

The Economic Case for Health Care Reform

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A former chair of the Council of Economic Advisers once described the job as playing economic pinball. Issues come flying at you from every direction. The Chair's job is to respond quickly with good economic analysis. For the first several months that I was on the job, most of the balls flying at me were at least squarely in my comfort zone. Recession, fiscal stimulus, financial crises, and banking were all topics I had studied and felt I understood well.

But recently, the balls have been coming predominantly from less familiar territory. In particular, having made it through a macroeconomic-centered first one hundred days, the President declared health care reform his number one domestic priority. For me, as I would tell my children, this was a chance to grow. I was encouraged along by the head of the White House effort on health care, Nancy-Ann DeParle, who asked me to write a report explaining the economic effects of successful reform.

What followed was surely the most intense six weeks of my life. My staff and I threw ourselves into serious analysis and economic modeling. Our findings are summarized in a report that the CEA just issued last week. The results can perhaps be best summarized by describing how my own views have evolved. As a result of the

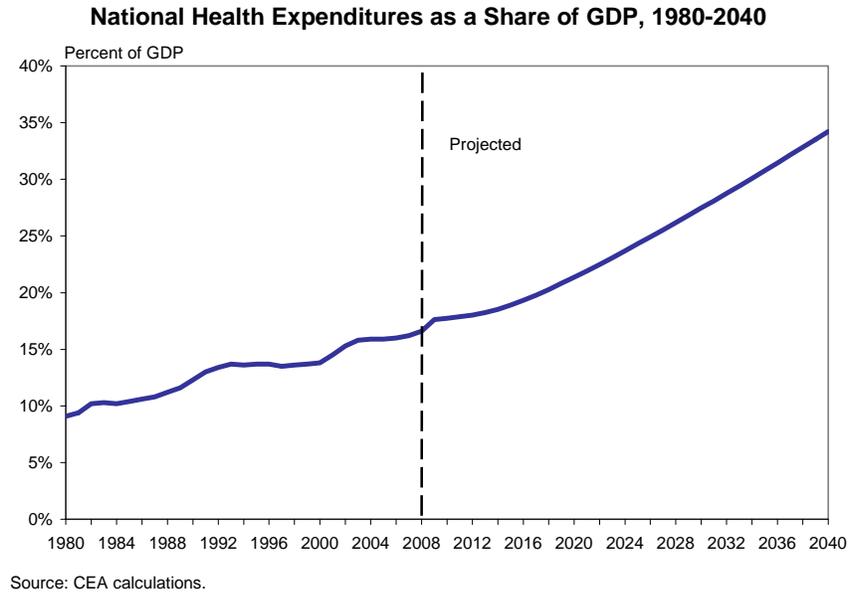
study, I have gone from being a positive, but somewhat passive, supporter of health care reform to a passionate advocate. What I would like to do this afternoon is describe some of what we found.

The key contribution of the report is to show that if we do health care reform well, the benefits to the economy will be enormous. If we can genuinely restrain the growth rate of health care costs significantly, while assuring quality, affordable health care for all Americans, living standards would rise, the budget deficit would be much smaller, unemployment could fall, and labor markets would likely function more efficiently. Because the economic benefits that we identify depend crucially on not just doing health care reform, but doing it well, we hope that our report will help strengthen the resolve of policymakers to undertake the serious changes that are necessary.

I. TRENDS IN THE ABSENCE OF REFORM

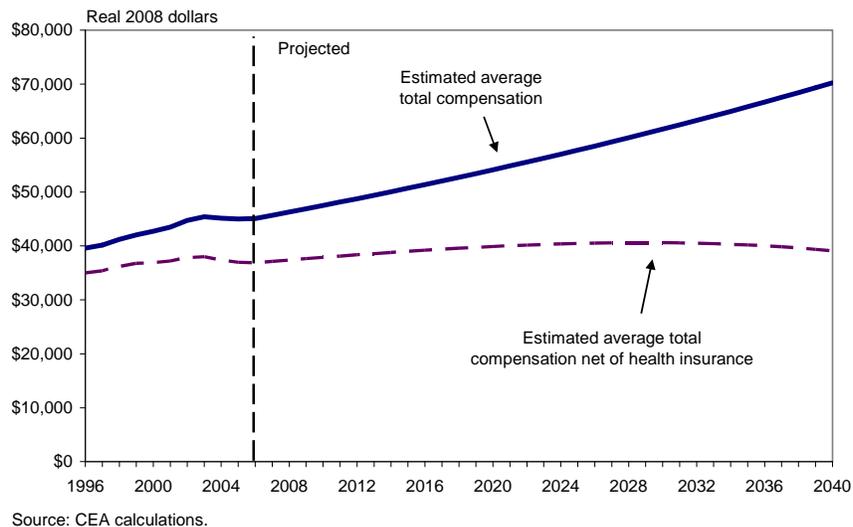
Let me start with a discussion of where we are. Many of the crucial economic trends in American health care are well known. But, CEA worked with others in the Administration to develop what we think are the crucial facts. Spelling out these facts and trends makes a compelling case that doing nothing is simply not an option.

Rising Health Expenditures. One fact that is well known is that health care expenditures in the United States are currently about 18 percent of GDP, by far the highest of any country. These expenditures are projected to rise sharply. This figure shows our projection of the likely path of national health care expenditures. By 2040, health expenditures could be roughly one-third of total output in the U.S. economy.



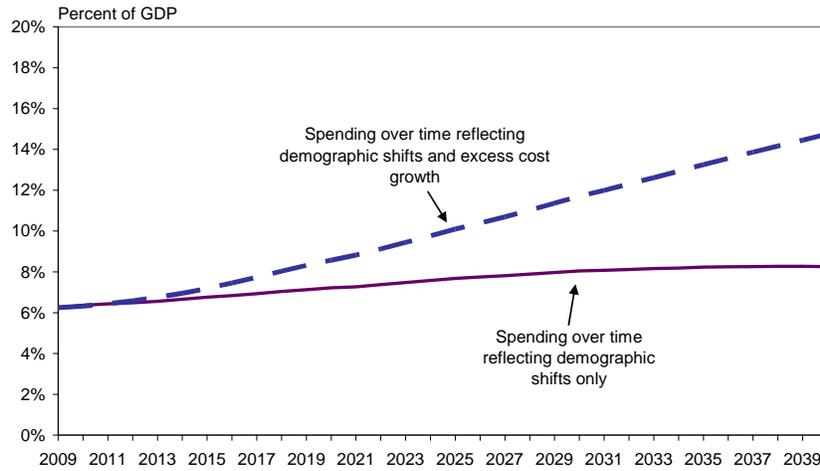
Effect on Households. For households, rising health care expenditures will likely show up in rising insurance premiums. Even if employers continue to pay the lion's share of premiums, both economic theory and empirical evidence suggest that this trend will show up in stagnating take-home wages. This figure shows our projection of total compensation and compensation less insurance costs, both in inflation-adjusted dollars. We project that without reform, the non-insurance part of compensation will grow very slowly, and likely fall eventually, as premiums rise sharply over time.

Projected Annual Total Compensation and Health Insurance Premiums



Effect on Government. Rapidly rising health care costs also mean that government spending on Medicare and Medicaid will rise sharply over time. This figure shows the projected path of combined Federal and state spending on Medicare and Medicaid. Our projections suggest that these expenditures, which are currently about 6 percent of GDP, will rise to 15 percent of GDP by 2040. The dashed line shows the projected rise in Medicare and Medicaid expenditures due to demographic factors, such as the aging of the baby boom generation. A crucial fact is that only about one-quarter of the total rise in government health expenditures is due to demographic changes. The other three-quarters is due to the fact that health care spending per enrollee is rising much more rapidly than GDP. In the absence of tremendous increases in taxes or reductions in other types of government spending, this trend implies a devastating, and frankly unsustainable, rise in the Federal budget deficit.

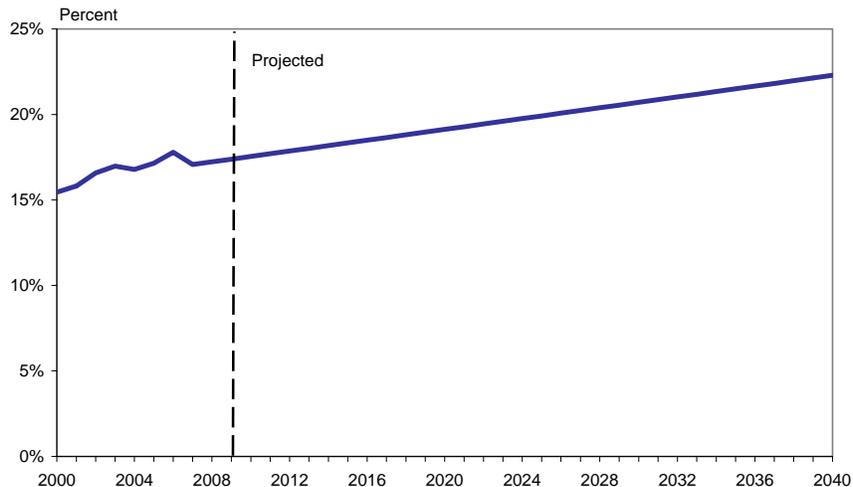
Projections of Total Spending on Medicare and Medicaid as a Share of GDP, 2009-2040



Source: CEA calculations.
 Note: Total spending includes both Federal and state expenditures.

Trends in Lack of Insurance. Another trend that is well known, but too crucial to be ignored, is the rise in the number of Americans without health insurance. Currently 46 million people in the United States are uninsured. In the absence of reform, this number is projected to rise to about 72 million by 2040.

Projected Percentage of the U.S. Population Under Age 65 without Health Insurance, 2000-2040



Source: CEA projections using U.S. Census Bureau's Annual Social and Economic (ASEC) Supplement.

II. KEY ELEMENTS OF REFORM

The President has set two fundamental goals for reform: it must slow the growth rate of costs significantly and expand coverage to the millions of uninsured Americans. He has also made it clear that he wants to work with the current system, rather than toss it out. One of his key starting points is that if you like your current plan and doctor, you get to keep them. The overarching goal is to develop a cost-effective health care system that preserves quality, expands coverage, and ensures choice and security for all Americans.

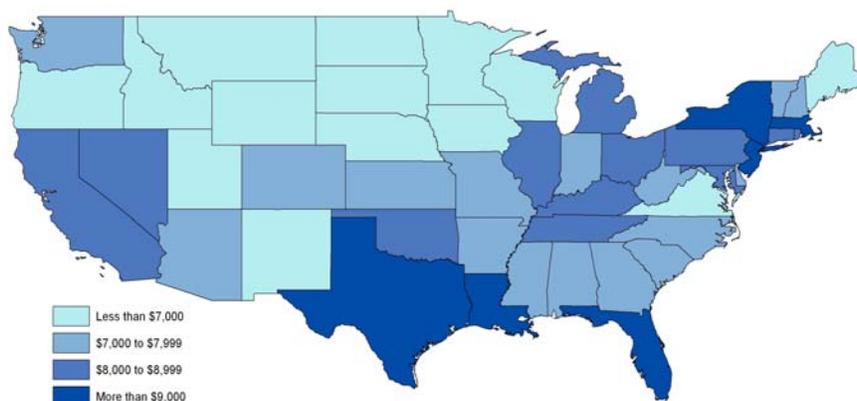
Cost Growth Containment. Let me talk first about cost containment. Two weeks ago, representatives of providers, insurers, health care workers, and industry met at the White House and pledged to work to slow the growth rate of health care costs by 1.5 percentage points per year. Currently, health care costs are rising by about 6 percent per year—substantially greater than the growth rate of our nominal GDP. Lowering that growth rate to 4.5 percent, not just for one year, but for each year going forward, would be a monumental accomplishment. Even slowing cost growth by a smaller amount—0.5 percentage point or 1 percentage point—would be a significant achievement that has crucial benefits.

One obvious question is: Could we really achieve this degree of cost containment without lowering quality? Here I feel the answer is absolutely yes. As wonderful as the American health care system is along some dimensions, there is widespread agreement that there is substantial inefficiency. Researchers often point to the fact that the United States spends roughly 5 percent of GDP more on health care than other developed

countries with comparable or better health outcomes. This is a crude indicator of the magnitude of inefficiency in the American health care system.

Better evidence is provided by the researchers at Dartmouth who have looked at health spending and other measures of medical inputs across states and counties within the United States. This figure shows Medicare spending per enrollee in different states. The research finds vast differences that cannot be explained by demographics, incomes, or health needs of the local population. The conclusion is that roughly 30 percent of health expenditures (which is again equivalent to about 5 percent of GDP) could be cut without affecting health outcomes. This is important in making the case that slowing the growth rate of costs by improving efficiency is absolutely possible. For example, our estimates suggest that we could slow cost growth by 1.5 percentage points per year for almost a quarter of a century before we have exhausted the existing inefficiency.

Per Capita Medicare Spending, 2006



Source: The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Atlas.

Now, the specifics of how that will be done are still under discussion. The President has committed to working with Congress to design the reforms, so I don't want to get ahead of that process. But, it is possible to talk about some of the likely reforms in broad terms.

One type of reform would be to reorient financial incentives for providers toward value over volume. Systems should reward providers who deliver care that adheres to evidence-based guidelines and should not pay for preventable medical errors. A concrete example of such reform is bundling payments for certain types of outpatient care such as diabetes management. This would ensure that a single provider has the right incentive to manage the care from start to finish and make sure that things are done right the first time.

Another important reform would involve giving patients a greater role. Engaging patients in medical decision-making can lead both to better alignment of treatment strategies with patient preferences and to lower costs. A related reform might be to give patients financial incentives to use high-quality lower-total-cost "centers of excellence" for complex surgeries.

A third reform would be to find ways to reward technological progress that is cost-reducing. In medicine, technological progress in recent decades has been almost exclusively cost-increasing. Payment strategies that respond to actual costs rather than historical precedent could create incentives for the discovery and adoption of new technologies that provide a less costly alternative to an existing treatment.

Our report provides a longer list of the kinds of reforms that could help to slow the

growth rate of costs. It is not designed to be exhaustive or to show the changes the Administration supports. Rather, it is designed to illustrate the kind of changes that could be done to achieve the President's goal of genuine cost containment. It serves to show that cost containment is feasible. At the same time, it also shows that such cost containment will not be easy. Every reform, no matter how sensible, will step on some toes. Achieving the will and cooperation to nevertheless do them will be a serious challenge. It will take an incredible degree of resolve and cooperation among policymakers, consumers, and providers to bring this about.

Coverage Expansion. Let me turn now to coverage expansion. At some level, this is the easier of the President's goals to achieve. Some of it simply involves the will to spend some additional money to prevent 46 million Americans from being uninsured. Some sort of subsidy schedule will surely be needed to ensure that uninsured people near the poverty line can afford to purchase coverage. Of course, much of this subsidy cost is not new money: it will largely replace our inefficient patchwork system of uncompensated care with a more rational one. In this way, coverage expansion dovetails nicely with cost containment. For example, setting up a system of widespread access makes it easier to reward providers for disease prevention, which ultimately constrains costs, rather than increases them.

Some of coverage expansion involves designing mechanisms that overcome market failures. For example, the fact that individuals know more about their likely health expenditures than potential insurers leads insurers to charge rates for individual and small group coverage that are above the average cost of providing coverage for these

segments in the population. Expanding coverage will likely involve the creation of some sort of insurance exchange that gives individuals and small groups the same benefits of risk-pooling and elimination of adverse selection that employees of large firms enjoy. Whether the exchange will be nationwide, statewide, or regional will be decided in consultation with Congress. Likewise, whether it includes a public plan among the private options is currently a hotly debated topic.

One feature of the insurance exchange and coverage expansion that the President has made clear is not negotiable is the limitation on coverage of pre-existing conditions. Americans with health problems need the security of knowing that if they change jobs or lose their job, they will still be able to get health insurance coverage.

III. ECONOMIC IMPACT OF SLOWING COST GROWTH

All of this discussion of where we are headed and the keys of successful reform are to some degree the necessary prelude to our more substantive contribution, which is to talk about the economic benefits of successful reform. In our study, we consider the effects of cost containment and coverage expansion separately. But obviously, the two are related. Expanding coverage is likely to make certain types of cost containment easier to achieve.

In our analysis of cost containment, we focus on slowing the growth rate of costs. This is the so-called “curve-bending” that can last for decades. This is quite separate from actions that we might take immediately to cut the level of government medical spending, such as the roughly \$300 billion of Medicare savings proposed in our budget.

These immediate level changes are unquestionably important for paying for the expansion of coverage in the next decade. But, for thinking about the changes that will save us from the unsustainable long-run trends I discussed earlier, slowing cost growth year after year is essential, and is what we focus on in our study.

We consider varying degrees of cost containment. In particular, we look at the effects of slowing the annual growth rate of health care costs by 1.5, 1.0, and 0.5 percentage points. To be conservative, we assume that it takes a few years for genuine curve-bending to kick in.

The fundamental thing that slowing cost growth does is free up resources. If we restrain costs by eliminating waste and inefficiency, we can have the same real amount of health care with resources left over to produce other things that we value. This causes standards of living to rise. It also causes the share of GDP devoted to health care to rise much more slowly.

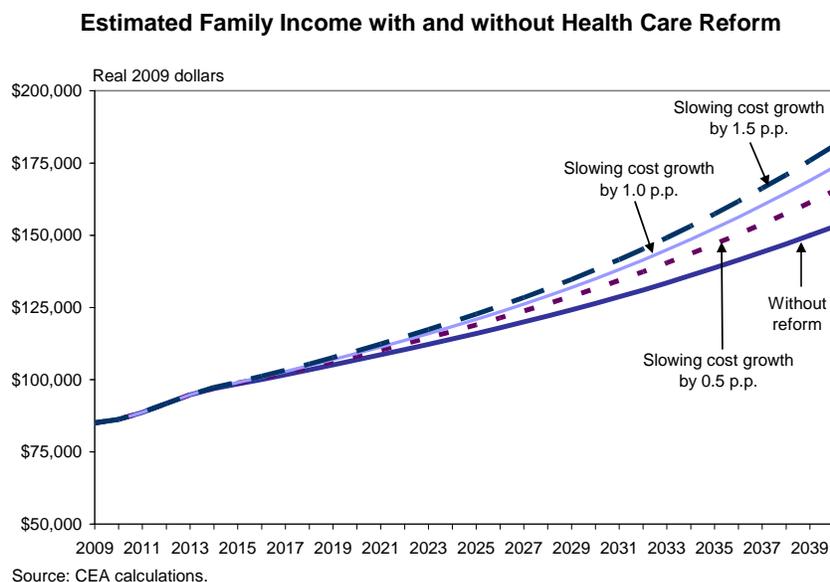
We analyze the effects of this freeing up of resources in a standard growth accounting framework. For those of you who like equations, the framework is spelled out in an appendix to the report. Now, nothing says how we would use those freed up resources. We may spend some of them on increasing the quantity of health care by expanding coverage. We also might choose to use some of the freed up resources to improve the quality of our health care. But, the crucial finding of our analysis is that we can have a lot more of the things we value as a country if we slow the growth rate of health care costs.

We then expand our framework to analyze what slowing cost growth would do for

the deficit and capital formation (or investment). Because the government is a major provider of health care, slowing the growth rate of health care costs would lower the deficit and thus raise public saving. And, efficiency gains that raise income would lead to some additional private saving. All of this increased saving would tend to lower interest rates and encourage investment. This extra investment increases output even more.

Our estimates suggest that the combined impact of greater efficiency in health care and greater investment is very large. If we can slow cost growth by 1.5 percentage points, we estimate that correctly measured real output in 2020 would be about 2½ percent higher than it otherwise would have been. By 2030, it would be nearly 8 percent higher. If we only manage to slow growth by 1 percentage point, real output would be about 1½ percent higher in 2020 and 5½ percent higher in 2030. These results show very clearly that the more we can slow cost growth, the more rapidly living standards will improve.

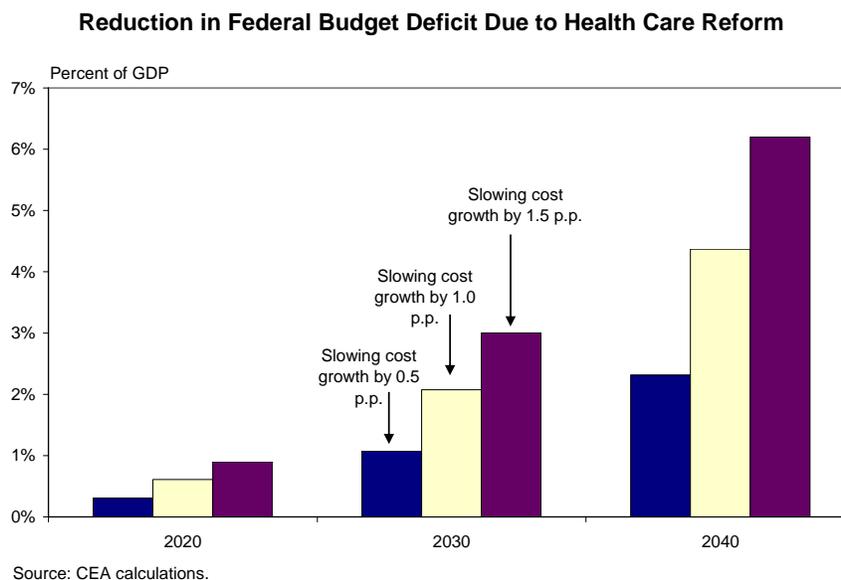
To make these numbers more concrete, we translate them into the effects on the income of a typical family of four (in constant dollars). These effects are shown in this figure. The bottom line shows the projected path of real family income without reform. The higher paths show family income under different degrees of cost containment. Our numbers suggest that if we slow cost growth by 1.5 percentage points per year, family income would be about \$2,600 higher in 2020 than it otherwise would have been. By 2030, it would be nearly \$10,000 higher.



I also want to discuss what our analysis implies about the effect of health care cost containment on the Federal budget deficit. I need to be very clear that our estimates are not official budget projections, which would be based on detailed projections of spending and revenues. Ours are more a back-of-the-envelope calculation. And, they do not include the costs of coverage expansion, because most of those costs will be covered by the spending cuts and revenue increases that are currently under discussion. Our numbers show the effect of slowing cost growth over the long term.

We find that the effects on the deficit are very large. This figure shows the deficit reduction in key years. If we can slow cost growth by 1.5 percentage points per year, we estimate the deficit in 2030 will be 3 percent of GDP smaller than it otherwise would have been. In 2040, it would be 6 percent of GDP smaller. The numbers illustrate the crucial truth that serious health care cost growth containment is the number one thing we can do to ensure our long-term fiscal health. Health reform is central to long-run fiscal

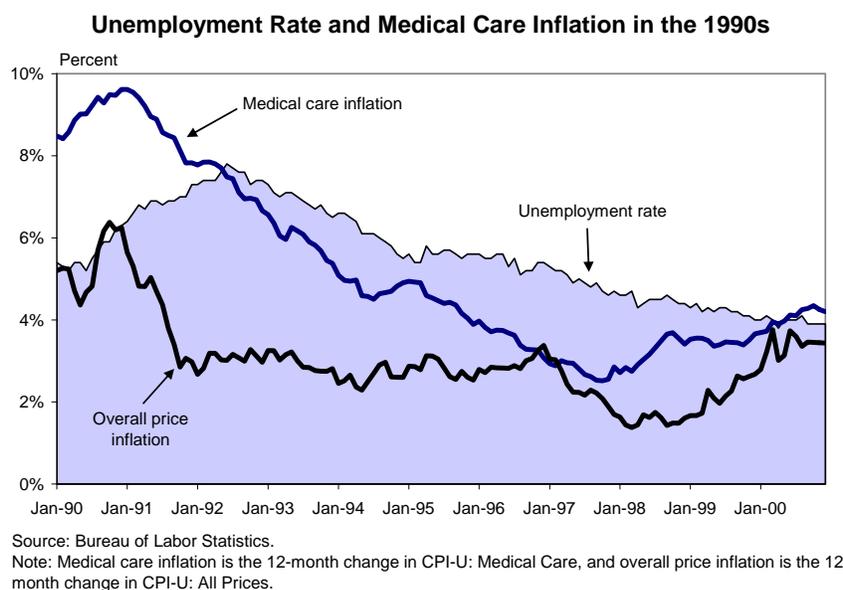
stability.



Another possible macroeconomic effect of cost growth containment is a short-run impact on unemployment and employment. When health care costs are growing more slowly, wages can grow without firms' costs rising, so firms do not raise prices as much. This allows monetary policy to lower the unemployment rate while keeping inflation steady. Our estimates suggest that slowing cost growth by 1.5 percentage points per year would lower normal unemployment by around $\frac{1}{4}$ of a percentage point. This translates into an increase in employment of about 500,000 jobs. While this is almost surely not a permanent effect, it could last for a number of years.

Studies find that this mechanism was one source of the unusual prosperity of the 1990s. This figure shows medical care inflation, overall inflation, and the unemployment rate in the 1990s. The widespread replacement of fee-for-service medicine with managed care led to a period of much lower health care cost growth. The growth rate in medical

care prices slowed from about 10 percent at the beginning of the decade to below 3 percent. You will see that the unemployment rate also fell steadily. Formal studies suggest that there was a linkage between the two and that the impact of slowing health care costs on the unemployment rate were quantitatively significant.



IV. THE ECONOMIC IMPACT OF COVERAGE EXPANSION

The final issue we examine is the economic impact of coverage expansion. The most important benefit of widespread access involves the economic well-being of the uninsured. We use the best available estimates to try to quantify the costs and benefits of expanding coverage to all Americans. Among the benefits we attempt to put a dollar value on are the increase in life expectancy and the decreased chance of financial ruin from high medical bills. The costs to society of covering the uninsured represent a mix of public and private costs and come from existing studies, not estimates of plans

currently being contemplated by Congress. We find the benefits of coverage to the uninsured are very large and substantially greater than the costs. Our estimates show that the net benefits—the benefits minus the costs—are roughly \$100 billion per year, or about 2/3 of a percent of GDP.

Another effect of expanding coverage that we consider is increased labor supply. With full health insurance coverage, some people who would not be able to work because of disability would be able to get health care that prevents disability. They would therefore be able to stay in the labor force longer. A related effect is that some workers currently in the labor force would be more productive with better health care. How large these effects might be are hard to predict. And, there could be offsetting effects: for example, with a better insurance market some workers who are working just to get health insurance might retire earlier. But, we believe that the net impact on effective labor supply will be positive and will further increase GDP.

The final impact that we identify is the effect of expanding coverage on the efficiency of the labor market. Expanding coverage and eliminating restrictions on pre-existing conditions would end the phenomenon of “job lock,” where worries about health insurance cause workers to stay in their jobs even when ones that pay more or are a better match are available. Our estimates, based on a range of economic studies, are that this benefit could be about 2/10 of a percent of GDP each year. Similarly, we examine the fact that small businesses are currently disadvantaged in the labor market because employer-sponsored insurance is so expensive for them. Moving to an insurance system

that removes this disadvantage should be beneficial to the competitiveness of the crucial small business sector of the economy.

The bottom line of our report is that doing health care reform right is incredibly important. If we can put in place reforms that slow cost growth significantly and expand coverage, the benefits to American families, firms, and the government budget would be enormous. To put it simply, good health care reform is good economic policy.