

THE CHALLENGES OF ECONOMIC POLICYMAKING: THE CASE OF HEALTH CARE REFORM

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I. INTRODUCTION

It is lovely to be here this evening, and to participate in the CPS Live Talk Series. But I must admit that it is a little intimidating to speak to an audience with so many old friends in it. It is one thing to mess up in front of an audience of strangers. It is quite another to do it in front of a group you will see at “Back to School Day,” or who your son will have to face in class tomorrow. So, just know you are a scarier crowd than you might think.

The topic that we chose for the lecture is “The Challenges of Economic Policymaking.” While I was working in the White House, and since I have come home, I have spent most of my time talking about jobs and macroeconomic policy. Where is the economy going? How did the Recovery Act work and what more should we be doing to reduce unemployment? What is going on in Europe and what will the repercussions be for the United States? I am sure that we will talk about many of those issues when we sit down for the conversation part of tonight’s talk. And obviously you can ask about that during the audience question period.

But as I was pondering what example to use to get us started this evening, it seemed to me that health care reform might be particularly interesting. Other than macro policy and jobs, health care was the issue that occupied most of my time at the Council of Economic Advisers. And it illustrates very well the tremendous challenges of

economic (and other) policymaking. It also provides a good window into how the Obama White House operated. So it is a chance for me to share some stories that haven't come up before.

II. HEALTH CARE IS AN ECONOMIC ISSUE

Now, right off the bat, one thing that might be puzzling you is my description of health care reform as an economic issue. Of course, it is much more than that. I certainly believe that health care is a moral and a social issue. Making sure that everyone has access to health care is fundamentally important for our quality of life, and for the essential strength and decency of our society.

But it is also a key economic issue. Someone once told me that no matter what kind of an economist you start out as, when you move to Washington you become a health economist—because health care is such an important economic policy issue. And it is not hard to see why.

First, health care is just a big part of our economy. More than 10% of Americans work in the health care industry. That's larger than the fraction who work in manufacturing. And health care's importance is expected to grow over time. So, making this industry function well is important to our long-run growth and prosperity.

Second, the cost and availability of health insurance also impacts every other industry. Because health insurance is typically provided by private employers, its cost affects all our firms.

Finally, the government pays for health care for a large fraction of the population—for the elderly through Medicare, and for the poor and disabled through Medicaid. Government health care spending is projected to rise dramatically over the

next couple of decades because of the retirement of the baby-boom generation and rising health care spending per person. As a result, it is a key source of the very scary projections about the federal budget deficit that often dominate the news. So, finding a way to slow the growth of health care costs, while preserving quality, is essential to the long-run solvency of the federal government.

For all these reasons, health care reform is an essential economic issue—which is why the Obama economics team was closely involved with the health reform initiative.

III. CHALLENGE NUMBER 1: PRIORITIZING

So, what were some of the challenges involved in that policymaking endeavor?

The first challenge was deciding whether to tackle health care reform at all. One of the things that you learn from working in Washington is that our legislative process is not well set up to handle lots of initiatives at once. The Senate, in particular, is just unfathomably slow. So the first issue we had to confront was whether to try to do health care reform at all.

On the one hand, as I have just described, it was an incredibly important issue for both people and for the long-run health of the economy. And it had been a centerpiece of the President's campaign—because it was an issue he felt passionately about.

On the other hand, the world had changed dramatically in the fall of 2008. What had started out as a slow-moving recession became an economic freefall after the collapse of Lehman Brothers in September 2008. The economy was losing three-quarters of a million jobs every month around the time President Obama took office. So, we clearly were in the middle of an economic crisis that had to be our top priority.

Now, the administration took a number of actions to deal with the recession very

quickly. We passed the Recovery Act to provide a large dose of fiscal stimulus just one month after taking office. And we took a number of measures to try to stabilize the financial system, and to help stem the tide of foreclosures.

But then in the spring of 2009, we had a serious discussion about whether to also take on health care reform. I will confess to initially being nervous about tackling such a large issue in the middle of an economic crisis. The argument, however, that carried the day was that health care reform was incredibly important and 2009 presented a unique opportunity to get it done. The President was very popular. And, we had a hope of getting the 60 votes needed in the Senate. So everybody got behind a full-court press.

The decision to try to accomplish health care reform certainly did not distract the Administration from working on jobs. Over the first half of 2009, it became clear that the recession was going to be even worse than we and most other forecasters had predicted. We spent a lot of time designing additional stimulus measures. For example, the Council of Economic Advisers was a big proponent of a tax credit for businesses that increased their payrolls. And the Administration formulated a proposal for another significant round of infrastructure spending.

Where the decision to pursue health care reform may have mattered was in getting those additional stimulus measures through the Senate. The House had passed a substantial second stimulus bill in December 2009. But the Senate was focused intently on health care. Most of the additional jobs measures never went anywhere. Now, it could just have been that the votes wouldn't have been there under any circumstances. But it is possible that they might have been forthcoming had tough votes on health care not been occupying so much time and causing so much unease.

IV. CHALLENGE NUMBER 2: DESIGNING THE HEALTH CARE LEGISLATION

So that is the challenge of prioritizing. Obviously, the next big challenge after deciding to go ahead with health care reform was to decide what to actually do. What are the needed components of good health care reform? This is a place where careful economic analysis was essential.

Very early in the process, Nancy-Ann DeParle, the director of the White House Office of Health Reform, came to me about writing a report. She thought we needed to make the case that health care reform would be good for the economy.

Such a report was just the thing that the Council of Economic Advisers is good at. The CEA is a unique government agency. It was formed after World War II to bring cutting-edge economic research to the policymaking process. Almost all of the staff are people like me—academics on leave from universities—or a much younger version of me—graduate students partway through their Ph.D. studies. I was putting together a team with a lot of expertise in health economics, so this was a chance for us to evaluate the evidence and jump into the discussion.

What we ended up showing is that there were large economic benefits both from expanding health insurance coverage and from slowing the growth of health care costs.

On expanding coverage, we found that people with access to health insurance and care were likely to be healthier and more productive workers. And access to health care would greatly reduce the chance of long-term disability from injuries and chronic conditions. Moreover, making health insurance widely available and portable from employer to employer could make our labor market more flexible, so that workers were more likely to end up in the jobs that fit their interests and skills best.

But the even more important finding of our study was how large the beneficial

impacts of cost containment would be. Obviously, if we could slow the growth in health care costs, that would be very good for the government budget deficit. But we also showed that the resources that would be freed in the private sector could also be very beneficial to business investment and long-run growth.

I like to think that the report helped to elevate cost containment as a central goal of the legislation. I know it certainly had the effect of turning me into a passionate believer in the importance of slowing the growth rate of health care costs. And I had a number of members of Congress tell me it had affected their thinking.

I also think it illustrates one of the best features of policymaking in the Obama White House—which is a deep respect for analysis and evidence. Throughout the policymaking process—on health care and other issues—scientific and economic research were front and center. The way you won arguments in front of the President was not by being strategic or talking the loudest. It was by having the best evidence to back up your points. Indeed, one of the things the President would say that I just loved was: “Show me what’s right—and I’ll figure out how to sell it.”

Now as it turned out, one of the policies we asked him to endorse tested that promise. The economics team went through all of the research on what would actually help to slow the growth of health care costs. And one thing that stood out was changing the tax treatment of employer-provided health insurance.

What your employer contributes for your health insurance is not taxed as income—this is referred to as “the exclusion.” Employer-provided health benefits are excluded from income for tax purposes. This favorable tax treatment encourages more generous health insurance benefits, which can have undesirable incentive effects. For example, it tends to encourage low deductibles and copayments—two things that may

insulate consumers from the cost of their health care decisions.

The evidence suggested that capping the amount of health benefits excluded from taxation could help make people more watchful consumers of health care. And it could encourage employers to bargain harder on workers' behalf for lower-cost policies.

Now back in 2008, John McCain had endorsed completely eliminating the tax exclusion for health insurance. And the Obama campaign had run some hard-hitting ads against the McCain proposal because it was very extreme. As a result, messing with the exclusion, even in a much more modest way, was not something the President's political advisors wanted to take on. Indeed, they actually had us watch some of the old campaign ads, just so we knew what we were asking the President to do. But in the fall of 2009, the economics team decided limiting the tax exclusion was very important.

I will tell you one Larry Summers story—which shows he can be both a bit annoying and ultimately a good guy. For anyone who doesn't know who Larry Summers is, he was the Director of the National Economic Council while I was at the CEA.

In fall of 2009, the economics team was having a rigorous internal debate about whether we should be pushing hard for more stimulus measures to spur job creation, or turning our attention to the deficit. I was on the side of more stimulus because I thought the jobs situation was a crisis. But I also thought we should be taking serious steps to address the long-run deficit.

One argument that I made several times was that perhaps we could kill two birds with one stone. We were in the middle of a Congressional debate on health care reform—why not work harder on long-term cost containment there? That would be good for the long-run deficit, and would allow us to focus more on jobs in the near term.

The first four times I said this, Larry completely blew me off: "I'm sure our

legislative team is doing all they can on cost containment.” About the fifth time I made the same point, Larry shouted at me: “Fine, what should we do that we aren’t currently doing?” I said, “How about endorsing a cap on the tax exclusion?” I could tell Larry was about to blow me off again when he paused and said, “That’s a good idea.”

Soon after, the economics team went as a unified group to the President. He ultimately backed a more politically palatable version of capping the exclusion—an excise tax on high-priced insurance plans. The President was convinced by the evidence (and probably by the somewhat shocking unanimity of his frequently fractious economics team). Against all odds, this measure ended up in the final legislation. And I believe strongly it will help to contain cost growth when it kicks in in 2018.

Now, that’s just one example of the many features included in the Affordable Care Act to slow cost growth, while maintaining or improving quality. There are lots more. For example, there are many demonstration projects to see if different ways of organizing and paying healthcare providers can lead to better outcomes at lower costs.

Of course, the final legislation does lots more than just try to slow the growth rate of health care spending. Most fundamentally, it provides health insurance coverage to about 30 million people who are currently uninsured. It does this by expanding the number of people covered by Medicaid, and by setting up a way for people who don’t qualify for Medicaid and who don’t get health insurance from their employer to buy private insurance at a reasonable price. The law also includes various new regulations to make health insurance more secure for people who already have insurance. For example, after a phase-in period, it eliminates the ability of insurance companies to deny coverage for pre-existing conditions. It also requires insurance companies to allow kids to stay on their parent’s insurance plans until they are 26.

In designing each feature of the act, the Administration worked with Congress to try to get the economics right.

V. CHALLENGE NUMBER 3: ADVOCATING FOR THE ACT

Challenge number 2 was designing the act. Challenge number 3 was actually getting it passed. A central part of the policymaking process in general, and of accomplishing health care reform in particular, was making the case for the legislation—to Congress and to the American people.

Obviously, lots of people both inside and outside the government played a huge role in building support for the legislation. But I am particularly proud of the role the Council of Economic Advisers played. We helped to make the case by doing careful research. If there is anything I believe in, it is that public policy should be designed and advocated for on the basis of careful analysis and evidence.

The CEA was blessed with a top-notch health economist, Mark Duggan, who was willing to not sleep for a year if it would help pass health care reform. With my support, Mark built a little empire of research assistants and staff economists that tried to argue for the legislation based on facts. I'll give you one example of work they did.

I mentioned that one of the elements of the bill was an expansion of Medicaid. Now Medicaid is a joint federal-state program. Though the legislation called for the federal government to pay for all of the expansion of coverage for a while, states were worried about how much it would cost them later on. So some governors were not supportive.

Mark and his team thought it would be helpful to figure out how much state and local governments were already spending to care for uninsured residents—through free

clinics, county programs, and public hospitals. But the numbers were not readily available.

So they started collecting them. For 16 representative states, they culled through state and city budgets. They called county officials. They produced a 100-page document that showed that the Affordable Care Act would save state and local governments money, not cost them more. The report helped diffuse the argument and brought some local officials to support the legislation.

Now how the bill actually eventually passed is a talk in itself. There were many political twists and turns at the end. But I vividly remember the weekend it cleared the Congress.

The whole legislative process had dragged on much longer than anticipated. It was getting to be March of 2010. Matthew, David, and I were scheduled to come out to California for Matthew's spring break on Saturday, March 20th. Then they scheduled the final vote for Sunday, March 21st. I knew that I didn't need to be in Washington—any part I had played was over. But even so, on the way to the airport, it finally hit that I just couldn't leave. This was something we had been working on for more than a year and it just didn't seem right to not be there.

So I put David and Matthew on the plane, and then I realized I had a Saturday with nothing I had to accomplish. So on the spur of the moment, I walked over to the JetBlue counter and bought a ticket to Boston. Our son Paul, who learned to love drama tech at CPS, has continued to build sets and work backstage for the MIT Shakespeare Ensemble. That night, they were putting on a performance of *Richard III*. I flew up for the evening and came back to Washington on Sunday morning.

Around 4 o'clock, a colleague and I headed up to the Capitol to watch the vote.

Walking into the Capitol, the legislative affairs person with us told us to cover up our White House badges because there were lots of angry protesters. The final vote happened around 10 p.m. Walking out, the crowd had completely changed. The angry protesters had all left, and they had been replaced by people cheering. Then as we were driving back to the White House, an email came on my Blackberry—"The President invites everyone involved in health care reform to a party on the Truman Balcony."

It was an amazing event. The first lady and the girls were away. Even though the President has a staff of people to do these things, the party definitely had the feel of a hastily arranged college get-together. I kept expecting to see the pizza rolls come out of the microwave.

But there was such a feeling of euphoria. Everyone who had worked on health care reform—from the President and Vice President down to the research assistants—had been invited. I remember wondering if the Truman Balcony had really been designed to hold that many people—but it did.

Around 1 a.m., the President said he was going to bed, but we were welcome to stay and to look around the residence. We all took advantage of this and went clomping through the Lincoln bedroom, sitting on the bed and checking out the bathroom.

VI. CHALLENGE NUMBER 4: IMPLEMENTING AND IMPROVING THE LEGISLATION

As joyous as that night was, it was not in fact the end of the process. Another thing one quickly learns in Washington is that implementing and sustaining a piece of legislation is incredibly hard. Even with 1000 pages of legislative text, there are still tons of details to be worked out as it gets put into effect. And that is the fourth big challenge of economic policymaking—following through with the details.

Before I left Washington, the Council of Economic Advisers was very involved in evaluating various regulations being written related to the law. We hear a lot about the burden of government regulations these days. Something that is important to know is that every time an agency proposes a new regulation, there is a rigorous review process. It is incredibly important that this process work well. What I saw was that often what seemed like a trivial change can have enormous consequences for the cost and complexity of a regulation.

One of my worries about the implementation of the reform legislation is that people may let their guard down. The economists at the Office of Management and Budget, the Council of Economic Advisers, and other agencies need to be participating very actively in the regulatory process.

Now, I should make it clear that I think the evidence does not support the view expressed by some that the regulations related to the Affordable Care Act are holding back job creation. We can talk more about this during the Q&A, but the evidence is strong that low demand related to troubles in housing market and in Europe is the key source of our slow recovery. But prudent implementation of the Affordable Care Act is incredibly important for the long-run cost savings and the efficiency gains the Act is supposed to provide.

As we move forward, besides implementation, two other huge issues remain with the legislation.

One is obviously the legal challenge. The central question there is whether the federal government can require people to buy health insurance. This is the so-called “individual mandate.” Now, I am not a legal scholar, so I can’t speak to the constitutionality of that provision—other than to say that Administration lawyers believe

it clearly passes constitutional muster.

But I can talk about the economics. The individual mandate is an integral component of the overall reform. At one point, after Scott Brown won the election in Massachusetts for Ted Kennedy's Senate seat, the Administration debated whether we should greatly scale back the health reform plan. The idea was that perhaps we should put in some popular new rules, like prohibiting the denial of coverage because of pre-existing conditions, but not try to do to the whole nine yards—including controversial things like the individual mandate.

What the economics team argued is that it was an integrated package. Forbidding insurance companies from screening people for pre-existing conditions doesn't work if you don't require everyone to have insurance. Private insurance could not stay in business if people could sign up and pay premiums only when they learned they were sick.

More generally, given that we as a society are not going to leave uninsured people who become ill to suffer and perhaps die without care, we need to set up a system that makes sure anyone who can afford insurance buys it. And those who can't afford it can qualify for Medicaid or subsidies to help pay for private insurance. I believe deeply in personal choice, but only when the person making the choice bears the consequences of his or her actions. People don't have the right, it seems to me, to choose to have other people pay for their health care if they have the means to do it.

The other great challenge with the health reform legislation is to build on the cost containment features. According to the non-partisan Congressional Budget Office, the Affordable Care Act, even with the increased spending required to expand coverage, will reduce the federal deficit by about \$1 trillion over the next decade. And they speculated

that the deficit reduction could grow in later decades if the cost-containment provisions work as anticipated.

That is very good, but it is not enough. Even with the Affordable Care Act, the long-run budget projections are very nasty. So we are going to need to find additional ways to slow the growth of government health care spending.

The existence of the Affordable Care Act makes it possible to consider some unpleasant but perhaps needed changes. For example, last spring, President Obama floated the idea of gradually raising the eligibility age for Medicare to 67. Now, that is clearly a benefit cut. But it probably makes sense. As we are living longer and more robustly, it is reasonable to expect people to work longer before getting government health benefits.

But such a change can only be contemplated if the Affordable Care Act goes in as scheduled. Because the act provides a way for individuals who don't have employer-provided insurance to purchase it at a reasonable cost, people who want or need to retire early will not be forced to work just to get insurance. And it would make sense to couple any such change in Medicare eligibility with reforms of our disability system, to ensure that people in physically demanding jobs, for whom working to age 67 might be difficult or impossible, have a way to retire with dignity and security.

The important thing is that we treat the Affordable Care Act as the beginning of further reforms, not the end.

VII. CONCLUSION

I know that health care reform is a controversial topic on which reasonable people often disagree. So it is a delicate subject to talk about in a congenial non-

partisan setting such as this.

But it is a very good laboratory for talking about the real-world challenges of economic policymaking: The need to prioritize—and the possible consequences of choosing to accomplish a particular goal on our ability to tackle other needs. The essential role of evidence and analysis—both in designing a good policy and in making the case for a policy action. And finally, the importance of following through—the more complicated the policy action is, the more important it is to remain vigilant about implementation. The devil truly is in the details.

The final verdict on the success or failure of the Affordable Care Act won't come for several years. My own view is that it will be one of the enduring legacies of the Obama Administration. It will be seen as an important step in the quest for insurance coverage for all Americans, and a bold move to slow the growth of health care spending.

One of the memories of my time in Washington I like best isn't nearly as flashy as the party on the Truman Balcony, but it is related to health care reform. It happened on Christmas Eve of 2009.

The President had vowed not to leave town until the Senate passed a version of the health reform legislation. The vote was finally set for 7 a.m. on Christmas Eve. Katie and Paul, our two older children, were home from college and graduate school. And, instead of sleeping in that Christmas Eve morning, all three kids asked if we could go to the Senate and watch the vote. So we all got up at 5:30 on a bitter cold morning, and were in the gallery when the legislation passed.

That vote turned out to be absolutely essential, because after the Democrats lost the Massachusetts Senate seat, it was impossible to get another 60-vote majority. As a result, the House of Representatives eventually had to largely accept the Senate version

to pass the legislation.

But even at the time, I had a sense that I was watching history being made, and sharing it with three members of the generation who would reap most of the benefits. Afterward, we went to the White House lawn and watched the President's helicopter take off in a cloud of snow kicked up by the rotors.

Whether that event truly was momentous will depend not only on whether the legislation takes effect as scheduled and planned. It will depend on whether we keep rising to the challenge of economic policymaking. Many of the health care reform steps are essentially well-reasoned policy experiments. Some will work and some surely will not. For the reforms to be truly successful, we will absolutely need to fix things that don't work, and further improve even the things that do.