

CBO

Reducing the Deficit: Spending and Revenue Options



MARCH 2011



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Discretionary Spending—Option 34**Function 600****Increase Payments by Tenants in Federally Assisted Housing**

(Millions of dollars)	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total		
											2012–2016	2012–2021	
Change in Spending													
Budget authority	-580	-1,180	-1,810	-2,470	-3,170	-3,260	-3,350	-3,450	-3,540	-3,630	-9,210	-26,440	
Outlays	-420	-1,020	-1,640	-2,290	-2,980	-3,230	-3,320	-3,420	-3,510	-3,610	-8,350	-25,440	

Most low-income tenants who qualify for federal rental assistance receive aid through the Housing Choice Voucher Program (sometimes called Section 8), the Public Housing Program, or project-based assistance programs (which designate privately owned, government-subsidized units for low-income tenants). Funded by the Department of Housing and Urban Development (HUD), those programs usually require that tenants pay 30 percent of their gross monthly household income (after certain adjustments) for rent; the federal government subsidizes the difference between that amount and the maximum allowable rent. In 2010, the Congressional Budget Office estimates, the average combined federal expenditure for all of HUD's rental housing assistance programs was roughly \$7,500 per household. That amount includes the housing subsidies and fees paid to the agencies that administer the programs.

This option would gradually increase tenants' rental contributions from 30 percent of adjusted gross family income to 35 percent over the 2012–2016 period. Provided that federal appropriations were reduced accordingly, those higher rent contributions would reduce outlays by a total of about \$8 billion over 5 years: about \$4 billion for the Housing Choice Voucher Program, almost \$2 billion for the Public Housing Program,

and about \$2 billion for project-based assistance programs. Savings would total about \$25 billion over 10 years.

An argument in support of this option is that, on average, renters not currently receiving vouchers or rent subsidies—"unassisted" renters—whose income is comparable with that of assisted renters spend roughly 40 percent of their income on rent. Even if the contribution requirement for subsidized renters increased to 35 percent of family income, that contribution would still be below the amount that unassisted renters currently spend on rent. Furthermore, households that received assistance would continue to benefit from paying a fixed percentage of their income toward housing, whereas unassisted renters with similar family income could confront increases in housing costs relative to their income.

An argument against implementing this option is that housing costs for most renters who currently receive assistance would rise, and even a modest increase in rent could be difficult to manage for households with very low income. In addition, by increasing the proportion of income that tenants are required to pay in rent, the option would reduce some participants' incentive to increase their income by working more.

Discretionary Spending—Option 35

Function 700

End Enrollment in VA Medical Care for Veterans in Priority Groups 7 and 8

(Billions of dollars)	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total		
											2012–2016	2012–2021	
Change in Discretionary Spending													
Budget authority	-5.6	-5.9	-5.9	-6.1	-6.2	-6.4	-6.6	-6.8	-7.0	-7.2	-29.7	-63.7	
Outlays	-5.0	-5.8	-5.9	-6.0	-6.2	-6.3	-6.5	-6.7	-6.9	-7.1	-28.9	-62.4	
Change in Mandatory Outlays	2.8	3.0	3.1	3.2	3.3	3.4	3.5	3.7	3.8	3.9	15.4	33.7	

Note: Discretionary savings accrue to the Department of Veterans Affairs; increases in mandatory outlays are projected for the Medicare and Medicaid programs and for federal subsidies to participate in health insurance exchanges.

Veterans who seek medical care from the Department of Veterans Affairs (VA) are enrolled in one of eight priority-care groups that are defined on the basis of income, disability status, and other factors. Veterans in priority group 8 do not have service-connected disabilities, and their annual income or net worth exceeds both VA’s means-testing thresholds and VA’s geographic income thresholds, which are updated annually. Veterans enrolled in priority group 7 have no service-connected disabilities, and their income is above the VA’s means-testing threshold but below the VA’s geographic index. About 2.3 million veterans who are currently enrolled in the VA health care system have been assigned to priority groups 7 and 8; not all of those veterans seek medical care from VA in any given year.

Although veterans in those groups pay no annual enrollment fees, they make copayments for their care; if they have private health insurance, VA bills those insurance plans for reimbursement. Copayments and private-plan billings cover about 18 percent of the cost of those veterans’ care. In 2009, VA incurred \$4.4 billion in net costs for those patients, or about 11 percent of the department’s total appropriations for medical care (excluding the medical care collections fund, in which amounts collected or recovered from first- or third-party payers are deposited and used for medical services for veterans). When the priority system was established in law in 1996, the Secretary of the Department of Veterans Affairs was given the authority to decide which priority groups VA could serve each year. By 2003, VA could no longer adequately serve all enrollees, prompting the department to cut off new enrollment of veterans in priority group 8. Veterans who were already enrolled were allowed to remain in the program. VA eased that restriction in 2009

to allow some additional enrollment of priority group 8 veterans.

This option would close enrollment for priority groups 7 and 8 and cancel the enrollment of all veterans currently in those two groups. Such action would curtail VA’s health care spending for veterans who do not have service-related medical needs and who are not poor. To be eligible for VA medical services under this option, a veteran would have to qualify for a higher priority group by demonstrating a service-connected disability, by documenting income and assets that were below the means-testing thresholds, or by qualifying under other criteria (such as exposure to Agent Orange, status as a Purple Heart recipient or a former prisoner of war, eligibility for Medicaid, or catastrophic non-service-connected disability).

Disenrolling all priority groups 7 and 8 veterans would reduce discretionary outlays on net by almost \$30 billion between 2012 and 2016 and by about \$62 billion between 2012 and 2021. Those estimates reflect the assumption that appropriations would be reduced accordingly. However, because this option would result in greater use of other government health care programs, implementing the option would increase mandatory spending for Medicare and Medicaid and for federal subsidies provided through health insurance exchanges by about \$15 billion between 2012 and 2016 and by \$34 billion between 2012 and 2021.

An advantage of this option is that it would refocus VA’s attention and services on its traditional group of patients—those with the greatest needs or fewest financial resources. Higher-income veterans without service-connected disabilities gained access to the VA system only in the mid-1990s, when the federal budget was under less

strain and experiencing less demand for services by higher-priority veterans. In 2007, 90 percent of enrollees in priority groups 7 and 8 had other health care coverage, most notably Medicare and private health insurance. As a result, the vast majority of the veterans who would lose VA coverage under this option would have continued access to other sources of coverage, and veterans without other health insurance options could be eligible to obtain coverage through health insurance exchanges in future years.

A disadvantage of the option is that veterans enrolled in priority groups 7 and 8 who have come to rely on VA for at least part of their medical care might find their health care disrupted by the change in enrollment rules. Some of those veterans—particularly those whose income was just above the income thresholds—might have difficulty identifying other sources of care. In addition, because of the relatively low out-of-pocket cost to veterans for VA health care, veterans switching to alternative sources of care might pay more than they would have paid at VA.

RELATED CBO PUBLICATIONS: *Potential Costs of Veterans' Health Care*, October 2010; Statement of Allison Percy, Analyst, Congressional Budget Office, before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, House Committee on Appropriations, *Future Medical Spending by the Department of Veterans Affairs*, February 15, 2007; and "Potential Growth Plans for Medical Spending by the Department of Veterans Affairs," attachment to a letter to the Honorable Larry E. Craig, July 14, 2006