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What dominates: budget policies or political agreements?

The influence of fiscal institutions on health care policy in the United States and the Netherlands

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The influence of fiscal institutions on health care policy in the United States and the Netherlands

Drs. Christiaan Schakel, Dr. Patrick Jeurissen, Prof. Sherry Glied, PhD

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1. Summary

Over the past decades, spending on health entitlements has constituted a growing share of the national budgets of countries within the OECD. OECD countries struggle with this development as this spending directly competes with other public programs and limits the spending power of individual taxpayers. Fiscal rules and other budget policies aim to control public spending and limit government deficits. In this paper, we assess existing budget policies for health entitlements for the US and the Netherlands on the basis of the budget process for fiscal year 2014. We look at Medicare in the US and all expenses under the Budgetary Framework for Health Care (BFH) in the Netherlands. We want to know which factor, budget policies or political agreements, has greater influence in determining health care expenditure policies. To this end we examine the importance of budget rules, budgeting timeframes and the way in which budget policies channel the choices politicians make.

Our evidence shows that for FY 2014 both in the US and the Netherlands the prevailing fiscal rules, which set numerical limits on budgetary aggregates, were complied with. In the US, as a consequence of the Budget Control Act of 2011, a set of automated austerity measures was triggered. Medicare spending was subject to a 2% across the board budget cut. In the Netherlands, the disciplinary budget rules triggered the adoption of an additional reduction package of €6 billion, of which €1.2 billion was health related. The procedural rules however, were not adhered to. In the US, the Pay-as-you-go rules, which enforce budget neutrality of new legislation in the medium to long term, were sidelined. In the Netherlands, the decision making process was not completed in the spring as the procedural rules prescribe, but took place all through the year. In addition, the budgetary caps were readjusted, while normally they are fixed for the full government term. Our conclusion is that budget rules seem to be effective, inasmuch as short-term deficit reduction is the goal. They seem not to be an effective instrument to balance health austerity measures against budget cuts in other spending areas, or to provide a balanced trade-off between short and long-term fiscal goals.

The use of comprehensive spending reviews, which develop savings measures based on the systematic scrutiny of baseline expenditure, has caught on in OECD countries since the onset of the financial crisis of 2008. In the Netherlands, there is a strong tradition of using recurrent spending reviews, although the most influential ones are those prompted by a period of economic downturn and the need for austerity measures in the medium to long term. In those instances, they have been highly influential in determining a new coalition agreement. In the US, spending reviews are less common, although there are advisory bodies that assess baseline expenditures, project expenditure trends and formulate savings options from policies that would alter the baseline projections. Although these advisory bodies have had some direct influence in the past, their position in the budgetary process is different and less obvious than in the case of the Netherlands.

2. Introduction

Over the past decades, spending on health entitlements has constituted a growing share of the national budgets of countries within the Organisation for Economic Co-operation and Development (OECD). OECD countries struggle with this development as this spending directly competes with other public programs and limits the spending power of individual taxpayers. Although in most countries health cost growth has stagnated or even decelerated since the beginning of the financial crisis in 2008, recent data show a moderate incline in growth rates since 2010, though even the new rates are considerably lower than pre-crisis growth rates.[1] Governments use budget policies and rules to put a framework and limits on how these challenges are addressed, but the rules themselves are still an understudied area among health policy scholars.[2] Thus it is of interest to know whether and how the design of budget rules and policies has contributed to health care cost containment. In this paper, we compare budget policies for the United States and the Netherlands and their effects through an analysis of the budget process and outcomes for fiscal year (FY) 2014.

Controlling public expenditure has become a more prominent issue as a result of the financial crisis of 2008. A study by the International Monetary Fund (IMF) shows that since the crisis, the number and comprehensiveness of fiscal rules and related measures to curb public expenditure has multiplied in both emerging and advanced economies.[3] These rules vary by country and have developed historically with path-dependent trajectories.[4–6] Countries within the European Monetary Union have been under scrutiny of a strict budgetary framework, the so called European semester. Other OECD countries have their own combination of laws and regulations that aim to control or lower the public deficit. Over the past years, some governments were more successful than others in taking necessary austerity measures and controlling public debt.[7]

Fiscal rules aim to discipline public spending in order to counterbalance the occurrence of a deficit bias; a tendency of policy makers towards expansionary policies which increase the budget deficit. This is a widely observed phenomenon throughout the OECD.[8,9] Some evidence reveals a positive correlation between the existence of fiscal rules and fiscal performance, which supports the premise that fiscal rules can contribute to the control of government deficits.[10–12] There is however additional literature that argues that the use of fiscal rules alone is not sufficient to attain fiscal discipline.[3,13–16] Some writers within this literature argue that fiscal rules can work if they are accompanied by a supporting institutional framework, such as independent forecasting agencies. We therefore adopt a broader approach and describe budget policies that entail the institutional, fiscal and procedural mechanisms that aim to contribute to a transparent, efficient and adequate distribution of resources. We define these budget policies as the composite of:

1. *Existing budget rules*, comprising of procedural and fiscal rules;
2. *The use of expenditure ceilings and budget forecasting*; and
3. *The use of spending review mechanisms.*

We briefly describe each element for both countries, focusing on Medicare in the US and the health expenses under the Budgetary Framework for Health Care (BFH) in the Netherlands. The budget process

for FY 2014 is central to our analysis. This particular budget process is of interest because in this year both administrations implemented a set of additional austerity measures to lower the deficit.

A comparison between the US and the Netherlands is of particular interest, because both countries have a relatively expensive health system. In both countries health care is largely an individual entitlement – providers are not employed by the government – and spending reductions are accomplished by eliminating covered services or raising cost-sharing, or by changing provider payment rates or budgets.[8] Global budgets – common among NHS types of health systems – hit constitutional and legal challenges. For this reason, it is even more important to have effective budget policies in place.

Large differences exist between the institutional settings in these two countries, which root in historical and cultural differences. Federal health care insurance programs in the US are primarily aimed at the elderly (Medicare) and the indigent and disabled (Medicaid) whereas the Netherlands bears universal coverage and community rated premiums. The budget process is also notably different in both countries. In the US, decision-making is politicized and often incremental, with both the executive branch and the legislature playing key roles. In the Netherlands, coalitions of political parties form a Cabinet, and a coalition agreement determines government policy for a period of four years. The influence of the States-General (the composition of the Senate and House of Representatives) on the budget process is much more limited than of the US Congress, although in recent years a minority government was forced into political alliances with non-governing parties, opening up this process. This heterogeneity makes a comparison at the institutional level interesting.

This brings us to the following research questions. Do budget rules matter in the context of health care policy? What is the right timeframe when budgeting for health? Do budget policies channel the type of health budget cuts that are adopted?

The structure of this paper is as follows. In chapter three, the focus and limitations of the paper will be discussed. Chapter four provides the framework by which the budget allocation process for health care entitlement programs will be analyzed. Chapter five and six describe health care budgeting in the US and in the Netherlands. In chapter seven, an analysis of the health care budget process and outcome of both countries will be provided for fiscal year 2014. Chapter eight will discuss the spending review mechanisms that influenced the budget preparation process. Chapter nine, ten and eleven will discuss our research questions, after which the paper will be concluded in chapter twelve. Chapter thirteen provides a Dutch summary.

3. Focus and limitations

The focus of this paper is on the expenditure side of the health care budget. As a result, we primarily discuss budget rules that cover the expenditure side of the budget.

We concentrate primarily on Medicare entitlement expenditures in the US and expenditure under the Budgetary Framework for Health Care (BFH) in the Netherlands. We choose Medicare, because it is the only strictly federal health program, which increases comparability with the health care setting in the Netherlands. In our subdivision of budget policies, we limit ourselves to spending reviews. This means we leave out organizations that perform oversight and accountability activities. Although these

organizations often have an impact on the fiscal performance of health systems, we regard this impact as indirect and less intertwined with the regular budget process.

FY 2014 is of particular interest because in both countries the budget process leading up to that year was dominated by a deficit reduction agenda, which led to the enactment of a set of austerity measures (Netherlands) or automatic reductions (sequester in the US). In some ways this year was less representative; most provisions under the Affordable Care Act (ACA) phased in, which led to considerable political turmoil in the US Congress, while the debate in the Netherlands was dominated by the Euro crisis.

The starting point for the analysis is the Budget of the US government (from here on: the President's budget) and the Dutch Cabinet budget, released in April 2013 and September 2013 respectively. Any subsequent changes that have influenced the FY 2014 budget and out-years are included in the analysis, as subsequent modifications determine the final outcomes of the established budgetary control procedures.

4. Health systems in perspective

To get a better understanding of the country specific institutional setting, we briefly provide a typology of existing health systems. There are two main categories. There is a national health care system in which health care expenditure is an integral part of the central government's budget. In this system, health care is financed mainly through tax revenues. This is referred to in the literature as a Beveridge type system. The other type of health system is a social insurance system, in which there is a separate stream of funds dedicated to health care which is financed by employers and employees through payroll deductibles. This is called a Bismarck type system. In practice, you will find that most countries have adopted elements of both in their health systems.[17]

Another useful classification is that of Private Health Insurance systems (PHIs) which include several OECD countries and notably the US. These systems are largely market driven and usually more expensive. There is a higher level of uninsured and there is generally more waste due to overutilization of services.[18] Although the US is expanding health insurance coverage and reducing the number of uninsured, market forces remain central to its health care delivery system. One consequence of which is that the US government may have a weaker negotiating position with health care providers and private insurance companies.

Central governments' budgets are typically divided into discretionary and mandatory expenses.[19] Discretionary spending usually is annually appropriated by the legislature, whereas mandatory spending is not. Mandatory spending or 'direct spending' is in principle controlled by legislation that establishes the eligibility criteria and payment formulas, rather than by annual appropriations. Entitlement programs are a form of mandatory spending. The spending level of an entitlement program is determined in large part autonomously and demographic and economic conditions are the most important drivers. Thus, controlling health care expenditure in countries that run predominantly mandatory systems is more difficult.[20]

4.1 The budget process

The budget process normally consists of three distinct phases: 1) budget formulation, 2) budget authorization or adoption and 3) budget execution. The design and length of these phases differ between countries, depending on the level of centralization of government, the status of the budget (i.e. whether the budget is a budget proposal or proposed law) and the (formal) role of the legislature in the budget process. In a presidential system for example, the legislature has a bigger role in the formulation process than in a parliamentary system, generally reflected in a lengthier budget formulation and authorization phase.[21]

The beginning of every budget process requires a budget proposal to be developed or formulated. Generally, on the basis of the most recent macroeconomic assumptions, revenues and expenditure ceilings or projections are updated. Budget policy proposals (cutbacks or policy initiatives) are incorporated. Typically, the process of budget formulation entails a period of several months during which line agencies negotiate with the Central Budget Authority (CBA) on their individual budgets. This Authority is typically part of a Ministry of Finance. In the US, the CBA is part of the Executive Office of the President. Depending on a country's institutional framework, the process for discretionary and mandatory spending can differ. First, there is variation in terms of the level of comprehensiveness of the budget (the number of line items in the budget) and the level of detail of aggregate ceilings. Some countries may use one aggregate ceiling for the total level of government expenditures whereas other countries have separate ceilings for individual line items, ministries, or even at the level of government programs. Second, in health systems with private providers and insurers, ministries of Health often rely on third-party providers for information on health care expenditure, which can severely delay reporting.[20] Such time lags severely limit the ability to recoup any overruns because the overrun is not even recognized until late in the budget cycle or often not until the budget cycle is over.

For a budget to come into effect, it must be authorized. This can either be by authorizing the making of separate appropriations or by adopting the entire budget. The authorization of mandatory spending usually follows a distinct trajectory, as these funds find their origin in separate laws. Most entitlement laws are open-ended, which means that restrictions on the level of spending are less self-enforcing.[22]

The final stage of the process is budget execution. During this phase, governments execute the budget within the predefined limits of the appropriated funds and/or baseline projections. During a fiscal year, the executive power usually reports to the legislature on the status of the budget which may result in a request for additional funding or (in the US) supplemental appropriations.

4.2 Budget rules

Studying budget rules is important because they can directly shape the outcome of health care policies. They limit room for maneuver for politicians and policy makers in various ways. We define a budget rule as either:

1. *a procedural rule* that establishes procedures for the budget process, or;
2. *a fiscal rule* that imposes a (long-lasting) constraint on fiscal policy through numerical limits on budgetary aggregates'.[3]

Procedural rules promote fiscal transparency and support the fiscal process. They define reporting requirements on fiscal outcomes or dictate how to achieve fiscal targets. In this way, they can act as safeguards that ensure budget process dilemmas are not simply solved by increasing the budget deficit.[16] Examples are the use of sectoral budgets with separate spending caps, or a prescribed timeframe in which additional costs have to be offset by savings.

Fiscal rules, on the other hand, place budgetary caps on the medium-term expenditure framework. Table 1 provides us with a breakdown of the characteristics of fiscal rules, as put forward by the IMF.[3]

Table 1 – Characteristics of fiscal rules

Characteristic	Description
Legal basis	The legal basis for a fiscal rule can either be statutory or based on a political commitment or coalition agreement.
Coverage	Coverage describes the extent to which a government program or outlay is subject to a certain fiscal rule.
Escape clauses	Escape clauses can sideline fiscal rules under particular circumstances.
Automatic corrections	Automatic corrections lower public spending / debt by a standard formula, within a pre-defined timeframe.
Enforcement mechanisms	The extent to which an external body monitors and enforces compliance with fiscal rules.

Together, these characteristics determine the individual strength of fiscal rules and their ability to effectively control public spending. It must be noted however, that the real world success of fiscal rules to a large degree depends on the willingness of politicians to comply with them. Schick (2003) states that '[fiscal] rules fortify politicians who want to be fiscally prudent, but they do not stand in the way of those who are determined to spend more or tax less than the rules allow'.[8(p28)] It is not necessarily true, according to Schick, that stricter and more imposing fiscal rules are more successful in attaining fiscal discipline. This argument is supported by others who question the effectiveness of fiscal rules as a depoliticized policy framework.[15,23,24] We are therefore interested to see to what extent fiscal rules are respected in the context of budgeting for health entitlements.

4.3 Budget forecasting and expenditure ceilings

Budget forecasting is a tool to monitor fiscal sustainability. It promotes timely budget decisions and the application of politically difficult cost containment measures as an offset for developing deficits. Since in both countries outlays of health entitlement programs are in large part determined by the

health system, outside of the usual spending controls of the legislative bodies, the health policy process relies greatly on closely monitoring the budget forecasts of these programs in the medium to long term.[25] Since the introduction of entitlement programs there has been a steady rise in these programs as a percentage of the total budget. In the US, spending on social security and major health care programs made up some 50% of the federal budget in 2014. In the Netherlands, this was almost 60%.[26,27]

The preparation of fiscal projections generally takes place within Finance ministries or agencies.[28] In some countries, independent bodies compile the budget forecast, or independent fiscal councils assess the overall fiscal policy, evaluate budget transparency and the quality of the forecasts. Although the IMF considers the independence of fiscal agencies that project and monitor fiscal outturns an important feature, it acknowledges that poor fiscal outcomes may persist despite this feature (perhaps because of poor implementation).[3]

Within most OECD countries it is nowadays common to use some sort of multi-year expenditure ceiling or global budget for health care. These budget ceilings can vary from indicative multi-year ceilings or budget targets, to fixed multi-year aggregate ceilings. There is however no convincing evidence that fixed budget ceilings alone are an effective instrument for cost-containment and they are often complemented by other institutional mechanisms.[25]

4.4 Spending review mechanisms

Strong budgetary procedures and rules support governments in their task of making accurate and timely decisions in order to keep overall expenditure levels in line with goals. It is of equal significance to systematically evaluate spending under the baseline expenditure level as well. This process is called spending review, which has gained popularity among OECD countries.

We follow Robinson (2013) in defining a spending review as:

> '[…] the process of developing and adopting savings measures, based on the systematic scrutiny of baseline expenditure'.[29(p3)]

Spending reviews have become more common since the onset of the financial crisis of 2008. In countries such as the United Kingdom, Canada and the Netherlands there has been at least one comprehensive review that identified an array of savings options for their national governments. Robinson argues that the budget preparation process focuses too much on new policy proposals, rather than on reviewing baseline expenditures. Spending reviews attempt to counterbalance this and strengthen the overall process.

Two forms of spending reviews can be distinguished; efficiency reviews, which focus on savings through improved efficiency, and strategic reviews, which focus on savings achieved by reducing services or transfer payments. Robinson argues that spending reviews should be an integral part of the budget process; in this way new spending proposals and savings options can be assessed simultaneously, and the spending review will reflect the specific budgetary objectives of a government.[29]

5. Health care budgeting in the United States

The US health care system is fragmented. One the one hand, it contains elements of a social insurance system; the two largest government funded programs Medicare and Medicaid are funded through payroll taxes, premiums and federal and state tax revenues. On the other hand, it is a largely market-driven Private Health Insurance System (PHI). Medicare and Medicaid costs made up 38% of total health care expenditure in 2013 and represent about 24% of federal, non interest expenditure.[30,31] Regulatory instruments however influence both the public and the private health care system. As a result, boundaries between both systems have increasingly blurred.[18]

Medicare is a social insurance program that provides health care coverage for elderly and persons with a disability. The program was enacted in 1965 and it gradually expanded into what it is today; a comprehensive social insurance program that finances health care costs for patients in inpatient and outpatient settings, in home health care settings and nursing facilities and pays for prescription drugs. With the expansion of the program, associated spending per beneficiary increased from $385 in 1970 to $12,210 in 2013.[32] The program is funded through two funds; the Hospital Insurance (HI) Trust Fund and the Supplementary Medical Insurance (SMI) Trust Fund, which are financed distinctly. The HI Trust Fund is financed through payroll deductions which occur independently under current law. The SMI Trust Fund is financed on a pay-as-you-go-basis; beneficiary premiums and general revenue income are adjusted by actuarial projections to cover the following year's costs.[33] An aging population, expanded coverage and Medicare expenditure growing at a faster rate than the US GDP have caused increased concern that the HI Trust Fund will be depleted in the near future[a].

Medicaid provides health care coverage for low-income individuals and families. It is an assistance program administered by the states, under federal guidelines and rules which the states must follow in order to qualify for federal matching funds for their Medicaid program expenditures. The federal share in spending for Medicaid is approximately 60%. States have considerable discretionary authority over benefits and eligibility levels for Medicaid.

The Affordable Care Act (ACA) of 2010 has increased access to health care, both by expanding eligibility for existing programs such as Medicaid and CHIP and by providing subsidies for new insurance coverage for low income individuals not covered by their employers to be purchased through newly established health care insurance exchanges at the state-level which assure the new policies meet minimum standards. The subsidies take the form of refundable tax credits that can be applied to premiums, and cost-sharing subsidies to reduce out-of-pocket-expenses such as deductibles and co-payments. People generally qualify for tax credits if their income is between 100 and 400% of the poverty level, provided they do not qualify for health coverage that meets minimum federal standards through an employer or an existing government administered program.[34] At the same time, the ACA attempts to increase the efficiency of the health care delivery system, for example, by restructuring Medicare's reimbursement policies (e.g., reduced payments to hospitals with high readmission rates) and other provisions designed to stimulate coordinated care.

[a] An additional concern is the strain on the federal budget as a result of growing expenses and related increased general revenue income under the SMI fund; the Board of Trustees estimates that SMI's general revenues of 1.4 percent of the GDP will equal 3.3 percent in 2088 under the projected baseline.

Baseline projections for Medicare and Medicaid are drafted by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), which in turn are incorporated into the President's Budget, drafted by the Office of Management and Budget (OMB). The Congressional Budget Office (CBO) releases its own projections for the purpose of the Congressional phase of the budget process. OMB-projections are based on payment update formulas for different categories, such as hospital inpatient and outpatient stays, and physician fees. This latter category is based on the Sustainable Growth Rate (SGR), a statutory formula aimed at controlling health care costs by aligning physician payment schemes with GDP projections[b]. Congress has consistently overridden the SGR since 2002 with temporary fixes, arguing that the formula is flawed and payment schemes under the SGR do not reflect actual physician costs. In April 2015, Congress adopted H.R. 2, the Medicare Access and CHIP Reauthorization Act (MACRA), which includes a permanent replacement of the SGR formula with a 0.5% update from 2016 through 2019 and two new performance based mechanisms from 2019 through 2025. Costs for the bill are partly offset by increasing Medicare premiums for part B for high income seniors and reducing the updates for certain providers of post-acute care, long term care services and hospital inpatient services.

5.1 The budget process

The federal budget process consists of two consecutive stages. At the outset of the process, the President submits his budget to the Congress. The next stage is the Congressional Budget Process, in which the Senate and House of Representatives consider the President's budget and underlying budget proposals in plenary sessions and numerous subcommittees. Finally, federal spending is authorized, either through the appropriations process or by the authorization of law for entitlements.

5.1.1 The President's Budget

Preparation for the President's Budget starts each year in spring, when OMB sends planning guidance to line agencies. This is about eighteen months before the start of the fiscal year. The following months are dominated by budget formulation within line agencies and budget negotiations with OMB. The Office of the Actuary within CMS constructs a baseline projection, using an actuarial model that estimates the increases in utilization, case mix and price by type of service, and formulates policy initiatives in close cooperation with the Department of Health and Human Services (HHS). The budget formulation process ends when the President, in accordance with provisions in the Budget and Accounting Act (BAA) of 1921, submits the budget to the Congress at the beginning of February of the following year. Budget totals in the President's budget usually account for a ten year window.[22] The President's budget is above all a budget proposal; it does not appropriate funds directly. Congressional action is essential for any funds to be appropriated or laws to be drafted or amended.

5.1.2 The Congressional Budget Process

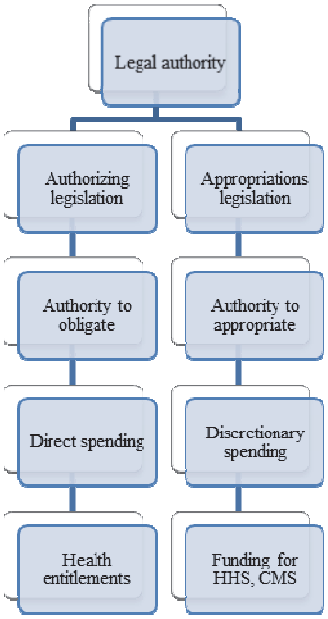
Shortly after receiving the President's budget, Congress starts working on a budget resolution containing a fiscal framework with budget aggregates and specific reconciliation instructions for revenue legislation, direct spending laws, or other provisions relating to the budget.[22] This budget resolution is

[b] The SGR is calculated based on: Medical inflation, projected growth in the domestic economy, projected growth in the number of beneficiaries in Fee-For-Service Medicare and changes in law or regulation (cms.gov).

drafted in the House and Senate Budget Committees and is considered a concurrent resolution, meaning that it is not law and that there is only a majority vote in Congress required. In recent years it is has repeatedly occurred that a budget resolution did not pass Congress, due to disagreement on its content.

To facilitate the Congressional budget process, the Congressional Budget Office (CBO) sends an analysis of the President's budget to Congress. In this report, CBO provides its own baseline projection of projected federal outlays and revenues, under current law. Every January, CBO releases its *Budget and Economic Outlook*, containing an economic forecast and projections of outlays and revenues under current law for the next ten years. The Outlook is updated in August. In addition, CBO annually prepares a *Long-Term Budget Analysis*, containing a forecast for the next 25 years.

Figure 1 – Legal framework for the federal budget process



Congress funds federal agencies and programs in two distinct ways; one leads to authorizing legislation, which establishes a legal basis for an agency or program, the other leads to the appropriation of funds, which enables agencies to incur obligations and expenditures[22]. This distinction is relevant because depending on the type of legislative action, distinct Congressional committees have the lead role in drawing up the legislation. Appropriations committees are in charge when it comes to discretionary spending, authorizing committees in the case of direct spending. In practice this can lead to remarkable budget practices, for example with the implementation of the ACA which affected both mandatory and discretionary spending. It affected mandatory spending because eligibility criteria for Medicare and Medicaid were changed, and health exchanges were created. It affected discretionary spending, because the government agencies most affected by the new law, CMS and the Internal Revenue Services (IRS) requested additional funds to be able to implement the new law. Congress however did not appropriate these funds, thus CMS had to utilize funding from other discretionary accounts, as well as funding from two mandatory accounts, which provided special trust fund dollars for initial implementation of the ACA to federal agencies.[35]

5.2 Budget rules

There are a large number of Congressional Acts that have governed the US federal budgeting process in recent decades. Some of them were more successful than others in addressing fiscal discipline.

The literature on federal budgeting considers the Balanced Budget and Emergency Deficit Control Act (BBEDCA; 1985), commonly referred to as the Gramm-Rudman-Hollings Act (named after their Congressional sponsors) as the first notable attempt to balance the budget, against the background of rising federal debt. It established fixed deficit targets for the federal budget and instituted a process of automatic spending cuts (sequestration). However, taking into account the development of the budget deficit in those years, the GRH-Act was not very effective, which some argue is attributable to its flawed design: it relied on projected deficits rather than actual deficits, which led 'to manipulation of budget estimates and bookkeeping tricks'.[22(p22)] The need for fiscal rules and fiscal discipline was however established, and the GRH-Act was soon to be superseded by the Budget Enforcement Act (BEA; 1990). The BEA made a distinction between discretionary spending, placing budgetary caps on the annual appropriations process, and introduced 'PAYGO-rules' (Pay-as-you-go) for revenues and direct mandatory spending. The latter encompassed the rule that all revenue and mandatory spending legislation must be either budget neutral or offset by appropriate budgetary measures. The BEA and statutory PAYGO-rules expired in 2002, although Congress applied its principles on an ad hoc basis between 2002 and 2010 (rule-based PAYGO).

Two dominant budget rules currently apply in the US context. The first one is a procedural rule, the second one is a fiscal rule. In 2010, the Obama-administration reenacted the statutory Pay-As-You-Go-Act. At the end of each Congressional session, the Office of Management and Budget (OMB) calculates the net costs on a five- and ten-year PAYGO scorecard. If either scorecard shows net costs in the budget year column, the President is required to issue a sequestration order, targeted at a select group of mandatory programs in an amount sufficient to offset the net costs on the PAYGO scorecard. This means that there is an imperative not to overspend in areas of the federal budget where the PAYGO rules apply, and to balance costs and savings close to the budget year. The PAYGO rules additionally state that Congress cannot use time shifts to avoid PAYGO.[36]

In an effort to strengthen overall fiscal policy, the Budget Control Act (BCA) was introduced in 2011. The Act placed a cap on discretionary spending and enforced an automatic spending reduction process (sequester) of $1.2 trillion, unless new legislation was adopted to prevent it. Medicare was subjected to a one-time 2% across the board budget cut, whereas Medicaid and a number of other federal programs were exempt from the sequester. A joint committee was created to put forward a bill that included the required spending cuts. The BCA stated that only a majority vote was needed to pass the joint committee bill. The committee however failed to come up with a bipartisan agreement on budget cuts, thus leaving the sequester in place.

5.3 Budget forecasting and expenditure ceilings

Both the Office of Management and Budget (OMB) and the Congressional Budget Office provide ten year expenditure and revenue projections. For its projections of health entitlement programs, OMB

turns to the Center for Medicare and Medicaid Services (CMS). The President's budget contains baseline projections for Medicare and Medicaid and the budgetary implications associated with proposed policy changes of those programs. CBO constructs its own baseline projections and assesses the budget proposals in the President's budget. CBO was created in 1975 as a non-partisan Congressional advisory body outside the executive branch, to counterbalance the hegemony of OMB in providing budgetary assumptions and to challenge their overall policy analysis. Although there is general consensus that the creation of CBO has enhanced the quality of fiscal policy in the US, there is in fact little evidence that supports this view. Some point to the fact that having two distinct scoring agencies in place contributes to scoring rivalry and divergent fiscal projections in order to support the policy position of their political principal.[22] Evidence from others suggests that the quality of OMB's fiscal projections has deteriorated since the creation of CBO.[37]

The applied methodology by CBO and CMS for the ten-year budgeting window for health entitlements is largely similar. There are however small differences. First, they use different economic assumptions. CBO can for instance apply more moderate assumptions with regards to the rate of inflation or unemployment. In part this has to do with timing; the President's budget is sent to Congress in February, whereas CBO publishes an analysis of the President's budget in March, drawing on revised baseline projections that were constructed in January. Second, there are technical differences which are not attributable to different economic projections. The Administration has, for example projected a more rapid growth in Medicare spending per beneficiary in its FY 2014 budget than CBO.[38(p15)]

Finally, OMB and CBO baseline projections can differ because they apply different assumptions to baseline projections. For example, in past President's budgets it was assumed that the SGR-problem in Medicare would be effectively addressed by Congress. OMB's baseline projection would therefore include a 'fix' to this problem, without appropriating the necessary funds. CBO on the other hand would argue that the baseline projection should include the revised payment rate for physicians. As the President's budget did not free-up the necessary funds for this policy proposal, CBO would add the additional funds necessary to effectively fix the SGR to the baseline.

In addition to different baseline projections, there can also be disagreement on projected savings within the President's budget; in CBO's analysis of the budget, CBO often has a distinct appreciation of policy changes which leads to different (often lower) projected savings (table 2).

Table 2 – Differences in forecasting methodology and baseline construction CBO and OMB/CMS

Type	Description
Macro-economic assumptions	Different projection of macro-economic variables such as the employment rate or overall growth of the economy.
Technical assumptions	Different non-economic assumptions, such as growth rate of Medicare spending per beneficiary.
Timing of the forecast	There is a time lag of several months between President's budget and CBO's assessment.
Baseline	OMB includes different items in the baseline projection than OMB/CMS.
Savings options	Different assessment of the budgetary effects of savings options.

Although political opportunism is lurking in projecting future outlays that are inherently uncertain, both institutions have a reputation to uphold. OMB has to uphold the integrity of the budget process, while at the same time serving the interest of the President's agenda. CBO on the other hand, should warrant its independence by serving both Democrats and Republicans in Congress, while at the same time providing clarifying analyses of the assumptions in the President's budget. Since its creation 40 years ago, CBO has gained a lot of authority and is nowadays viewed as the 'authoritative source of information on the economy and the budget in the eyes of Congress, the press and the public'.[39]

There are no expenditure ceilings for health entitlement programs in the US, as prevailing budget rules do not contain or enforce any. One argument is that the use of strict ceilings for health entitlements works best in the context of a single payer and universal coverage.[40] Since public health programs in the US only make up 38% of total health expenditure, there is a clear risk of health care providers opting out of a public program when budgetary caps enforce a lower reimbursement rate for services than private insurers. Some, however, would like to enact explicit long-term budgets for Medicare and to reestablish and simplify the PAYGO-rules for mandatory spending programs, as PAYGO-rules are often overridden with respect to these programs.[41]

5.4 Spending review mechanisms

The US has a limited tradition with regards to spending reviews. The CBO does periodically release a comprehensive report that describes an array of policy options, including for Medicare. These reports are however not focused on health exclusively and do not include clear savings targets.

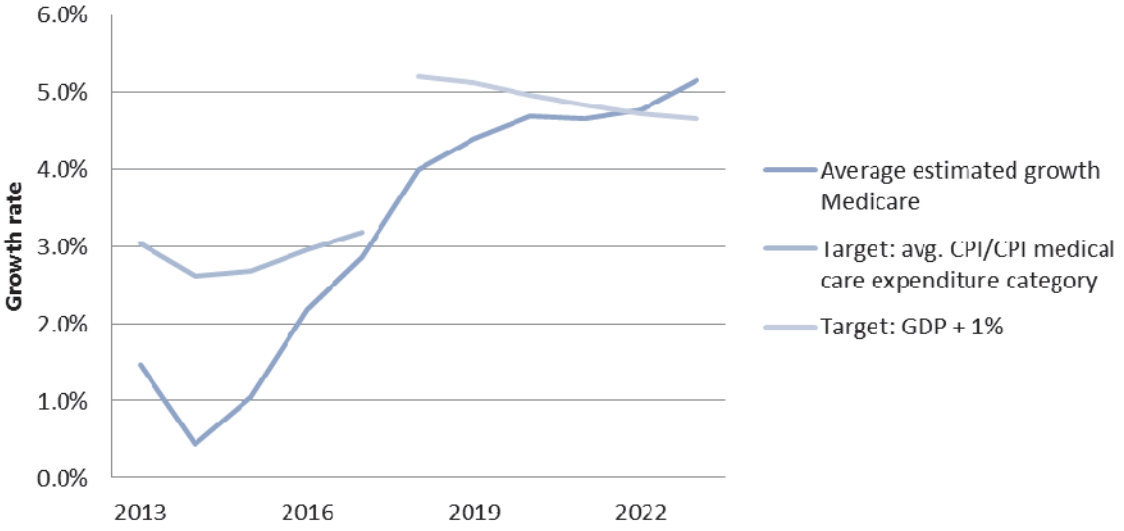
One recent attempt to develop savings measures by means of a comprehensive assessment of baseline expenditure, was the 2010 National Commission on Fiscal Responsibility and Reform. Although their final report lacked the supermajority required to force a vote in Congress, some elements were adopted in subsequent legislation, such as the discretionary spending caps in the BCA of 2011.

We want to mention two entities here that either have influenced the decision making process on Medicare expenditure through the scrutiny of its baseline, or potentially will in the future. The Medicare Payment Advisory Commission (MedPAC) is a Congressional advisory board consisting of seventeen members, established by the Balanced Budget Act (BBA) of 1997. It advises Congress on Medicare payment policies and access to and quality of care, by releasing two reports annually and participating in Congressional hearings. MedPAC not only reports on issues concerning Medicare, but also reviews the effect of payment policies on the delivery of health care services outside Medicare, and is to '[…] assess the implications of changes in health care delivery in the US and in the general market for health care services on the Medicare program'.[42] The main focus of MedPAC's activities however is analyzing the Medicare payment system and proposing changes or updates.

MedPAC's influence on Medicare extends beyond the formal publication of reports and is both direct and indirect. First of all, MedPAC's recommendations on Medicare policy set the tone of the debate, both in the political arena as well as in the media. Their nonpartisan status gives them a high level of credibility on issues concerning Medicare and the US health system as a whole. Second, in addition to its primary outlets (the March and June reports) MedPAC exerts considerable influence through reports that are requested by Congress on specific topics. Third, there is a high level of behind-

the-scenes interaction between MedPAC-staff and politicians and Congressional staff. Often, MedPAC staff previously worked at CMS or on Capitol Hill. MedPAC has consistently advocated the repeal of the SGR, until its replacement in 2015.

Figure 2 – IPAB determination under current law



The Independent Payment Advisory Board (IPAB) was created as a part of the ACA in 2009. It is to be composed of fifteen independent health care experts, appointed by the President, who will make recommendations on health care savings in the event of projected Medicare expenditure exceeding a specific target (see figure 2). For the determination years 2013 through 2017, the target growth rate is the average of the growth of the Consumer Price Index (CPI) and the medical expenditure category of the CPI. For 2018 and later years, the target growth rate is set at the GDP per capita plus one percent.[33] As figure 2 highlights, the first year when the average growth of Medicare is forecasted to exceed the target is 2022.Their recommendations are binding, unless the Congress adopts legislation to change them. The constituting law (Social Security Act Sec. 1899A) specifically prescribes that 'the proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums […], increase Medicare beneficiary cost sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.' The recommendations are rather aimed at 'improving the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement'.

The IPAB was specifically designed as a backstop. Its members have not been appointed and it has not produced any recommendations as a result of the declining rate of the growth in health costs since the introduction of the ACA.

Both MedPAC and the IPAB address one part of the definition of a spending review, as both formulate savings measures, based on the systematic scrutiny of baseline expenditure. There is a distinction to be made here. MedPAC has a broad mandate and systematically advises Congress on payment policies and the access to and quality of care. It is however, for Congress to adopt the recommendations made by MedPAC. IPAB recommendations on the other hand, are binding. IPAB's

assessment of Medicare does not take place systematically; it will only provide recommendations when Medicare spending exceeds projected outlays. In addition, the IPAB has a limited mandate; it cannot make recommendations that reduce Medicare's benefits or impose additional costs on its beneficiaries.

5.5 The US institutional framework

Based on the findings in this chapter, we expect the following:

1. *Procedural budget rules might not be upheld.* Considering that Congress has consistently overridden the SGR over the past years, we expect this will be the case for FY 2014 as well. The costs associated with a possible override are considerable, which raises the question if the PAYGO-rules will be upheld by Congress in this matter.
2. *The US budget process is myopic.* Since there are no (multi-year) expenditure ceilings in place for health entitlements, the timing of possible budget cuts will likely be more towards the end of the ten-year forecasting period.

6. Health care budgeting in the Netherlands

The Dutch curative health care system is as a system of regulated competition[43–45]. There are private health care insurers that are subject to strict regulations which include the obligation to accept everyone regardless of their health status or age group (open enrolment) and to provide them with a community rated (fixed) nominal premium. Insurers and providers compete in terms of volume and price of services and by doing so are incentivized to operate efficiently and contain health care costs. There is a risk-adjustment mechanism in place that compensates for enrollees with high risks. The health care insurance package is legally defined and includes access to primary and secondary care as well as (partial) compensation for drugs and medical appliances. Basis for the curative care is the Health Insurance Act (HIA) of 2006.

Recent policy reforms include agreements with the association of hospitals, curative mental health organizations and general practitioners on a significant reduction of the nominal growth of expenditures. Signatories to these 'health agreements' committed to further efforts to lower curative health costs by reducing bureaucracy, fraud and overtreatment. Last resort of the agreement is a budgetary fine called the 'macro-controlling instrument (MCI)'; if a budgetary overrun occurs, providers need to refund the percentage overrun of their own subsector, standardized by their own market share.[25]

Dutch health care expenditure is fully integrated into the budget of the central government. There are three relevant budget discipline sectors associated with the national budget, which include the State Budget (e.g. expenses for Education, Defense, civil servant salaries), the Budgetary Framework for Social Security and Labour Market (BFS) and the Budgetary Framework for Health Care (BFH). The budget of the Ministry of Health contains both discretionary and mandatory items. Mandatory expenditures are exclusively related to the BFH, whereas discretionary expenditures pertain to the State Budget. The category includes subsidies, expenses for sports policy and childcare.

At the outset of a new Cabinet period, a multi-year expenditure ceiling is determined for each of the three budget discipline sectors. The Netherlands Bureau for Economic Policy Analysis (CPB) constructs a baseline projection for health care expenditure for five years, which the new Cabinet (generally) incorporates into the national budget. Annually, health care projections are updated and confronted with the baseline projection. Information on health care expenditure is indirectly obtained through insurance companies which results in a delay in performance data, although there have been recent efforts to limit this delay. The minister of Health must ensure that updated budget estimates align with the baseline projection. Since the largest part of Dutch health care expenditures are entitlement-based, most budgetary measures cannot be enacted until the following year, which often leads to sudden shortages in the current year that cannot be recouped. Table 3 provides us with a breakdown of the development of the BFH since 2004. It shows recurring budgetary overruns from 2004 – 2012, except for 2007. In 2013 and 2014 realization of BFH-expenditure was below the budget ceiling.

Table 3 – Vertical development BFH-expenditure (in € billion)

Year	Budget	Realization	Overrun (%)
2004	€41.1	€42.6	4%
2005	€41.7	€42.3	2%
2006	€43.5	€44.3	2%
2007	€47.9	€47.6	-1%
2008	€51.4	€51.8	1%
2009	€54.7	€56.4	3%
2010	€57.1	€58.7	3%
2011	€59.7	€61.8	3%
2012	€63.5	€64.0	1%
2013	€65.8	€64.6	-2%
2014	€67.8	€65.1	-4%
Data derived from annual reports 2004-2014, ministry of Health, Welfare and Sports			

6.1 The budget process

The annual budget process starts in December, thirteen months before Fiscal Year (FY), when agencies within the Ministry of Health formulate budget proposals with regards to the discretionary part of the budget. These proposals are assessed by the internal budget authority and agreed upon by the ministers and executive board of the Ministry of Health. In the beginning of March, new information on health care expenditure (the mandatory part of the budget) is received and analyzed, and compared with baseline projections. Around that time, the minister of Finance informs line agencies about the requirements of and the framework for budget proposals and the negotiation process. A 'policy letter' is formulated and sent to the minister of Finance, containing budget proposals with regards to the discretionary and mandatory part of the budget, including a four year outlook.

In the beginning of April there is a bilateral meeting between the minister of Finance and the minister of Health to reach an agreement on the budget proposals. After the bilateral meeting, adjustments to the budget are made and the minister of Finance prepares a 'decision-making memorandum' containing the result of all bilateral meetings with Cabinet members. Successively the

Cabinet agrees on the memorandum and the lion's share of the budget for the Fiscal Year is agreed upon. Over the summer there are slight adjustments to the agreed budget; in July there are limited mutations to the expenditure side and in August, when new information on spending power is available, the revenue side of the budget is agreed upon. On set times throughout the year, the CPB prepares budget outlooks with new macroeconomic assumptions which are incorporated in the budget.

On 'Prinsjesdag', traditionally the third Tuesday in September, the Cabinet sends the budget proposal to the States-General. Information on entitlements is included in the budget, but mainly for informational purposes. Formally, the House of Representatives cannot amend entitlements through the budget law, but only through the respective entitlement law itself. From that moment until the end of December budget deliberations take place between individual ministers and both Chambers. Formally, the House of Representatives has the right to amend respective budget laws, whereas the Senate can only accept or reject an entire law.

After the budget laws have passed both legislatures, FY formally starts on January 1st. Over the last few years it has become common practice that the Senate adopts the budget in the first few weeks of January. The European semester, the budget cycle of the European Commission, requires Member States to provide information on the budget and reform programs already in the spring. In recent years this jeopardized the confidentiality of the budget, as information on the budget was already publicly available over the summer. This has led to a debate on the length of the deliberations in the States-General and the timing of 'Prinsjesdag'.

During any budget year, the government sends regular updates to the States-General on the budget. In spring, an update on the Current Year (CY) is given. In May, the government gives account for the Prior Year (PY). In the fall a second update on the CY is given.

6.2 Budget rules

The most important budget rules in the Netherlands, are the so called 'disciplinary budget rules'. This is a comprehensive set of procedural and fiscal rules that was established prior to the start of the current Cabinet and is valid for the full government term. The basis of the rules lies in the coalition agreement; there is no statutory obligation to comply with them.

Since the beginning of the 1990s, the Dutch budget rules have in large part been based on the same principles. The outline of the budget is decided upon in the spring, so that all overruns, windfalls, policy initiatives and budget cuts can be jointly considered. There is a strict separation between revenues and expenditures in the budget. This is to prevent the possibility that shortfalls on the revenue side have direct repercussions on expenditures and vice versa. It is argued that this 'automatic stabilization' increases the stability of the government's budget and subsequent policies; there is no need for sudden austerity measures in a period of economic downturn. In respect to the health budget, recent literature shows however that there is a noteworthy interaction effect between health expenditure and revenue streams, as downward changes in tax revenue significantly determine health care spending changes, more than changes in the GDP or the political affiliation of the governing party.[46]

Each budget sector has a four-year spending cap in real terms; ceilings are only annually adjusted for inflation, through the average price level development of private and public consumption and

investments. In this manner, annual budget negotiations are not influenced by price fluctuations.[47] The BFH is then annually adjusted for the difference between the general inflation and the actual price development of public expenditures under the BFH. This can result in either a technical overrun or shortfall that has to be compensated accordingly. The mechanism is supported by a covenant with employer organizations that places general wage development for the health care sector in line with the overall market. This feature is comparable to physician- or other updates in Medicare.

Budgetary shortfalls must be compensated within respective budget discipline sectors. In the past this rule has not been observed for health. Since the mid-nineties until very recently there were significant budgetary overruns in health that were compensated by windfalls within the social security framework (BFS) or just accepted as they were. As the overall growth of health care expenditure has slowed down during the past few years, for the first time there have been significant budgetary windfalls which have been used to compensate for other shortfalls or new policy initiatives.

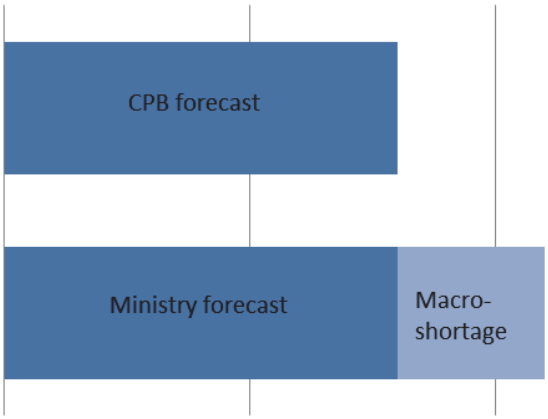
There are no formal enforcement mechanisms in place to ensure compliance with budget rules set out in the coalition agreement. The Dutch Cabinet in tradition is built on consensus, headed by the prime minister who leads Cabinet meetings and is responsible for overall policy formulation but who is functionally a 'primus inter pares'. In practice, during budget negotiations, the minister of Finance and the prime minister are in close contact to ensure compliance with budget rules and the Cabinet's overall policy objectives. The EU Maastricht Treaty of 1993 sets limits to relative budget deficits and the national debt. The Treaty prescribes that the budget deficit can be no higher than 3% of the GDP of a Member State. The national debt can be no higher than 60% of the GDP. If budgetary projections exceed these targets, government reform and the implementation of austerity measures can be enforced by means of the Excessive Deficit Procedure (EDP). Following the recession of 2008, the Netherlands was subject to the EDP from 2009 until 2013. During this period, not only were there budgetary targets set to gradually lower the public deficit, the European Council also made country-specific recommendations for the Netherlands to reform the labor market, pension system and the long-term care (generally defined as care lasting more than one year). The latter included the recommendation in 2011 that the Netherlands should 'prepare a blueprint for reforming long-term care in view of an ageing population'.[48] This recommendation was fulfilled in the 2012 coalition agreement.

6.3 Expenditure ceilings and forecasting

As outlined in the previous paragraphs, four-year expenditure ceilings are drafted by the Netherlands Bureau for Economic Policy Analysis (CPB) and normally adopted by the Cabinet at the outset of a government term. Although the CPB is technically part of the Ministry of Economic Affairs, it is functionally independent and conducts research 'on CPB's own initiative, or at the request of the government, parliament, individual members of parliament, national trade unions or employers federations'.[49]

The medium-term public health expenditure forecast of the current government is based on four determinants: demographic, epidemiologic and budgetary factors, and residual growth. There have been recent efforts to improve the methodology. One possible modification includes the use of 'income' as a determinant for health expenditure growth.

Figure 3 – Macro shortage in Netherlands health care projections



The Ministry of Health constructs its own budgetary forecast, using a bottom-up approach, although this forecast is not published and not used to openly challenge the CPB-forecast. In the past this has frequently resulted in higher forecasted expenditures. The discrepancy between the CPB-forecast and that of the Ministry is called 'macro-shortage' (see figure 3). As a result of this, underlying sectors within the health budget would receive *ex ante* budgetary cuts. In 2011, the Netherlands Court of Audit, an independent government body that scrutinizes the budget and reports on its findings to parliament, conducted an investigation on health expenditure in the Netherlands. It concluded that the translation of the macro-shortage into sectoral health budgets is not transparent. It therefore recommended that both forecasting methods should become publicly available and provided to parliament.[50] The Cabinet reaction was that disclosing the translation of the gross budget into sectoral budgets can jeopardize budget negotiations with the representatives of the health subsectors.

A widely acknowledged challenge with concern to the Dutch health budget is the existing delay in reporting health expenditure to the Central Budget Authority (CBA). Of the participating countries in an OECD survey[c] on budgeting practices for health, the Netherlands together with Switzerland, was the only country that has delays in reporting up to 24 months.[25] An important reason for this is the fact that information on health spending in the Netherlands is staggered; data-collection and analysis takes place at various levels, before it is incorporated into the budget.

6.4 Spending review mechanisms

The systematic use of spending review in the Netherlands has been common practice for quite a number of years.[29,51,52] One example is the use of recurring reviews called Interdepartmental Policy Reviews (IPR). Review committees are membered by civil servants from the Ministry of Finance and the Prime Minister's Office as well as members from other departments. The committee tackles a specific policy field and formulates a number of reform options. The mandate typically prescribes that one policy option should include a 20% reduction in spending and/or tax expenditures. Depending on the budgetary size of the line agency, IPRs are being held once every year to once every few years for

[c] The US did not partake in the survey.

smaller agencies. Most recent reports on health care policies were on Academic Research Hospitals (2012) and transboundary health care (2014). The IPRs are mostly efficiency reviews. This was not the case for the comprehensive spending review reports of 2009/2010; prompted by the economic decline, 20 reports were issued covering a broad range of policy areas, including curative and long term health care. In 2012 a taskforce published the report 'Towards better affordable health care', providing a range of reform options that seek to increase efficiency and engage the health care delivery system in this effort.[53]

The Netherlands Bureau for Economic Policy Analysis (CPB) traditionally analyzes election programs of political parties in the months preceding the elections. In the evaluation of its analysis after the 2012 election, the CPB concluded that assessing health reform options is a lengthy and laborious undertaking, and that evaluating these options separately would improve the analysis. It therefore joined hands in the beginning of 2014 with the Ministry of Finance and the Ministry of Health to form a technical working group 'Zorgkeuzes in Kaart' to analyze possible healthcare policy options for after 2017. Not only would this provide more time for the analysis, it would also allow for the input of external experts. More than 100 policy reform options were analyzed in the area of the curative and long term care, prevention, covered services and out-of-pocket payments. The report provides input for health paragraphs of future election programs and coalition agreement.

6.5 The Netherlands institutional framework

Based on the findings in this chapter, we expect the following:

1. *Procedural budget rules will prompt interaction* between health budget and other spending areas. In the disciplinary budget rules is confined that there is a single aggregate budget ceiling with three budget discipline sectors. We therefore expect tradeoffs between the health budget and other spending areas.
2. *A budget ceiling alone is not sufficient to attain fiscal discipline in the medium to long-term.* Although there is a strict budget ceiling for health expenditure in the Netherlands, previous budgetary rounds have shown that this ceiling was unsuccessful in limiting growth of the health budget to the prescribed ceiling. Additional measures, such as a macro-controlling instrument (MCI) were needed.
3. *Spending reviews can make a difference.* Although mostly prompted by a period of economic downturn, the recurring use of comprehensive spending reviews in the Netherlands has influenced health care policy significantly in the past. Budget proposals in the report of the Taskforce of 2012 were for a large part incorporated into the coalition agreement of that year.

7. The budget process leading up to FY 2014

We will first describe the regular budget process for the US and the Netherlands separately. Then we will jointly describe their impact of existing fiscal rules on the health care budget in both countries.

The President's budget proposal for FY 2014 contains health savings totaling $400 billion between 2014 and 2023, most of which come from savings under Medicare 'that build on the ACA by eliminating

excess payment and fraud and supporting reforms that boost the quality of care'.[54] These measures, together with savings in other mandatory and discretionary spending categories and a proposed tax reform, total nearly $1.8 trillion in savings over a ten year period, which could potentially replace the budget cuts as a part of the sequester under the BCA of 2011.

On January 1st 2014 most provisions under the ACA phased in, the most prominent being the subsidized health plans that became available through state and federal market places. During the 113th US Congress, which took place from January 3rd 2013 to January 3rd 2015, there was broad conflict between Democrats and Republicans on the merits of the ACA and its budgetary ramifications. In the House Budget Committee, a concurrent resolution was put forward called 'the Path to Prosperity', which in essence repealed the ACA, and would replace it with a voucher system, or 'premium support program', that provided financial support for lower-income beneficiaries. The resolution however did not get past the Senate. As a result of this conflict and the political deadlock, a limited number of legislative proposals on Medicare passed Congress. Congress did not adopt any of the proposals from the President's budget.

Table 4 – Adopted legislation on Medicare and subsequent changes to Medicare outlays 113th Congress (2013-2015) in $ billions, (+) outlays increase, (-) outlays decrease[a]

#	Description	2014	2015	2016	2017	2018	2019	2014-2019	2014-2024
H.R. 4302	Protecting Access to Medicare Act of 2014	6.1	8.3	2.7	0.3	0.1	0.1	17.7	-1.2
H.R. 4994	Statutory Pay-As-You-Go Effects for H.R. 4994, the IMPACT Act of 2014[b]	0.0	0.0	0.0	0.1	0.0	0.0	0.1	0.0
H.J. Res 59	The Continuing Appropriations Resolution; Pathway to SGR reform 2013	4	3.6	1.1	-0.2	-0.3	-0.3	7.9	-0.3
	Total	10.1	11.9	3.8	0.2	-0.2	-0.2	25.7	-1.5

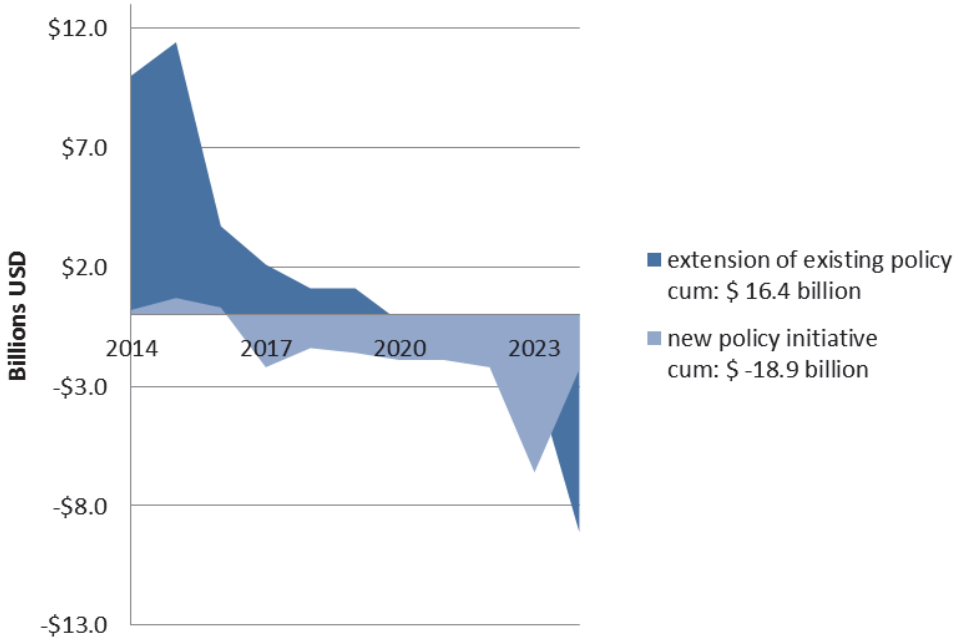
[a]Derived from CBO calculations[55]

[b]this includes the reduction of the Medicaid Disproportionate Share Hospitals (DSH)

Table 4 shows a cumulative overrun of the budget of almost $26 billion between 2014-2019, which will be fully offset in the years 2020-2024. This overrun is primarily caused by the override of the Sustainable Growth Rate (SGR) for three months (January 1st – March 31st 2014; H.J. Res 59) and one year (April 1st 2014 – March 31st 2015; H.R. 4302). Most significant savings come from the realignment of the Medicare sequester for 2023 (H.J. Res 59) and 2024 (H.R. 4302). By shifting savings from the last six months of both fiscal years to the first six months, these savings are fully counted in the ten year budgeting window[d]. In reality no additional net savings will be realized; this is merely a technical reallocation.

[d] For HR 4302 this means: It changes the timing of the Medicare sequester so that there will be a 4.0 percent sequester for the first six months and a 0.0 percent sequester for the second six months, instead of a 2.0 percent sequester for the full twelve-month period. While the overall amount of the 2024 sequester remains basically unchanged, this provision allows more of the sequestered amounts to be counted as savings in the ten-year budget window used for scoring the fiscal effects of this Act (US House of Representatives; Summary of Health Provisions in the Protecting Access to Medicare Act of 2014).

Figure 4 – Distribution of outlays as a result of adopted legislation for Medicare 113th Congress



If we take a closer look at the underlying line items in H.R. 4302 and H.J. Res 59, it shows that some 70% of the budgetary changes involve the reenactment of existing policies. Some of them date back to provisions in the ACA, while others date back to still older legislation. Figure 4 shows that the total costs of this reenactment of existing policies amount to $16.4 billion between 2014 and 2024, which is offset by new policy measures. Over the course of the ten year period, cumulative net changes to the Medicare budget are balanced, but the weight of additional outlays in the first years is considerable. The PAYGO-rules prescribe that time shifts are not counted on the PAYGO scorecard, which would potentially leave out savings from the realignment of the Medicare sequester. Congress however included a provision in H.J. Res 59 and H.R. 4302 which excludes the budgetary effects of the legislation from the PAYGO scorecards. In other words, Congress, within this legislation, has deliberately suspended the procedural rule that enforces budget neutrality of all new legislation, in order to avoid the President to issue a sequestration order targeted at a select group of mandatory programs.

In the Netherlands, the budget process leading up to the FY 2014 budget was not a text-book process either. One reason is that the incumbent government of Liberals (VVD) and Labour (PvdA) is a minority government in the sense that it has a majority in the House of Representatives, but lacks sufficient seats in the Senate. All legislation is drafted in the House of Representatives, but must also pass the Senate. Support for legislation from the governing parties alone is thus not sufficient to ensure adoption of the proposal. Where previous governments could fully rely on the budgetary principles and process guidelines as set forth in the disciplinary budget rules, the current administration must consult with minority parties on separate pieces of legislation and on the entire budget during the budget process. The negotiation process leading up to 'Prinsjesdag' normally takes place within Cabinet and behind closed doors, but was now part of the debate with political groups in the States-General and the public debate at an early stage.

A second reason is the development of the budget deficit as a result of the economic and financial crisis. Budget forecasts by the CPB in 2013 showed projected deficits larger than 3%, to as much as 3.9% in 2014[27]. In the spring of 2013, the Cabinet therefore agreed on a reduction package of €6 billion with members of the so called 'constructive opposition'. This opposition consisted of a number of smaller political groups that committed to the reduction package in return for a say in the specifics of the underlying austerity measures.

Where in normal years the presentation of the budget on 'Prinsjesdag' entails numerous new proposals, this year the budget was a mere reflection of the negotiation process that was concluded in the spring and was already public by then. Furthermore, in October 2013 the Cabinet and constructive opposition decided on the 'fall agreement', reallocating resources for education, defense and health care. This package was not prompted by the 3% threshold rule, but was rather aimed at continuing broadened support for legislative proposals of the Cabinet. A budget reallocation of this size at this point in the year is uncommon in the tradition of budgeting in the Netherlands.

Table 5 displays the reallocation of the health budget within the Budgetary Framework for Health, as prepared for the FY 2014 budget. It is based on the annual budget of the Finance ministry and has been slightly adjusted for presentation purposes.[27]

Table 5 – Netherlands health expenditure reallocation FY 2014
in € billions, (+) outlays increase, (-) outlays decrease

Description	2013	2014	2015	2016	2017
Baseline BFH start of Cabinet period	0.0	0.0	0.0	0.0	0.0
Macro mutations	0.1	0.1	0.4	0.3	0.3
Health expenditure update (overrun long-term care)	0.3	0.3	0.3	0.3	0.3
Additional reduction package	-0.6	-1.1	-0.4	-0.7	-0.9
Other	-0.1	-0.4	-0.5	-0.6	-0.6
Baseline readjustment (+ = lowering expenditure baseline)	0.0	1.0	0.2	0.6	0.8
Baseline BFH budget FY 2014	-0.3	0.0	0.0	0.0	0.0
Fall agreement	0	-0.4	-0.4	-0.5	-0.4
Final BFH budget FY 2014	-0.3	-0.4	-0.4	-0.5	-0.4

The table shows that the Ministry of Health was able to compensate for its budgetary overruns and in addition contributed to the €6 billion additional reduction package. The BFH-baseline was readjusted after this agreement. This was interpreted as a means through which the minister of Finance tightened the reins on an individual line-minister, as baselines are normally fixed for the full government term. The total contribution from the health budget in FY 2014 to the overall national budget is €1.4 billion (the €1.0 billion baseline readjustment and the €0.4 billion from the fall agreement).

The Budget Control Act of 2011 contains fiscal rules which place caps on discretionary spending and set in motion a process of automated spending cuts, including a 2% across the board budget cut of Medicare. As the Joint Select Committee on Deficit Reduction did not reach an agreement on alternative measures replacing the sequester, payment reductions in Medicare were sustained. This led to mandatory reductions in the Medicare fee-for-service program, encompassing all individual services

covered under Medicare Part A and B, and monthly contractual payments to Medicare Advantage plans and Part D plans.

Table 6 shows the impact of the effective fiscal rules. It shows that, although the rules vary to a high degree in terms of legal basis, coverage and enforcement mechanism, the impact of both rules is largely similar. In both countries, the rules enforced a cut in mandatory health spending of around 20% relative to the overall budget cut. In both instances these budget cuts were (mostly) targeted at health care providers, and less towards beneficiaries. Although the BCA provides much more guidance in terms of the predetermined cuts to the health care budget, and to the specifics of the various budget cuts, the more general formulation of the Dutch rules has led to very similar policy outcomes.

Table 6 – Impact of effective fiscal rules FY 2014

Description	United States	Netherlands
Fiscal rule	Budget Control Act (2011)	Disciplinary budget rules (2012), which triggered the 'additional reduction package'
Overall goal	Lower federal deficit by imposing: - Discretionary budget caps - Automatic budget sequestration	Comply w/ 3% deficit threshold European Commission
Imposed reduction in health spending	2% mandatory payment reductions in Medicare	Not pre-specified
Cutback in public health budget: **- absolute amount/per capita** **- relative to total deficit reduction**	- $11 billion / $212 per beneficiary (2014) - 20,3% of the non-defense function reduction[56]	- €1.2 billion[a] / €70 per capita (2017) - 20,9% of total deficit reduction[27]
Target	Health care providers (100%)	Health care providers (87%) Beneficiaries (13%)

[a]Note that this amount is higher than the amount mentioned in table 5 (€0.9 billion). The reason for this is that one line-item (reduction of the health premium compensation for low-income families) technically is part of the revenue side of the budget.

8. Spending review mechanisms

We have defined spending review as the process of developing and adopting savings measures, based on the systematic scrutiny of baseline expenditure. We have seen that both countries use a different approach to spending reviews and position them differently. In the US, the process is channeled either through recommendations of a high level advisory body (MedPAC), or as a direct mandate and a measure of last resort (IPAB), both situated outside the federal government. In the Netherlands, spending reviews are recurring, scrutinizing a specific budget sector under the baseline (the IPRs), or ad-hoc with a clear reduction objective, often motivated by sudden deficits. Reviews in the Netherlands are situated inside government.

The best recent example of MedPAC's influence has been the repeal of the SGR. For over more than ten years, MedPAC has put the issue of repealing the physician update schemes based on the SGR on the agenda in Washington DC. In its March 2013 report it dedicated an appendix of its report to 'moving forward from the Sustainable Growth Rate',[57] suggesting a movement towards a system that incorporates value based mechanisms rather than a volume-control formula. With the enactment of the

Medicare and CHIP Reauthorization Act (MACRA) of April 2015, the SGR was replaced by another update formula, which incorporates value based mechanisms from 2019 onwards. As discusses, the IPAB has not yet convened, nor produced any recommendations.

In the Netherlands, spending review has been an effective tool to support the political decision making process in the past; much of the proposed policy measures and legislation has emanated from one of the spending review reports. It must be noted that the biggest impact of spending reviews come from strategic reviews, that have been invoked as a result of a period of economic downturn and the need for austerity measures in the medium to long term. Part of the deficit reduction package of 2013 was the so called 'health agreement', an agreement with health care providers and insurers to limit curative care spending to a certain threshold. It contains measures such as counteracting the inappropriate use of care, limiting variation in health care practice, substitution of health care provisions and role redefinition of health care professionals.[58] This agreement built on previous, similar agreements that derived from the 2012 spending review 'Towards better affordable health care'.

9. Do budget rules matter in the context of health care policy?

Budget rules aim to shape the decision making process and enforce the acceptance of politically fraught cutbacks when needed, with the goal of creating a transparent process and furthering fiscal discipline. We have distinguished two types of budget rules; procedural rules, which establish procedures for the budget process, and fiscal rules, which impose a (long-lasting) constraint on fiscal policy through numerical limits. In our analysis of the budget processes leading up to FY 2014, we see that both types of rules were present.

The most important procedural rules in the US were the PAYGO-rules, which enforce the budget neutrality of adopted legislation for mandatory programs. We have seen that Congress sidelined the PAYGO rules in the provisions of the adopted Medicare legislation, as the rules do not permit time-shifts. The Netherlands 'disciplinary budget rules' contain a number of procedural rules, most important being the use of a medium-term expenditure framework with annual budgetary caps and a central decision-making moment in the spring. We have seen that these rules were not complied with. After the agreement on the additional reduction package, the Budgetary Framework for Health Care (BFH) was revised downwards in an attempt to further strengthen fiscal discipline. In addition, the decision-making process was fragmented and not limited to the spring, due to various rounds of negotiations as a consequence of the incumbent government not having majority control of the Senate.

At the same time, in both countries, there was compliance with existing fiscal rules. In the US there was political disagreement on how to address the imperative for deficit reduction. Provisions in the Budget Control Act of 2011 however enforced a 2% across the board budget cut of Medicare payments, thereby automatically reducing the federal deficit. In the Netherlands, the 3% threshold-rule enforced an additional deficit reduction package of €6 billion, of which €1.2 billion came from health related austerity measures.

Budget rules seem to be effective inasmuch as short-term deficit reduction is the goal. We have not found evidence that the specific institutional design of fiscal rules is determining for the outcome of the

budget process for health. On the other hand, budget rules have not proven to be an effective instrument to balance health austerity measures against budget cuts in other spending areas, or to provide a balanced trade-off between short and long-term fiscal goals.

10. What is the best timeframe when budgeting for health entitlements?

The US and the Netherlands each have a distinct approach when it comes to budgeting for health entitlements. In the US there is a ten year budgeting window, with no enforceable budget ceilings; the Administration is guided by the development of the overall deficit, rather than over- or underspending of budgetary caps in the health care sector. At the same time, PAYGO-rules aim to balance costs and savings of new legislation. In the Netherlands, there is a five year budget window with distinct budgetary caps for health, social security and other expenses. When budgeting for health, we have seen that this institutional difference leads to different outcomes.

Medicare legislation adopted during the 113th Congress used the full ten year window to offset costs and savings. Most savings are realized near the end of the forecasting period. A consequence is that additional outlays in the first years exert upward pressure to the federal budget and – ceteris paribus – force the federal government to run up debt to meet its financial obligations in those years. In the Netherlands, there is less trade-off in time, but rather between different budget sectors. An overall expenditure cap for the national budget ensures compliance with fiscal objectives, whilst allowing for an interaction between the three sectors. In the past, there were consistent budget overruns of the BFH, which were compensated by windfalls within the social security framework (BFS) or just accepted as they were. We have seen that the interaction between sectors in the process leading up to FY 2014 has led to a significant contribution from the health budget, by means of a contribution to the additional reduction package and a contribution to the 'fall agreement'.

So do timeframes matter when budgeting for health entitlements? The argument could be that balancing costs and savings in a short timeframe is more beneficial. As the forecasting period lengthens, parameters become less reliable. There is also the issue of accountability; the incumbent government cannot be held responsible for its fiscal policy ten years from now. Political reality however shows a tendency towards fiscal myopia. Decisions on health entitlements are made on a rolling basis, often dictated by a country's current fiscal situation, rather than by its projected fiscal situation some years from now.

At the same time, a longer budget timeframe alone does not seem to generate reduced fiscal discipline. It is rather the institutional setting around the adopted projection period that most determines the success of meeting preset fiscal objectives. If this setting allows for budget tricks or budgetary disobedience, this affects fiscal performance.

11. Do budget policies channel the type of budget cuts that are adopted?

Finally, we are interested in whether budget policies have influenced the type of cuts that were adopted for FY 2014. We have seen that prevailing fiscal rules in the US and the Netherlands have yielded rather similar outcomes. Around 20% of the overall deficit reduction comes from health

entitlements and cuts were mostly targeted at providers. In the US, the latter is implemented through the sequester that exclusively targets Medicare payments to providers. In the Netherlands this can also be explained by a mechanism that by default targets health care providers; over the last years, the enforcement of the budgetary cap of the BFH has been supported by a macro controlling instrument (MCI) which limits health care providers ex ante. This was also the case for FY 2014, when a new health agreement with a supporting MCI was agreed upon. Though both mechanisms operate at different levels, functionally they are the same. In both countries there seems to be a clear preference to intervene by reducing reimbursements at the level of providers, rather than making changes that affect beneficiaries directly.

The preceding goes to show that budget policies do, albeit indirectly, shape policy outcomes of the health budget through default mechanisms. They can enforce the adoption of austerity measures in a situation of political deadlock, but it seems that this default is mainly or exclusively targeted at providers. After all, the limiting of services or raising of deductibles is preeminently a political choice that requires public support which is obtained with difficulty.

The use of spending reviews has shown to be an important instrument for policy formulation and reform. In the Netherlands, the most influential reviews are prompted by a period of economic downturn and often precede elections. Their comprehensiveness and interrelatedness with the budget process has proven to be a powerful catalyzer for health reform. In the US, spending reviews are less common. There are mechanisms in place that scrutinize health baseline expenditure and formulate alternative policy proposals, such as MedPAC, and they have achieved some direct results.

12. Concluding remarks

Budget policies can have a clear impact on the rationing of health care by setting spending targets and formulating or prompting savings options. Fiscal rules seem to have more impact on budget outcomes, than procedural rules do on the budget process. Thus budgetary rules seem less successful in enforcing a transparent budget process or a balanced trade-off between short and long-term fiscal goals. Budget policies can also channel the type of austerity measures that are taken, either through spending review mechanisms, or through the enforcement of specific default measures.

13. Dutch summary

De afgelopen decennia hebben de publiek gefinancierde zorguitgaven van OECD landen een steeds grotere plek ingenomen op de nationale begrotingen. OECD landen worstelen met deze ontwikkeling omdat de overige overheidsuitgaven hierdoor in de knel zijn gekomen en de koopkracht van individuele burgers onder druk is komen te staan. Begrotingsbeleid en begrotingsregels beogen tegelijkertijd de publieke uitgaven te beheersen en overheidstekorten terug te dringen.

In dit onderzoek bestuderen we het bestaande begrotingsbeleid voor de publiek gefinancierde zorg in de Verenigde Staten (Medicare) en Nederland (het Budgettair Kader Zorg), op basis van de uitkomsten van het begrotingsproces voor begrotingsjaar 2014. We onderzoeken wat doorslaggevend is bij het ontwikkelen van zorgbeleid; het begrotingsbeleid of de politieke arena. We kijken daarbij naar

het belang van begrotingsregels, de gehanteerde tijdspanne en de wijze waarop begrotingsbeleid de keuze voor maatregelen beïnvloedt.

De analyse laat zien dat voor 2014 zowel in de VS als in Nederland de vigerende 'harde' begrotingsregels, die nominale limieten aan de uitgaven stellen, zijn nageleefd. In de VS heeft de Budget Control Act van 2011 een aantal automatische bezuinigingen in gang gezet, waaronder een 2% korting op de Medicare-uitgaven. In Nederland hebben de begrotingsregels een bezuinigingspakket van 6 miljard euro in gang gezet, waarvan 1,2 miljard vanuit de zorg is bijgedragen. In beide landen zijn de procedurele regels, die het begrotingsproces inrichten, echter niet nageleefd. Een belangrijke procedurele regel in de VS is de zogenoemde 'pay-as-you-go' regel. Die regel schrijft voor dat budgetintensiveringen gepaard moeten gaan met extensiveringen van gelijke grootte. Het Amerikaanse congres heeft zich echter niet aan deze regel gehouden. Een belangrijke procedurele regel in Nederland betreft het hoofdbesluitvormingsmoment in het voorjaar. Op dat moment worden door het kabinet alle over- en onderschrijdingen en in- en extensiveringen van beleid in samenhang bezien. Als gevolg van de minderheidspositie in de Eerste Kamer was het kabinet echter genoodzaakt op meerdere momenten in het jaar afspraken te maken over de begroting, zelfs na Prinsjesdag. Ook zijn de budgettaire kaders neerwaarts bijgesteld, iets wat in beginsel niet is toegestaan binnen de huidige begrotingsregels.

Het gebruik van 'spending reviews', het inventariseren en doorvoeren van bezuinigingsmaatregelen op basis van een systematische doorlichting van de uitgaven, heeft een vlucht genomen in OECD landen sinds de crisis van 2008. In Nederland bestaat een traditie van terugkerende spending reviews, alhoewel de reviews die onder druk van een economische en financiële crisis ontstaan, het meest invloedrijk zijn gebleken. In de VS zijn spending reviews minder gebruikelijk. Er zijn weliswaar adviesorganen van het Congres die systematische de uitgaven doorlichten en bezuinigingsmaatregelen inventariseren, maar hun positie is anders en hun invloed minder vanzelfsprekend.

Al met al kan begrotingsbeleid een aanzienlijke bijdrage leveren aan korte termijn budgettaire doelstellingen en het op korte termijn beheersen van de zorguitgaven. Het beleid lijkt echter minder succesvol in het bevorderen van een billijk en transparant begrotingsproces op de middellange termijn. Begrotingsbeleid kan daarnaast van invloed zijn op het type zorgmaatregelen dat wordt getroffen, door middel van het gebruik van spending reviews, of door middel van afspraken over *default* maatregelen.

14. References

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15. List of abbreviations

Abbreviation	Description
BFH	Budgetary Framework for Health Care
BFS	Budgetary Framework for Social Security and Labour Market
CBA	Central Budget Authority
CBO	Congressional Budget Office
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
CPB	Netherlands Bureau for Economic Policy Analysis (Central Planning Bureau)
CY	Current Year
EC	European Commission
EDP	Excessive Deficit Procedure
EIC	Earned Income Tax Credit
FY	Fiscal Year
GAO	Government Accountability Office
GDP	Gross Domestic Product
HI	Hospital Insurance (Trust Fund)
HIA	Health Insurance Act
HHS	Department of Health and Human Services
IPR	Interdepartmental Policy Review
IMF	International Monetary Fund
IPAB	Independent Payment Advisory Board
LCA	Long-term Care Act
MCI	Macro-controlling instrument
MEDPAC	Medicare Payment Advisory Commission
OACT	Office of the Actuary
OECD	Organization for Economic Co-operation and Development
OIG	Office of Inspector General
OMB	Office of Management and Budget
PPACA	Patient Protection and Affordable Care Act
PY	Prior Year
RAC	Recovery Audit Contractors
SGR	Sustainable Growth Rate
SMI	Supplementary Medical Insurance
SSA	Social Support Act