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ESSAYS ON TRENDS, INNOVATIVE IDEAS AND CUTTING-EDGE RESEARCH IN HEALTH CARE

Scoring Health Legislation

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The fate of legislative proposals in the U.S. Congress may hinge on how much they are estimated to increase or decrease the federal budget deficit. This essay aims to explain the basic elements of budget estimating, or "scoring," and to dispel some common misconceptions about the process.

What is scoring, and why is it important?

Scoring, or scorekeeping, is the process of estimating the federal budgetary cost or savings that would result from enacting a bill into law. If all legislative proposals came with fixed price tags, this task would be straightforward. However, the largest federal health programs—Medicare, Medicaid, and the tax exclusion of employer-sponsored health insurance—are open-ended. The law establishes the eligibility criteria and benefit levels, but it does not specify the total dollar amount of spending or forgone revenue. Thus, when a legislative proposal would change one of these programs, the budget estimator must tackle the complicated task of determining how much the change is likely to alter federal spending and revenue.

House and Senate rules bar consideration of bills that would increase the deficit through changes in taxes or in mandatory spending programs, such as Medicare and Medicaid, which continue automatically from one year to the next without an annual appropriation. These are widely known as pay-as-you-go, or PAYGO, rules. Unless the House and Senate vote to waive PAYGO, any proposals that increase federal spending must include offsetting reductions in spending or increases in revenues. Rules in the two chambers differ slightly but generally require that legislation be deficit neutral over the current year and the next 10 years.

The principal scorekeepers for the Congress are the House and Senate Budget Committees, which furnish the presiding officer with the estimates needed to determine compliance with PAYGO and the annual Congressional budget resolution.[1] The budget committees, in turn, almost always use estimates prepared by the Congressional Budget Office (CBO). By law, CBO provides estimates of the budgetary effects of all bills reported by a Congressional committee. CBO may also prepare formal or informal cost estimates for proposals at earlier stages of the legislative process, including both introduced legislation and draft bills. For revenue proposals involving a change to the tax code, CBO relies on estimates from the Congressional Joint Committee on Taxation (JCT).[2]

Figure 1. Key Points about Legislative Scoring

- By design, cost estimates measure only the effects of legislative proposals on the federal budget – not costs or savings of non-federal entities.
- Cost estimates do, however, take account of a wide range of dynamic behavioral responses to legislation, as well as the interactions between separate provisions of a bill.
- Congressional pay-as-you-go rules bar consideration of most bills that are estimated to increase the deficit through changes in revenues or mandatory spending. Deficit neutrality is generally required for the current year and over the next 10 years.
- Budget estimating, or "scoring," follows rules and procedures adopted by the Congress and the Administration over many years.
- Scoring will play a critical role as the Congress considers health reform legislation.

What is the budget baseline?

The cost or savings of a bill is measured relative to the budget baseline, which is a multi-year projection of federal spending and revenues under current policies. The baseline is not a prediction of what will happen to the budget. Rather, it serves as a benchmark against which to compare the spending and revenue effects of proposed legislation.

In building the baseline, CBO follows rules that were originally agreed upon by the Congress and the Administration in 1990. These rules generally assume that current laws affecting revenues and mandatory spending continue unchanged. For example, the baseline assumes that reductions in physician fees required by Medicare's sustainable growth rate formula will go into effect, even though the Congress has typically stepped in to prevent such reductions. There are, however, a few exceptions to the general rule. In particular, mandatory spending programs that are scheduled to expire, such as the Children's Health Insurance Program, are automatically assumed to continue in the baseline if they have outlays of more than $50 million and were established on or before August 5, 1997.

What goes into a federal cost estimate

The cost estimate, or "score," for a bill measures its budgetary impact as the difference between the amount of spending and revenues projected in the baseline and the amount that would occur if the legislation were enacted. The estimators at CBO and JCT aim to provide as complete a picture as possible of the ways in which a legislative proposal would affect the federal budget, considering the best evidence available to them.

Budget estimates are dynamic, in that they take into account how individuals, state govern-

ments, health care providers, employers and insurers would respond to changes in economic and other incentives.[3] For example, limiting the tax exclusion for employer-sponsored health insurance would discourage some employers from offering health insurance to their workers. The cost estimate would incorporate assumptions about how compensation would shift from non-taxable fringe benefits to taxable wages and would include an estimate of the resulting increase in federal tax revenue. In assessing the size of such behavioral changes, CBO's analysts weigh the latest data and research findings. CBO also draws on an expert panel of health advisers that meets periodically to assess cutting-edge research in health policy and to advise the agency on its analyses of health care issues.

Budget estimates also account for ways that policies in a specific bill interact with each other, rather than simply considering the individual provisions in isolation. Most bills contain many separate provisions, often affecting several different spending programs and sources of revenue. The total budgetary effect of a bill depends on all of its provisions, and their combined effect may be greater or less than the sum of their separate effects. For example, additional research on the comparative effectiveness of different medical treatments may not slow health care spending significantly unless payment policies are changed to encourage physicians to use the findings.

Macroeconomic responses are the only potentially significant item traditionally excluded from cost estimates. The House and Senate budget committees specify the economic assumptions that are used in Congressional budget estimates. These are generally the same economic assumptions underlying the most recent budget resolution, including levels of employment and productivity, although the assumptions may be updated when the economic outlook is in flux. Enactment of some proposals – or packages of proposals – might affect the overall economy in various ways. For instance, improvements in health care might expand the labor force by reducing mortality and disability, whereas separating health insurance from employment could have the opposite effect by allowing more early retirement. Cost estimates exclude such macroeconomic responses, in large part because they are subject to considerable uncertainty. CBO sometimes provides supplementary analysis of the macroeconomic effects of budgetary proposals, but these estimates are informational only and are not used in the budget enforcement process.

What cautions apply to using cost estimates?

Like all tools, budget estimates must be used with care. Here are a few cautions.

First, by design, federal budget estimates do not include costs or savings accruing to non-federal entities, such as individuals, businesses, or state and local governments, nor do they consider non-economic benefits. The cost estimate for a proposal to expand health insurance coverage, for example, would not record the improvements in health and reductions in out-of-pocket health costs of those who cease to be uninsured. CBO often discusses such matters, however, in the text accompanying the cost estimate or in a separate analysis. Policymakers must weigh these other factors, as well as budgetary costs, in evaluating a proposal.

Second, budget estimation combines art and science. The Congress expects CBO to produce timely estimates for every reported bill, and CBO must apply its professional judgment to the information in hand. In many instances, the evidence is substantial and consistent. According to a recent *Health Affairs* article, for example, "hundreds of studies have shown that prevention usually adds to medical spending."[4] Sometimes, however, the direction of an effect is not clear. Paying for a medical "home" for chronically ill Medicare beneficiaries, for instance, could save money by eliminating duplicative services and avoiding complications but could also increase spending by assuring that patients receive all appropriate care. CBO concludes that there is still insufficient evidence to estimate whether medical homes would create enough savings to offset the additional costs of managing care.[5]

Third, the uncertainty surrounding budget estimates grows with the time horizon, and extending the budget window beyond 10 years would increase that uncertainty. Although this time frame arguably disadvantages proposals with significant up-front costs but potentially larger savings later, claims about budgetary saving beyond the 10-year estimating period are often speculative. Moreover, allowing policymakers to offset certain short-run costs with uncertain long-run savings is likely to lead to larger deficits.

What scoring issues are likely to arise in 2009?

Whether comprehensive health reform should meet a pay-as-you-go requirement will be hotly debated until legislation is enacted. The Obama Administration's budget proposal says that any health reform plan should pay for itself, and the budget identifies more than $600 billion over 10 years in potential health savings and new revenues as partial funding.[6] Some groups, however, have opposed requiring that health reform be deficit-neutral within a 10-year budget window.

If PAYGO applies to health reform, the Congress will be looking long and hard for legislative changes that will save federal dollars and offset its budgetary cost. CBO has issued two volumes that provide significant insights into the agency's approach for estimating the cost or savings of health-related proposals, including the evidence on which CBO's estimates are based.[7] In the absence of a legislative proposal setting out a specific combination of reforms, the new reports provide cost estimates for individual initiatives that might be included in future legislation. These estimates indicate that reductions in federal health spending can be achieved – but not easily. Of course, the ultimate fiscal impact of health reform will depend on how its provisions are combined, and any future legislative package will require new scoring that accounts for the interactions between the bill's components.

The Obama Administration has also proposed writing a PAYGO requirement into law to help move the federal budget toward a sustainable long-run path when the economy improves. A statutory PAYGO requirement applied from 1991 through 2002, although it was generally waived during the latter years of that period. In enforcing statutory PAYGO, the White House's Office of Management and Budget would be the ultimate scorekeeper, because a Congressional agency, such as CBO, may not constitutionally carry out executive functions. If a pay-as-you-go requirement again becomes law, understanding scoring rules and procedures will become even more important. ■

1 R Keith. *Introduction to the Federal Budget Process.* Washington: Congressional Research Service, CRS Report 98-721, updated March 7, 2008. Available at http://www.budget.house.gov/crs-reports/RS20095.pdf.

2 Congressional Budget Office (CBO). *CBO's Policies for Preparing and Distributing Its Estimates and Analyses,* April 2005.

3 CBO. *Budget Estimates: Current Practices and Alternative Approaches*, January 1995.

4 L Russell. "Preventing Chronic Disease: An Important Investment, but Don't Count on Cost Savings," *Health Affairs*, January/February 2009;28:42-45.

5 CBO. *Budget Options, Volume I: Health Care*. December 2008;78.

6 Office of Management and Budget. *A New Era of Responsibility: Renewing America's Promise*, February 26, 2009;27-29.

7 CBO. *Budget Options*; CBO, *Key Issues in Analyzing Major Health Insurance Proposals*, December 2008.