CBO Scoring: Methods and Implications

The Health Care Imperative
Institute of Medicine
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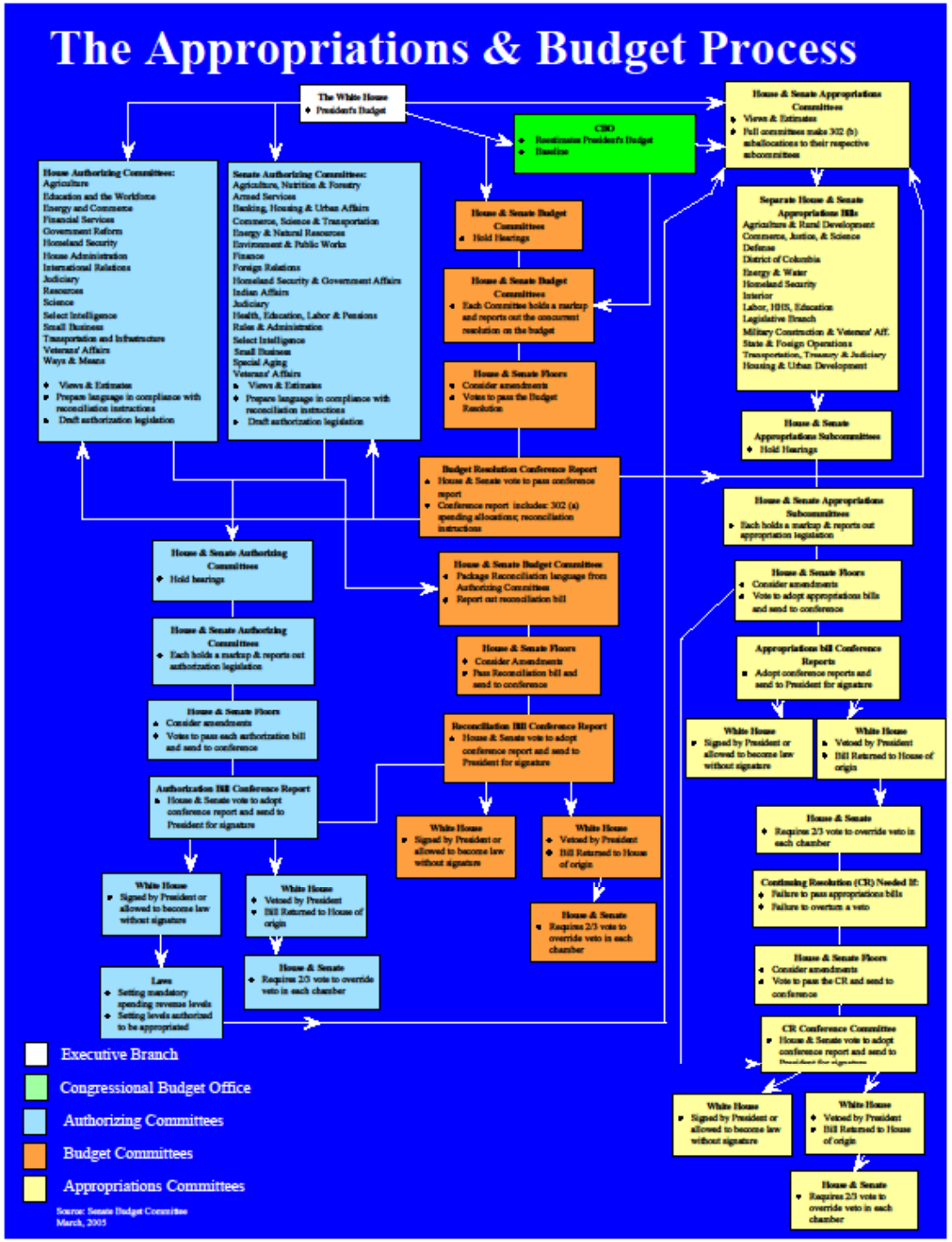
The Appropriations & Budget Process



CBO nsFAQs

Created by the Congressional Budget and Impoundment Control Act, 1974. Began operations, 1975.

Director appointed by Speaker of the House and President Pro Tem of the Senate on advice of budget committees. Current director Doug Elmendorf.

Major products:

- Budget and Economic Outlook
- Analysis of the President's Budget
- Cost Estimates
- Budget Options
- Long-Term Budget Outlook
- Analytic Studies

Cost estimates

A CBO cost estimate is:

- An estimate of the potential impact of legislation on **federal spending and revenue**
- Incremental, relative to the **current law baseline**
- A 5- or 10-year **projection**
- Based on **legislative language**
- The result of analytic **modeling**
- Only as good as the underlying **data, assumptions, and understanding** of complex economic, social, and political systems
- A **guide** to legislative decisions

PRELIMINARY ESTIMATE OF THE EFFECTS ON THE DEFICIT OF H.R. 3200, THE AMERICA'S HEALTH CHOICES ACT OF 2009

	By Fiscal Year, in Billions of Dollars											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2014	2010-2019
NET CHANGES IN THE DEFICIT FROM COVERAGE PROVISIONS [a, b]												
Effects on the Deficit of Insurance Coverage Provisions	3	4	1	69	107	141	158	171	187	202	184	1,042
CHANGES IN DIRECT SPENDING FROM OTHER PROVISIONS [c]												
Changes in Outlays	9	6	-4	-11	-37	-31	-26	-34	-42	-50	-36	-219
CHANGES IN REVENUES FROM OTHER PROVISIONS [d]												
Changes in Revenues	1	35	33	59	65	70	74	78	82	86	192	583
NET CHANGES IN THE DEFICIT [a, b]												
Deficit Impact	11	-24	-36	-1	5	40	58	58	62	65	-44	239

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: Components may not sum to totals because of rounding.

a. Does not include federal administrative costs or account for all effects on other federal programs.

b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit. Does not include effects on spending subject to future appropriation.

c. These estimates reflect the effects of interactions between insurance coverage provisions and other Medicare and Medicaid provisions.

d. JCT's estimates for H.R. 3200, as introduced (JCX-31-09); includes effects on Social Security revenues that are classified as off-budget. In addition to these amounts, CBO estimates that other provisions in Division B would increase revenues by about $500 million over the 2010-2019 period.

Inputs

Data sources

- Program data from Medicare, Medicaid
- Survey data – MCBS, MEPS
- Private insurer data
- Experimental data
- Other sources of health, demographic, economic data

Modeling assumptions

- Scholarly literature
- Direct observation of market trends
- Comparison with past proposals
- Consultation with experts, including CMS and insurance actuaries

A range of complexity

Factors that increase the estimating challenge:

- **Novelty** – no previous experience increases uncertainty
- **Number of provisions** – additional provisions increase the chance of complex interactions
- **New market or administrative structures**
- **Magnitude of intended impact** – "big" policies could generate a larger and more unpredictable behavioral response
- **Vague or incomplete specifications**
- **Time pressure**

Example: Reduce payment update

Least complex: Reduce Medicare's hospital update factor by 1 percentage point

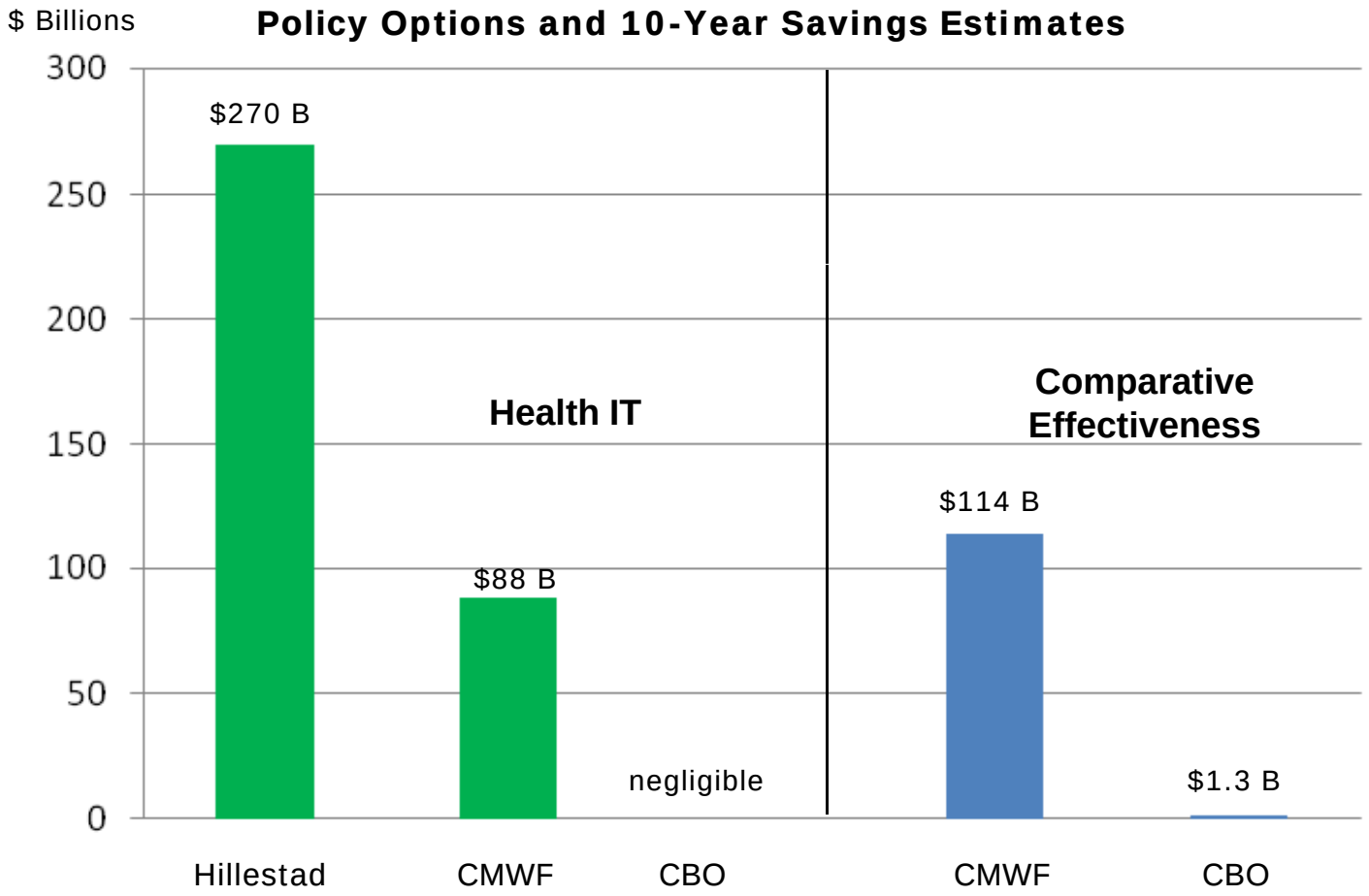
- An old stand-by; similar policies have been proposed/implemented over the past 20 years
- Completely under federal control; no change in payment structure or health delivery system
- Little debate on aggregate financial impact on the budget or on hospitals
- Potential impact on quality and access—outside CBO's purview
- **Savings are offset by policy-induced changes in admissions, patient mix, use of non-inpatient services**

Example: Prevention

More complex: Expand the use of clinical preventive services

- **Many moving parts:**
  - Clinical/cost effectiveness of the service
  - Subsidy or mandate?
  - Targeted to relevant population?
  - Take-up by patients
  - Covered by other insurance?
- **Costs/savings**
  - Direct cost of preventive service
  - Adverse reactions
  - Follow-up testing and treatment
  - Additional costs of care over extended life span
  - Savings from health care avoided

CBO is a hard marker



What does it take to get a good score?

This helps:

- Adopted by several health plans or providers
- In use over significant time period
- Extensive data collection
- Studies by ***independent*** analysts
- Legislative proposal closely tracks what already exists

But remember:

- What matters to CBO is federal cost, not broader system savings or improved quality that does not reduce federal spending
- 50 published studies not as good as one relevant analysis
- Interactions and external factors may turn savings into cost