should be available to offset tax cuts or entitlement increases provided in other legislation. Deficit reduction legislation should specify that the net savings the legislation achieves are not available to offset the costs of other legislation. The 1990 deficit-reduction legislation that created the original statutory Pay-As-You-Go rule included that prohibition. So did the deficit reduction bills that policymakers enacted in 1993 and 1997. Similarly, the current Senate Pay-As-You-Go rule specifies that net deficit savings achieved in a budget reconciliation bill are not available to offset the costs of other legislation.