

Economic Advisors Admit: Obama Will Cut Social Security, Medicare

The following is a full transcript of a June 2 event at the Old Executive Office Building in Washington, D.C., where Council of Economic Advisors (CEA) chairman Christina Romer presented the latest CEA report on "The Economic Impact of Health Care Reform." Also speaking were Sens. Max Baucus (D-Mont.) and Christopher Dodd (D-Conn.); other participants were Obama's top economic advisor Larry Summers, Budget Director Peter Orszag, White House Director of Health Care Reform Nancy-Anne DeParle, and Obama spokeswoman Linda Douglass.

Despite the fact that the event was an open press conference, it has been treated by the White House as if it were a secret hearing, as no professional video or transcript of the event has been made public. We are thus providing an admittedly imperfect transcript, based on non-professional equipment, as an exclusive. This transcript of the hearing on the genocide being prepared by the Obama Administration, which has otherwise been suppressed, speaks for itself. Subheads have been added.

Christina Romer: Good morning. It is lovely to be with you today to unveil or introduce a new report that the Council of Economic Advisors has just written, called "An Economic Case for Health Care Reform." I'm Christina Romer. I'm chair of the Council of Economic Advisors, and I am delighted to be joined this morning with a number of distinguished guests. We have two distinguished Senators—Sen. Max Baucus, chair of the Committee on Finance, and Sen. Chris Dodd, chair of the Senate Banking Committee, but of course, also a key member of the Committee on Health, Education, Labor and Pensions, where he serves as the chair of the Subcommittee on Children and Families.

I'm also glad to be joined by two of my White House colleagues, Peter Orszag, director of the Office of Management and Budget, and Nancy-Ann DeParle, director

of the White House Office on Health Reform. Larry Summers is in briefing the President, but if he lets him go, he's going to come and join us, as well.

To give you just a little sense of how the morning is going to go, I'm going to take a few minutes to talk about what's in the report, and then I will turn it over to Senators Baucus and Dodd to give some remarks, and then we'll open it up to questions and give you some answers.

The Objective: Restrain Health-Care Costs

All right. So, my job is to introduce the report briefly, and I'm delighted to be here. As I said, the report is on "An Economic Case for Health Care Reform." The key contribution of the report is to show that, if we do health reform well, the benefits to the economy would be enormous. If we can genuinely restrain the growth rate of health-care costs significantly, while assuring quality, affordable health care for all Americans, living standards would rise, the budget deficit would be much smaller, unemployment could fall, and labor markets would likely function much more efficiently.

Because the economic benefits that we identified depend crucially on not just doing health-care reform, but doing it well, I am particularly honored to be joined by these two distinguished Senators who will be so central in formulating the legislation. And I would be remiss if I didn't acknowledge the dedicated members of the House of Representatives, who are very sorry they couldn't be with us this morning, but will obviously also be central to the reform effort.

All right. Well, the report has four key sections. The first discusses some of the key projections of what's likely to happen in the health-care sector without successful reform. If you want, it shows the cost of doing nothing. And one fact that is well known, is that health-care expenditures in the United States are currently about 18% of GDP, by far the highest of any country,



J. Scott Willey

In her opening remarks to the meeting, Christina Romer (center) set the tone, with happy talk about the plan to “reform” health care by “eliminating waste and inefficiencies,” and other euphemisms for letting people die without medical treatment. Sen. Chris Dodd (left) is a leading spokesman in the Senate for the Obama Nazi health plan; Budget Director Peter Orszag (right) is the leader of the White House “behavioral economists,” who have formulated the policy.

projections suggest that these expenditures, which are currently about 6% of GDP, will rise to 15% of GDP by 2040. In the absence of tremendous increases in taxes or reductions in other types of government spending, the trend implies a devastating, and frankly, unsustainable rise in the federal budget deficit.

Another trend that’s 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. All right. Well, let’s say, that’s what will happen if we

and these expenditures are projected to rise sharply. By 2040, health expenditures could be roughly one-third of the total output of the U.S. economy.

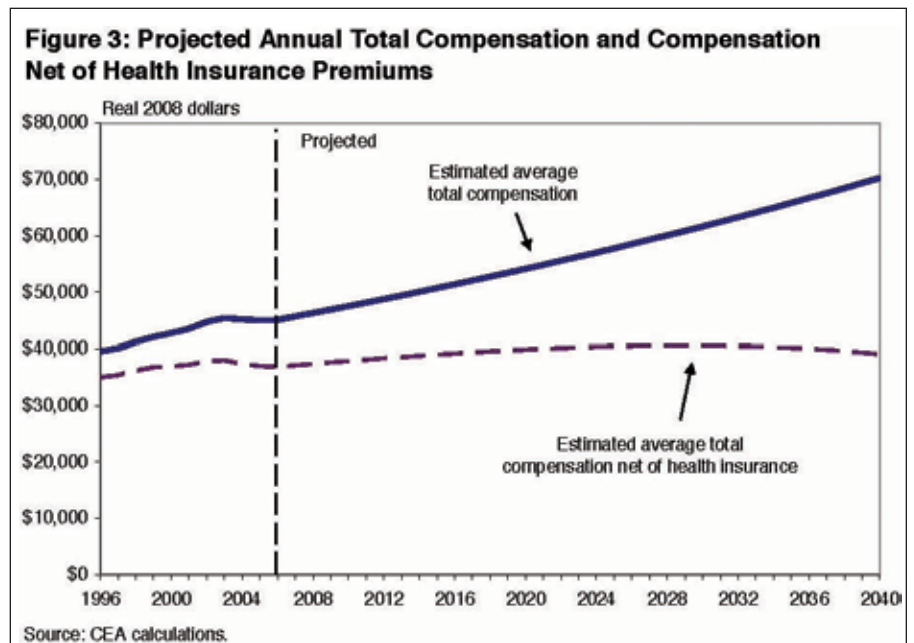
For households, rising health-care expenditures will likely show up in rising insurance premiums. Even if employers continue to pay the lion’s share of premiums, both economic theory and empirical evidence suggest that this trend will show up in stagnating take-home wages.

Let’s see. This is **Figure 3** over there, a figure from the report, that shows our projection of total compensation, and below the line, compensation less insurance premiums. And what you’re supposed to see is that we project, without reform, that, bottom line, basically workers’ take-home pay, will likely stagnate, probably even fall eventually, as insurance premiums, that wedge between those two lines, rise sharply over time.

Now, rising health-care expenditures also mean that government spending on Medicare and Medicaid will rise sharply over time. Our

don’t do anything.

The second key part of our study looks at inefficiencies in the current system and the market failures that lead to a lack of insurance. This part of the report also discusses the key goals the President has laid out for reform. One is to genuinely slow the growth rate of health-care costs, while maintaining quality in choice



of doctors and plans. And another is to expand health-care coverage to all Americans.

Now, since reform plans are very much in the process of being developed cooperatively with the Congress, we don't describe in detail the reforms that will 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. We also surveyed the evidence, much of it from international comparisons, and comparisons of cost in different parts of the United States, that there's substantial inefficiencies in the current system. It's important in making the case, that slowing the growth rate of health-care costs by improving efficiencies is absolutely possible.

For example, our estimate suggests that we can slow cost growth by 1.5 percentage points per year for almost a quarter of a century, before we have exhausted the existing inefficiencies.

However, I don't want to sugarcoat the situation. Slowing cost growth by 1.5 percentage points per year may sound small, but my staff has told me, many times, it's likely to be very challenging. It will take an incredible degree of resolve and cooperation among policy-makers, consumers, and providers to bring this about. But, what our study shows is that it should be possible.

Health Care or Fiscal Health?

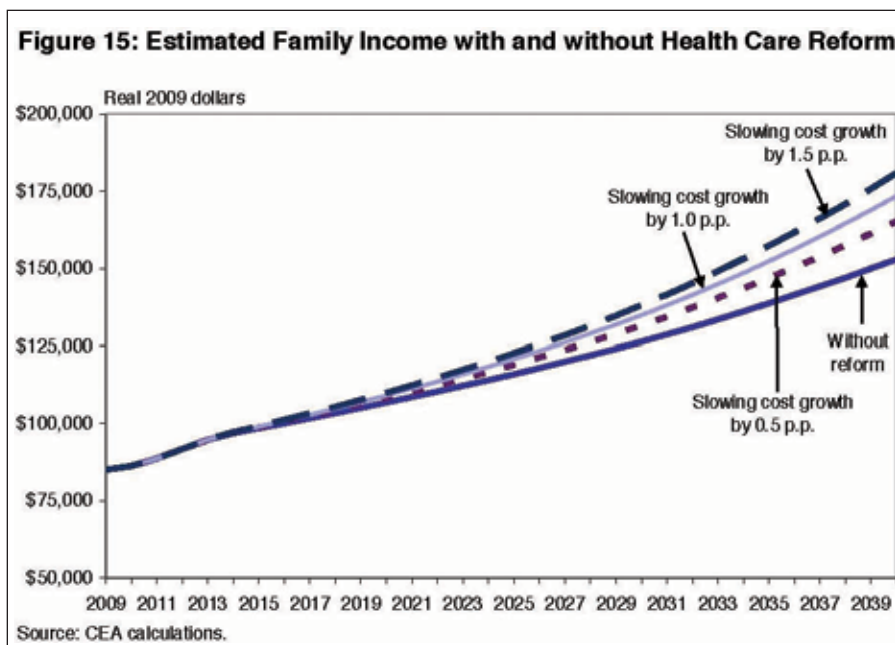
Most fundamentally, what our study shows is that the economic benefits of slowing cost growth would be enormous. This is, in fact, the conclusion of the third key part of our study, which looks at the economic effects of successful reform. In our study, we considered the effects of cost containment and coverage expansion separately, but of course, the two are related. For example, expanding coverage is likely to make certain types of cost containment easier to achieve.

In our analysis of cost containment, we focus on slowing the growth rate of costs. This is the so-called curve bending that can last for decades. The fundamental thing that slowing cost growth does is to free up resources. If we

restrain costs by eliminating waste and inefficiencies, we can add the same real amount of health care with resources left over to produce the other things that we value. We analyze the effects of freeing up resources in the standard growth accounting framework. For those of you who like equations, the framework is spelled out in the appendix of the report. The crucial finding of our analysis is that living standards can be substantially higher 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. Slowing the growth rate of health-care costs would lower the deficit and raise public savings. And efficiency gains that then come with these lead to additional private savings. All of this increased saving would tend to lower interest rates and encourage investment. And 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. To make the effect on output more concrete, we translate that into the effect on the income for a typical family of four in constant dollars, and these effects are shown in this **Figure 15**, which shows "Estimated Family Income With and Without Health Care Reform." The bottom line shows you without reform. The various other lines show you, with different degrees of cost containment, what you could expect. Our



numbers suggested if we slow cost growth by one-and-a-half percentage points per year, family incomes will be about \$2,600 higher in 2020, than it otherwise would have been. By 2030, it will be nearly \$10,000 higher.

I also want to show you what our analysis found about the effect of health-care cost containment on the Federal budget deficit. And I need to be very clear that our estimates are not Peter [Orszag]'s kind of estimates, not the official budget projections. They're more of a back-of-the-envelope calculation. And they do not include the cost of coverage expansion, because most of those costs will be covered by the spending cuts and revenue increases that are currently under discussion.

What we find is that the effects on the budget deficit are very large, and the last figure, the one Peter appropriately is standing in front of, is the reduction in the Federal budget deficit due to health-care reform. If, again, if we can slow health-care cost growth by 1.5 percentage points per year, we estimate that the deficit in 2030 will be 3% of GDP smaller than it otherwise would have been. In 2040, it would be 6% smaller. These numbers illustrate the crucial truth that serious health-care cost containment is the number one thing we can do to insure our long-run fiscal health. Health reform is central to long-run fiscal stability.

Another possible macroeconomic effect of cost growth containment is the short-run impact on unemployment and employment. When health care costs are growing more slowly, wages can grow without firms' costs rising, so firms may 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, again by the 1.5 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.

Finally, the report, in the last section, 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 high medical bills. Not surprisingly, we find that the benefits

of coverage to the uninsured are very large. But, crucially, we find that the net benefits, that is, the benefits minus the cost, are also very large, roughly \$100 billion a year, or about two-thirds of a percent of GDP.

Another effect of expanding coverage that we considered is expanded labor supply. With full health insurance coverage, some people who would not be able to work because of disability, would be able to get health care that prevents disability, and therefore, be able to stay in the labor force longer. How large these effects might be is hard to predict, but we believe that the net impact on effective labor supply will be positive, and will further increase GDP.

The final impact that we identified is that of expanding coverage on the efficiency of the labor market. Expanding coverage and eliminating restrictions on pre-existing conditions would end the phenomenon of job lock, where worries about health insurance cause workers to stay in their jobs, even when ones that pay better or are better matched are available. Similarly, we examined the fact that small businesses are currently disadvantaged in the labor market, because employer-sponsored insurance is so expensive for them. Moving to an insurance system that removes the disadvantage should be beneficial to the competitiveness of the crucial small business sector of the economy.

Well, 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. Thank you, and now let me turn it over to Senator Baucus.

Baucus: We Must Cut Health Care—Now!

Thank you very much, Dr. Romer. The key point of this report is that it demonstrates an underlying imperative of doing health-care reform now. It shows so clearly that announcing health-care reform now means that we're on a stronger path to economic recovery. We can address the budget deficit. We can begin to cut back on the cost that families pay for health insurance premiums, out-of-pocket costs. We can also provide more coverage hopefully, universal coverage for all Americans.... [inaud]

Number one is the cost of health care, today, in America is just too much for Americans to bear. We

spend twice as much per capita on health care, than the next most expensive country, and we're not twice as healthy. All international indicators show, that we show up 18th in terms of health-care outcomes, and yet we spend so much more per person on health care than other countries.

And if this path continues, if this path of rate of increase in health-care costs continues, an average family

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baucus.senate.gov

will pay half its health insurance premiums, excuse me, [half] an average family's budget will be in health insurance premiums. We'll easily spend about \$2.45 trillion a year in health care, over ten years, about \$4.23 trillion a year in health care in America. It means that American companies are going to be much less competitive, in the future, even as they are today, compared with other countries' companies. It means that the number of current bankruptcies due to health care—about 1.1 million a year—will perhaps double. We have to cut health-care costs.

Now health-care reform has several components. One is to make sure that all Americans have health insurance—that's critical. That will also help reduce health-care costs. Certainly, uncompensated care costs at hospitals are quite something [inaud]. The other major goal of health-care reform is health insurance market reform, so Americans are not denied health insurance coverage based upon pre-existing conditions and health-care status. And the rating bands are narrow enough so all Americans can have access to good quality of health insurance, and that too will begin to

reduce health-care costs.

A huge, big part of health-care reform is doing system reform, so we begin to align payment more with quality, than quantity and volume. The main point here, which is so critical, is that this report just underlines, demonstrates, and shows that we have an obligation and opportunity to have health-care reform now, and the key, underlying part of it is getting control over the increase in health-care costs. We want all Americans to be covered. We want health insurance reform. It's critically important to get a hold of health-care costs, and this report shows why that's so very, very important.

And the next job, obviously, is to do it. It's to find ways to control health-care costs, and that's the job of us in the Congress, to work through the President. And I've got lots of ideas of how we can do that, but I'm committed, as the chairman of the Finance Committee, to do everything that we possibly can, to bend the cost curve, to get the rate of increase of health-care costs *down* to an acceptable level, so that budgets, state budgets, family budgets, health budgets, and so forth, [are] in control. And that's what this report again shows why it is so vitally important that the Congress find ways to get a hold of that increase in the growth of health-care costs.

Now, I'm honored to introduce Chris Dodd, who's working on health issues. There are two major committees in the Senate working on health-care reform, the Finance Committee and the health committees [inaud] . . . doctors and health meetings.

Dodd: No Choice But To Get This Done

Thank you very, very much. First, let me begin by thanking Dr. Romer, Dr. Orszag, and Nancy-Ann DeParle, and Mr. Summers as well. This is a major report. Obviously, it [inaud] the ability to argue that the importance of this issue. And, for course, Max [Baucus], the chairman of the Finance Committee of the Senate, has outlined the importance of the issues that'll be debated. I think if I had to synthesize everything Dr. Romer said, in a sentence or two, it would come down to the following: that health-care costs are rising faster than our economy is growing. And that's not only unacceptable, but it's unsustainable for a country. We have no other choice, in my view, but to get this done.

I'm here this morning, replacing someone who's irreplaceable on this issue, and I hope he'll be back in the coming days—Senator Kennedy, obviously the

chair of the Labor Committee. I talked to him this morning. I talk to him almost on a daily basis, and my hope is he'll be back, as the chair of our committee. But Barbara Mikulski, Senator Mikulski, Sen. Tom Harkin, Sen. Jeff Bingaman, as members of our committee, have already been doing extensive work on coverage, and quality, on prevention issues. We've been working closely, obviously, with Senator Baucus, Senator Enzi, other members and staffs, over the last number of weeks and months, to bring us to this point, on the cusp, on the brink, and now we're deploying in the coming 8 or 10 weeks, we can see if we cannot package this proposal together, to make a difference on expanding coverage and reducing the cost of health care.

These numbers, obviously, these large numbers, although Dr. Romer certainly got into the details, need to be brought down in a way so that average families can understand what's at stake in all of this. And there are some very compelling numbers. The 46 million who have no coverage, 1 in 6 Americans. There's another number in all of this, however, that ought to be disturbing to people, and that is, just between 2007 and 2008, 87 million Americans at one point or another, had no health-care coverage at all—that's 1 in 3 Americans under the age of 65. The premium costs, that have gone up over the last ten years or so: an 85% increase. For a family of four, roughly over \$6,000 to around \$12,000, in premium costs. Over \$1,100 of that cost, is coverage for the uninsured, of that figure.

So, when you see the importance of these issues, beyond the human element, which is compelling enough, but obviously the economic issues.

I was here 15 years ago, with a lot more black hair than gray hair, when this last battle was waged. And there was a tremendous effort on the part of the Clinton Administration to move forward on this issue. We did not succeed in those days. What you just heard this morning, is a new, compelling element that was missing, frankly, back in the early 1990s. It was there, but the case was not made as strongly as it has been made this morning, and that is the economic advantage to this, that Max has talked about, and Dr. Romer has laid out in rather a good detail this morning. It's going to be critically important that we bring together those elements that are going to be so adversely affected by all of this, if we don't make the kind of change that the proposals that are on the table, will achieve.

So, on behalf of Senator Kennedy, and the Labor Committee, we look forward to these coming days, to work closely with the President, who's made this a priority of his domestic agenda. He talked about it extensively in the campaign, and he's fulfilling that promise, as early as he has, to see us move forward on this issue. We'll be going to work with Mike Enzi, the Republican ranking member of the Labor Committee, along, of

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course, with Max, with Senator Grassley, and others, as we pull this front matter together here, on behalf of the people who, as I said a moment ago—this is not just an issue that is unacceptable—it is unsustainable. We cannot sustain this, if we don't make the change that's being laid out by the administration.

Linda Douglass: After that, we will take some of your questions. I know the Senators are going to have to leave fairly soon, because they've got a vote. And I'll stand here.

New York Times: Senator Baucus, you said you have a lot of ideas. I wonder if you might share with us two or three of your top ideas for bringing costs down. And you're going to see the President later, I hope you'll be sharing these ideas with him, but maybe you could—

'Overutilization': Patients Using Too Much Medical Care

Baucus: Yeah, sure. First of all, just, we *will* find ways to make this happen. I've encouraged my office to find a green book of credible ways to get health-care growth down below the rate of the medical index—if we could get close to the CPI [consumer price index], that'd be great. Whatever it is, whatever it takes to get the rate of growth down, over ten years, down to that, coming close to the CPI.

Yeah, first of all, it takes time for this to take hold. It's all the delivery system reforms. When we start re-

imbursing based on quality, rather than quantity, or volume, we're going to start to get rid of all the *waste* that occurs in the current system. The estimates are that about a third of the American health-care system is waste. It's waste due to different practice patterns, in different parts of the country, geographic variation. It's waste because we reimburse based on quantity, and volume, not on quality. It's waste because doctors don't have the correct—information available to health IT, to comparative effectiveness, to practice more evidence-based medicine. So, a large component of this—it takes time to kick in—will be delivery system reform, where we're reimbursing based on quality, not quantity and volume.

That quantity and volume also lets the fraud, waste, and abuse in the American system. The significant savings there. We're going to be very, very tough on fraud, waste, and abuse.

After that, we're going to implement the best we can, the provisions recommended by the various industry Presidents. A couple weeks ago, we asked them to come up with \$1.7 trillion in savings. And a lot of them will agree. And we're going to implement a lot of those, through Medicare, and working with the private sector as well.

A lot of it's going to come through identification in the health insurance applications and delivery, and the wording, and a very, very simplified process, when a person applies for health insurance—insurance, and also claims for health insurance [inaud]. In exchange, we're going to dramatically reduce the number of options the insurance companies will have—let alone address all the problems, that is, prohibit denial based on pre-existing conditions, health-care status, and so forth, which in itself must [inaud], because in many ways it starts with savings in the health-care industry.

There are other ways we could attack [the overuse]. One way, we'll have to work our way through. We have to identify solutions. I personally believe that [setting] an appropriate limit on benefits would begin to reduce overutilization in health care. Overutilization's a big problem in America. I know that's an issue we have to work out with the President, because I think initially we will work it out because *all* experts believe that we have overutilization in America, probably because there's no limits on the benefit package, that an employer can provide to his or her employees. And I think we have to look at that very closely, and working with the President, and see if there's a way to address that too.

Those are several ways, but there are a lot of others, and believe me, action is vital because we have *no choice*. We have no choice. We've got to figure out how to put a provision in the *law*, not just voluntary, but in the law, which will get that cost curve of growth down to acceptable levels, and to me, acceptable means getting pretty close to CPI.

'What's the Stick?'

Modern Health Care: Yesterday, the Administration, and people from the care and provider community, outlined a number of different ways that they planned to help, in order to [inaud] to achieve this. Could you talk a little bit about how this report dovetails with the initiative that the care and the providers outlined? And also, what's the stick? How do you make sure that that community that's so vital to reform, actually carries through on what it pledges?

DeParle: Well, first, I give the group of providers a lot of praise. They came forward a month ago, to the President, and pledged to do their part to bring health-care costs down. And they acknowledged the very things that we've talked about this morning, [inaud] and that they can do better in providing high-quality care, and that they want to do that. I challenge anyone in this room to go back to your organization and try to do the same things; that's a very hard exercise. They then met with the President, and he told them he appreciated their offer, and he wanted to work with them. They've spent tens of hours together, working on what they submitted yesterday [inaud].

And I think we should follow this—and I agree with Chairman Baucus, that they have some very solid ideas and proposals, that we'll want to work closely with them on this. And they'll produce savings for the American people that will reduce health-care costs, and that will have some tangible benefits, although in the short term—

Baucus: On that point, let me just say, I've met with the same group, and they were quite honest, a couple days later. My goal is to help the President to keep their feet to the fire. Okay, everybody, where's the beef? You promised this, but where is it? According to us, they honestly couldn't tell me at that moment, but I said, "Okay, I want to know myself. And at the White House, the President wants to know, say in a week." And I called a couple of CEOs later, and extracted promises out of them to get their recommendations up. One, the Hospital Association, last Friday, and others, at later

dates. We meet with the pharmaceutical industry today. And one main goal is to ask them, “Where’s the beef? Where is it, here?” A number of them figure out ways to implement that, in the legislation.

The key here is, working through Medicare, and developing metrics and quality measures and so forth, that are also applied to the private sector. And developing the metrics with the private sector. Because we can get some, we could learn a little bit about how the private

If you're just looking at this and that, you may be underestimating the amount of work that's going on behind the scenes. I'm assuming we're going to harmonize the approaches. There's been a tremendous amount, tens of hours a day, and hundreds of hours being spent, on staff both in the House and the Senate working on this....

—Nancy-Ann DeParle



White House/Pete Souza

sector could develop these metrics. So, it’s working together to get these metrics, quality measures, so that we can begin to reimburse—well, that’s just one. Also, developing comparative effectiveness, quality measures, you know, for procedures, for medical equipment, for the drugs, and also, make sure health IT really works in a good way.

The real key to all this is integrated systems. It’s integrated systems. If you look at integrated systems around the country, they’re doing it right. Geisinger Health Systems, Integrated Healthcare, Kaiser, Mayo, Denver Healthcare—there are a lot of them. Pick their brains, how they do it. The key is to try to figure out how we transfer that over to the country as a whole. That’s going to, itself, realize real savings for this country, and take advantage too, in the *companies* that are doing it—GE, Safeway, Wal-Mart, Pitney Bowes—they’re doing it themselves, and they’re realizing it’s in their interest, too. And a lot of that is wellness, prevention. They’re

able to get their health-care costs down with wellness, prevention, and we’re going to do the same.

Bloomberg News: First, to the Senators: Both of you talked about what needs to happen [interruption—laughter]. . .

Dodd: Well, we’re doing it. There have been a lot of the meetings that have not been on the radar screen, between the staffs and others for the last number of weeks and months, to try and work towards a common bill, and goal. I think the goal is—and Max will correct me if I’m wrong on all of this—certainly Harry Reid’s goal is, to have a single bill before the Senate, not disparate bills in the Finance Committee, the Labor Committee, but rather to meld these bills together so we’re giving our colleagues a comprehensive approach.

I think the leadership has decided—in fact, I’m going to spend some time this evening with Mike Enzi, to talk about where we can come together on these issues, where the differences may be; to see how we can achieve those goals. I would love to see—I know Max as well, has spoken about this—the goal is to have a broad comprehensive support for a health-care reform bill. That’s our ultimate goal. If we could achieve that goal, that would be important. Not only in terms of passing the bill, but sustaining the efforts. This is more than just a one-year effort. We’re going to have to sustain that for more than a decade, to get this done.

So, starting out with the kind of broad support that will be necessary, is critical. And I feel pretty good about where things are today. I’ve been meeting with my Democratic colleagues in the Labor Committee on the work that’s been done already. Eleven hearings we’ve had on the Labor Committee, on prevention, coverage, and quality, that my three colleagues that I’ve mentioned have held already. And again, a lot of cooperation, particularly in the prevention areas, for instance. It’s almost unanimous in meetings, that here’s a real cost savings, in prevention, in what we need to do in that area.

So I begin the process; and as I said before, having been through this 15 years ago, we’re in so much better shape today, for the reasons, frankly, that people are aware of. If there’s any silver lining in the economic crisis we’re going through, it is, this has brought home the reality of dealing with these economic issues. And you can’t deal with our economic issues, without deal-

ing with health care. It's not sustainable. And that, I think, is going to do an awful lot to drive this process politically, within the Senate of the United States, to achieve the kind of compromise that we're going to have to achieve for this to succeed.

The Train Is Running on Time

Baucus: We *will* pass a comprehensive, meaningful health-care reform bill this year. It's going to happen. The train's leaving the station. And all groups know it. They know they'd better be on the train. They know they'd better offer a constructive solution, or they're off the train, and will be left out. There will be meaningful, comprehensive health care reform legislation passed, this year. Mark my word. I'll bet my bottom dollar on it. *It will happen this year.*

And why is it going to happen? It's going to happen because Congress wants it, the President wants it, the people in the country want it. Groups are working together for the first time. It's *amazing*. It's a lot of fun working all this. If you talk to all these groups, man, they want to be part of the solution! They don't want to be part of the problem, they want to be part of the solution. And Senators want it, Republicans and Democrats together. Now, of course, we haven't written all the details as yet—dot the i's and cross the t's. But it will pass this year, because there's such enthusiasm for passing health care this year. We will get it passed this year, there's no doubt about it. I'm positive, because also, it's such an inclusive process.

Recall that in '93, the President submitted health-care reform, and laid it on the Congress. This time, it's just the opposite. We say to the President, look, here's eight principles. Okay, well, we're doing principles. It's totally inclusive. The [inaud] we've got umpteen, cajillion millions. [laughter] And on the roundtables, the walkthroughs, all the subjects, and all the meetings—you won't believe the meetings we've had on health-care reform. And it is needed, because the learning curve on a lot of this, is pretty steep. This is complicated stuff. And so we've had all these meetings, which have made it more likely to learn the health-care process people wanted, with all the meetings, we've started to understand how part A fits into part B.

National Public Radio: Nancy-Ann DeParle, you've all been up on the Hill, dealing with the committees in the Senate and the House, and we're starting to

hear some of the details. Obviously, these committees have a little bit different idea of how to put these things together, and we're starting to see some details emerge, and most of it fits within the guidelines that you put out. But there are a bit different approaches. Are we going to start to see published, soon, published from the Administration, about which of these approaches you prefer, or are you going to let a [thousand?] flowers bloom, and see what comes out of the Congress?

DeParle: Well, first, you may be, if you're just looking at this and that, you may be underestimating the amount of work that's going on behind the scenes. I'm assuming we're going to harmonize the approaches. There's been a tremendous amount, tens of hours a day, and hundreds of hours being spent, on staff both in the House and the Senate working on this, and together [inaud]. And actually, quite a bit's [been done]. So actually, I think you're going to see that there's far more agreement than disagreement. There's very much agreement on the basic principles, very much the same outline, the same basic elements, 95% of it very friendly. And then, I think the President today will be working through our two leaders here, and they're going to go talk about their approaches to this, and we'll be [inaud].

NPR: Will you be expressing a preference for how it should be?

DeParle: We'll be working closely with the Congress, as we have been all the way through.

Staff: I think the Senators have to leave. Before they do, I would just note that Max Baucus is a depiction of [the kind of] a man who runs ultramarathons. [laughter]

Staff: Exactly.

Baucus: Thank you. I also want to say, Nancy and I meet constantly. Peter and I meet constantly. Larry [Summers] and I meet constantly. There's an awful lot of meetings going on. We'll be meeting with the President this afternoon, Chris and I, and the Democrats on the Health Committee, Democrats on the Finance Committee. Just another example that we'll compare notes, and put this together. It's going to happen.

'Hard, Scoreable Savings'

Question: Peter, I was going to ask this of Senator Baucus, but I think you can answer this: When we get on the cost discussion, do we have an estimate yet of how much cost savings can we squeeze out of the

system, to help finance the insurance for those uninsured?

Orszag: I think it's a very significant share. I can't give you a specific estimate right now, but a very substantial share of the overall upfront cost of this reform effort will come from savings within the health-care system.

And I want to actually just pause here; I think there's

You've heard about comparative shopping as changes in financial incentives towards quality, bundled payments, all the other stuff that the Institute of Medicine and others have been highlighting as crucial to a more efficient health-care system, and then backstopping it with hard, scoreable savings over the next decade, so that the program overall is deficit neutral.

—Peter Orszag

been a lot of confusion about this. And be very clear, about two different types of cost containment measures. One is the type that will be necessary to reach the deficit neutrality test that we are applying to health-care reform, and to get the bill passed. The other step will be necessary to make the reform successful over time. Ironically, most of the things that are going to prove to be most important to a sustainable health-care system over time, do not score, to any significant degree, they're not going to chill out, as an offset, to any significant degree, over a 5- or 10-year window, but nonetheless, are absolutely essential for the kinds of things that Christie Romer has been highlighting, in terms of making our health-care system more efficient in capturing these potential economic benefits.

I do not think you can read that Atul Gawande piece in *The New Yorker*, highlighting the dramatic variation in our health-care system, without concluding that there are very significant opportunities for efficiencies in treatment. And if that's all we were doing, we could say we're spending more now to save money in the future. But that is *not* what we're doing. We're doing a belt-and-suspenders approach, where we're doing those

steps—you've heard about comparative shopping as changes in financial incentives towards quality, bundled payments, all the other stuff that the Institute of Medicine and others have been highlighting as crucial to a more efficient health-care system, and then backstopping it with hard, scoreable savings over the next decade, so that the program overall is deficit neutral.

So, another way of putting it is, at worst—and this is, I think, very much at worst—it's a net neutral fiscal change. And if you believe all of the health-care policy analysts who put forward proposals, and I think we're doing as much as can possibly be done—if other people have ideas, for that second category of game changers, which might not score, but which are crucial to the feasibility requirement—we would welcome it. We think we're dialing that up as much as possible, and to the extent that that pays off, we will see the kinds of effects that the report this morning highlights.

Question: Well, can you give me an example of the “hard, scoreable savings?”

Orszag: We've already put \$300 billion in Medicare and Medicaid savings on the table. There will be more to come. Of that \$300 billion, roughly a little over half comes from reducing overpayments to Medicare Advantage plans, and there are a whole variety of other changes that we have put forward in our budget document. There will be more to come, in terms of Medicare and Medicaid payments, and you will see the committees also coming forward with specific, scoreable savings that will be scored by the Congressional Budget Office. And the package as a whole, will be deficit neutral, by that score.

Why Not Get Rid of HMOs?

Moderator: We'll take a couple more questions.

EIR: Paul Gallagher with Executive Intelligence Review News Service. You've said “cuts” and “savings” innumerable times. You've even said that as much as a third of the total spending on health is essentially wasted and cuttable, but you're not talking about cutting. You're leaving the HMOs in charge of the process, which are the source of the great volume of overhead and waste in the system. So, how do you deny that you're talking about rationing care, you're talking about denying care the way the British health system does with the NICE [National Institute for Clinical Excel-



EIRNS/Stuart Lewis

Paul Gallagher of EIR challenged the speakers to explain why they weren't talking about shutting down the HMOs, instead of rationing care. "You're talking about, in effect, defining lives that are 'unworthy to be lived,'" he charged.

lence] organization, you're talking about, in effect, defining lives that are "unworthy to be lived," because the procedures that they need are not cost effective? Why not get rid of the HMOs?

Orszag: The President has said that we have a system that is based in part on private insurance through employers, and we are going to retain that.

But let me go directly to the heart of your question, because no one here is talking about rationing. What we are talking about, and I'm going to come back again: Look at the source of that—most of that 30% or so in potential efficiency gained in the health-care system, are from unnecessary procedures, unnecessary days in the hospital, unnecessary applications of technology, and what have you. I'm going to again refer you both to the evidence from the Dartmouth Atlas, and from, on a micro basis, stories like the one Atul Gawande told. We have very dramatic variations in the way health care is practiced across the United States, in which the more efficient providers do not seem to generate worse outcomes than the less efficient providers. In other words, cost and quality don't go in the normal correlation.

And to get directly to your point, we are not talking about eliminating tests and procedures that are helping people. We are talking about not knowing, and often

doing things that actually don't help people, paying for them—we have a payment system that facilitates more of such procedures and tests. And frankly we're then also, even apart from the financial impact, who wants to be exposed to unnecessary days in the hospital and unnecessary procedures—because those do pose health threats—which is one hypothesis for why the correlation actually goes in the opposite direction.

So, I guess I would put back to you, that after spending years and years at the Institute of Medicine and the Congressional Budget Office and other analyses, and looking at the evidence on this dramatic variation within the United States—we're not talking about other countries—within the United States, that there do appear these very significant efficiency improvements within the health system,

so that we could have either the same or better outcomes at lower cost in the future, and that is what we're talking about.

Gallagher: So—on followup—so the main source of savings is from tests and procedures?

Orszag: The main source of savings is, as Senator Baucus said, is through delivery-system reform. Most of the—if you look across a variety of studies, whether it's the Kinsey Global Institute study, or the Dartmouth study, or others, cost differentials are rising from a variety of sources, but the most important driver in the variation, across the United States, for example, is the intensity of services provided for the same kind of patient. So, if you have a given condition, and you get set in one county of Texas, versus another county in Texas, as the *New Yorker* article highlights—very much different things happen to you. In one setting, you have a lot more tests applied, you're much more likely to be hospitalized, you're much more likely to undergo surgery, and that would all be very much worth it, if we got better outcomes, but that is not what the evidence suggests.

Question: May I ask a followup on the question about the payment for the uninsured? That would pre-

sumably have quite a large part of that—we don't know exactly what it would be—but wouldn't that undermine fairly dramatically, some of the savings from a federal budget perspective?

Romer: One of the things that Peter has so very well described, in the plan that we'll be putting forward out of the Congress, and what the President has dedicated himself to, is paying for things with hard, scoreable savings, and revenue increases, in that ten-year budget window. So I think that's a crucial point to make. The other thing, if you kind of do a little bit of a back-of-the-envelope calculation, we've talked about how much waste there is. Another thing people throw around, either from your international comparisons, or from comparisons across states in the United States, it's about 5% of GDP. And that is a huge amount of money. If you think of any of the numbers, and we don't have a plan yet that has a number, but the numbers out there in the literature are all well less than 1% of GDP, for what it would cost to expand coverage. That gives you a little bit of a sense of the amount that you're talking about.

And one other thing that I do want to emphasize again, as Peter points out, the things that don't score, the so-called game changers that are really what's lying behind our study, those things that would genuinely slow the growth rate of health-care costs, those are so unbelievably crucial. That's why I practically cheer every time Max Baucus opens his mouth, precisely because those are the kinds of things, when you look 20, 30 years in the future, that are going to be utterly crucial.

Getting Out the Inefficiencies

Question: I just want to [clarify] again, that this analysis on this chart [Figure 3] does not account for the net, for the costs associated with any Federal outlays for helping to close the uninsured gap.

Romer: It does not. This is just the effect of slowing the growth rate, that long-term curve.

Orszag: One way of thinking about this is, we are committed to, and I want to again emphasize, deficit neutrality, hard, scoreable savings, so that the net impact is, at worst, near zero. And then in addition to that, we have a variety of changes aimed at getting out the inefficiencies in the health-care system, which could help to reduce the growth rate. So, this does not include the first set of things, because they are deficit neutral. It focused on the potential impact from slowing the growth rate,

by, I don't know, half a percentage point per year, or 1.5 percentage points per year, from the changes in the structure of the health-care system, that will lead to even improved efficiencies.

Question: Okay, that question to Mr. Orszag—

Summers: Can I just...? I think this is a crucial point, so I want to just emphasize this one more time.

The greater permeation through the system of the results of cost effectiveness research, and effectiveness-based medicine; the benefits and economies that come from the improvements in the quality of care promoted by health information technology; the greater knowledge of the differentials that Peter and Christine have stressed, that will come from the benefits of promoting information technology.

—Larry Summers



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The coverage savings that the Administration anticipates [gaining back] coverage increase, are being paid for, in large part, by direct changes in identified costs paid to providers: measures such as the Medicare Advantage reform. Those measures will, along with the whole program, provide for a balanced-budget approach. Entirely separate from that effort, are a set of major goals for promotion of preventive care, which ultimately will reduce costs. The greater permeation through the system of the results of cost effectiveness research, and effectiveness-based medicine; the benefits and economies that come from the improvements in the quality of care promoted by health information technology; the greater knowledge of the differentials that Peter and Christine have stressed, that will come from the

benefits of promoting information technology.

All of those things, which have the potential to bring about broad cultural change, are *not* being relied on to finance increased coverage. They are a separate component. They are a separate component, but, given the estimates suggesting that a third of the system is waste; given the evidence that health-care inflation in excess of regular inflation is not constant, but something that varies over time, and varies over time in ways that can be related to the degree of government concern with respect to health-care costs, these costs are the source, potential source, of the 1.5% savings; and that 1.5% savings brings the very powerful benefits that Professor Romer's study discussed.

So it's very important, in looking at our bill, to draw—our approach—to draw that distinction between the components of hard, scoreable savings, and the broader effort at system transformation, which is what this study is about.

AP: Could you provide any estimate as to how much in new revenue taxes will be required? And since Senator Baucus mentioned that he is going to bring up with the President the tax exclusion, what is the White House posture currently on that?

Orszag: Well, first, in regard to that amount of revenue that may be necessary in the short run, as we were just discussing in that first, brief [inaud] to ensure deficit neutrality, the Congress requested that earlier about Medicare and Medicaid savings, so again, I will just give the same answer: The bulk, or a significant share, of short-term costs will come from savings within Medicare and Medicaid. There will temporarily need to be some additional revenue also.

Question: How much?

Orszag: I'm not going to give you the exact [inaud] right now. It will depend on—you have the multiple pieces of legislation that I'm moving, they have slightly different price tags, the shares are going to depend on where all of that lines up. With regard to the health exclusion, I think we have been clear that it is not in the President's plan. It was not in our budget. You heard today from Senator Baucus that he and others have been putting that idea forward, and I think we need to stay where we are. It is not in our plan, and it's not in our budget. We are saying that we want the legislative process to play out, and that's all we have to say on that. . . .

A Formulary of U.S. Nazi-Medicine Terms

by Marcia Merry Baker

June 6—The bum's rush called the White House/Congressional "health-care reform" process, bent on producing "comprehensive" reform legislation this Summer, is intended by the genocide lobby orchestrating it, to drastically cut care and reduce the population, while also continuing infusions of funds into the HMO insurance privateers. Since using such straight language would halt the game, a special lexicon of euphemisms has been formulated and put into wide circulation.

The following are definitions of some of the most-used Nazi-medicine expressions, defined from the vantage point of those who originated the cant. The "strength-through-joy" terms are presented in two categories: overview lies and specific falsehoods.

Overview Lies

Term: *The U.S. health-care system today is unsustainable.*

Meaning: For the HMO/international finance circles, the U.S. government and citizenry must be stampered into accepting that their care will be drastically cut, sickness and death rates will rise, in order for payments to HMOs to continue and increase, despite the effects of the crash that is ruining households, states, and localities. How do you make continued HMO payments and loss of life sound acceptable?

Appeal to popular ignorance and demoralization. Cast blame at chosen targets, to account for the asserted "unsustainability" of today's high-cost, bad health care: Blame "greedy, mistake-prone doctors and hospitals." Blame old people for wasting so much expensive care by "unnecessary end-of-life" treatment. Blame high-technology equipment for excessive expense. Blame money going to nursing homes to care for Medicaid patients, instead of in-home care. Blame the obese, disease-prone, immigrant, and other groups for using up care, and "driving up costs." Blame the disabled and mentally ill for wanting to