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THE ECONOMIC CASE FOR HEALTH REFORM

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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THE ECONOMIC CASE FOR HEALTH REFORM

FRIDAY, JUNE 19, 2009

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:00 a.m., in room 210, Cannon House Office Building, Hon. John Spratt [chairman of the committee] presiding.

Present: Representatives Spratt, Schwartz, Becerra, Doggett, Blumenauer, Berry, McGovern, Tsongas, Etheridge, Yarmuth, DeLauro, Edwards, Larsen, Connolly, Schrader, Ryan, Hensarling, Garrett, Diaz-Balart, McHenry, Lummis, and Latta.

Chairman SPRATT. I will call the hearing to order. Good morning, and welcome to the Budget Committee's hearing on The Economic Case for Health Care Reform.

We are privileged this morning to have with us Dr. Christina Romer, who is the Chair of the President's Council of Economic Advisers. Under her guidance, the CEA has developed an incisive analysis of our health care sector, the high price we pay for its flaws, distortions, and inefficiencies, and the advantages to be gained from addressing these flaws in a thoughtful, constructive way.

The CEA report provides critical context as Congress begins its consideration of health care reform legislation. This is the latest in a series of hearings related to health care that we have held here on the House Budget Committee. They have all pointed to the same conclusion, that we have a system with huge inefficiencies that need to be addressed, the sooner the better.

In 2007, we examined the nature and extent of overpayments to private health care plans operating through the Medicare Advantage program. We then held a hearing on the role of the Tax Code in health insurance coverage. And last year we held a hearing exploring possibilities for getting better value from our health care spending.

Today's hearing was called at the request of Mrs. Schwartz, who is engaged in the health care debate here, in the Ways and Means Committee, and at home, where her husband and son are both physicians. I am going to limit my remarks, therefore, and yield to her before turning to our ranking member, Mr. Ryan, for an opening statement.

Mrs. Schwartz.

Ms. SCHWARTZ. Thank you, Mr. Chairman, and thank you for those additional credentials. There is a lot of discussion about

health care in my household. It is definitely true. But it is also true that there is a lot of discussion about health care and health care reform in my community and from my constituents, both individuals, families, businesses, and of course here in the Budget Committee, a lot of concern about the growing costs of health coverage and some of the inefficiencies and changes we might make.

So I thank the chairman for holding this hearing, and of course thank you, Dr. Romer, for your presence here.

The recent report from the President's Council of Economic Advisers, of course you are Chair, on the economic case for health care reform could not be more timely. As you obviously know, we will see draft legislation come out, be reported out today by the committees, but we really do want to hear from you and look forward to it.

The challenges in our economy and the challenges in our health care system and the degree to which they are linked, that is going to be very, very important. As we talk about rebuilding our economy in order to enable American businesses to be more competitive and to restore stability for our budget and to bring our country back to the path of strong fiscal standing, we know that we have a challenge to create a uniquely American solution to health care costs and coverage.

We have already begun this work. In just the first 3 months of the administration in which you serve, and I am so delighted to see you making such progress already, we have already strengthened the health care more so than we have done in the past decade. And I am really proud of the fact we have extended affordable health coverage to 11 million children of working parents, taken major steps to modernize medicine through health information technology. That investment is important. And of course made a significant investment in life-saving medical research. And we also did create a way to help those who have been laid off from their jobs, at least in the near term, to be able to have access to health coverage.

So all three House committees, as you know, today have all been working on crafting comprehensive health reform legislation, and will be releasing that report today, that proposal today. My colleagues here on the Budget Committee have repeatedly heard me argue for health care reform as both an economic and moral imperative, to use the President's words, and I do that often. I believe it is our fundamental responsibility to improve health outcomes and to expand access to affordable, meaningful health coverage to every American.

We have also heard in this committee that really the really very grave implications for the Federal budget if we do not enact health care reform that controls the rate of growth of health care spending.

So at today's hearing I know we will be focusing on the economic imperative to achieving meaningful health care reform this year, to our Nation's troubled economy, and to our future economic growth. Health care reform that slows the growth of health costs will lower the Federal deficit and promote national savings and capital formation. I hope you will address that in more specifics.

Expanding health coverage for all Americans will improve Americans' health status and increase workforce productivity, free up dollars that are now used for benefits for increased wages and additional job growth, because we hear from many employers who say they would actually add jobs if they didn't have to worry about the rising cost of health coverage.

So what we do know is we need to take action. Many of us believe that. There are a lot of different opinions about what that action will be. But I think this hearing is very important to creating the economic consequences of action or inaction, and I look forward very much to hearing your testimony.

Thank you.

Chairman SPRATT. Mr. Ryan.

Mr. RYAN. Thank you, Chairman. Dr. Romer, I think this is your first time here to the Budget Committee, so welcome, we are glad to have you. There is no debate in Washington more controversial, more critical, and more consequential for the future of our Nation than the current debate over health reform. Our economic future hinges on the results of this debate.

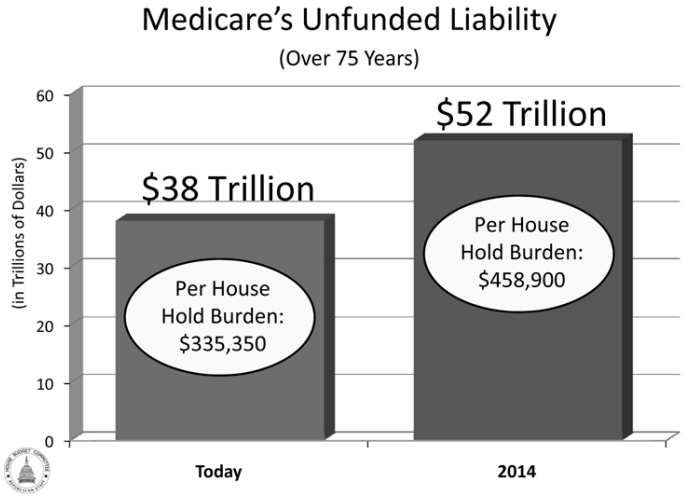
Dr. Romer, I read your report, The Economic Case For Health Care Reform, with great interest, and I have to say I agree on the huge benefits of slowing health care inflation. If we can achieve this goal, the economic benefits are vast. And I am pleased that we all share this goal.

However, at this stage in the game, with CBO fully engaged in scoring the proposals, I am less concerned with figuring out whether slowing the growth of rates will help. I know it will help. What I am more concerned about is how we slow the growth rate.

The specifics of how we do this matter very greatly. Just this week CBO Director Doug Elmendorf said, quote, large reductions in spending will not actually be achieved without fundamental changes in the financing and delivery of health care. So what are the fundamental changes that need to take place?

Congress is a legislative body, and it is not enough for us to assume that health care reform will have a positive effect on our long-term economic growth. We need to prescribe exactly how these changes are going to take place. What changes we make will actually bend the cost curve over time? The question must be answered and answered quickly, since our long-term economic outlook worsens with each year Congress fails to act.

If you could bring up the chart, please.



We recently learned from the Medicare trustees that the program's unfunded liability has grown to $38 trillion just this year, a single year increase of $2 trillion. Failing to reform this one program for just 1 year has cost us $2 trillion.

While I applaud the administration for proposing real scorable Medicare savings, many of which were included in the Republican budget, I have yet to see a single Democrat health care proposal that would direct these savings to deficit reduction. These savings are swallowed up by even greater spending increases.

As OMB Director Orszag noted, quote, our political system unfortunately does not appear to be particularly effective at addressing gradual long-term problems such as rising health care costs, end quote. Again, I agree, which is why we shouldn't give any proposal the benefit of the doubt that it will magically bend the health care cost growth curve over time.

Whether we can achieve these savings depends entirely on the specifics of these changes, none of which are in this particular report. Are they fundamental changes that remove market distortions and remove payment structures or reform payment structures, or are they provider cuts that Congress has reversed in the past and tax increases? According to CBO, there is no guarantee that the health care system's response to near-term cost reductions would produce greater quality or efficiency. While I believe these cost reductions are important, bending the cost curve requires changes more fundamental than simply provider cuts.

As CBO noted, quote, the government can spur those changes by transforming payment policies in Federal health care programs and by significantly limiting the current tax subsidy for health care or changing it.

Last Congress I introduced an entitlement reform bill, A Roadmap for America's Future. And just a couple weeks ago I, along with a number of my colleagues, introduced a health care bill, The Patient's Choice Act. Both of these bills transform the payment structure of federal health care programs and reform the current tax subsidy for health insurance.

The President has stated repeatedly that, quote, health care reform is entitlement reform. Again, we completely agree with that. The two are critically tied to each other. However, the fundamental drivers of entitlement costs must be addressed to put any health care reform proposal on a sustainable path.

As I review the administration's health care plan and where it is headed in the Congress, I conclude that it is more likely to weaken the quality of health care, increase its costs, and worsen our severe long-term budget problems.

CBO raised the same exact caution, stating, quote, without meaningful reforms, the substantial costs of many current proposals to expand Federal subsidies for health insurance would be more likely to worsen the long run budget outlook than to improve it, end quote. I agree with the benefits of reducing health care inflation and expanding coverage, but I hope you can explain how the administration's proposals will actually reduce health care costs and address the Nation's severe long-term budget problem.

Thank you, and welcome to the Budget Committee.

Chairman SPRATT. Dr. Romer, welcome to the Budget Committee. We are glad to have you. The piece of work you have done is an excellent piece of work. We appreciate it, and that is why we wanted you to come here this morning to talk about meaningful reform and what it means if we can discard the dysfunctional features of our health care system and move to a system with fewer flaws, greater efficiency. What is there to be gained, not just in the costs, but what is there to be gained for the welfare of our economy as a whole?

Before turning to you for your statement, let me ask unanimous consent that all members who have not been able to make an opening statement be allowed to submit a statement for the record at this point. We will take your report and make it part of the record. You can summarize it as you see fit, but you are the only witness this morning, so you can take your time and plow through it as thoroughly as you like. We are glad to have you, and we look forward to your testimony.

[The report, "The Economic Case for Health Care Reform," may be accessed at the following Internet address:]

http://www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/

STATEMENT OF CHRISTINA D. ROMER, CHAIR, COUNCIL OF ECONOMIC ADVISERS

Ms. ROMER. Well, thank you so very much, Chairman Spratt, Vice Chair Schwartz, Ranking Member Ryan, members of the committee. It is indeed an honor to be with you today to discuss the economic impact of health care reform.

The President, as has been noted, has identified comprehensive, meaningful health care reform as a top priority. In my testimony today I will be discussing the impact of successful reform on American families, businesses, the government budget, and the overall economy. As has been noted, 2 weeks ago the Council of Economic Advisers issued a report on this topic. And with your permission, I would like to submit a copy of the report for the record. It contains the detailed analysis and citations to the relevant literature that form the basis of my comments today. It also is going to con-

tain the sources and methodology for all of the figures that I will be showing you this morning.

Well, as has been noted, the key finding of the report is that doing health care reform well will have tremendous benefits for the economy. 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 to strengthen the resolve of policymakers to undertake the serious changes that are necessary.

So let me start with a discussion of where we are and where we are headed without reform.

Many of the crucial trends in American health care are well known. The Council of Economic Advisers, however, worked with others in the administration to develop what we think are the crucial facts. We feel that spelling out these facts and these trends makes a compelling case that doing nothing is simply not an option. So let me start.

One fact that is surely 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. The expenditures are projected to rise sharply.

Here I would like, let's look at the first slide. This shows you national health expenditures as a share of GDP. It is going from its current rate, that is the dashed line, of 18 percent, and what this shows is 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 United States' economy. That would be one of every $3 that we make would be going to health care.

The second effect or second trend to think about is where we are with households, because for households this trend of rising health care expenditures are likely going to show up as rising insurance premiums. And 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.

So let's look at the second figure. So the top line is showing you total compensation. This is the total amount that firms pay for workers. That includes both their wage and any fringe benefits. What the dashed line shows you is total compensation minus our projection of health care premiums. So what it is going to cost for workers. And all of these are in inflation-adjusted dollars.

What we project is that without reform, the noninsurance part of compensation, that dashed lower line, will grow very slowly and likely fall eventually as premiums rise over time. And what you see, the way to think about that wedge between the two lines, those are the insurance premiums that is projected. We can see it has already risen, but crucially expected to rise very dramatically over time. And obviously where that is going to show up is less noninsurance compensation going to our workers.

All right. Let me talk about the effect on government. Rising health care costs could also mean that the government spending on

Medicare and Medicaid will rise sharply over time. Let's go to, I guess it is the fourth figure now. All right. So this, the top line shows the projection of total spending, Medicare and Medicaid, including the State portion, as a percent of GDP. And what our projections show is that these expenditures, which are currently about 6 percent of GDP, will rise to 15 percent of GDP by 2040. Now, as I said, the dashed line shows the projected rise in Medicare and—I guess it is actually the solid line shows the rise in Medicare and Medicaid expenditures just due to demographic factors.

We do know that the American population is aging. The baby boom is going to be retiring sooner than we think. But what that solid line shows you is that if that were all that was happening, Medicare and Medicaid spending would obviously be rising, but not nearly as much.

The thing that is really driving the projections of the long-term expenditure is the fact that the cost per enrollee is going up substantially. And in fact just to give you some numbers, roughly one-quarter of the projected rise in expenditures on Medicare and Medicaid as a share of GDP is coming from the demographic changes, and the other three-quarters is coming from the fact that spending per enrollee is rising much faster 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.

Finally, another trend that is well known but simply 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 72 million by 2040. And there is the figure that goes with that.

The one thing I would add here is experts will tell you that though this is the numbers we give, like 46 million, have to do with how many people are uninsured at a point in time, but another fact that we know is that if you look say over a 2-year period, the number of people that have some spell where they don't have health insurance is much larger than that. You hear numbers closer to 80 million of people who go through some period without health insurance.

All right. So let's talk about the key elements of reform. So if these are sort of the trends of where we are going without reform, let's talk about the kind of reforms that the President has talked about. And he has set two fundamental goals for this 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 just toss it out. One of his key starting points is that if Americans like their current plan, they like their doctor, they can keep it, and they can keep him or her. 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.

Now, since reform plans are very much, as has already been mentioned, in the process of being developed cooperatively with the Congress, our report does not describe in detail the reforms that would enable us to achieve these goals. But to make the analysis

credible, we give a sense of the kind of changes that might be implemented. For example, we discuss changes in payment systems, investments in health information technology, and research on what works and what doesn't that could help to slow the growth rate of health care costs over time.

The President in his speech last Monday to the American Medical Association made some specific suggestions for reform along these lines. He also said that he would be open to changes that would give the recommendations of the Medicare Payment Advisory Commission a greater chance of adoption and implementation.

The Council of Economic Advisers report also surveys the evidence, much of it from international comparisons and for comparisons across different parts of the United States, that there is substantial inefficiency in the current system. The finding of this survey is that up to 30 percent of health expenditures in the United States, which is equivalent to about 5 percent of our GDP, could be cut without affecting health care quality or outcomes.

This is important for making the case that slowing the growth rate of costs by improving efficiency is absolutely possible. For example, our estimate suggests that we could slow cost growth by 1½ percentage points per year for almost a quarter of a century before we would have exhausted the existing degree of inefficiency.

However, I don't want to sugarcoat the situation. Slowing cost growth by 1½ percentage points per year may sound small, but it is, as has been suggested, likely to be very challenging. It will take an incredible degree of resolve and cooperation among policymakers, consumers, and providers to bring this about. It will surely require policymakers to take actions that will likely step on toes now, but whose cost-slowing benefits may not be felt until 5 or even 10 years into the future. But what our study shows is that slowing health care cost growth significantly should be possible.

Let me turn also to coverage expansion. 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 individuals in small groups that are above the actual cost of providing coverage for these segments in the population. Expanding coverage will likely involve creation of some sort of an 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.

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

All right. Well, at some level all of this discussion of where we are headed and the keys to successful reform are the necessary prelude to our more substantive contribution, which is to talk about the economic benefits of successful reform. Now, in our study we considered 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. For example, widespread access to primary care is likely to increase the emphasis on disease prevention and wellness. Smoking cessation and weight management are two preventative measures that could genuinely reduce cost growth over time, while obviously improving health and the quality of life.

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. Slowing the growth rate of costs is quite separate from the actions that we may take immediately to cut the level of government medical spending, such as the more than $300 billion of Medicare and Medicaid savings proposed in our budget, and the roughly $313 billion of additional savings that the administration proposed just last Saturday. These immediate cuts are unquestionably important for paying for the expansion of coverage and health care reforms in the next decade.

But for thinking about the changes that will save us from the unsustainable long run trends that I discussed earlier, slowing cost growth year after year is essential, and what we focus on in our study. Now, we considered various degrees of cost containment.

All right. In particular, we looked at the effects of slowing the annual growth rate of health care costs by one and a half, one, and just half a percentage point. And to be conservative, we assumed that it is going to take a few years before that genuine curve bending kicks in. All right. Well, this figure, though, is going to show you that the most direct effect of slowing growth in health care costs is that it would reduce the growth in the amount of resources that we have to devote to health care. As a result, the share of health care spending in GDP would rise more slowly.

And so what this picture is going to show you is the projected path of health care spending as a share of GDP under the assumption that the cost savings are devoted to nonhealth spending. All right. So the top line shows the path that we are on without reform. You have seen that before. Health care expenditures as a share of GDP rising steeply. The other lines show the projections under the different degrees of cost containment. If you want it, you get the very visual idea of bending the curve, in this case looking at what it is going to do to health care expenditures as a share of GDP. If we look at the bottom line, if we lower annual health care cost growth by 1½ percentage points, the share of health spending in GDP in 2040 would be just about 23 percent of GDP rather than 34 percent, which is where we are currently headed.

Fundamentally, what slowing cost growth does is free up resources. If we can restrain costs by eliminating waste and inefficiency, we can have the same real amount of health care with resources left over to produce the other things that we value. This causes standards of living to rise. So in our report we analyze the effects of this freeing up of resources in a standard growth accounting framework. And if you like equations, there are lots of them in the appendix.

Now nothing says how we would use those freed up resources. We may spend some of them to increase the quantity of health care by expanding coverage. We might also choose to use some of those freed up resources to improve the quality of our health care. But the crucial finding of our analysis is that we can have more of all

of the things that we value as a country if we slow the growth rate of health care costs.

We also expand our framework to think about what slowing cost growth would do for the deficit and for capital formation or investment. Because the government is a major provider of health care, slowing the growth rate of health care costs could lower the deficit and thus raise public saving. And efficiency gains that raise income would lead to additional private saving. All of this increased saving would tend to lower interest rates and encourage investment, and this extra investment is very good for standards of living and the level of output that we can produce.

Now, our estimate suggests that the combined impact of greater efficiency in health care and greater investment is very large.

Why don't we go to the next slide.

And a way to make sort of these effects very concrete is to translate them into the effects on the income of a typical family of four, again everything in constant dollars, adjusting for inflation, and these effects are shown in the figure. The bottom line shows the proposed path or 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 1½ 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 show you what our analysis implies about the effect of health care cost containment on Federal budget deficits. I need to be very clear that our estimates are not the official budget projections, which would be based on detailed projections of spending and revenues. Ours are more back-of-the-envelope calculations. They are also looking very much down the line 2 and 3 decades from now.

The other thing to be very clear is that our numbers do not include the cost of coverage expansion, and this is because the President has pledged that those costs in the next 10 years will be covered by hard scorable spending, savings, and revenue increases that are currently under discussion. Our numbers show the effect of slowing cost growth over the long term.

The key thing is that we find the effects on the deficit are very large. This figure shows deficit reduction in key years. And the different bars in each year show you the different degrees of cost containment. The purple is if we manage to slow cost growth by 1½ percentage points. What you see if you look there in 2030 is that if we can slow cost growth by 1½ percentage points per year, we estimate that the deficit will be about 3 percent of GDP smaller than it otherwise would have been. By 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 that we can do to ensure the long run fiscal health of the country. Health reform is absolutely central to long run fiscal stability.

Another macroeconomic effect of cost growth containment is a shorter 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 1½ percentage points per year would lower normal unemployment by about a quarter of a percentage point. This translates into an increase of employment of about 500,000 jobs. While this is almost surely not a permanent effect, it could last for a number of years.

Now, what this picture shows, it relates to studies that find that this mechanism was one source of the unusual prosperity of the 1990s. This figure shows medical care inflation, that is the heavy blue line, and it shows overall inflation, that is the black line, and then the shaded blue area shows you the unemployment rate. And what you can't help but notice is that medical care inflation fell dramatically in the 1990s. Greater attention to costs and widespread changes in the nature of health insurance led to a period of much lower health care cost growth.

What we also know, it sort of fell, medical care inflation fell from about 10 percent at the beginning of the decade to below 3 percent. What you certainly probably remember is that the unemployment rate also fell steadily over this period. Formal studies suggest there was a linkage between the two, and that the impact of slowing health care costs on the unemployment rate were quantitatively significant.

All right. Well, our report also discusses the benefits of coverage expansion. The most important of these involves the economic well-being of the uninsured. We used the best available estimates to try to quantify the costs and benefits of expanding coverage to all Americans. Among the benefits that we attempt to put a dollar value on are the increase in life expectancy and the decreased chance of financial ruin from higher medical bills. The costs to society of covering the uninsured represent a mix of public and private costs, and come from existing studies, not from estimates of plans being currently contemplated by Congress.

What we find is that 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 two-thirds of a percent of GDP.

Another effect of expanding coverage that we considered 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 or effectively treats that 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 the 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 preexisting conditions could end the phenomenon of job lock, where worries about health insurance cause workers to stay in jobs even when there are ones that pay better or are a better match available. Our estimates, again based on a range of economic studies, are that this benefit could be about two-tenths of a percent of GDP each year.

Similarly, we examine the fact that small businesses are currently disadvantaged in the labor market because current employer-sponsored insurance is so expensive for them, due in large part to the fact that they do not have a large workforce over which to pool risk. Moving to an insurance system that removes this disadvantage should be beneficial to the competitiveness of the crucial small business sector of the economy.

So 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 benefit to American families, firms, and the government would be enormous. To put it simply, good health care reform is good economic policy.

Thank you.

[The prepared statement of Ms. Romer follows:]

PREPARED STATEMENT OF CHRISTINA D. ROMER, CHAIR, COUNCIL OF ECONOMIC ADVISERS

Chairman Spratt, Ranking Member Ryan, members of the Committee, it is an honor to be with you today to discuss the economic impact of health care reform. The President has identified comprehensive health care reform as a top priority. In my testimony today, I will discuss the impact of successful reform on American families, businesses, the government budget, and the overall economy. Two weeks ago, the Council of Economic Advisers issued a report on this topic. With your permission, I would like to submit a copy of our report for the record. It contains the detailed analysis and citations to the relevant literature that form the basis for my comments today.

The key finding of the report is that doing health care reform well will have tremendous benefits for the economy. 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.

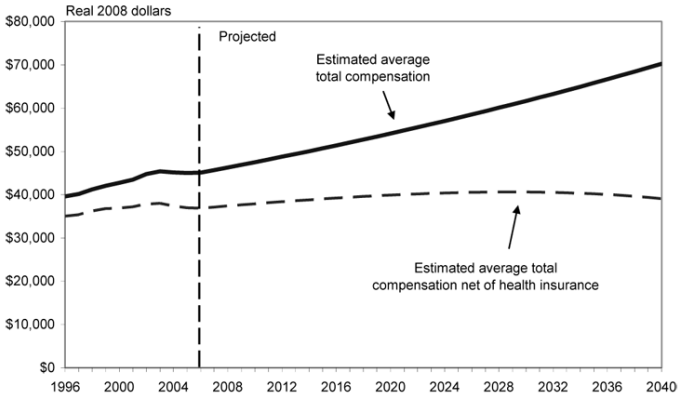
TRENDS IN THE ABSENCE OF REFORM

The report has four key sections. The first discusses some of the key projections of what is likely to happen in the health care sector without successful reform. If you want—it shows the costs of doing nothing.

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. By 2040, health expenditures could be roughly one-third of total output in the U.S. economy.

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 (Figure 3 in the report) 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.

Figure 3: Projected Annual Total Compensation and Health Insurance Premiums



Source: CEA calculations.

Rapidly rising health care costs also mean that total government spending on Medicare and Medicaid (including state spending) will rise sharply over time. Our projections suggest that these expenditures, which are currently about 6 percent of GDP, will rise to 15 percent of GDP by 2040. 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.

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.

NEEDED REFORMS

A second key part of our study looks at the inefficiencies in our current system and the market failures leading to our lack of insurance. It is important to diagnose the problem before one can sensibly discuss solutions. This part of the report also discusses the key goals the President has laid out for reform. One is to slow the growth rate of health care costs significantly, while maintaining quality and choice of doctors and plans. Another is to expand health insurance coverage to all Americans.

Since reform plans are very much in the process of being developed cooperatively with the Congress, our report does not describe in detail the reforms that would enable us to achieve these goals. But, to make the analysis credible, we give a sense of the kind of changes that might be implemented. For example, we discuss changes in payments systems, investments in health information technology, and research on what works and what doesn't that could help to slow the growth rate of health care costs over time. The President, in his speech last Monday to the American Medical Association, made some specific suggestions for reform along these lines. He also said that he was open to changes that would give the recommendations of the Medicare Payment Advisory Commission greater chance of adoption and implementation.

The CEA report also surveys the evidence, much of it from international comparisons and comparisons across different parts of the United States, that there is substantial inefficiency in the current system. The finding of this survey is that up to 30 percent of health expenditures in the United States (which is equivalent to about 5 percent of GDP) could be cut without affecting health care quality or outcomes. This is important in making the case that slowing the growth rate of costs by improving efficiency is 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.

However, I do not want to sugarcoat the situation. Slowing cost growth by 1.5 percentage points per year may sound small, but it is likely to be very challenging. It

will take an incredible degree of resolve and cooperation among policymakers, consumers, and providers to bring this about. It will require policymakers to take actions that will likely step on toes now, but whose cost-slowing benefits may well not be felt until five or even ten years into the future. But, what our study shows is that slowing health care cost growth significantly should be possible.

ECONOMIC IMPACT OF SLOWING COST GROWTH

More fundamentally, what our study shows is that the economic benefits of taking actions to slow cost growth will be enormous. This is, in fact, the conclusion of the third key part of our study, which looks at the economic effects 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. For example, widespread access to primary care is likely to increase the emphasis on disease prevention and wellness. Smoking cessation and weight management are two preventative measures that could reduce cost growth over time, while improving health and quality of life.

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. Slowing the growth rate of costs is quite separate from actions that we might take immediately to cut the level of government medical spending, such as the more than $300 billion of Medicare and Medicaid savings proposed in our budget and the roughly $313 billion of additional savings the Administration proposed last Saturday. These immediate cuts are unquestionably important for paying for the expansion of coverage and health care reforms 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 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.

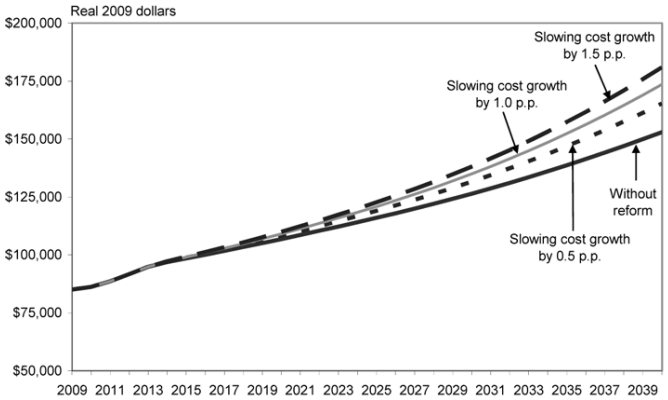
We analyze the effects of this freeing up of resources in a standard growth accounting framework. Now, nothing says how we would use those freed up resources. We may spend some of them on increasing the quantity of health care by expanding coverage. We also might choose to use some of the freed up resources 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 (Figure 15 from the report). 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.

Figure 15: Estimated Family Income with and without Health Care Reform

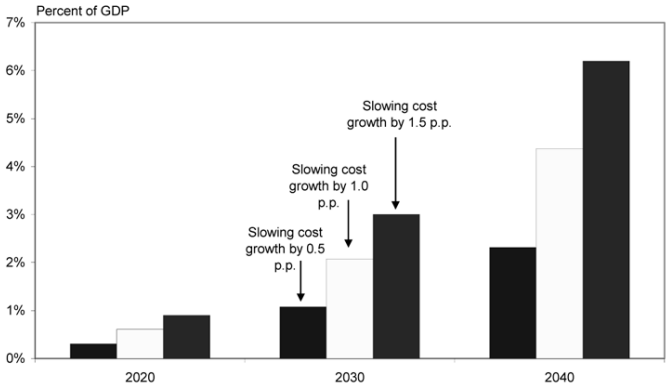


Source: CEA calculations.

I also want to show you 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 (Figure 14 from the report) 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.

Figure 14: Reduction in Federal Budget Deficit Due to Health Care Reform



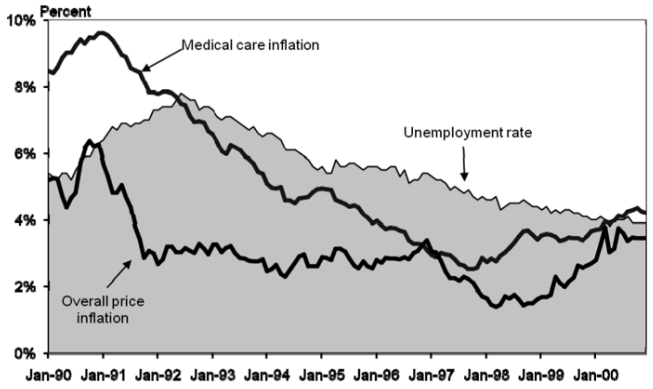
Source: CEA calculations.

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 ¼ 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 (Figure 16 from the report) shows medical care inflation, overall inflation, and the unemployment rate in the 1990s. Greater attention to costs and widespread changes in the nature of health insurance 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. The unemployment rate also fell steadily over this period. 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.

Figure 16: Unemployment Rate and Medical Care Inflation in the 1990s



Source: Bureau of Labor Statistics.
Note: Medical care inflation is the 12-month change in CPI-U: Medical Care, and overall price inflation is the 12-month change in CPI-U: All Prices.

THE ECONOMIC IMPACT OF COVERAGE EXPANSION

The report also discusses the benefits of coverage expansion. The most important of these 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 ⅔ 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 or effectively treats the 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 preexisting 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 current employer-sponsored insurance is so expensive for them (due in large part to the fact that they do not have a large workforce over which to pool risk). 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.

Chairman SPRATT. Thank you very much, Dr. Romer. A couple of questions on my part, and then in the interests of seeing that everyone gets a chance, I will limit my questions.

But first for detail, health care as a percentage of GDP, sometimes you see 16 percent, sometimes 18 percent. You have used 18 percent here. What is the reason for the difference?

Ms. ROMER. Some of it certainly has to do with sort of how up to date your numbers are. One of the things that is true is as GDP has gone down, that is making the current amount that we spend a bigger fraction. So I think it probably just has to do with sort of are you looking at 2009, are you giving a number for 2007, 2008? I think that is the main source of the difference.

Chairman SPRATT. Years ago I remember when we were having a similar debate, I think it was on Social Security, someone made a presentation to a Senate committee, and Senator Moynihan was a member of that committee, and when the presentation was through, it was about the cost of expanding health care, expanding Medicare and limits on it, and he said excuse me for being skeptical, but you can write it up to 25 years of being burned. In other words, I have seen these estimates before, and they simply didn't come to pass.

What you are proposing today, the bottom line I absolutely agree with. We all do. It seems counterintuitive, though, and that makes your burden of persuasion all the more difficult, because basically we know what it costs to insure 46 million people, roughly that, because we insure through Medicare nearly that number. They are higher cost beneficiaries for sure, but still it gives you a benchmark to refer to, and it is a pretty substantial sum, over $300 billion a year.

One of the questions that is raised, I don't think there is any doubt about the things that you are talking about, the doubt is about how do you implement them? How do you take the practices in Minneapolis and the good practices that are more efficient and ship them to Miami and implement them in Miami? How do you deal with preventive care? How do you police the way people eat? My daughter is an endocrinologist. She says to me I will tell you how you can cut the costs of health care in this country by 50 percent. Change the way people eat. As she does it, she sort of nudges her father and points towards me, but I am a case study in how difficult it is to change cultural styles.

How do we do this? How do we implement it, and how do we police to it to see that we are moving towards these goals, which I think you would agree are not going to happen overnight, they will have to happen in the latter part of the 10-year period that we are looking at?

Ms. ROMER. I couldn't agree with you more in the sense that it is going to be hard, and I certainly heard that in Congressman Ryan's remarks as well. One of the ways that I think of our report

is it is saying it is worth it. Right. We are absolutely putting in your hands doing these kind of meaningful, fundamental reforms. And it is certainly going to, as I said, step on some toes. And we are trying to show how important it is to do it.

In terms of what we do, again I am trying not to get too much ahead of the legislative process. But the crucial thing is that there are good ideas out there. People laugh when I say my bedtime reading, I keep it on my bedside table, the giant CBO volume of 108 things that you can do to slow the cost growth in Medicare spending. There are things that experts have said. Of course we don't know for sure how much they will work, that we will get exactly the cost containment that they are estimating. But there are crucial good ideas out there. And what we are asking is to get them into the legislation.

We have tried to put on the table certainly the spending cuts for right now that we think will pay for the reforms we are trying to do and the expansion of coverage, but also having the concrete proposals like more research in what works and what doesn't work. The President's proposal on maybe giving MedPAC a greater role, proposals about how do you deal with productivity changes in the medical care sector to make sure that gets reflected in prices. Changes in how we bundle and how we do payments, like bundling payments. You know, there is a lot of evidence, you mentioned some of the success stories, the Kaisers, the Mayo Clinics, that we think manage to actually do better by patients and have slower cost growth.

So that is exactly the huge challenge. I guess one of the things we have tried to say is there are the ideas out there, and basically asking you to take them.

Chairman SPRATT. One final question along the same line. Let's take IT, information technology, since we are already spending a substantial sum on it as a result of the Recovery Act. What sort of time frame do we expect for, number one, the implementation of these IT reforms and, number two, the achievement of gains from that technology in which we are investing at a pretty heavy pace?

Ms. ROMER. You are absolutely right. I think one of the wonderful triumphs of the American Recovery and Reinvestment Act is that we did get that money in there for health IT, and it is absolutely getting out the door. And so we anticipate that we will be seeing these innovations.

I think one of the things, again, this very much gets to your previous question, which is sort of when will we see the cost saving effects? You know, here the best analogy I would give is the computer revolution. When we looked at it as economists, we saw the consumer or the computer revolution coming to American business, and for the longest time, 10 years even, we said why isn't it showing up in the data? And then one of the views about another reason why the 1990s were so good is it was like bam, that is when it kind of all came together. And one of the things we learn is that it is not enough just to have the computer there, it starts to become a way of life. You start to have a generation that understands how to use it where it is not a new-fangled contraption, and then that is when you start to get the incredible productivity gains.

And I have heard David Cutler, who is an expert in health economics, talk about how there will certainly be a lag, and it could unfortunately, in our numbers we say we probably don't get a lot of this curve bending for at least 5 years until this technology diffuses, people become comfortable, we design a system that works with it rather than trying to deal with it in our old system. So it is almost surely going to take time. I would say the evidence from the computer revolution is absolutely the productivity benefits, the cost slowing benefits will come. It could easily take 5 to 10 years.

Chairman SPRATT. Well, thank you, ma'am. We look forward to working with you to achieve all of these goals.

Mr. Ryan.

Mr. RYAN. Thank you, Chairman. I enjoyed your study, and I would just simply say I think we all agree with these conclusions. That is really not the issue here. We all know if we bend the cost curve, good things happen. That is pretty much something we all agree on. But we are leapfrogging the facts before us, which is how do we achieve that? What is Congress going to do legislatively to achieve these goals we know are all very good? So that is really what we are focusing on here.

One of the assumptions you have in your study is that all these cost savings go to the deficit reduction and then all these good things happen. But let me ask you this. When we are looking at the way this bill is being set up, all these cost savings are going to create a new benefit.

So let's just take the Medicare savings, for example. I can only speak to things we read in the press because we haven't seen the legislation yet, but let's just say it is the $400 billion in Medicare savings. I think that is the number we hear. Any of my Ways and Means colleagues want to correct me?

Let's just assume it is 400 billion. That 400 billion isn't going to the bottom line to the taxpayer, it is going to create a new benefit. And so the cost savings are going to create new liabilities. And here is my big concern. It seems to me that what we are putting on the tracks here is a brand new entitlement program that could very well likely rival the size and liabilities of Medicare itself.

Look at the experience of the last 10 years. 1997, we passed the BBA. That was a bill that created the SGR, created a lot of payment reforms in Medicare, and was at the time estimated to save about $370 billion over 10 years of Medicare savings. It was a bipartisan bill. Bill Clinton was President, Republican Congress, cut capital gains taxes, paved the way for the surpluses that occurred later. A great budget agreement that this man right here was a big part of.

But what happened after that? Congress gave back all the savings. We had the BBRA, we had BIPA, we had all these bills where we gave back all of these savings. And I will agree that some of them were artificial price controls that didn't work. Point being, though, Congress created the savings and then interest groups came, lobbied, and the money went away. And what happened? The liabilities continued to grow.

So here is what we are doing again. We are creating a new benefit, a new entitlement, a universal entitlement, and we are setting up a pay-for system that is not a self-financing system. We are set-

ting up a pay-for system with a grab bag of tax increases and a grab bag of provider cuts, which history shows us always fade away, but the new entitlement continues on. And so we are basically doing this all over again.

And so what I can't comprehend or what I can't get my mind around is how are we fixing the problem here of our long-term fiscal liabilities when we are creating a new entitlement, paying for it within the first 10 years, when all of the experience and history shows us that these pay-fors fade away, the entitlement grows, and voila, another huge new health care entitlement.

How do you reconcile that?

Ms. ROMER. All right. So I think the crucial thing is to draw the distinction between paying for the things that we are doing right now and the reforms that are going to slow the growth rate of costs. Because fundamentally, what the President has said is, you know, we do know that expanding coverage, we do know that, as we have already described the investments in health IT and research and what works and what doesn't work, those do cost money. And that is why the President, through his budget and other things that he has announced, has put $948 billion on the table to pay for this in the next 10 years. You know, he has said very clearly this absolutely has to be deficit neutral in the short run. And then exactly what our report is talking about and what we are asking the Congress to do is to in that process of expanding coverage, doing these reforms, to put in the kind of changes that will slow the growth rate of costs over time. That is just simply so important, and that is why it is not just these level savings that we have been talking about now, but the more significant reforms in how we pay providers, emphasizing value over volume, how we set up systems to deal with productivity improvements, how we change the incentives used for technological change. Those are just so crucial for the long run deficit.

Mr. RYAN. Right. Because I want to be sensitive to people's times. The clock doesn't run for the two of us, but I want to be sensitive to that. Why didn't you talk about ideas to bend the cost curve itself? You talk about the conclusion of bending the cost curve. You assume 1.5 percent, which by the way I think you say is the upper bound.

Number one, my question is do you think that is an actual realistic assumption? But number two, why not talk about the game changers that Federal policy can actually effect, like the changing of the tax subsidy, which most economists, and I think you would probably agree the tax exclusion is a source of health inflation. Why not talk about restructuring the way Medicare finances health care, the tax subsidies? Why not talk about those things that the Federal Government can actually do that we are fairly confident will change health inflation instead of just assuming changes in health inflation occur and then talking about all the good things that happen from that?

Ms. ROMER. Okay. So various things. First, on whether 1½ percentage points per year is an upper bound by how much we could slow the growth rate of costs. We do think it is going to be very hard, and so we did put that in. I will tell you I was at a symposium with Mark McClellan and David Cutler, again two distin-

guished health economists, and Doug Holtz-Eakin, and David Cutler said I think you should have had 2 or 2½. So he absolutely thinks that we were not at the upper bound. And he certainly has thoughts again, he is such a big proponent of health IT, he thinks at some point you could get substantially more. So we were trying to be quite cautious. And I will say there are others out there.

I do feel, as you have surely seen in our report, we didn't list particular things, we certainly didn't have legislative language, we did try to describe what the game changers were like. Because to make this credible it is absolutely the case that we are going to need to do these things.

We didn't want to get ahead of the legislative process. Our job was, as I described it, basically to show you all how valuable it would be, to give you the support you need to say we are doing these hard things, but it genuinely will matter.

But I will again commend to you the report that came out from Doug Elmendorf at the CBO this week about the long run fiscal situation, but had these very concrete game changers. I think you will see we have proposed or the President has spoken about most of those as things that are important. He has talked about accountable care organizations. He has talked about bundling payments. You know, we think that is one of the things that both improves the quality of care, makes sure that one person is watching this process beginning to end, but also has been shown to slow the growth rate of costs. He has talked about things like Centers of Excellence as a way of—you know, we find that patients again get better care, lower risks, and restraining cost growth.

So we do think those things are out there and very much on the table.

Mr. RYAN. So again we agree that with the economic benefits of bending the curve, you know, ceteris paribus, but you do this in isolation. And when taking account of the administration, all the other economic policies that the administration is providing, you know, using your work, you know, it is as if we are imposing all these adverse exogenous tax policies. And so what that means is, what I am trying to say here is I am a fan of your prior work, we are raising taxes on businesses, we are raising tax rates on small businesses, we are raising taxes on capital, we are maintaining the second highest tax rate in the industrialized world on corporations, we are taxing worldwide American firms on their overseas operations, making it harder for them to be more competitive in the global economy, we are engorging ourself on deficits and debt, which is going to make our borrowing costs go up, make our interest rates go up, and so we are engaging in this kind of economic policy that is sure to harm our economy. This is not an opinion; I think any kind of good regression analysis would show this.

And so yes, bending the cost curve in health care is good, but if we are really trying to see what we are going to do to achieve prosperity in America, shouldn't we look at all things that the government is doing? And since you are the CEA, shouldn't you incorporate in these kinds of studies all the other things that the Federal Government is doing that I think you would have argued are not good economic policies?

Ms. ROMER. I certainly should look at all of the things that the Federal Government is doing, and I think we are doing a spectacular job. I would say the American Recovery and Reinvestment Act was incredibly useful spending, that there is simply nothing worse for the deficit than having the economy go off a cliff. And bringing us back from that cliff has been absolutely crucial. I think what the President has——

Mr. RYAN. You are welcome, I set you up on that one there.

Ms. ROMER. What the President has been talking about is not only getting through this crisis, but putting us on a stronger footing going forward. And you have seen he has done a financial regulatory reform, he is talking about health care reform, all the things that we need to do to make us stronger going forward.

I also want to come back, since you brought up the issue of taxes, again I have to come back to the Recovery Act, because surely you know one of the biggest things that we did was give substantial tax cuts to the vast majority of the American population. So the crucial Making Work Pay tax cut.

And then I think you and I do not disagree that deficits are a problem, and that is why I am here today. You know, I have from long before I had this job those CBO studies that showed the trajectory that we were on for Medicare and Medicaid spending. It is just something I can't emphasize enough that can't last. And so I think what we all need to talk about is what can we possibly do to bend the curve to slow that cost growth. Because it has to happen. The trajectory we are on cannot come to be without the country really getting into big fiscal trouble.

Mr. RYAN. Thank you. I will just simply conclude by saying CBO is warning. They are telling us our deficit path is unsustainable. It will never get below $600 billion. We end the budget window with the tripling of the national debt, 5.4 percent of GDP deficit. They are telling us in their long-term projections on health care we are going in the wrong direction. We are possibly adding a new third health care entitlement that I think most observers would say will not be fully paid for. We are not even doing long run scoring outside of the 10-year window to see what kind of liabilities we are piling onto the next generation.

And so you know, obviously we have differences of opinion on some of these things. We do agree bending the health care cost curve is a good thing for many reasons. We just might disagree on how we achieve that.

Thanks for coming.

Chairman SPRATT. Mrs. Schwartz.

Ms. SCHWARTZ. Thank you. I often find myself having to decide between asking my question and engaging some of the debate I want to engage in and then just answering Mr. Ryan. So coming after him, I always have that sort of little dilemma personally, because I do want to say that much of what Mr. Ryan said, well, our agreement is that we want to grow this economy, right. And in fact, some of the suggestions that Mr. Ryan made, I have to say, while we are looking at all the options, there is nothing in your report that suggests either an entitlement or the kind of taxes that he is talking about. So without spending time on that, there is nothing that we are discussing today that suggests that.

What you are saying, in very, very clear terms, and I wanted to just sort of follow up on this, is that if we are to grow this economy, if we are going to enable businesses to be able to have the capital to make the investments, whether it is new employees or expanding their business in other ways, they need to have that capital. And they are finding increasing dollars, scarce dollars that they have in this economy going into health care benefits. They want to see that shrink for themselves, and certainly their employees do.

In addition to the issue about the Federal budget, what I really wanted to ask you about, because you mentioned this certainly in your comments, and in the report it comes out pretty significantly, is that one of the questions we have been asked by our constituents, they care about the Federal budget and the deficit, it is very important to us on the Budget Committee, they care about economic competitiveness, but what they mostly want to know is how it is going to affect them. Most Americans have health insurance coverage. Now, a lot of them are really worried about that cost. A lot of them are worried about losing it. A lot of them don't change jobs because they don't know what their health care coverage is going to look like. A lot of them don't start new businesses because they say they may have a preexisting condition, and they know they are just never going to be able to pay for health care coverage, and they worry about that.

So without giving all the answers here, I think this is important, but what I would like you to be as specific as you can on, how is this going to matter to the millions of Americans who now have health insurance coverage for us to actually take the action that you have laid out that we believe that we have to take in order to bring down the deficit and to be able to address the concerns about the insecurity that so many Americans feel about health insurance coverage?

So if you could speak a little more specifically to the—should anybody be listening—to the millions of Americans out there who say what does this do for me?

Ms. ROMER. Absolutely. And it absolutely is crucial to Americans at just so many levels. So let me start with one, which is one of the things that the President wants to make sure is that people aren't frightened by health care reform. Right. That he wants to make it clear if you like what you have, if you like your doctor, we are not going to—we are going to preserve that. And that is so important.

A second thing, though, is what they may well be—what the average American may well be reacting to is they have seen the same numbers, the same studies coming out. They realize that on the trajectory we are going they might not be able to have what they have now because the status quo just can't last. We are seeing these health care costs rise so dramatically. They know that their premiums are going to be going up dramatically. They are worried. We see with small businesses the number of them that have dropped their employer-sponsored health insurance has just really been skyrocketing over the last few years as costs have been going up. So we do projections when costs go up even more, even more of those are going to drop.

Ms. SCHWARTZ. So some of the risk adjustments, some of the risk pooling that we can do for small businesses could make a very, very big difference in their actually seeing a change, a reduction, a decrease in what they are paying for health insurance.

Ms. ROMER. Absolutely. I think that is just so crucial, to make sure that Americans have the security that if they like what they have, it can last, because we will take the kind of reforms that will make sure that costs don't rise astronomically.

Your point about security. I think the President's emphasis on as we do this right, as we get something like a health insurance exchange, we can get rid of the limitation on preexisting conditions. Because, you are right, so many Americans, one of the things they worry most about losing their job is if I have got a preexisting condition, will I ever be able to get insurance again. To take away that source of insecurity for the average American, I think, is going to be incredibly important.

I think the other thing, oftentimes when we have been talking about financial regulatory reform or any of these big things that we are talking about, of course the things right down next to home are important. But I keep trying to come back to the bigger picture, which is every American benefits from a healthier economy.

And so taking the kind of steps that slow the growth rate and costs so that our budget deficit doesn't go through the roof, so that we don't have interest rates rising over the next two or three decades, all of that is so important. They may not notice it much. It is not like it is right there in their paycheck every month. But it is fundamental to their economic well-being and what they can hope to leave to their children. The kind of economy and society that we will have.

And so I think keeping that big picture in mind is crucial for each person.

Ms. SCHWARTZ. My time is up, but certainly it is going to be very real to American families if they have more money in their paycheck after a decade of stagnant wages and if they actually have some money to save for the future, those extra dollars, because they get cheaper health care coverage, but better quality health care coverage and maybe they are healthier, will be real to them.

I appreciate your comments and really commend all of my colleagues to read your report fully. I think it really states the case for us to take action. Thank you. I yield back.

Chairman SPRATT. Mr. Hensarling.

Mr. HENSARLING. Thank you, Mr. Chairman. Dr. Romer, if the purpose of your testimony is to convince us that health care reform is a must and that there are great benefits for our citizens and our economy to control health care inflation, I would say either, one, your testimony is not needed, or it has succeeded beyond its wildest expectations. I don't think there is any disagreement on any of those propositions on either side of the aisle.

Ms. ROMER. May I take the second one?

Mr. HENSARLING. The question is not should, the question is how. In that regard, the President, I guess on Monday, gave a speech to the American Medical Association. And you have alluded to this. I think the President has said it on many occasions, but

he said, "If you like your health care plan, you will be able to keep your health care plan. Period."

Now, one of the major Democratic plans that is on the table today is the Kennedy-Dodd bill. CBO recently came back with analysis of parts of that bill that indicated, "The number of people who had coverage through an employer would decline by about 15 million, and coverage from other sources would fall by about 8 million."

Given this estimate from CBO, do you accept that estimate? And, if so, given the President's commitment on Monday, if the Kennedy-Dodd bill came across his desk, is that something he would reject?

Ms. ROMER. It is so important to realize that, as you well know, there are lots of bills being talked about, and we are going to be getting just a whole slew of CBO scores as these various bills make their way through. The other thing that is important is, of course, in that particular case what was being scored was a very incomplete part of it. So what the President has, he has definitely sketched out his vision. I strongly recommend——

Mr. HENSARLING. Dr. Romer, let me try it a different way, then. Let's divorce it from the Kennedy-Dodd bill. If legislation comes across his desk that CBO analyzes will have a significant decline in the number of people who are covered through their employers, would the President veto that legislation?

Ms. ROMER. I am not going to presume to speak for the President. I will tell you that he has said many times part of the American way of health care insurance is largely employer-sponsored. And that is something he wants to maintain. And he has talked about ways that he would do that. That is certainly very important to him.

Mr. HENSARLING. Let me ask you about something else the President has said, Dr. Romer. I guess on June 11, 2009, in his town hall meeting in Green Bay, Wisconsin, the President said, If the private insurance companies have to compete with a public option, it will keep them honest and it will help keep their prices down.

I don't know of any hospital administrator, I don't know of any physician that has certainly walked into my office since I have been a Member of Congress who hasn't said essentially we have non-Medicare patients who end up subsidizing Medicare patients. Essentially, what some do not pay in premiums in the front door, they end up paying in taxes in the back door.

So I am just somewhat curious. If I am a private competitor, how do I compete with somebody who writes the rules of the game and essentially has a printing press of Federal money in the back warehouse? I mean, how do you expect to compete with the government?

It seems to me we kind of tried this in the mortgage market with something called Fannie and Freddie. They drove out within their section of the market—for all intents and purposes, they drove out all of the private competitors, and now we have seen what has happened. And it has blown up in the marketplace.

So, how do you really expect any type of private insurance company to end up competing with somebody who can print money, subsidize the plan with taxes, and write the rules?

Ms. ROMER. Let's first be clear, the reason that the President has supported a public plan, he wants to make sure that every consumer has choice. And we do know if you set up exchanges, depending on sort of the level at which you set them up, we do know that there is a lot of geographic concentration, and so wanting to make sure that everybody has a number of plans to choose from. One way you can do that is make sure that there is a public one. So I think that is very important.

Your point, I think, it is going to be in the details. I very much take your point to heart that we do need, when we have this public plan, it needs to be on a level playing field.

Mr. HENSARLING. But you at least admit there is the possibility that a public plan, if not properly engineered, could drive out private plans?

Ms. ROMER. The important thing is how we design it. That is true with so much of what we do.

Mr. HENSARLING. I see my time is up. Thank you.

Chairman SPRATT. Mr. Doggett.

Mr. DOGGETT. Thank you very much. Thank you so much for your testimony and your important work, Dr.

With reference to the revenues that will be necessary to finance health care reform, after we have gotten the most that can be had in terms of savings and have tried to assure as efficient a program as possible, I know the President has suggested some ways of providing those revenues.

Is it important in an economic sense that the financing for any health care plan be progressive in its effect on our population?

Ms. ROMER. You are absolutely right that the President has, as he has been proposing, how are we going to pay for what we have been proposing, he absolutely has said that this needs to be paid for. That is why he is done more than $600 billion in hard spending savings. But he has suggested a particular tax increase. Limiting the itemized deduction for high-income Americans.

The President has looked at the trends over the last decade, where we do know that middle-class families have taken a hit. And he feels it is incredibly important that we not raise taxes on middle-class families. He has made a very strong commitment to that promise. And we think it is important for the economy that it take the form that he has described.

Mr. DOGGETT. In current economic conditions, what is the likely effect of, for example, deciding to finance reform by putting a tax on payroll—some kind of payroll tax or of taxing the benefits that middle-income people get through their employer for their health insurance now if they, say, have a dental policy or a policy with low co pays?

Ms. ROMER. You can very much see our attitude on this from the American Recovery and Reinvestment Act. When we designed a tax cut that we thought would help get the economy going again, it was a broad tax cut for working Americans earning in the middle-income range, because we do feel that that is—they are the people that, when you give the money, are very crunched, and go out and spend it. And that is part of the reason why we think it is going to be very effective.

That follows on the other way. If you are thinking about how to pay for something, you don't want to raise taxes on the people that need the money very much to keep their spending going, for the economy as it is today.

Mr. DOGGETT. Let me focus a little on the public option and the role it plays in addressing the concerns that you have raised this morning. Only on Tuesday of this week, three major insurance companies indicated that they were continuing their practice of dropping any sick people that they could from their rolls, even though they paid their insurance premiums. They call it rescission. For a family with a sick member, it is, I think, a much more harsh term.

We also know that from the charts you had that the percentage of health care of our Gross Domestic Product is scheduled to about double.

If you don't have an effective public option, how do you get control of costs as well as access to people that are being terminated by private insurers even though they have paid their premiums, just because they are sick?

Ms. ROMER. I do want to come back to the public option as a source of choice. And basic economics does tell you that competition is good for cost control. I think that is certainly very important.

The other thing that I think is useful to put on the table is the idea of the public option as a leadership role, as a source of innovation. We have had conversations at the White House with private insurers that are saying some of the things that you are proposing, say, for Medicare, we would love to see you do more on the bundling side, because you can be our leader. You can make it easier for us to do some of those things.

I think another important role that the public option can play, is as a leader of innovation in the kind of reforms that can slow costs over time.

But then also your point, the President couldn't agree with you more on the importance that people with preexisting conditions can't just—that they need to know that there will always be insurance there for them. And setting up that is going to be a crucial part of how we set up the exchange. Certainly, the public option helps to make that very real.

Mr. DOGGETT. Thank you very much.

Chairman SPRATT. As you can see, we have about 8 minutes to vote. I am going to stay here through this vote so that any members who wish to do so, may do as well. But we will move now to Mr. Diaz-Balart.

Mr. DIAZ-BALART. Thank you very much, Mr. Chairman. Let me first thank you for your service. Public service isn't always the easiest task. So I really, really appreciate you doing that. We know what a sacrifice it is, particularly on your loved ones, because of your time.

Let me go back to something, because I think obviously there are reasons, not of this administration necessarily, but there are reasons to be skeptical about some numbers and some projections, obviously. By the way, I do want to echo what Mr. Hensarling said. You mentioned a while ago that good health reform is good economic policy. That is absolutely the case. I guess the converse of

that would be that health care reform that is bad would be bad economic policy. Not only that, but bad family policy and devastating to individuals and families. I think, obviously, that is something we would all agree on.

On January 9 of this year, as Chair Designee of the Council of Economic Advisors there was the report: The Job Impact of the American Recovery and Reinvestment Plan, the stimulus plan.

On page 5 of the report, it contains a chart showing the projected unemployment rate with and without the recovery plan. Based on those numbers that you had, the stimulus would have capped the unemployment rate at about 8 percent. About 8 percent. Now, as you can clearly see in the chart, unemployment for the last three months, March, April, and May, is substantially higher than was projected by the administration with the passage of the stimulus. But what is ironic, it is even higher than projected unemployment, according to those numbers, if we wouldn't have spent one penny on it.

So, obviously, there are several conclusions that can be drawn because of that.

Now, cynics will say—and I don't agree with this, and I would condemn it. But obviously you have heard it out there. Some cynics say, well, Congress was misled. And it was an effort to mislead Congress. That is, obviously, not something which I agree with. And I would condemn people saying that.

The more likely scenario, of course, is the stimulus has, frankly, just been a failure. That unemployment has soared past 8 percent despite the fact that we have spent and put on our children and grandchildren's credit card billions of dollars in increased debt.

Now, with all due respect, I just heard from you—and I say this with all respect—that a wonderful job is being done. I just got the last economic numbers from Florida. I just got it on my Blackberry right now. Unemployment in Florida has just shot up to 10.2 percent, up in 1 month from 9.7.

With all due respect, that is not good. Those are not rosy numbers. People are losing homes and jobs.

So it may be a semantical issue, but I think we have to be very careful, because saying that that is doing a great job, with all due respect, I don't agree with.

Now, here's my question. How can you reassure us, this committee, that the information that we are being provided today by the administration is more accurate and hopefully less flawed than the obviously flawed, obviously didn't work numbers of the stimulus plan?

Ms. ROMER. I would be happy to. One, since you mentioned the toll that this job takes on loved ones, I do have my husband and son here today. So I did—the one perk that they get is that they occasionally get to see their mom and wife in action.

Mr. DIAZ-BALART. You are an optimist because I know that it is a tough job. Again, I do want to thank you, and I respect and admire you.

Ms. ROMER. So, let's take on these numbers absolutely, because the crucial thing—so let me first talk about Florida's unemployment numbers, because I will be the first to say that those are ter-

rible, and I can't think of anything worse than what is happening to American families and these unemployment rates.

What I do take the most strenuous exception with is that those numbers are a sign that the recovery plan isn't working; it is a sign that Congress—you said you didn't agree with this—that Congress was misled. What it is a sign of is how much the economy deteriorated in early January and February. And you will see when we did this chart back in early January, we were doing the best estimates that we could. And I will tell you that the forecast certainly—I think the strongest point in our favor is your point that things are much worse than what was being forecast without any recovery plan.

What deteriorated was where we—the estimates of where we were headed. You see this in every private forecast. The blue chip consensus forecast deteriorated between January and February and March—again, on the unemployment rate—by about a percentage point.

What we learned was a lot of information. The rest of world that we had a hope maybe was going to be not synchronized with us tanked in January and February. And so really what we saw was a tremendous deterioration in the

baseline.

So one always does forecasting. You make the best estimate you have at the time. And at the time we were smack in the middle of what other private forecasters, the Federal Reserve, all of those, were making.

In terms of the recovery plan, I can't help but say that thinking about where we were in January and how the economy—we lost 743,000 jobs in January. That was just—we were all shocked at how quickly the economy—the acceleration of the downturn. And one of the things, of course, we can't say that things are good now, but it is encouraging that the rate of job loss is slowing. It is encouraging that retail sales that had been plummeting earlier this week actually rose. The housing market, where we know we have just seen unbelievable declines in building, we actually saw building permits turn up.

So the sense, whether you call them the green shoots or the glimmers of hope, the crucial thing is we are seeing signs that what was truly a precipitous free-fall is slowing, and we have every hope and anticipation that it is going to bottom out and start to grow again. That is, again, what you see in the professional forecasts.

I will tell you again the blue chip forecast is now forecasting that we will basically have zero GDP growth in the third quarter, we will stop falling, and in the fourth quarter it will be positive again.

And I absolutely feel that the Recovery Act and, of course, what we have done with the financial stabilization, what the Federal Reserve has done, all of that has been crucial to stopping the precipitous decline and bringing us these encouraging signs.

Mr. DIAZ-BALART. But your estimates now are going to be better than the past estimates.

Ms. ROMER. Let me just very quickly; that is a forecasting issue. I absolutely feel very strongly that the numbers for what we think the Recovery Act will do in terms of the impact are absolutely still

correct and accurate. And I will be making reports to Congress that will be testing all of those assumptions.

The thing that changed is the unknowable at some level of where the economy was headed without policy. Very much what we have been talking about here is what are the effects of the changes that we are talking about, and I firmly believe that those numbers are as good as they can be.

Chairman SPRATT. We are trying to get enough time for Mr. Blumenauer to ask questions. Mr. Blumenauer.

Mr. BLUMENAUER. I just want to apologize for your husband and son. If this is their day in D.C., that makes my blood run cold. So I will be brief and get on and maybe only miss one vote.

I did listen to my colleague, Mr. Ryan. I voted against the balanced budget agreement because I didn't think it was real. And I am sorry that the Republicans gave back all the savings when they were in charge. But that doesn't indicate that we can't structure something that will make a difference.

I come from one of those low-cost, high-value States, Oregon. If every part of the country had a Medicare practice like Oregon's, we wouldn't have that huge deficit.

So I appreciate what the administration has done indicating that you want at least half the cost to come from providing greater value to recipients.

We have had lots of evidence in our Ways and Means Committee, in the Budget Committee, that lots of and lots of care, test procedures, a dozen different physicians, doesn't necessarily give better health care to the people. I commend you and the President for focusing in on this.

I have, this week, introduced legislation to deal with choices for end of life. Right now, Medicare doesn't pay a doctor for sitting down for an hour and working with a patient and their family. It will pay all sorts of tubes and tests and procedures, but not something that would help them and undoubtedly save costs over time. We don't have a transitional benefit to help make sure people stay out of health care.

And one of the things I feel very strongly about is a bonus to reward low-cost, high-performance communities, for rewarding what they are doing, rather than rewarding, I think you said, volume over value.

You have staked out the public plan. And I wanted to give you the next 2 minutes to just speak about this incredible specter of something that is going to be a heavily subsidized, prescriptive, intrusive actor in the health care arena that doesn't comport with anything I have heard the President say, working with members of his team, or what you said here today. Can you take a minute or two and clarify the intent?

Ms. ROMER. I absolutely will. I do want to come back and, again, I think your reference to Oregon is so important, because when we look at the variation in spending across the country, absolutely we see places with high-value care often being some of the lowestcost. And so that is so important, that we can have quality, maintaining all that is good in improving it, and slowing the growth rate of costs. So that is crucial.

Also, what you were describing about empowering patients, that is one of the things that I have heard the President be so eloquent about.

Why does he support the research on what works and what doesn't? It is just unbelievable that I can know more about the car I am buying than some surgery that I am thinking of getting done. And so the idea that we need to empower patients and talk to patients about what do they want in their treatment is just crucial.

The public plan is absolutely something that is designed not to, in any way, supplant the current system, not to, in any way, hurt current insurers. It is designed to provide choice to make the market work better. That is the fundamental idea, is to make sure that there is competition, to make sure that consumers always have a choice of a number of plans that can satisfy their needs. But it is absolutely, the President has made it clear, that he wants it on a level playing field with the private insurers.

It is there to be an innovator, it is there to be someone that, again, is providing choice and competition. But certainly we'll be working closely with the Congress in thinking about what would be a desirable way to structure it.

Mr. BLUMENAUER. But not a heavily subsidized——

Ms. ROMER. Never.

Mr. BLUMENAUER. Startup costs only, deficit-neutral.

Ms. ROMER. Make it so that it stands on it its own. That it is there separate from the government.

Mr. BLUMENAUER. Thank you. I appreciate your willingness to make that a part of the record. Thank you, Mr. Chairman, for your courtesy.

Chairman SPRATT. We have got two votes and we will be back as quickly as possible. We appreciate your forbearance.

Ms. ROMER. It is an honor to be here, so I will be here when you come back.

[Recess.]

Chairman SPRATT. We will go to Mrs. Lummis next, then to Mr. McGovern.

Mrs. LUMMIS. Thank you very much, Mr. Chairman. Welcome, Dr. Romer. It was nice to meet you in the back room. I look forward to asking you a couple of questions. So thank you again for joining us today.

I have two questions specifically that I want to focus on. While you offered no specifics about how the efficiency gains assumed in your study will be obtained, your study does assume that they can be obtained.

So let's assume for a moment that we could fill in the detail gap of your study and achieve savings without compromising quality, something that I think we all would like to achieve.

The transference of the attained health savings to economic benefits is based on your assumption that health savings will be devoted to deficit reduction. And my question is: Is that a realistic assumption, and are there ways that that could be enforced and assured?

Ms. ROMER. There are a couple of things to say. The health savings, the only ones that I was assuming were going to deficit reduction are the ones the government gets, because of course what we

are talking about are savings to the whole system. So that we know a lot of the expenditures are private. And those will go back to the private sector.

So, what we were assuming is that anything the government saves from, again, from these long-term curve-bending actions will go into deficit reduction.

Again, I guess I am going to have to throw it to you because it would be for Congress to make sure that that happens.

One thing I would point out is the numbers we are talking about are huge. The important thing is about curve bending is it slows that growth rate year after year, and that is what adds up so dramatically over time. So if some of it didn't go to deficit reduction, there is still an awful lot of money there on the table. So how much goes obviously tells you how much the deficit shrinks relative to what it otherwise would have been.

Mrs. LUMMIS. Your assumptions as to government savings due to curve-bending are that it would all go to deficit reduction.

Ms. ROMER. So those numbers where you get the deficit shrinking by 3 percent of GDP in 2030 and 6 percent in 2040, that is based on that assumption. And if some of it didn't, those numbers would be smaller.

Mrs. LUMMIS. Very good. Thank you. In your testimony, you refer to the over $300 billion in Medicare cuts announced by the administration over the weekend to immediately pay for health care reform. Do you believe these cuts have a realistic chance of being enacted by Congress? I know that a lot of good things can happen in the eye of the "King for a day," if that person can be king for a day. But as I have observed Congress over the years—I am a freshman—a lot of the assumptions of the King for a day don't come true because Congress doesn't follow through. So could you talk about the $300 billion in Medicare cuts and whether that is realistic?

Ms. ROMER. I will confess to being a freshman as well. My first venture into government.

I think what the President would certainly say is we have put really close to $635 billion of suggestions on the table of things that we think realistically can be done, things in our budget. We have putting Medicare Advantage up to competitive bid. In the things that he proposed last Saturday, they are such sensible things, like in Medicare paying for a hospital admission and the time afterwards so that the provider has the right incentive to not send the patient home too early. To do what it takes to make sure that that patient is ready to go home. That is just something that improves patient quality and it controls costs that that is such a win-win. I think things like that ought to be able to go through.

I think what the President would say is we have put $635 billion on the table. If you don't like those, come up with your own.

So I think the important thing is to have the resolve. And you are showing that that is the crucial issue. And the President, I know, has it. I hope it is here as well.

Mrs. LUMMIS. Mr. Chairman, I would just comment that some of the things that the President has put on the table in terms of ways to raise taxes are hard in other ways on my constituents. And so the tradeoffs are tough. But I thank you for your testimony.

Chairman SPRATT. Mr. McGovern.

Mr. MCGOVERN. Thank you, Dr. Romer, for being here. I think you captured the moment. You said the President has the resolve to get this done. Everybody around here is saying they agree with you that we need to control health care costs and that there are ways to find savings and we could put it toward deficit reduction. But the fact is, for the last 8 years their plan has been take two tax breaks and call me the morning. It hasn't worked.

We have seen as you know in your testimony health care costs are rising at a much faster pace than wages. Between 2000 and 2007, average health care premiums rose from $6,772 to $12,075, an increase of more than 78.3 percent. Wages, however, only rose about 15 percent. Premiums continue to grow, and in 2008 reached $13,244 for a family of four, or a little over 26 percent of median household income.

So it is clear that if we are committed to the goals that you outlined in your report, that we need to embrace comprehensive health care reform, and we are going to have to do some things that are complicated and not easy. But if it was easy, we would have done it a long time ago.

When we are talking about health care reform, we have been hearing a lot about primary care and keeping people well, or preventative care. And the chairman talked about eating well. One of my passions, along with my colleague, Congresswoman DeLauro, has been a lot of work focused on ending hunger and promoting healthy nutrition, which I think need to be incorporated more fully into our health care policies.

Often, families suffering economic hardships have to make tough decisions. Healthy food costs more, and families have to choose between buying two pieces of fruit or 10 packages of Ramen noodles.

Just looking at the price inflation of food, health care, basic necessities, average households and those that rely on Federal benefits find that higher costs can cause a genuine decline, short-term or permanent, in real purchasing power.

So could you just speak to the economic impacts of reforming health care and keeping people well? What might it mean for the average family, and especially for the uninsured family? For example, will it help restore some income and purchasing power for the average- or lower-income family, which I hope might help put healthier choices in a family's weekly shopping cart. Because part of what we need to do is to get people to make healthy choices, but healthy choices are more expensive. So it is more complicated than just kind of willing it. If you could comment on that, I would appreciate it.

Ms. ROMER. So many good points here. I know if the First Lady were here, she would be cheering, because she has so made the cause of healthy nutrition and making sure especially children know the importance of fresh fruits and vegetables. She would probably be your biggest supporter on many of these issues.

So you have raised so many good points. I think one of the things we do have to emphasize is just how important good health care reform is for the average family, the typical worker, and that that graph that I showed you before, we have seen wages stagnating, and certainly in our projections may even go down, your take-home

wage, precisely because such a big part of your compensation will start to take the form of those insurance premiums.

You gave some numbers, but one of the ones from our study, you go out to 2040, you are looking at numbers like $45,000 to insure a family of four. So that is mind-bogglingly large. You can see how that is going to take an incredible bite out of—how could anyone can get a wage increase when employers are having that kind of a fringe benefit that they are paying for. So that is crucial.

But your point about the uninsured—I have been spending so much time talking about what it is going to do to the overall economy and how it could create jobs in the short run. But we can never lose sight of the fact of the benefits that this will have obviously for the low-income workers who are currently not insured just in terms of what it will do to life expectancy, to disability, to financial risk, that one of the crucial things that insurance does is that it means that if you have a major medical expense, you are not thrown into bankruptcy. Your life is not destroyed. And that is something that empirically is a very big point.

And then the last thing, I do, again, want to bring it back to the average American. Even someone with insurance—the crucial point is we have a lot of uncompensated care now, and that that is something that there is sort of a hidden tax on people who have insurance. And going to a system where we expand coverage is fantastic for those that are getting the expansion, but it is also fantastic for all the rest of us because that hidden tax disappears and the overall economy is going to do so much better.

Mr. MCGOVERN. If I can make one last quick point. Going back to this issue of food security and healthy choices, one of the things that I hope you might want to consider urging the President to do is to get—I hate to use the word czar, but get somebody to help kind of organize a domestic agenda to try to end hunger and food insecurity in this country to help increase people's ability to purchase healthier foods. It includes the Secretary of Education, who oversees a lot of the school feeding programs, as well as a number of other agencies.

Sometimes it is difficult because the challenge to prevention here, to promote prevention, falls under multiple agencies and multiple departments. And it needs to be a coordinated effort.

Food is medicine. We have an obesity problem in part because of people making wrong choices. But it is important that we have a coordinated comprehensive plan to deal with that issue. And I think it would help deal with the issue of lower health care costs.

Ms. ROMER. I will absolutely take that message back. But on the importance of wellness, I think you are definitely getting at one of the ways that expansion of coverage can help to slow the growth rate of costs. I think weight management is one of the ones that clearly works. And so anything we can do along those lines would be important.

Mr. MCGOVERN. Thank you very much.

Chairman SPRATT. Mr. Garrett.

Mr. GARRETT. I thank the chairman and I thank the witness, Dr. Romer, for being here today. I would like to thank you for your professionalism already that you have brought to the Council of Economic Advisers. I say that because you were recently quoted in the

New York Times regarding a document that we are discussing today. I don't read The New York Times, but I heard about it. I pulled out.

And you said—and this is the good thing you said—you did not want to put schlocky arguments there.

And so I appreciate that argument. So I pulled out The New York Times, or my staff did, and here is what it says: Mrs. Romer, the only woman serving among the top advisers—so on and so forth—their clashes have come out when he takes a more political view. "A recent example involved a report by Mrs. Romer, released last Tuesday, that analyzed the administration's economic case for overhauling the health care system. Mr. Summers pressed Mrs. Romer to make the argument that health care reform could make American businesses more competitive globally, adding that it is among the political advisers' favorite talking points.

"He did so again when Mrs. Romer outlined her final draft at a recent well-attended meeting. She cut him off, saying that some of his own staff agreed the point did not belong in the paper."

So I appreciate the fact that you stood up to Larry Summers on this. And I appreciate the fact that this is one of his favorite political talking points. But I would encourage the Chair that in the future, we may not have witnesses with such integrity, and it may be appropriate to ask witnesses in the future whether they are receiving calls or pressure from other members of the administration to politicize their documents in a way just to include talking points that may be favorable to the administration. But I thank you for standing up.

Now, regarding that very same report, as was just indicated a moment ago, it assumes a reduction in medical inflation by 1.5 percentage points, talks about the benefits of the reduction. We all agree on that, of the benefits that would occur. As the young lady just indicated, you assume that those savings achieved from less health care spending would go for deficit reduction.

As far as the proposal that we have seen so far from the administration, and the number you throw out is $635 billion, we have seen those would actually increase spending and as a result would increase the deficit. Early estimates of the Senator Kennedy and Dodd bill would actually see a projected increase in spending of $1 trillion. Some private forecasters have estimated this number could rise as high as $4 trillion.

So in order to pay for this new spending and array of new taxes—I noted that you did not use that term, you used the euphemism "revenue enhancers," but I think the people at my district would see them as taxes—have been proposed.

The title of the hearing we are in today is called: The Economic Case for Health Care Reform. But you are an economic adviser. So I wonder, can you discuss the economic case for a $4 trillion tax increase and what impact that would have on the economy.

Ms. ROMER. Let's be very clear. The President in his

AMA speech—speech to the AMA said that the kind of plans he was looking at that he thought were appropriate were likely to cost on the order of $1 trillion or $100 billion a year over the next 10 years, and he has very carefully put $948 billion of savings and new revenue on the table to pay for that.

Mr. GARRETT. New revenue could mean taxes.

Ms. ROMER. He has proposed limiting the itemized deduction on high-income earners as one of the things. I think it is important to know we have had well over $600 billion in savings. So he has very much, if you think about how he is proposing to pay for this, he is very much emphasizing the savings reduction. So that is unbelievably, I think, important.

Mr. GARRETT. Let me ask you, since you are an expert. That is one option. Would another option to be lower—and I know someone on the other side of the aisle just made a comment in regard to how our idea is always about lowering taxes—but would another idea be perhaps to address the issue of international competitiveness and the like and, to address this issue as well, to actually lower corporate income taxes. Would that actually potentially do more in the long term, in the big picture, to solve this equation that we are in right now?

Ms. ROMER. Certainly, I believe that the evidence on corporate income taxes, when people give numbers about how taxes are higher in the U.S. than abroad, often don't take into account. They look at just the rates and not the various special exceptions. I think when people do the careful studies, you don't find the big differences across countries.

The other thing is, for exactly some of the same reasons why the competitiveness argument on the health care costs is not always accurate, the same is going to hold true to business taxes. Because a lot of these differences in costs in general end up being reflected at some point in the exchange rate.

Mr. GARRETT. What do you mean by the argument about the competitiveness nature because of the health——

Ms. ROMER. The question of whether if you lower health care costs, what does that do to the competitiveness of American businesses. And it is very much a similar thing if you were to reduce taxes on American firms. So at some level——

Mr. GARRETT. It is not as big a deal as some people say.

Ms. ROMER. Not as big a deal as some people say, precisely because it is, to some degree, reflected in exchange rates, certainly over long periods of time. So that is the argument.

Mr. GARRETT. I thank you very much for your answers, and for your integrity. Thank you for standing up.

Chairman SPRATT. Ms. Tsongas.

Ms. TSONGAS. Thank you, Dr. Romer, for your testimony. I have enjoyed it very much. I am from the Commonwealth of Massachusetts and, as you know, several years ago we put in place a system to attempt to bring and try to bring hundreds of thousands of people and to provide coverage for them. One of the long-term goals around that was that it would give people access to chronic disease management, preventive care, wellness programs, all the things that, in the long term, generate savings, but in the near term it takes a while to realize those.

And I have to say that as a Member of Congress, and as I travel around my district in the State, you can see and know immediately when somebody has not had access to care in the course of their life. And it is a cost that we pay for many times over as they age

and need more complicated care than someone who might have access to care early on.

So, my question is to you really that we do—some have proposed addressing inefficiencies in our health care system before expanding coverage. But can you discuss why expanding coverage and bending the cost curve through such things as what I was just discussing is the most fiscally responsible way over the long run for us to move ahead?

Ms. ROMER. Absolutely, because I think exactly what you are getting at is this idea that cost containment and expansion of coverage often go together. That by getting people—if you go in and out of health insurance or if you don't have it, you tend not to have a relationship with a doctor, not someone who can say, as Chairman Spratt's children will say to him, Get your weight under control, get your eating under control, get healthier lifestyles.

That is, we think, very important for long-run sort of cost containment. I think that is incredibly important.

The other thing, Massachusetts has been an important experiment for us as a country and something that we are very much trying to learn from as we are thinking about what would work and what wouldn't.

One of the things that—one of the facts that I have heard that I find so interesting is that when Massachusetts put in this system, employer-sponsored care actually increased, because suddenly workers wanted—it now became something that they pressed their firms to do. And I think that is something that I find very interesting, because the President has said that is sort of the employer-sponsored system is something that does work for many Americans, and to make sure that it continues.

Ms. TSONGAS. It is true. One of the issues we still struggle with, and why I think it is so important that we put in place a system across the country, but some of the issues that can bring down costs, we don't have in place the way in which we incentivize providers through a payment structure; having a comparative effectiveness resource so that you can sort of assess—physicians can assess what is the best way to go with their patient. Electronic recordkeeping is very piecemeal. It is very helpful where it exists, but still we need something more uniform.

Ms. ROMER. Absolutely. Doing the two together, I think that is something that the President has been so clear about, that you don't want to just stay with where we are and expand it, because we do know all those statistics that I showed you before. The trajectory is very frightening. Take this as an opportunity to provide coverage to the millions that, as you have described, their whole quality of life, their life expectancy, all of that is being affected. And, at that same time, put in place those genuine reforms that, quite honestly, can often be easier to do on a national level than on a State level. That that just makes incredible sense for solving two problems at once.

Ms. TSONGAS. Thank you. I yield back.

Chairman SPRATT. Mr. McHenry.

Mr. MCHENRY. Thank you, Mr. Chairman. Thank you, Dr. Romer, for your testimony. Part of the discussion and part of the intent based on the President's frequent comments, and I think

there is bipartisan agreement with, is with controlling the cost drivers in medicine. Can you touch on that?

Ms. ROMER. Absolutely. We have seen—again, the numbers are just incredibly clear of how costs are rising over time, and we do think it has to do with a lot of how we have structured the system. That we do have payment systems that tend to reward volume over value. We have a system that tends to reward technological change that is cost-increasing but not technological change that is cost-saving. And all of those things are important.

Mr. MCHENRY. In terms of cost drivers, there is a utilization component. Too many tests ordered. In that regard. Can you touch on that as well?

Ms. ROMER. Yes. We certainly do think that there are duplicative tests and things like that that can be important. We do—when the studies that have, for example, looked at the difference across States in Medicare spending do find that it is often quantity, not the price, that is much higher in some areas than others. That is, again, that then feeds in. Our report very much talks about that as one of the drivers.

Then, how do you fix it? Well, part of the way you fix it is perhaps to bundle care so that there is one provider sort of looking at the whole chain and making sure there aren't duplications and things like that.

Mr. MCHENRY. There is also defensive medicine being practiced. You have doctors that are ordering tests, even though they believe they have the correct conclusion, for fear of lawsuits. And that has been a component and a large discussion in my State of North Carolina and certain States around the country on liability insurance for medical providers. That tends to be a significant cost driver. There have been various studies, and I am sure you are very familiar with it. But I haven't heard and I haven't seen proposals from the administration on limiting medical liability and bringing the cost of medical liability down.

Ms. ROMER. We touch on defensive medicine as one of the things that can matter in our report. The President has also mentioned it in his AMA speech.

Mr. MCHENRY. A passing glance.

Ms. ROMER. He did come out and say that it was something that he understood was a possibility. He has expressed views that he is not willing to put caps on awards.

Mr. MCHENRY. Why no caps?

Ms. ROMER. But he has very much talked about ways that we could make a middle ground.

Mr. MCHENRY. Why no caps? We have a number of different bits of evidence. Oregon is a model for a State pre-cap, with caps, then caps revoked. And the cost drivers—the cost of liability insurance for those practicing medicine jumped severely after the caps were removed. Do you disagree with that evidence that caps absolutely have an impact on the cost of liability insurance for medical providers?

Ms. ROMER. There are of course trade-offs. And what the President has described is he is worried about fairness to people that have been harmed. And that is part of what he certainly mentioned in his speech of why he was not in favor of caps. But he is very

much in favor, and it fits so much into the research on what works and what doesn't, he is very much in favor of doctors saying let's establish better protocols so that we have a presumption on what is reasonable and so that that is a way to help, again, get to a middle ground.

Mr. MCHENRY. You know, in terms of the developed nations around the world, we pay the highest price as a percentage of our GDP in lawsuits of any country in the world. Two percent of our GDP goes to lawsuits. Isn't that a significant driver of health care? Shouldn't that be, in a holistic approach if we are going to talk about everything, shouldn't that certainly be on the table, caps on lawsuits?

Ms. ROMER. Certainly there is a lot——

Mr. MCHENRY. We can just stop with "certainly."

Ms. ROMER. No, there is evidence across countries of course of very large differences in spending in general. And a big part of thinking about how to reform things is figuring out what those sorts of differences are. The President has identified a number of things that we think can slow the growth rate of costs that don't go to the things that you are talking about, things that absolutely will work.

Mr. MCHENRY. Just as a parting glance, Mr. Chairman, I have read significantly that there has been a number of stories about the Safeway model, what they have done to control health care costs. Has that been a point of discussion within the administration?

Ms. ROMER. It certainly has. And it certainly gets to some of what Mr. McGovern was talking about, about doing innovative things to reward wellness. And that is something I think many people agree on, are things that encourage prevention and wellness are an important part of cost containment.

Mr. MCHENRY. Thank you.

Chairman SPRATT. Mr. Connolly.

Mr. CONNOLLY. Mr. Ryan likes Latin, and I would say to him mirabile dictu, I actually get to ask a question as a freshman. And I thank you, Dr. Romer, so much for being here today. A couple of things.

Picking up on the last line of questioning, we hear so much of an ideological commitment to capping lawsuits, and somehow that is the secret to providing massive health care to the 46 million people who aren't covered. Even if we did all of that, is that a significant contributor compared to the other factors you have outlined for us today?

Ms. ROMER. What we know is that so many things are contributing to the high cost of health care in the United States. And certainly our report really goes through all of the sources of inefficiency, like the fragmentation in our system, the way we pay doctors and all providers that emphasize quantity over quality, the technology——

Mr. CONNOLLY. But Dr. Romer, you don't have any study that says, hey, that is the one variable that somehow would get our handles around the cost of rising health care?

Ms. ROMER. Absolutely not. We know it is a very multi-faceted issue.

Mr. CONNOLLY. Thank you. Let me ask you this. To begin with, in terms of health care costs you outlined the President's goals. To some critics and to some observers it might seem there is a fundamental incompatibility with the two goals you laid out on behalf of the President. One is bringing down the overall cost of health care is essential as we move forward for the health of this economy and for the budget while expanding coverage to the 46 million Americans who now don't have health insurance.

Could you address that seeming incompatibility?

Ms. ROMER. Absolutely, because the two, as we have discussed before, absolutely go together in many ways, that by expanding coverage we can get the kind of primary care that we think can change lifestyles and certainly slow cost growth. So that is fundamentally important. I think the other way that the two go together is just in a practical sense, that at a time when you are thinking about doing an expansion of care to the millions of Americans that are not covered now, that is a very natural time to do the other reforms. That gives you sort of the opening and the ability to make so many of these fundamental reforms. And I can't emphasize enough they have to be made. That is exactly what all of our discussion of the status quo and how it can't last, those absolutely have to be done. And now is a sensible time.

Mr. CONNOLLY. You know, our friends on the other side of the aisle want to always focus on what it will cost to try to institute this reform. And a trillion dollars perhaps over the next 10 years and they scoff at the 948 billion the President has put on the table to help pay for that. But let me ask you a different question. Let's look at the next 10 years.

Looking at the trajectories you showed us in your presentation, what is the cost of doing nothing, just letting the system continue the way it is?

Ms. ROMER. The cost of doing nothing is exactly what I showed you where we were headed. So the cost of doing nothing is that American families would see their take-home wages stagnate and eventually go down. We would see the government budget deficit go up astronomically because we are not doing anything to control health care costs. We would see standards of living put lower because we won't have those health care savings to be put into investment and make our economy more productive.

So absolutely the costs of doing nothing—the way to think about it is when I showed you the picture of how much higher GDP could be if we do do reform versus what we don't, just flip that around and it's saying, by not doing reform you are condemning us to this lower standard of living.

Mr. CONNOLLY. Far be it from me to make a political suggestion to the White House, and you know you do empirical work and analytical work, you are not into politics, but I do think it is very critical we not allow people who only want to focus on a number in terms of health care reform to ignore the other number, the cost of doing nothing. And I urge you to come up with a number that reminds the American people of what that would be if we in fact do not have health care reform.

My time is running out, so I will ask you one final question, if I may, Dr. Romer. What are the views of the White House, and I

am not trying to entangle you, but guidance, there are kind of competing proposals about the so-called public option in terms of health care insurance coverage and creating a risk pool, and maybe creating something like a co-op that would still be a private sector way of approaching it rather than a public option. Any views on the desirability of one approach over the other?

Ms. ROMER. I think right now what the President has said is that he does think a public option is something that he wants on the table. You know, what he has said from the beginning is this is a collaborative process, and he wants to work with Congress and get your opinions and think about what is going to be best for the country going forward. So he is certainly open to talk about a whole range of things.

Mr. CONNOLLY. I thank the Chair for my time, and I also want to congratulate Dr. Romer on a piece of very fine work. This is really a seminal piece of work as we try to tackle this issue. Thank you.

Ms. ROMER. Thank you so much.

Chairman SPRATT. Mr. Schrader.

Mr. SCHRADER. Thank you, Mr. Chairman. I apologize for that, Ms. Romer. It would appear that—I mean Mr. Ryan and others have commented on the rapid growth of Medicare costs, frankly Medicaid costs for that matter. Is it pretty safe to say that absent some sort of major initiative in health care reform that our national debt will just continue to skyrocket? It is like one of the key, if not the most important element?

Ms. ROMER. Absolutely. And I think the important thing to say is that Medicare has been going up much like health care costs throughout the system. But it absolutely has been going up at a very large rate. And absolutely, I believe those CBO studies and our own studies that say it is going to be a source of just unsustainable budget deficits when you go out in the future.

Mr. SCHRADER. There has been a lot of talk about the up-front costs, you alluded to those, to get a system started, to pay providers appropriately, make sure people have access, everyone has access, if you will. And the scoring that CBO does focuses, obviously, on the very tangible, scorable, for lack of a better term, up-front costs. But they have difficulty, as I understand, scoring the long-term bending of the curve, you know, the savings that will result from the things we actually all agree on like preventative care, chronic disease management, primary home, frankly the bipartisan things that we do agree on.

Don't you think that over the long haul that the long-term savings could be indeed very, very, very considerable compared to the up-front costs?

Ms. ROMER. I do indeed. And I think that is in some sense the crucial point is we need to do the up-front costs because it is the right thing for the millions of Americans that don't have coverage, it is the crucial investments that are going to help us to get some of these cost savings. But absolutely the kinds of reforms that are very much on the table, the what we call the game changers, the things that genuinely slow the growth rate of costs, those are absolutely crucial to do. And you all are in a hard position because they don't score. You don't get to go back and say look, I did this. All

you are going to get is the gratitude of all of our children that 40 years from now we will not be a bankrupt country because you made those choices now. But they are fundamentally important.

Mr. SCHRADER. I hope it is a little sooner than 40, at least 10 or 20. How is that? It would appear, looking at a different report that appears to complement yours from the Small Business Majority, I mean I am a small businessman myself as a veterinarian, I serve on the Small Business Committee, Chair of the Tax and Finance Committee, and they have some pretty interesting findings in the report that was done by Jonathan Gruber at MIT with his unique health care economics model. It has got a lot of play, and I would just like to draw attention to that.

One of the findings in his study is that without reform, small businesses will pay nearly $2.4 trillion over the next 10 years in health care costs for their workers. And that with reform, small businesses could save as much as $855 billion, a reduction of 36 percent. Would you agree with the general tenor of that?

Ms. ROMER. I would. I mean we do know that precisely because of some of the problems inherent in health insurance markets that small businesses that don't have the big pool of workers to spread risk over are disadvantaged in the labor market. They do pay more for medical insurance for their employees, and it is something that is absolutely hurting their competitiveness within our economy. And so anything that we can do to level that playing field across big and small firms is incredibly important for their long run health.

Mr. SCHRADER. It is a top issue in the small business community in my State. Certainly we have had NFIB talk about it here in the Capitol. It is critical to getting done without being obsessed with the particulars. This same study also indicates that without reform, 178,000 small business jobs could be lost by 2018 as a result of health care costs. I think that is pretty substantial. And perhaps most importantly, if you are a small businessman, at the end of the day is that without reform small businesses will continue to spend more and more on health care, limiting their ability to reinvest in their businesses, reinvest in new jobs and new ventures, and that small businesses would lose up to $52 billion in profits, and that health care reform could reduce these losses by more than 56 percent.

Would you agree with the tenor of those conclusions also?

Ms. ROMER. Yes. And I would also, you know, the other way that this could play out is what we are seeing is absolutely the number of small firms dropping health insurance coverage for their employees. And so bringing it back to the workers, that is another place where this is going to be very devastating, because we do see more and more workers losing their employer-sponsored care from small businesses. So that would be another effect that I would highlight.

Mr. SCHRADER. Just a final comment, Mr. Chair, and that is that those savings could really help grow our economy and create a lot of great jobs.

Thank you. I yield back, Mr. Chair.

Chairman SPRATT. Mrs. DeLauro, you have forbearing, you get to bat cleanup.

Ms. DELAURO. Thank you very much, Mr. Chairman. Dr. Romer, thank you, it is wonderful to see you, and thank you for your great work.

I do want to make a comment that might be personal. Listening to you with the CBO report next to you and reading that, I mean, you know, some of us go home and watch C-SPAN. And so all of us have got to get a life here. But thank you for reading those reports and for your knowledge in this area.

I will make one other point, and then I will get to my question. I think we have to keep pushing back the notion that most of our colleagues on the other side of the aisle just like to say, and it is more than a gratuitous comment, that what the President is proposing is to raise taxes. That is not at all what the President is proposing or what you are talking about. So we just can't let those comments go by. I think every time that comes up we have got to bat it back out of the park.

My question is on prevention. You know, 75 percent of health spending in the U.S. is attributable to chronic disease, many of which are largely preventable. We have got a study by economist Ken Thorpe, who says that over 30 percent of the recent rise in Medicare spending in the last 10 years is associated with the persistent rise in obesity in the Medicare population. Yet less than 3 percent of our health care spending goes to preventive health services and health promotion despite the fact that proven preventive measures can reduce the risk for developing chronic diseases such as heart disease, diabetes, stroke, some cancers. Now, we know that investing in prevention can save money, but sometimes the savings are not evident until 10 or 20 years later. Other times prevention is very cost effective, but not necessarily cost saving.

Can you talk to us about the value of investing in prevention as a long-term strategy for bending that cost curve? Can the savings be quantified? And what data are needed to quantify them? And will health care reform and the expansion of coverage ultimately be sustainable without significantly increasing our attention and our investments in prevention both inside the clinical setting and out in the community where people live, work, and play?

Ms. ROMER. That is a wonderful question. I have to tell you I keep being reminded I was doing an interview a few days ago and someone said, yes, but this focus on prevention, won't it cause people to live longer? And I said guilty as charged. And I don't think there is a person in America that would think that was a bad thing.

So I mean I think one of the key points that you are making is the importance of more research, of finding out about what kinds of prevention are the most helpful. And again, you have focused in on smoking cessation and weight management. Certainly the evidence seems very strong there that those are important. The other thing, again it gets into reform, how important how you pay providers can be for getting that kind of prevention. Because part of what say bundling payments for someone who has diabetes, what that may do is to give the person, you know, the primary provider the right incentive to say you know what, nutritional counseling might be terrific here. And you know, these number of tests will be great for really monitoring your blood sugar. And so I think, you

know, thinking about our reforms and how they feed into prevention is absolutely crucial.

Ms. DELAURO. In terms of quantifying it, and to be specific to the way that this institution runs and what we have to go on is how do you score prevention? How do you deal with that in terms of cost saving for this effort? And how does that get factored into the overall costs or lowering the costs when—well, how do we score it?

Ms. ROMER. It is exactly the problem. I guess what I would like to do is to reassure you that maybe it is not as serious a problem as we think in that, you know, when we talk about the expansion of coverage that we are doing, and the reforms that we want to do now, and how the President has described paying for it, and obviously wants to hear from Congress how it wants to pay for it, at some level these other things that we are talking about like making reforms towards prevention, making reforms towards all these other things, the fact that they don't score is surely frustrating, but the crucial thing is we absolutely need to do them anyway.

Right? And that sort of comes back to this issue that the real score is going to be we will say 15 years from now, right, when we were going to go off a cliff at that budget deficit and we are not. That is really the score that you are going to get is that we are doing these things that are slowing things now. And at some level not having them—I mean, making sure that we are doing other hard scorable savings now to pay for what we are doing now leaves those for helping to deal with those long run trends that I described were so unsustainable and would be devastating.

Ms. DELAURO. Mr. Chairman, can I just make two comments? And then I know my time is up.

Chairman SPRATT. Go right ahead.

Ms. DELAURO. Thank you. My colleague, Mr. McGovern, talked about children, nutrition, a variety of efforts. I would just say again in the description, yours, the President's, et cetera, when we are talking about children is to focus in on the benefits of insuring all children, not some, and what that benefit will be in terms of the future.

And my final comment is with regard to the public plan. And what is of concern to me these days is that the notion of a public plan choice is what this seems to me to be about in the mixture here. And we ought to describe it that way. And we ought to be reassuring to people, and again my colleague says about the politics and advising on politics for the White House, but I think there has to be a more fulsome description not of specific details, but that no one is talking about a public plan choice that is less, has less benefits, is, if you will, a second rate to what is being offered, so that the minds of the public and those who would be able to take advantage of that, that it will have a benefit package that will be competitive with what else is on the table.

Ms. ROMER. The President couldn't agree more that what he is thinking about is making sure that every American has choice, and that is really important.

Ms. DELAURO. Thank you. Thank you, Dr. Romer. Thank you, Mr. Chairman.

Chairman SPRATT. Thank you, Mrs. DeLauro. Dr. Romer, you have made a major contribution to the debate. You have helped us

frame it. You have helped us answer the right questions, and we will be looking to you, I am sure, for further answers as we move through this process. But thank you for coming today, for the time and forbearance, and your excellent responses, forthright responses.

Just as a final housekeeping detail, I would ask unanimous consent that members who have not had the opportunity to ask questions of the witness be given 7 days to submit questions for the record. Without objection, so ordered.

The committee is now adjourned. Thank you again.

Ms. ROMER. Thank you.

[The statement of Mr. Connolly follows:]

PREPARED STATEMENT OF HON. GERALD E. CONNOLLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Chairman, thank you for holding this hearing on the economic impact of our health care system.

The human face of health care reform is real; it is 46 million Americans and rising without any health insurance. It is the 45 percent of Americans who have some form of pre-existing condition that may find themselves either denied insurance in the future, or more frighteningly, they find that they have insurance, but not coverage as their preexisting condition is unexpectedly denied coverage. It is the fact that a child with appendicitis is five times more likely to die without health insurance, than if he or she was covered. We cannot put a price on a child's life; however, we can recognize that it is far more cost effective to proactively treat the symptoms of appendicitis rather than treat the results of a burst appendix.

The economic face of health care reform is visible in the rapidly rising premiums that millions of Americans with health insurance must face each year. It is the 21 percent of Americans who had extreme difficulty last year paying for necessary health care procedures or medicine; up dramatically from the previous year. It is in the estimated $1,000 that each and every taxpayer incurs as a result of the increasing use of emergency rooms for those lacking health insurance. It is in the fact that despite paying far more per capita than the median for health care—more than $5,200 in 2005 compared to the industrialized nations' median cost of $2,200—and a far greater percentage of our Gross Domestic Product—15.3 percent in 2006 as opposed to the next highest nation, Sweden, the socialist model, at 11.3 percent, the United States ranks below many nations in health care results. Out of the world's 224 nations, the U.S. ranks fiftieth in life expectancy. Since 1975, annual health care spending per capita has outpaced overall economic growth by 2.1 percent per year. In 1960, health care spending in the United States was 5 percent of GDP, has risen to almost 18 percent today and is projected to continue to rise to a staggering 34 percent of GDP by 2040. We cannot afford those kinds of increases. If we are not receiving our moneys' worth, then why are we paying record amounts on health care? Something must be done.

As we debate the various proposals for health care reform, there are five overarching principles upon which I will base my support.

First, every child in America deserves health care coverage. We cannot continue to place selfish ideology above the health of our children.

Second, nobody should be financially destroyed due to a catastrophic illness. The tremendous costs associated with combating deadly medical conditions often wipe out savings and force many families to choose between life giving care and a lifetime of debt.

Third, insurance companies should not be allowed to cherry pick those who they cover based upon pre-existing conditions. The purpose of insurance is to spread and mitigate risk. Denying coverage for pre-existing conditions will force more Americans into the emergency rooms to receive treatment.

Fourth, there must be universality of access to health care. It is an essential principle for any advanced, industrialized society that every person should have access to health care coverage.

Finally, we must respect the right of individuals to choose health insurance and providers. Assisting some Americans in accessing health care must not come at the expense of restricting access for others.

I look forward to Dr. Romer's testimony and to this Congress' discussion and deliberation on reigning in the expanding costs of health care, and providing real reform that reduces the number of uninsured Americans.

[Whereupon, at 12:40 p.m., the committee was adjourned.]

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