Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

ANSWERS TO QUESTIONS FOR THE RECORD

Following a Hearing on

The Oversight of CBO

Conducted by the
Committee on the Budget
U.S. House of Representatives

March 8 | 2024

On January 31, 2024, the House Budget Committee convened a hearing at which Phillip L. Swagel, the Congressional Budget Office's Director, testified about the work of CBO.[1] *After the hearing, Chairman Jodey Arrington and Representatives Buddy Carter, Ben Cline, Drew Ferguson, and Rudy Yakym submitted questions for the record. This document provides CBO's answers. It is available at* www.cbo.gov/publication/60031.

Chairman Arrington

Question. When scoring legislation or the baseline, has CBO ever taken direction from the Office of Management and Budget (OMB) instead of the Budget Committees? If so, what is the protocol for notifying the Budget Committees of such action? Can you provide thorough examples of when this has occurred? Under the Congressional Budget and Impoundment Control Act of 1974, CBO reports to Congress, the Legislative Branch, not the Executive Branch. Why would CBO take directives from OMB instead of Congress? There was once an instance where CBO took direction from OMB on a supplemental Dairy Margin Coverage (DMC) policy beginning in the July 2021 baseline; Budget Committee staff was not made aware of this direction until September 2023. The Consolidated Appropriations Act of 2021 (CAA) included a bipartisan provision that authorized DMC supplemental payments based on updated producer's production histories through January 31, 2023, consistent with other farm programs. Initially after the CAA passed, CBO carried the DMC provision in its baseline, but then after solely consulting with OMB and not Congress, removed it.

Answer. CBO consults with OMB staff on some technical and conceptual matters, but CBO does not take direction from OMB, and it makes its own assessments when preparing its baseline budget projections and estimating the costs of legislation. When providing budgetary information to the Congress, CBO adheres to laws and rules concerning the federal budget and to a set of principles that include 16 scorekeeping guidelines that have been agreed upon by OMB, CBO, and the budget committees.

CBO also regularly consults with its OMB counterparts on the implications of actions taken by the Administration. In most cases, CBO adopts the Administration's budgetary treatment for federal programs—though generally not OMB's numerical estimates—in its baseline and cost estimates because the Administration determines how the programs are operated and accounted for in the budget.

In some cases, CBO's budgetary treatment differs from OMB's, particularly when the agencies' conceptualizations of an activity or program differ. For example, CBO considers the activities of the government-sponsored enterprises Fannie Mae and Freddie Mac to be governmental and projects their budgetary effects on an accrual basis beyond the current year, whereas OMB treats them as nongovernmental and projects their payments to the Treasury on a cash basis.[2]

You note an issue that arose with regard to the estimated cost of a supplemental DMC program established by the Consolidated Appropriations Act, 2021. One of many questions that CBO had to address in preparing its estimate was whether that program was part of an existing broader program that, under the rules governing baseline construction, was assumed to be extended in the baseline or was a separate, smaller program that, under those rules, would not be extended in the baseline. In the short time available to complete the estimate, CBO initially concluded that the supplemental coverage was an addition to the existing DMC program.

On that basis, and consistent with the Deficit Control Act (2 U.S.C. § 907(b)(2)(A)(i)), CBO estimated the cost of the supplemental DMC provision for the entire baseline projection period instead of reflecting the expiration at the end of 2023 that was specified in the legislation. Because the cost estimate was completed in close conjunction with the February 2021 baseline, the baseline also showed costs for the supplemental DMC program throughout the projection period.

In a subsequent baseline published in July 2021, CBO revisited its budgetary treatment of the supplemental DMC. At that time, CBO determined that the supplemental DMC was *not* part of the existing DMC program and, therefore, should not be extended in the baseline. In

1. Testimony of Phillip L. Swagel, Director, Congressional Budget Office, before the House Budget Committee, *The Accuracy of CBO's Recent Baseline Projections* (January 31, 2024), www.cbo.gov/publication/59905.

2. See Congressional Budget Office, *Accounting for Fannie Mae and Freddie Mac in the Federal Budget* (September 2018), www.cbo.gov/publication/54475.

making that decision, CBO consulted with OMB, as the agency typically does when considering how a program will be implemented, but CBO did not take any direction from OMB; CBO's determination was based on its own understanding of the two programs and the Deficit Control Act's guidelines for constructing the baseline.

Representative Carter

Question. In November, the Budget Committee sent CBO a letter asking the budget office to explain its approach to analyzing policies that impact patient access to new drugs. As followup on that letter, we would specifically, like to understand how CBO is considering GLP-1 prescriptions, in particular, new indications, for example, in cardiovascular diseases expected this year. As a result, patients with obesity and cardiovascular diseases will be able to access a GLP-1 under Medicare. How are you factoring new indications into developing CBO's baseline? How are you factoring in new indications for GLP-1s that are considered medically accepted indications and not excluded under the current weight-loss prohibition?

Answer. CBO is incorporating information about treatments for cardiovascular conditions in its estimation of the effects of policies that would authorize coverage of medications for the treatment of obesity in Medicare. CBO expects that if the Food and Drug Administration (FDA) approves glucagon-like peptide-1 (GLP-1) agonists for cardiovascular indications, then Medicare will cover those drugs for the treatment of cardiovascular conditions among people with obesity. In that case, CBO would add the costs of covering GLP-1 agonists for Medicare patients with the newly approved indications to its baseline, and the cost of legislation to broaden coverage of those drugs for treating obesity would fall. The amount of spending that would be attributed to the baseline and would no longer be attributed to legislation would depend on the details of the indications approved by the FDA and on the language in any legislation. CBO is refining its baseline projection of what new indications are likely to be covered by Medicare under current law and will share more information when it is available.

Representative Cline

Question. The baseline that CBO is required to produce is often described as reflecting "current law." Please list the deviations from current law that are built into the baseline as a result of Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985? Compared to a theoretical baseline that is calculated without these assumptions, does the official baseline assume outlays that are higher or lower? What about revenues? How then would this dynamic affect the scoring of legislation that applies to the aforementioned assumptions, as opposed to scoring legislation against a true "current law" baseline without them?

Answer. The Deficit Control Act's instructions for preparing the baseline, including the required deviations from current law, are described in detail in a recent CBO publication.[3] Regarding mandatory spending and revenues, entitlement authority (for Social Security benefits, for example) is assumed to be fully funded, certain expiring programs (such as the Supplemental Nutrition Assistance Program) are assumed to continue, and expiring taxes dedicated to trust funds (such as certain transportation-related excise taxes) are assumed to continue.[4] Regarding discretionary funding, budget authority is assumed to equal amounts provided in the current full-year appropriation, with adjustments for inflation (as well as for any caps that have been imposed by law); if full-year appropriations have not been enacted, budget authority is assumed to reflect the annualized amount provided to date for the current year, with those adjustments.

Without those assumptions, total outlays and revenues in CBO's baseline projections would be lower during the projection period. Estimates of the effects of proposed legislation by CBO and the staff of the Joint Committee on Taxation (for proposals affecting income, estate and gift, excise, and payroll taxes) would reflect that fact. The net effect of proposed legislation relative to that different baseline would depend on the programs affected and the details of the legislation.

3. Congressional Budget Office, *CBO Explains the Statutory Foundations of Its Budget Baseline* (May 2023), www.cbo.gov/publication/58955.

4. For details about the costs for mandatory programs that continue beyond their current expiration date in CBO's baseline, see Congressional Budget Office, "10-Year Budget Projections," Supplemental Table 1, www.cbo.gov/system/files/2024-02/51118-2024-02-Budget-Projections.xlsx.

Representative Ferguson

Question. Over the past 25 years, what is the Congressional Budget Office's 10-year score accuracy? Specifically, what is the rate in which the Congressional Budget Office can accurately score the projected cost of a piece of legislation relative to the actual cost once implemented?

Answer. CBO has published analyses of the accuracy of some prior cost estimates and of what it has learned from its errors. The analyses were published several years after enactment of the legislation, once sufficient data were available to study the effects of the enacted policies. They include:

- *Federal Budgetary Effects of the Activities of the Center for Medicare & Medicaid Innovation* (September 2023), www.cbo.gov/publication/59274;
- *A Review of CBO's Estimate of Spending From the Department of Defense's Medicare-Eligible Retiree Health Care Fund* (October 2020), www.cbo.gov/publication/56653;
- *A Review of CBO's Estimate of the Effects of the Recovery Act on SNAP* (December 2018), www.cbo.gov/publication/54864;
- *CBO's Record of Projecting Subsidies for Health Insurance Under the Affordable Care Act: 2014 to 2016* (December 2017), www.cbo.gov/publication/53094;
- *Competition and the Cost of Medicare's Prescription Drug Program* (July 2014), www.cbo.gov/publication/45552; and
- "Actual ARRA Spending Over the 2009–2011 Period Quite Close to CBO's Original Estimate," *CBO Blog* (January 5, 2012), www.cbo.gov/publication/42682.

As a result of those analyses, CBO has updated its approaches to estimating the effects of similar legislation. For example, after analyzing its underestimate of the cost of increased SNAP benefits that were provided by the American Recovery and Reinvestment Act of 2009, the agency revised its modeling: CBO determined that in a cost estimate for similar legislation, it would estimate a larger increase in SNAP participation, and thus higher costs, in the event that the country was facing economic conditions comparable to those that prevailed from 2009 to 2013.

For most cost estimates, CBO cannot make such comparisons because the legislation is never enacted into law, the proposal becomes part of a larger piece of legislation and cannot be assessed separately, the legislation makes changes to an existing program that cannot be identified separately from other spending on that program, the legislation is an authorization whose funding depends on future appropriations, or the enacted legislation differs from the version CBO analyzed (usually when ordered reported by a full committee). In addition, it can take years for the effects of a policy change to be evident.

CBO also regularly assesses the accuracy of its baseline projections and economic forecasts by comparing them with actual outcomes.[5] For example, on the basis of actual outcomes from 2006 through 2021, CBO determined that the projections of total outlays for those years that it had prepared 11 years earlier were often too high; the average absolute error was about 11 percent. CBO's projections were generally more accurate over shorter forecast horizons: The average absolute error for projections made 2 years earlier was 2 percent; for those made 6 years earlier, it was 6 percent. Analyzing errors in baseline projections helps improve the agency's understanding of how programs operate and thereby improves the accuracy of cost estimates.

Representative Yakym

Question. Many of those living with obesity currently have coverage for anti-obesity medications (AOMs) through commercial insurance, the VA, Tri-Care, and FEHBP, to name a few; Medicare remains an outlier in providing access. As you work through the modeling of AOMs, how many individuals currently being treated with such medication do you estimate are expected to enter Medicare and lose coverage as a result? Has CBO considered the impact to the baseline, as a result, of patients stopping treatment for obesity if they regain the weight and develop a comorbidity like diabetes, when it could have been prevented by retaining access to their obesity treatment?

5. For reports about the accuracy of CBO's projections of outlays, revenues, deficits, and debt, see Congressional Budget Office, "Accuracy of Projections," www.cbo.gov/topics/budget/accuracy-projections. Up-to-date data on the history of those projections and actual outcomes are available on GitHub (https://github.com/US-CBO/eval-projections). For a series of reports about the accuracy of CBO's economic forecasts, see Congressional Budget Office, "Major Recurring Reports, Economic Forecasting Record," www.cbo.gov/about/products/major-recurring-reports#7.

Answer. CBO is currently gathering information about the number of people being treated with such medication and the effects of their use of the treatment. Continuous use of the medication over time is needed for people to maintain its health benefits. People who discontinue the medication, whether because of side effects or because of lost insurance coverage, tend to regain weight and may develop associated health conditions. CBO's analysis of proposals to expand Medicare's coverage of GLP-1 agonists accounts for that aspect of the medication. The agency will update you and your colleagues when more information is available.

Question. If CBO were to score the proposed PBM delinking legislation such as Delinking Revenue from Unfair Gouging Act, what do you estimate the budgetary impact to be? Is there any administrative burden associated with moving all existing PBM contracts to a 'delinked' model, and would there be a premium impact in the commercial or Part D space? How does delinking interplay with the upcoming Part D redesign, which was signed into law as a part of the IRA? Several private sector healthcare economists such as Alex Brill and Casey Mulligan have begun evaluating the impact of PBMs on the economy. Have you analyzed their studies, and have you factored these economic analyses into your modeling? Additionally, there are discussions regarding banning spread pricing for PBMs in the commercial market, what do you estimate the budgetary impact for such legislation to be?

Answer. CBO has not yet estimated the budgetary impact of the Delinking Revenue from Unfair Gouging Act. That act's restrictions on pharmacy benefit managers (PBMs) include a provision that would prohibit PBMs from linking their compensation to the list price of a drug and a ban on spread pricing—that is, charging an insurer more for a drug than the PBM pays the pharmacy.

In CBO's assessment, policies that regulate the practices of PBMs (for instance, by restricting the revenues that PBMs retain or requiring greater transparency with the plan sponsors they contract with) tend to lead to lower premiums for both Medicare Part D and commercial insurance plans and to federal budgetary savings. Those outcomes are the result of two partially offsetting effects: Greater transparency improves the ability of some plan sponsors to negotiate lower-priced pharmacy benefit contracts, but PBMs tend to offset those losses by increasing revenue in other parts of the pharmacy supply chain and by raising other fees charged to plan sponsors—thereby increasing administrative costs for plan sponsors.

CBO expects that provisions of the 2022 reconciliation act (sometimes called the Inflation Reduction Act, or IRA), including those related to the redesign of Part D, will lead to a decline in manufacturer rebates and discounts over time, which will dampen the effects of legislation related to PBMs' transparency and delinking on federal spending.

CBO incorporates information from many sources, including Alex Brill and Casey Mulligan in addition to other researchers and stakeholders, to conduct its analyses. The agency will continue to update its analyses as new information comes out.