Congressional Budget Office

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Answers to Questions for the Record Following a Hearing by the House Committee on the Budget on the Work of the Congressional Budget Office

On June 3, 2015, the House Committee on the Budget convened a hearing at which Keith Hall, Director of the Congressional Budget Office, testified about CBO's work. After the hearing, Chairman Price and other Members of the Committee submitted questions for the record. This document provides CBO's answers.

Chairman Price

Question. In CBO's scoring of H.R. 1907, The Trade Facilitation and Trade Enforcement Act of 2015, there is an assumed spending increase of $200 million from 2015-2025 as a result of increased interest payments for certain distributions under the Continued Dumping and Subsidy Offset Act (CDSOA) amendment. As the original act was written, it states that "all interest" should be distributed to the affected domestic industry and it was assumed until an admission by Customs and Border Patrol (CBP) in 2014 that they had been carrying out the payments as directed by law and Congressional intent. In its cost estimate of H.R. 1907 it appears that CBO relied on CBP's interpretation of the CDSOA and is treating it as a change in law rather than a clarification of existing law. By adopting CBP's interpretation of the law to determine the baseline it is in essence forcing Congress to pay for an agency's mistake in order to correct it under the current PAYGO rules.

- When issuing cost estimates, do you feel that CBO should use a baseline that strictly follows what the governing statute says or do you feel that CBO should also take into account how the respective agency has been carrying out the law, even if they have been applying it erroneously?

- Do you feel that if the baseline is determined based on an incorrect interpretation by the agency and shows an increased cost, loss in revenue, etc. it makes it more difficult for Congress to correct the error and abide by its original intent?

Answer. Through its cost estimates, CBO strives to inform the Congress how enacting a piece of legislation would affect the budget in comparison with what would happen under current law. To assess the budgetary effects of proposals affecting revenues or direct spending, CBO measures projected outcomes under proposed legislation against a benchmark, the baseline. That baseline incorporates the effects of how executive branch agencies execute (or plan to execute) current laws—but CBO does not judge the validity of those agencies' actions. Therefore, when Members of Congress believe that an agency has misinterpreted the statutory language, proposed legislation to correct the perceived error could be estimated to have a cost.

With regard to the amendment to H.R. 1907, the Trade Facilitation and Trade Enforcement Act, CBO ascertained from Customs and Border Protection (CBP) officials how current statutes are being implemented: CBP first allocates certain payments of delinquent antidumping and countervailing duties to interest accrued during the delinquency, and that amount is deposited in the Treasury. Once that accrued interest amount has been set aside, any remaining balance is paid to domestic producers who meet eligibility requirements under the Continued Dumping and Subsidy Offset Act. CBO's baseline reflects how CBP is currently implementing the statute.

The amendment in question would have required CBP to pay the full amount of collections to eligible producers. If that amendment became law, the agency would have to distribute about $200 million to firms over the 2015–2025 period instead of depositing those funds in the Treasury, as it will under current law. Thus, CBO's estimate indicated that implementing the amendment would cost $200 million over that period. CBO does not judge whether that $200 million *should* be paid under current law, but only that it would not be paid.

Question. To what degree are there difficulties, or improvements that could be made, in obtaining qualified staff in estimates and analyses?

Answer. In the past several years, CBO has struggled to fill crucial Ph.D. economist positions with people having skills in econometrics and financial modeling. Some legislative changes could help CBO attract and retain top talent by enhancing the agency's hiring and pay authorities.

CBO faces considerable competition in attracting and retaining highly educated and skilled employees. More than two-thirds of CBO's staff consists of economists and budget analysts. One strong competitor for economists is the Federal Reserve, which paid about $25,000 more than CBO could offer to people recently receiving their Ph.D. this past year. The Office of Management and Budget (OMB) does not generally make job offers to the same economists that CBO does but sometimes makes offers to the same budget analysts. Both OMB and the Government Accountability Office (GAO) can pay more than CBO does: OMB and GAO are authorized to pay up to $183,300 in 2015. The Federal Deposit Insurance Corporation (FDIC) can pay technical experts, including financial economists, up to $276,558 in 2015.

Allowing CBO to pay employees up to the maximum amount for Senior Executive Service and Senior Level employees would help make CBO comparable to other government agencies, including OMB and GAO. Increased pay authority would also allow the agency to relieve some of the compression of pay between some employees with substantially different amounts of responsibility. Both effects (comparability to other agencies and reduced pay compression) would help CBO attract and retain top talent. That ability would reduce the costs associated with turnover and training and increase the efficiency with which CBO could produce high-quality products. Even with such authority, however, CBO could not match the salaries offered to economists working for academic institutions, private companies, the Federal Reserve, and some executive branch agencies with special pay authorities, such as the FDIC and the Securities and Exchange Commission.

CBO is also constrained in the kinds of people it can hire. Most recent graduates from Ph.D. economics programs are foreign nationals who hold nonimmigrant visas. CBO had the authority to hire employees with nonimmigrant visas until the Consolidated Appropriations Act, 2010 (Public Law 111-117), changed a long-standing governmentwide provision regarding the use of appropriated funds. Allowing CBO to again hire foreign nationals

holding nonimmigrant visas would increase the pool of potential job candidates, making it more likely that the agency would find people with skills that match its needs.

Question. Are there improvements that can be pursued in obtaining better information, or more responsiveness, from executive branch agencies?

Answer. CBO's ability to obtain information is crucial to providing high-quality objective analysis to the Congress, which has granted the agency authority to obtain or preserve access to information when needed. Continuing to offer that support when CBO encounters new challenges in ways that the Congress has in the past would be helpful. In general, CBO has succeeded in obtaining information—both data and professional expertise—from executive branch agencies, though it has occasionally faced challenges. For example, CBO sometimes encounters problems obtaining data on health care and other benefits provided to veterans.[1] And on some occasions, agencies make it difficult for CBO analysts to talk with those people who are most knowledgeable about a particular issue. Congressional committees can sometimes help by urging agencies to supply the information necessary for CBO to prepare particular cost estimates or analytical studies.

Although other government agencies have often been willing to give CBO information, they want to be sure that disclosure to CBO is permitted and that CBO will protect any information it receives. Two provisions of the Congressional Budget Act of 1974 help offer such assurance. Section 201(d) establishes a broad statutory right of access to agency records, requiring federal agencies to supply CBO with the information necessary for its analytical and estimating activities for the Congress.[2] Section 203(e) requires CBO to maintain the same level of confidentiality with respect to agency records as is required of the head of the agency from which they are obtained. That section further states that officers and employees of CBO are subject to the same statutory penalties for unauthorized use or disclosure as employees of the source agency.[3]

In accordance with those provisions, CBO and executive branch agencies have negotiated data use agreements that detail how CBO will receive information and the steps CBO must take to preserve confidentiality. Such information includes data on labor market conditions and prices, military procurement, the earnings and benefits of federal employees, federal loans and loan guarantees, federal health care expenditures, and other financial transactions of federal agencies.

The Congress also has supplemented CBO's general authorities with specific statutory authority for certain sensitive information. For example, CBO is authorized to use federal tax information for long-term models of the Social Security and Medicare programs.[4] CBO also is

1. See testimony of Matthew Goldberg, Deputy Assistant Director of CBO's National Security Division, before the Subcommittee on Health of the Committee on Veterans' Affairs, U.S. House of Representatives, *Comparing the Costs of the Veterans' Health Care System With Private-Sector Costs* (January 28, 2015), www.cbo.gov/publication/49905.

2. Codified at 2 U.S.C. §601(d) (2012). CBO also has a broad right of access to fiscal, budgetary, and program information under 31 U.S.C. §1113(b) (2012).

3. Codified at 2 U.S.C. §603(e) (2012).

4. See sec. 1(a)(7) of the Consolidated Appropriations Act, 2001, P.L. 106-554, 114 Stat. 2763, 2763A–638 (2000). Sec. 1(a)(7) enacted by reference H.R. 5662, the Community Renewal Tax Relief Act of 2000, 106th Cong., as introduced on December 14, 2000; sec. 310(a) of that act contains the relevant language. Codified at 26 U.S.C. §6103(j)(6) and (p) (2012).

authorized to obtain information about prescription drug programs.[5] When establishing the Troubled Asset Relief Program, the Congress required that the Secretary of the Treasury make available to CBO all information used in connection with the program, "including the records to which the Comptroller General is entitled."[6]

Often, however, CBO seeks not data or records but rather the perspective of professionals with experience regulating an industry or implementing a federal program. CBO's analysts have developed a network of contacts in executive branch agencies. Candid responses from civil servants are invaluable. In CBO's view, creating a formal or confrontational process to obtain such information could be counterproductive because of the "chilling effect" it would have on these important informal interactions. Instead, CBO must reassure federal employees that they are authorized to give the agency information and will not face adverse consequences for doing so.

Question. Are there difficulties that you can identify in relations with JCT, GAO or CRS? Would greater coordination with these Congressional support agencies improve estimates? In particular JCT has a different display for their revenue estimates, and GAO provides invaluable information, but not always easily understood in conjunction with CBO estimates.

Answer. CBO enjoys constructive and cooperative relationships with the staff of the Joint Committee on Taxation (JCT), the Government Accountability Office, and the Congressional Research Service (CRS). Although the functions of each agency in supporting the Congress may differ, each shares a common mission to provide lawmakers with nonpartisan, objective information and analysis in support of the Congress's legislative duties. To avoid duplication of effort and overlap, CBO regularly consults with each of its sister Congressional support agencies. To help prepare analyses, CBO staff also consult regularly with analysts at the other Congressional support agencies to gain valuable insights and information. To ensure that CBO's analysts are familiar with GAO's work, members of CBO's senior staff receive GAO's "Month in Review" email listing of recent publications.

With respect to preparing cost estimates, only JCT shares that statutory duty with CBO. Under the Congressional Budget and Impoundment Control Act of 1974, JCT staff prepare cost estimates for most revenue legislation, and CBO uses JCT revenue estimates in its own estimates and analyses. Consequently, CBO and JCT staff are in frequent contact regarding the preparation of cost estimates for pending legislation that may include both spending and revenue provisions. (However, because of limited resources, CBO and JCT cannot always address the competing needs and priorities of various Congressional committees as quickly as both agencies would like.) The two agencies have collaborated particularly closely on estimates for legislation related to the Affordable Care Act and to immigration. Under the requirements of this year's budget resolution to prepare cost estimates that include macroeconomic effects, the two agencies have begun planning new ways to coordinate on producing estimates and on explaining the results.

Question. To what degree can estimates be prepared using a set template with a consistent use of terminology? Specifically the use of terms like "negligible," "insignificant," or the use of outlays without specifying such, or the use of footnotes?

5. See, for example, the provisions codified at 38 U.S.C. §8126 and 42 U.S.C. §§1320b-23, 1395w-112(b)(3)(d), and 1396r-8 (2012).

6. See sec. 201 of the Emergency Economic Stabilization Act of 2008 (division A of P.L. 110-343), 122 Stat. 3765, 3800 (2008) (codified at 12 U.S.C. §5251 (2012)).

Answer. The format and type of information contained in cost estimates differ according to the nature of the budgetary effects and the complexity of the analysis. Even so, CBO strives to ensure that each estimate includes all the information necessary for budget enforcement purposes. The agency's goal is to display information and use terminology consistently. For example, CBO uses the term *insignificant* in cost estimates to mean budgetary effects (for either spending or revenues) that total less than $500,000. The term *negligible* is sometimes used when CBO estimates that enacting a bill would have a budgetary effect that is effectively inconsequential (that is, significantly less than $500,000).

CBO also strives to clearly identify the effect of proposed legislation on the federal budget. For bills that would affect discretionary programs, CBO's estimates identify the amount of spending that the bill would specifically or effectively authorize (sometimes labeled the *authorization level*) as well as the outlays that would result from that authorization, if the Congress appropriated the necessary amounts. For such authorizing bills, CBO generally uses the term *cost* to refer to the outlays that would result from future appropriations provided to implement the bill's provisions.

For legislation affecting direct spending programs, the effects on budget authority and outlays are usually the same in each year. So saying that enacting a bill would increase costs usually refers to increases in both. (When estimates of budget authority and outlays differ, CBO aims to clearly identify the differences.)

CBO aims to fully explain the basis of its analysis in the body of a cost estimate, rather than in footnotes (although footnotes can be a useful way to include additional information or to refer to the agency's related work). CBO often consults with the budget committee staff—and will continue to do so—when uncertainty exists about the most useful way to present information in cost estimates.

Question. Can you identify any important deficiencies in scorekeeping practices and guidelines, and in particular departures from CBO and OMB methodologies in the use of the existing ones?

Answer. CBO finds the current scorekeeping practices and guidelines generally straightforward to apply, although questions of interpretation or implementation sometimes arise. The process for resolving such questions generally works well. When questions arise about how to apply a guideline, CBO consults with the budget committees or, for issues related to how executive branch agencies implement programs, the Office of Management and Budget. Usually, those informal consultations are enough to resolve any uncertainties about how to apply guidelines to pending legislation. The staff of the budget committees have helped by addressing scoring questions, and CBO will continue to consult with committee staff to resolve questions that may occasionally arise. More general questions about scorekeeping practices and applying guidelines are discussed at annual meetings of the various entities involved in budget enforcement.

Question. One critically important area in which you plan to enhance CBO's capabilities lies in estimating health care costs, including the Affordable Care Act. CBO recently reduced its projection of health insurance premiums for the 2016–25 period based on data from 2013. That, however, was before the ACA's enrollments started. Recent reports indicate that insurers, now armed with actual experience with new enrollees, are likely to seek higher-than-expected premium increases. Up-to-date and accurate information in this area is especially

important given that ACA clearly creates conditions that will inevitably place upward pressure on premiums and insurers who are in the process of setting their 2016 rates. How and when will CBO's current baseline projections change given the availability of new data now that the exchanges have been operational and regulations have been in effect? How do you envision incorporating actual experience into your estimating models?

Answer. CBO and the Joint Committee on Taxation have continually monitored developments in the health insurance markets and have adjusted the baseline projections to reflect recent data on exchange premiums and enrollment. Specifically, the March 2015 baseline incorporated available data about premiums for exchange-based coverage offered in 2014 and 2015 and about people selecting plans through exchanges through mid-February 2015. That information indicated that premiums for exchange plans were lower than the agencies had expected. After taking into account that information as well as other data indicating that health care spending was continuing to grow relatively slowly, the agencies reduced their projections of premium levels and growth rates over the 2016–2025 period. Even so, CBO and JCT expect that exchange premiums will rise at an average rate of 8.5 percent per year over the 2016–2018 period.[7]

CBO and JCT may further adjust the baseline projections when CBO issues its regular updates to the budget outlook this summer (reflecting available data about 2015 experience to date) and in January (reflecting available data about 2015 experience and initial data about 2016 premiums and enrollment). To incorporate additional information about what happened in 2015 and new information about premiums and enrollment for the 2016 plan year, the agencies will make more comprehensive revisions next spring in preparing the baseline projections used for the Congressional budget resolution.

CBO and JCT are following early reports of proposed premium increases for exchange-based plans offered in 2016. But how these early reports will translate into final premium increases for the second-lowest-cost silver plan—the benchmark for determining subsidies—is not yet clear. Recent reports indicate that some plans are proposing substantial premium increases. However, those reports partly reflect the fact that plans seeking to increase premiums by 10 percent or more must submit those requests for review—so the extent to which some plans are expecting smaller increases is harder to assess. Whether state regulators will approve those proposed increases is also unclear. Several recent studies, using data from sources covering various areas of the country, suggest that premiums for all silver plans will grow by an average of 6 percent to 14 percent in 2016. However, the average increase in premiums for benchmark plans offered in exchanges will be lower—between 1 percent and 5 percent—according to those studies.[8] More comprehensive data on premiums will become available later this year.

Projections of growth in spending by private health insurers and growth in exchange premiums are both highly uncertain. In CBO and JCT's view, their current projections reflect the middle of a wide distribution of possible outcomes. However, the agencies will continue to

7. For more discussion, see Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), Appendix, www.cbo.gov/publication/49973.

8. See Jesse Geneson and Kev Coleman, *Obamacare Insurers Propose 12% Higher Premiums for 2016* (HealthPocket, June 11, 2015), http://tinyurl.com/ngg2fur; Caroline F. Pearson, *Lowest-Cost Exchange Premiums Remain Competitive in 2016: Consumers May Be Able to Keep Increases Small by Selecting a Low-Cost Silver Option* (Avalere Inc., June 11, 2015), http://tinyurl.com/ocq6l4y; and Cynthia Cox and others, *Analysis of 2016 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces* (Kaiser Family Foundation, June 24, 2015), http://tinyurl.com/phgbpam.

incorporate new information on national health expenditures and exchange premiums into their baseline budget projections.

Question. Beyond the ACA, CBO has reported on the dire fiscal situation facing our mandatory spending programs such as Medicare. Clearly these programs are the key drivers of future spending growth and, consequently, the outlook for deficits and debt. Can you elaborate for the committee on the sources and data CBO currently uses to inform health care cost estimates and spending projections? How much of CBO's analysis is based on what the administration may provide to CBO compared to independent or third-party sources? Given the size and scope of Federal health care spending, how is CBO currently incorporating outside data and feedback to inform cost estimates and spending projections?

Answer. CBO relies on a diverse group of data sources and seeks to consult as broadly as possible within the time available to guide estimates and projections related to health care. The agency takes these measures to ensure that estimates and projections are objective and impartial and draw upon all relevant available data and the expertise of knowledgeable people outside CBO. CBO also relies extensively on administrative data from the Department of Health and Human Services for Medicare, Medicaid, and the insurance exchanges so that projections and estimates reflect the most recent information on actual spending and enrollment in those programs. Though CBO has no reason to doubt the accuracy of those data, the agency in general analyzes the data independently instead of relying on analysis by the Administration.

To model how individuals, employers, and others will respond to incentives under current law and to changes in law, CBO also uses data from national surveys on health insurance coverage and on use of health care. Those sources include the following:

- The Current Population Survey,
- The Survey of Income and Program Participation,
- The Statistics of Income database,
- The Medical Expenditure Panel Survey,
- The Medicare Current Beneficiary Survey, and
- Estimates and projections of national health expenditures.

CBO often seeks input from its Panel of Health Advisers (as a group and individually) as well as other experts. For example, at last year's meeting of the panel, participants discussed the sustainability of reductions in Medicare's updates to hospital payments, insurance plan offerings in exchanges, and issues in assessing proposals to reduce obesity. The agency also seeks to augment its understanding by undertaking research projects and preparing reports to the Congress that use an array of data sets, published studies, and other sources.

Question. The committees of jurisdiction over Medicare and Medicaid have found that some of their cost-savings proposals have been scored as *costs*, not savings by CBO, because CBO assumes the Center for Medicare and Medicaid Innovation (CMMI) would adopt the proposals, which would then be incorporated in the baseline. Could you detail what assumptions CBO uses in constructing the baseline for CMMI? CMMI is charged with

finding cost-saving, innovative payment and delivery ideas. The ACA appropriated $10 billion for CMMI for the FY 2011–2019 period, and then $10 billion for each subsequent period. While we see that significant money is being spent on CMMI initiatives, we haven't seen savings of the same magnitude. To make matters worse, the committees of jurisdiction over health care have been told several times by CBO that their cost-saving proposals in the Medicare and Medicaid space would not be scored by CBO as savers because these savings are already assumed in the CBO baseline. Because CBO cannot evaluate cost-savings proposals, the committees are forced to seek guidance from outside scoring groups, which may undermine CBO's authority. What is your perspective on CMMI's savings to date?

Answer. CMMI was established to test innovative approaches regarding the delivery of and payment for health care, primarily in the Medicare and Medicaid programs. Importantly, the Department of Health and Human Services (HHS) also was given broad authority to expand approaches that reduce spending and to terminate approaches that do not. Because CBO expects that some projects will prove successful and will expand, the agency estimates that CMMI will generate savings that exceed the costs of conducting the tests and trials. However, CBO cannot predict which projects will work. Over the 2016–2025 period, those net savings will total $27 billion, CBO estimates. Projects that CMMI has initiated are still in their early stages and so have not yet yielded noticeable savings; that result is broadly consistent with CBO's current estimates.

CBO examines any legislative proposals that seek to enact approaches similar to ones that CMMI is testing, to determine whether HHS would do something different under the proposal from what it would do under current law. That analysis involves some judgment, which CBO must apply on a case-by-case basis. To the extent that legislative proposals overlap with initiatives that CMMI is undertaking (or is expected to undertake), the potential for additional savings is reduced. And if those proposals would delay implementation of promising initiatives or limit CMMI's flexibility, they could increase federal costs. When such overlaps may arise, CBO tries to work closely with staff from the relevant committees as those proposals are being developed, both to understand the proposals and to explain the analysis. If those proposals are made public and contained in legislation that a committee approves or that comes to a vote in the House or Senate, CBO endeavors to make its budgetary analysis and the basis for that analysis public as soon as possible.

Issues related to CMMI have generated substantial interest among lawmakers and Congressional staff. Therefore, the discussion below further describes the context in which CMMI operates and how CBO estimates the budgetary effects of CMMI itself and of legislative proposals that may overlap with initiatives being tested through CMMI.

Background on Medicare Demonstrations and CMMI. Before CMMI was created, the federal government had long used demonstration projects to test new policies for Medicare. Those demonstrations were either initiated by HHS, acting under its statutory authority, or mandated by legislation. Demonstrations that HHS initiated were funded through its research budget, which has varied greatly, whereas funding for demonstrations mandated by legislation often came from that legislation. HHS initiated most demonstrations through the early 1980s, but legislation mandated most demonstrations that came later. For example, one recent study found that about 60 percent of the Medicare demonstrations that were planned or under way as of January 2008 were legislatively mandated.[9]

9. For a summary of this history, see Amanda Cassidy, *The Fundamentals of Medicare Demonstrations* (National Health Policy Forum, July 22, 2008), www.nhpf.org/library/details.cfm/2634.

Over the years, Medicare has conducted many demonstrations of new payment and service delivery models to determine whether they improve the quality of care, reduce program spending, or both. The results have been mixed: Although most demonstrations have not reduced program spending, a few have.[10] In the past, legislation mandating demonstrations typically did not give HHS the flexibility to modify projects on the basis of early experience, expand projects that succeeded, or terminate projects that did not succeed. Funding constraints also limited HHS's ability to develop and test new models.[11]

In light of that history, the legislation that created CMMI included several key provisions that influence CBO's estimates of CMMI's budgetary effects:

- It provided dedicated resources for CMMI ($10 billion for fiscal years 2011–2019 and an additional $10 billion for each subsequent decade).
- It created a mechanism to solicit, screen, and develop ideas for new models to be tested that is much broader and more rigorous than the development process that existed under prior law.
- It gave priority to designing demonstration projects that could be scientifically evaluated using appropriate research methods, including requirements for sample sizes large enough to allow statistical analysis.
- It gave the Secretary of HHS broad authority to modify and refine the models being tested midstream.
- It created an incentive for the Secretary to end unsuccessful models by supplying a finite amount of funds to develop and test models ($10 billion every 10 years).
- Finally—and most important for CBO's conclusion that CMMI would reduce federal spending over a 10-year period—the legislation authorized the Secretary to expand models that proved successful.[12]

Although CMMI has demonstrations under way or in development that are testing a diverse set of payment and delivery models, little information on potential savings is available. Designing, implementing, and evaluating demonstrations requires several years of effort. CBO expects that detailed assessments of some models will become available over the next few years. To date, detailed findings are available for only one model, which did not yield net savings. But those preliminary findings, covering only the first year of operation, may not indicate future results.[13]

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10. See Congressional Budget Office, *Lessons From Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment* (January 2012), www.cbo.gov/publication/42860.

11. See Chapter 1 of Medicare Payment Advisory Commission, *Report to the Congress: Aligning Incentives in Medicare* (June 2010), www.medpac.gov/documents/reports/Jun10_Ch01.pdf (534 KB).

12. Those provisions define success as reducing program spending without harming quality of care or improving quality of care without increasing program spending. The provisions also require the Chief Actuary of the Centers for Medicare & Medicaid Services to certify the expected budgetary effects before the Secretary may expand a model.

13. That model is called the Comprehensive Primary Care (CPC) initiative. According to its evaluation, the results "from this first year suggest that CPC has generated nearly enough savings in Medicare health care expenditures to offset care management fees" paid by HHS. See Erin Fries Taylor and others, *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report* (submitted by Mathematica Policy Research to the Centers for Medicare & Medicaid Services, January 2015), http://tinyurl.com/mpr-ecpci.

CBO's Baseline Projections for CMMI. CMMI received initial funding of $10 billion in 2010 to identify, develop, test, and evaluate models through 2019. It will receive another appropriation of $10 billion for each subsequent decade beginning in 2020. Spending for CMMI has increased as the program develops new models (with models that start being tested in the same year commonly referred to as a cohort). CBO projects that CMMI's spending will reach a steady state of slightly more than $1 billion per year in 2017, with total spending of about $11 billion over the 2016–2025 period.

Although determining the costs of operating CMMI is relatively straightforward, estimating how its operations affect federal spending is more complex. CMMI's effects on the federal budget depend not only on the amount of spending for model development and evaluation but also on the amount of any savings or additional costs that the models being tested generate. As with CBO's assessment of prior demonstrations, the agency expects that only a few models in any given cohort will reduce program spending. However, CBO cannot predict which models will succeed, and CMMI has not operated long enough to determine its overall track record. Therefore, CBO generally bases its projections on the following judgments, which reflect both the provisions governing CMMI and experience with HHS demonstrations:

- On average, models that succeed will operate for four to seven years before HHS decides whether to expand them.
- HHS will expand models that succeed, and expanded models will yield federal savings over time.
- On average, models that do not succeed will operate for two to five years before HHS cancels them.

For most models that succeed and some that do not, those time frames include a two-year period in which to collect data, conduct an independent evaluation, and obtain actuarial certification of the results.

The upshot of those judgments is that—for a given cohort of models—CBO projects that federal costs will increase in the initial years. But those net costs will start to decline in year three and then will change to net savings as HHS expands successful models and cancels unsuccessful models. Across cohorts, the net budgetary effect of CMMI's overall operations thus depends on how many operating cohorts are in their initial (cost-increasing) stages versus their later (cost-reducing) stages and on how many completed cohorts have resulted in cost-reducing expansions of successful models.

In total, CBO projects that CMMI will increase federal spending by about $0.2 billion in 2015, that the program will start generating net savings in 2017, and that the net savings in 2025 will amount to about $6 billion. Over the 2016–2025 period, CMMI's operations are projected to reduce spending by about $27 billion, on net. Those net savings reflect the projected amount by which savings generated by successful programs—including those HHS will have expanded—will exceed the sum of additional costs from unsuccessful programs and CMMI's spending to develop and evaluate models. Specifically, CBO estimates that savings totaling $38 billion over the 2016–2025 period will more than offset CMMI's spending of about $11 billion on model development and evaluation over that period.

CBO monitors the entire CMMI process, from the collection of ideas for new models through the testing, refinement, and evaluation phases of models selected for testing. As the CMMI program matures, CBO also will monitor expansion decisions and the implementation of those decisions, updating projections to account for those decisions.[14]

Estimates for Proposals That May Overlap With CMMI Models. CBO analyzes proposals for new demonstrations on a case-by-case basis. A crucial factor in the agency's analysis is the nature and extent of any overlap with models that CMMI is testing or is likely to test under current law—and thus whether the proposal would yield results that differ from current law. In making that assessment, CBO accounts for how much interest CMMI has shown in similar models, either in terms of the tools it uses (for example, management of prescriptions before a hospital discharge) or the opportunities for savings that it targets (such as avoiding hospital readmissions). CBO looks at both tools and targets because multiple tools could target the same problem, but the resulting savings can often be realized only once. For example, although many approaches may seek to reduce hospital readmissions, a given readmission can be avoided only once.

CBO might estimate reduced federal spending for some legislative proposals even though they overlap with CMMI's efforts. Indeed, CBO probably would estimate savings for an overlapping proposal under the following circumstances:

- If the proposal would implement a model that HHS has decided not to expand, even though the evaluation showed that the model reduced spending and the Chief Actuary has certified that expanding the model would also generate savings;
- If the proposal would speed up implementation of a model that is expected to generate savings[15]; or
- If HHS has decided to expand a successful model that would be implemented on a voluntary basis, but a proposal would make the implementation mandatory.[16]

At the same time, CBO has often advised committee staff that proposals to implement models similar to ones being developed and tested through CMMI would increase federal spending. In general, that conclusion stems from one or more of the following considerations:

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14. The Chief Actuary recently certified that expanding a program involving accountable care organizations (ACOs) would reduce Medicare spending. That certification was part of a parallel mechanism established for ACOs, which operates outside CMMI's authority. CMMI is also testing initiatives related to ACOs.

15. For example, CBO estimated savings for a provision that would have broadened a demonstration that CMMI had already initiated in selected states. That demonstration involved requirements to receive authorization for repeated use of ambulance transport in nonemergency situations. See Congressional Budget Office, cost estimate for H.R. 1021, the Protecting the Integrity of Medicare Act of 2015 (March 16, 2015), www.cbo.gov/publication/50037. That provision was later enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10).

16. For example, CBO recently estimated that implementing bundled payments for all care related to a hospital admission on a mandatory basis (and reducing those total payments by a specified percentage) could generate federal savings, even though CMMI has already begun testing such approaches on a voluntary basis. See Congressional Budget Office, *Health-Related Options for Reducing the Deficit: 2014 to 2023* (December 2013), pp. 44–53, www.cbo.gov/publication/44906. Later developments regarding bundled payments in Medicare will affect CBO's analysis of proposals in this area.

- The proposal includes a statutory requirement that would delay implementation of a model under development and therefore delay realized savings if that model proved successful.

- The proposal would limit the flexibility that HHS has to design and refine a model, thereby decreasing the likelihood that the model would succeed and reducing the expected savings if the model does succeed.

- The proposal would permit or require expansion of a model without requiring that the model meet the cost criteria (including actuarial certification) in current law for expansion under CMMI. Such a proposal would make expansion of a cost-increasing model more likely and thus would increase spending in relation to CBO's baseline—because under current law, the agency estimates that CMMI will terminate cost-increasing models.

CBO always seeks to consult with the staff of the relevant committees as they are developing their proposals to better understand the proposals, discuss any evidence related to their likely effects, and explain relevant analysis that the agency has undertaken.

Congresswoman Black

Question. You have indicated that as the new Director of the Congressional Budget Office (CBO), you are resolved to improve CBO operations and increase transparency. You have previously discussed your plans to further develop health care models by adapting CBO methodology to incorporate data and hard evidence rather than theory and conjuncture. CBO has long been concerned that expanding Medicare coverage for telehealth would drive up spending due to increased utilization, but there is little, if any, data to support that. In fact, Medicare has almost no data to support this. There are, however, large amounts of data from the private payers showing that, when used appropriately, telehealth visits and remote monitoring can replace or avoid more expensive in-person visits for certain primary care services and reduce spending in the process. What data sources is CBO utilizing when preparing cost estimates for expanding telehealth and remote patient monitoring services through Medicare? What additional data does CBO need with respect to Medicare reimbursement for telehealth and remote patient monitoring services?

Answer. Whether expanding Medicare coverage for telemedicine services would increase or decrease federal spending is difficult to predict, but doing so depends on two main considerations:

- The payment rates that would be established for those services, and

- Whether use of those services would substitute for (or reduce use of) other Medicare-covered services or would be used in addition to currently covered services.

If all or most telemedicine services substituted for or prevented the use of more expensive services, coverage of telemedicine could reduce federal spending. If instead telemedicine services were mostly used in addition to currently covered services, coverage of telemedicine would tend to increase Medicare spending. Many proposals to expand coverage of telemedicine strive to facilitate enrollees' access to health care. Therefore, such proposals could increase spending by adding payments for new services instead of substituting for existing services.

Because coverage of telemedicine services in Medicare's traditional fee-for-service program is limited, so is evidence about the effects of such coverage. Thus, CBO must often draw inferences from other sources—such as the experience of private managed care plans—when developing cost estimates. However, an important limitation of that evidence is that private plans generally have more ways to influence doctors' choices and to limit the services that their enrollees use than are available in Medicare's fee-for-service program (which the Department of Health and Human Services and its contractors run). As a result, even if coverage of telemedicine reduced net costs for some private plans, the greater difficulties involved in ensuring that services are used appropriately in the fee-for-service Medicare program mean that proposals to expand coverage of services in that program could increase federal spending.

CBO analyzes proposals to expand Medicare coverage of telemedicine on a case-by-case basis. The agency considers the design of those proposals—including what services would be covered under what circumstances and how their payments would be determined—as well as any relevant evidence. Having more evidence about how the telemedicine coverage affects spending would thus be useful. The results of a demonstration project conducted within the fee-for-service Medicare program would be particularly useful, especially if the approach tested was similar in its design to the specifications defined in a legislative proposal.

Proposals related to telemedicine have generated substantial interest among lawmakers and Congressional staff. Therefore, CBO has prepared the discussion below, which further describes the issues that arise in defining a telemedicine benefit and how CBO estimates the budgetary effects of those proposals.

Defining a Telemedicine Benefit. Telehealth or telemedicine—which simply means health care provided at a distance—encompasses an array of services. Telemedicine services include virtual visits with doctors or other professionals, remote monitoring of patients' conditions, and off-site analysis of medical imaging or test results. Providers may offer telemedicine through various means of communication, including phone calls, video chats, text messages, email, and websites. With the varied possibilities, proposals to expand coverage for telemedicine or telehealth services in Medicare would need to define several factors, including:

- The services that would be covered and their allowed methods of delivery,
- The types of providers and sites of care that could be paid to offer those services, and
- The types of patients or beneficiaries who would be eligible to receive such services.

Proposals also would need to specify how to determine Medicare's payments for those services (for example, whether payments would equal Medicare's fees for physician services provided in person or would be some percentage of those fees).

CBO's analysis of such proposals would take into account how they differed from Medicare's coverage of telemedicine services under current law. Now, Medicare providers can be paid to furnish certain telemedicine services by using specified methods and sites of service—but only for patients who live in rural areas. (Those patients generally visit a facility that has some staff but that accesses some doctors remotely.) In general, Medicare pays the distant doctor or other provider of telemedicine the same fee that Medicare would have paid for an in-person office visit, and the site where the patient receives the services is paid a facility fee. Medicare's total payments are thus higher for telemedicine services than for equivalent services delivered

conventionally. Whether similar arrangements would apply for any expansion of coverage for telemedicine depends on the details of legislative proposals.

How CBO Estimates Effects on Spending. CBO seeks to incorporate information from a variety of sources when estimating how proposals to expand telehealth or telemedicine services that Medicare covers might affect the budget. Those sources include available data about the costs of covering similar services and the results of academic studies investigating how telemedicine affects health care spending. In particular, CBO considers the evidence about spending on telemedicine services in Medicare itself, in the Department of Veterans Affairs, and in the Medicaid program. CBO also considers evidence about the use and effects of telemedicine in Medicare Advantage plans (private plans delivering Medicare's benefits) and other private health plans. In doing so, the agency accounts for the potential differences in benefit management between private and public plans noted above. CBO also consults experts who help the agency understand how telemedicine may affect health care spending.

Considerable uncertainty surrounds estimates of the likely utilization rates for covered telemedicine services themselves and of the downstream effects on other services that might be induced or avoided. In its analysis, CBO examines whether use of telemedicine as proposed would prevent the use of more expensive services, such as emergency room visits or hospital admissions, or would instead increase the use of other services to provide follow-up care.

To some extent, proposals to expand coverage may reflect a "long-standing hope that telehealth could be used to overcome a lack of local medical and surgical subspecialists in rural areas."[17] Although offering telemedicine to rural enrollees could improve the quality of care that such enrollees receive, and could be more convenient for them, doing so might not reduce Medicare spending on their care. More broadly, if rural or urban enrollees would otherwise not have received care because of difficulties in obtaining access to doctors, providing telemedicine might well increase spending on services Medicare covers instead of substituting for services that would otherwise have been covered. Without other constraints, the added convenience for enrollees of receiving telemedicine rather than face-to-face care could increase their demand for and use of Medicare-covered services. Provisions governing the cost-sharing requirements that enrollees face for telemedicine services also would affect their demand for those services.

Because Medicare coverage of telemedicine is limited, CBO does not have extensive data that would help project how expanding such coverage would affect federal spending in the Medicare program. CBO's analysis would benefit from having the results of new and well-designed academic studies examining how introducing telemedicine services would affect health care spending in the Medicare population. The results of a demonstration project conducted in the fee-for-service Medicare program could be especially valuable, in light of the particular challenges of controlling spending on new benefits in that program. (An answer to another question from this hearing—which asked about the Center for Medicare & Medicaid Innovation—includes a broader discussion of demonstration projects within Medicare.)

Question. The Affordable Care Act created the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) to test and

17. Matlin Gilman and Jeff Stensland, "Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth," *Medicare & Medicaid Research Review*, vol. 3, no. 4 (2013), pp. E1–E14, http://go.usa.gov/3f4VB.

implement innovative payment and service delivery models. Ten billion dollars for the fiscal year (FY) 2011 through FY 2019 and $10 billion for each subsequent 10-year period thereafter was appropriated for CMMI. When legislation is introduced to implement payment and delivery reform pilots and projects through the center, it appears that CBO is assuming that the cost for these pilots and projects will add additional cost to the system rather be incorporated into the existing funding structure for demonstration projects. Please thoroughly explain the thought process and any evidence used to support this reasoning.

Answer. The answer to a question above from Chairman Price addresses this question.

Congressman Buchanan

Question. In your most recent baseline, you project a cumulative 10-year deficit of more than $7.2 trillion. While mandatory spending will drive much of this deficit growth, interest on our debt is also a major factor. You estimate that our annual interest payments will grow from $229 billion in FY 2014 to more than $800 billion in FY 2025. It is my understanding that this assumes the weighted average interest rate will rise from 1.7 percent to 3.8 percent. Some economists on the left, including Paul Krugman, have argued that we do not in fact have a budget crisis because CBO is incorrect in assuming that interest rates will rise. My first question to you is: how do you respond to critics that say that an interest rate increase is implausible?

Answer. Interest rates are quite low now, by historical standards. However, CBO forecasts that the labor market and the overall economy will improve during the next few years. As a result, CBO expects that the Federal Reserve will begin raising short-term interest rates in the second half of this year, which will put upward pressure on other interest rates.

In CBO's forecast, the federal funds rate—the interest rate that financial institutions charge each other for overnight loans of their monetary reserves—rises to 0.6 percent by the end of this year and then settles at 3.7 percent in 2019.[18] Officials at the Federal Reserve, financial market participants (as reflected in prices in financial markets), and a diverse group of professional forecasters expect increases in the federal funds rate and expect those increases to raise other short-term interest rates. Continued improvement in economic conditions and the expected rise in short-term interest rates will lead to higher long-term interest rates as well. CBO expects the interest rate on the 10-year Treasury note to rise from 3.0 percent at the end of 2015 to 3.9 percent in 2017 and then settle at 4.6 percent by the end of 2019.

Although interest rates are expected to rise, several factors are likely to dampen real (inflation-adjusted) interest rates. Using inflation as measured by the consumer price index for all urban consumers, CBO forecasts that the real interest rate on 10-year Treasury notes will equal 2.2 percent between 2020 and 2025. That would be well above the current real rate but roughly three-quarters of a percentage point below the average real rate between 1990 and 2007. CBO uses that period for comparison because it featured fairly stable expectations for inflation and no significant financial crises or severe economic downturns. According to

18. For more discussion of CBO's economic forecast and the factors affecting interest rates, see Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (January 2015), Chapter 2, www.cbo.gov/publication/49892.

CBO's analysis, several factors will act to push real interest rates on Treasury securities lower than their earlier average:

- Slower growth of the labor force (which reduces the return on capital),
- Slightly slower growth of productivity (which also reduces the return on capital),
- A greater share of total income going to high-income households (which tends to increase saving), and
- A higher risk premium on risky assets (which increases the relative demand for risk-free Treasury securities, boosting their prices and thereby lowering their interest rates).

Other factors will act to raise real interest rates from their earlier average:

- A large amount of federal debt as a percentage of gross domestic product (GDP), which increases the relative supply of Treasury securities;
- Smaller net inflows of capital from other countries as a percentage of GDP (which reduces the supply of funds available for borrowing);
- Fewer workers in their prime saving years than the number of older people drawing down their savings (which tends to decrease saving and thus also reduces the supply of funds available for borrowing); and
- A higher share of income going to capital (which increases the return on capital assets with which Treasury securities compete).

CBO expects that, on balance, those factors will result in real interest rates on Treasury securities that are lower than those in effect between 1990 and 2007.

CBO's forecast aims to be in the middle of the distribution of potential outcomes. Actual interest rates could be higher or lower than forecast if any of the factors discussed above turn out to be different from what CBO expects. Uncertainty about interest rates also affects the uncertainty about the amount of federal debt in the future. Over the long term, CBO estimates that federal debt held by the public would be 107 percent of GDP in 2040 under CBO's forecast of interest rates. That debt would be 89 percent of GDP if the effective interest rate on federal debt was 0.75 percentage points lower than that forecast in each of the next 25 years. However, it would be 130 percent of GDP if the effective interest rate on federal debt was 0.75 percentage points higher than that forecast in each year.[19]

Question. During my service in the House, constraining our growing debt has been my primary focus. I am particularly alarmed that our economy is projected to grow at an average annual rate of only 2.1 percent over the next decade, but our deficits will average 3.1 percent of our GDP over the same period. We cannot continue to allow our debt to grow faster than our economy. At some point, it will become more difficult to attract investors to buy our debt. There are only two possible outcomes in such a scenario—both of which are bad. First,

19. For more discussion of the sensitivity of the budget to interest rates in the long term, see Congressional Budget Office, *The 2015 Long-Term Budget Outlook* (June 2015), Chapter 7, www.cbo.gov/publication/50250.

investors could demand a higher interest rate to compensate for the risk of securities backed by a government whose balance sheet is out of whack. By your own estimates, the additional cost of a single percentage point increase in interest rates would add $1.7 trillion to our deficits over the next 10 years. Second, and more frightening, is that the United States could begin to resemble Greece. If investors believe that our country lacks the resolve to tackle our long-term budget problems, our debt could rapidly become unsustainable, crippling our country. Given the importance of this issue, can you describe the resources that you have in place to predict interest rate increases? Are you working to identify the point at which our nation could enter a debt spiral?

Answer. Twice each year, a group of economists at CBO prepares an economic forecast that includes the agency's expectation of interest rates for the next 10 years. CBO draws information for its forecasts from ongoing analysis of daily economic events and data, the major commercial forecasting services, consultation with economists both within and outside the federal government, and the advice of the experts on its Panel of Economic Advisers. One important consideration is information about the expectations of participants in the financial markets as reflected in the current interest rates on financial instruments.

On the basis of that forecast, in its recent report on the long-term budget outlook, CBO projected that, if current laws remained generally unchanged, federal debt held by the public would decline slightly in relation to GDP over the next few years. After that, however, growing budget deficits—caused mainly by the aging of the population and rising health care costs—would push debt back to, and then above, its current high level. The deficit would grow from less than 3 percent of GDP this year to more than 6 percent in 2040. At that point, 25 years from now, federal debt held by the public would exceed 100 percent of GDP.

Moreover, debt would still be trending upward in relation to the size of the economy. Consequently, the policy changes needed to reduce debt to any given amount would become larger and larger over time. The rising debt could not be sustained indefinitely; the government's creditors would eventually begin to doubt its ability to cut spending or raise revenues by enough to pay its debt obligations, forcing the government to pay much higher interest rates to borrow money.

CBO's forecast is influenced primarily by the factors that have explained U.S. interest rates in recent decades. Therefore, the forecast does not explicitly factor in the possibility that interest rates on federal debt will increase sharply because of such a fiscal crisis. Two important indicators of the risk of a fiscal crisis are the level and projected trajectory of debt. However, no way exists to confidently predict whether or when a fiscal crisis might occur in the United States, partly because several other factors—including the government's near-term borrowing needs and the health of the domestic and global economy—influence the risk of a crisis.

The history of fiscal crises in other countries does not necessarily indicate either the conditions under which investors might lose confidence in the U.S. government's ability to manage its budget or how such a loss might affect the nation. On the one hand, the United States may be able to issue more debt (in relation to output) than the governments of other countries can without triggering a crisis. Investors around the world have often viewed the United States as a safe haven, considering U.S. government securities among the world's safest investments. On the other hand, the United States may not be able to issue as much debt as the governments of other countries can because of a relative lack of domestic demand for

government debt. The private saving rate has been lower in the United States than in most developed countries, and foreign investors have bought a significant share of U.S. debt.[20]

Congresswoman Lee

Question. I worked extensively with the previous CBO Director Doug Elmendorf on the issue of poverty and how we can quantify the way that Congressional action affects the over 45 million Americans living in poverty today. I would like to continue working to find a way that is not overly burdensome for your agency to demonstrate to Members how their votes and their bills affect low income American families. I would like to hear your thoughts on how the CBO could move forward with this idea.

Answer. CBO will continue to work with the Chairmen and Ranking Members of both the Senate and the House Committees on the Budget as well as with the various committees of jurisdiction to determine how the agency can best support the Congress in quantifying the distributional effects of policies. CBO's recent work in this area includes the following:

- *The Effects of Potential Cuts in SNAP Spending on Households With Different Amounts of Income* (March 2015)[21];
- *The Distribution of Household Income and Federal Taxes, 2011* (November 2014), the latest in a series examining income and taxes by income group[22];
- *The Effects of a Minimum-Wage Increase on Employment and Family Income* (February 2014)[23]; and
- *The Distribution of Federal Spending and Taxes in 2006* (November 2013), a continuation of CBO's analyses of taxes by income group and by household type and CBO's first analysis of all federal government spending by income group and by household type.[24]

Examining the distributional effects of programs as they currently operate is difficult, and predicting the effects of changes to programs is even more so. The availability of data varies widely among programs, complicating efforts to consistently allocate benefits under current law by income group or by household type. Moreover, predicting who will ultimately be affected by some policy changes is challenging. Decreased payment rates for Medicare providers might affect both providers, who could receive lower payments despite offering the same services, and beneficiaries, who could experience reduced quality and availability of services. CBO will, however, continue to build its capacity to analyze how programs or policies affect different income groups and types of households.

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20. For more discussion of this topic, see Congressional Budget Office, *Federal Debt and the Risk of a Fiscal Crisis* (July 2010), www.cbo.gov/publication/21625.
21. SNAP = Supplemental Nutrition Assistance Program (also known as Food Stamps). See www.cbo.gov/publication/49978.
22. See www.cbo.gov/publication/49440.
23. See www.cbo.gov/publication/44995.
24. See www.cbo.gov/publication/44698.