http://en.wikipedia.org/wiki/Peter_R._Orszag

Peter Richard Orszag (/ˈɔrzæg/; born December 16, 1968) is an American economist who is a Vice Chairman of Corporate and Investment Banking, Chairman of the Public Sector Group, and Chairman of the Financial Strategy and Solutions Group at Citigroup.[2] He is also a columnist at Bloomberg View,[3] a Distinguished Scholar at New York University School of Law, and an adjunct senior fellow at the Council on Foreign Relations.

Before joining Citigroup, he was a Distinguished Visiting Fellow at the Council on Foreign Relations and a contributing columnist for the New York Times Op-Ed page.

Prior to that, he was ***the 37th Director of the*** Office of Management and Budget under President Barack Obama and ***had also served as the Director of the*** Congressional Budget Office.

Orszag is a member of the Institute of Medicine of the National Academies of Science. He serves on the Boards of Directors of the Peterson Institute for International Economics, the Robert Wood Johnson Foundation, the Mt. Sinai Hospital, New Visions for Public Schools in New York, the Partnership for Public Service, and ideas42.

BIOGRAPHY[edit]

Orszag grew up in Lexington, Massachusetts,[5] the son of Reba (née Karp) and Steven Orszag.[6] His father was a math professor at Yale University and his mother was the president and owner of a research and development company.[7] After graduating from Phillips Exeter Academy with high honors (1987), he earned an A.B. *summa cum laude* in economics from Princeton University in 1991, and a M.Sc. (1992) and a Ph.D. (1997) in economics from the London School of Economics. He was a Marshall Scholar 1991–1992, and is a member of Phi Beta Kappa.[8]

CAREER[edit]

Orszag became a lecturer at the University of California, Berkeley and taught macroeconomics in 1999 and 2000.[9]

He was a senior fellow and Deputy Director of Economic Studies at the Brookings Institution, where he directed The Hamilton Project and (in conjunction with Georgetown University's Public Policy Institute) the Pew Charitable Trust's Retirement Security Project.

He served as Special Assistant to the President for Economic Policy (1997–1998), and as Senior Economist and Senior Adviser on the Council of Economic Advisers (1995–1996) during the **Clinton administration.**

He also formed a consulting group called Sebago Associates, which merged into Competition Policy Associates and was bought by FTI Consulting Inc. for a reported $70 million.[10]

After leaving the Obama administration, Orszag took a job with Citigroup.[11]

He is also an invitee of the Bilderberg Group and attended the Swiss 2011 Bilderberg conference at the Suvretta House in St. Moritz, Switzerland

CONGRESSIONAL BUDGET OFFICE[edit]

Orszag was director of the **Congressional Budget Office** from *January 2007 to November 2008*. *During his tenure, he repeatedly drew attention to the role rising health care expenditures are likely to play in the government's long-term fiscal problems*—and, by extension, the nation's long-term economic problems.

"I have not viewed CBO's job as just to passively evaluate what Congress proposes, but rather to be an analytical resource. And part of that is to highlight things that are true and

that people may not want to hear, including that we need to address health-care costs."[13] During his time at the CBO, he added 20 full-time health analysts (bringing the total number to 50), thereby strengthening the CBO's analytical capabilities and preparing Congress for health-care reform.[13] http://prospect.org/article/number-cruncher-chief (voir plus loin)

He was widely praised for his time at CBO for preparing the agency for the debates to come. When he stepped down, National Journal noted that « *Orszag, who will turn 40 on Dec. 16, has been* ***praised by lawmakers from both parties as an objective analyst with deep knowledge of the most pressing fiscal issues of the day, including health care policy****, Social Security, pensions, and global climate change. He is the unusual economist who blends an understanding of politics, policy and communications in ways that wrap zesty quotes around complex ideas* ».

Office of Management and Budget[edit]

On November 25, 2008, President-elect Barack Obama announced that Orszag would be his nominee for director of the Office of Management and Budget, the arm of the White House responsible for crafting the federal budget and overseeing the effectiveness of federal programs.[15][16]

Orszag, in a November 2009 speech in New York, said that deficits, which were expected to add $9 trillion to the existing national debt of $12 trillion over the next decade, are "serious and ultimately unsustainable." He said that deficit spending was necessary to help boost the economy when unemployment is hovering around 10 percent. But he said that red ink must be stopped as the economy recovers. During a recovery, private investment will again pick up and compete with the federal government for capital.[17]

In July 2010 Orszag said that "The problem now is weak growth and high unemployment rather than outright economic collapse,". Still, the deficit would be equivalent to 10 percent of the gross domestic product, the highest level since World War II. The Office of Management and Budget's mid-session review, forecast a smaller deficit and stronger economic growth than the administration's initial budget release. The deficit forecast in 2011 increased to $1.42 trillion, up from the $1.27 estimate in February. For 2012, the deficit estimate rose to $922 billion, up from $828 billion in the previous report. The annual budget shortfall would bottom out in 2017 at $721 billion, or 3.4 percent of GDP, and begin rising again in following years.[18]

A review of Orszag's daily schedules shows his sustained focus on healthcare reform as soon as he joined Obama's Cabinet.

The daily schedules for Orszag, who left his position as Office of Management and Budget director in July 2010, reveal that he and key White House aides regularly met to discuss healthcare starting in January 2009, within days of Obama entering office. ***Orszag also had meetings with insurance executives and health experts as the White House made health reform its top legislative priority after enacting the $814 billion stimulus.***

When Orszag resigned, the Progressive Policy Institute summed up his time in office: "*For an administration numbers-cruncher, he was unusually visible, which was a good thing. With a reputation for impartiality and brilliance, Orszag gave the administration's agenda analytical ballast.* There will no doubt be efforts on the right to brush Orszag with the red ink that the administration finds itself swimming in, but that's politics as usual. Inheriting the worst economy since the 1930s, Orszag presided over the Herculean task of preventing a complete meltdown and setting the foundation for a recovery. *In many ways, he's a reflection of the administration at its best: a rigorous, pragmatic empiricist.*

Citigroup and Bloomberg[edit]

Orszag currently holds three jobs at Citigroup: Vice Chairman of Corporate and Investment Banking, Chairman of the Public Sector Group, and Chairman of the Financial Strategy and Solutions Group.[20] He joined Citigroup in 2011.

According to New York Magazine, "*for an ambitious economist like Peter Orszag, going to work for Citigroup represented a choice. As a young staffer working in the Clinton White House, he saw laid before him two different paths:* ***Stiglitzism*** *and* ***Rubinism***. There were both intellectual and career-arc components to these.

While both are liberal Democrats, ***Rubin*** was the consummate insider, whose philosophy was that the free markets, balanced budgets, and limited regulation would create a rising tide that would lift all boats (or at least make Wall Street not complain too much about Clinton's social programs).

Stiglitz, the public intellectual, is as concerned with the boats as with the tide. Orszag certainly had a lot in common with Stiglitz's academic mien, having grown up in an intensely intellectual family in Lexington, Massachusetts, outside Boston. His father was the celebrated Yale math professor Steven Orszag. But Orszag possessed an ambition that would take him beyond the ivory tower. **He ultimately chose Rubinism**. It makes perfect sense that Orszag would have been drawn toward Rubin. It must have been incredibly seductive seeing this world, watching the Rubin wing of the Democratic Party move so easily from government to Wall Street boardrooms to the table with Charlie Rose." [21]

Orszag has also been writing a weekly column for Bloomberg View.[22] His early columns covered topics such as consumer-directed health care,[23] political polarization,[24] and growing gaps in life expectancy.[25]

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PETER ORSZAG DIRECTOR, OFFICE OF MANAGEMENT AND BUDGET (OMB)

Date of Birth: Dec. 16, 1968. Education: A.B., Princeton University; Ph.D. in economics, London School of Economics.

Career Path: Orszag began his career working for President Bill Clinton, first at the Council of Economic Advisors and later as Special Assistant to the President for Economic Policy. He then teamed up with mentor Robert Rubin – the former Treasury Secretary -- as director of the Brookings Institution's Hamilton Project. In 2007 Orszag was named director of the Congressional Budget Office, where he quickly gained attention for his focus on health care costs. He nearly doubled the number of health analysts at the CBO.

Role in Health Care Reform, 1993-1994: None.

Why He's a Player Now: As OMB director, Orszag has considerable clout managing the administration's budget and fashioning the administration response to any health legislation. His CBO experience will enable him to anticipate how the CBO might "score" any legislation. He argues that long-term fiscal responsibility depends on reining in health care spending. Orszag is a strong believer in comparative effectiveness, and argues: "In health care, unlike in other sectors, higher quality currently seems to be associated with lower cost -- not the opposite." He believes doctors and hospitals need to make "substantial efficiency improvements," and it is likely that any health reform will include his principles.

Quote: "Health-care costs are the key to our fiscal future….To transform our health-care system so that it improves efficiency and increases value, we need to undertake comprehensive health-care reform, and the president is committed to getting that done this year. Once we do, we will put the nation on a sustainable fiscal path and build a new foundation for our economy for generations to come." (*Wall Street Journal* op-ed, May 15, 2009)

http://prospect.org/article/number-cruncher-chief

THE AMERICAN PROSPECT

The Number-Cruncher-in-Chief

EZRA KLEIN

DECEMBER 11, 2008

Meet Obama's budget guru, Peter Orszag.

"The history of health reform," explains Sen. Ron Wyden of Oregon, "is congressmen sending health legislation off to the Congressional Budget Office to die." That's not the history you often hear. Budget analyses do not make for gripping headlines. Editors want heroes and villains, narrative arcs and telling anecdotes. They do not want numbers. They do not want bureaucracies. *But numbers, and the bureaucrats who decide them, can be quietly decisive in whether major policy reform lives or dies.*

In the coming years, no bureaucrat will be as decisive as Peter Orszag -- the former director of the Congressional Budget Office who is now the head of Barack Obama's Office of Management and Budget -- *and few bureaucracies will be as important as the CBO and the OMB*. ***For every major policy and legislative fight, those organizations will decide the Number: the official price tag of a government program***. And you can't do anything without the Number.

The work of government is fundamentally the work of raising money and spending it. But the basic questions -- how much money taxes will raise and how much money policies will cost -- are unanswerable. Imagine the difficulty of trying to price out a health-care plan that only exists on paper. What medical technologies will emerge in coming years? Will there be a recession that forces more Americans onto government subsidies? Will doctors stop overprescribing antibiotics? Will the next flu season be a bad one? Enlightened bureaucrats can take their best guess, but it is only a guess. Even so, you need the Number. Without the Number, you can't put together a budget. If you can't put together a budget, you can't run a government. So Washington operates atop a tacitly agreed-upon imprecision: The Numbers may be wrong, but they need to be accepted. Which means someone credible has to be responsible for them. In Congress, that someone is the CBO.

"In this town," says ***Henry Aaron, a senior economics fellow at the Brookings Institution***, "*it's not infrequent to hear people say it doesn't make any difference what it really costs. It only matters what CBO says it costs*." It's the world's most consequential guessing agency. ***And over the past two years, Peter Orszag has been trying to ensure that it guesses in favor of health reform, rather than against it.*** the congressional budget office is the byproduct of a heated dispute between Richard Nixon and the 93rd Congress. Nixon wanted more federal money for defense than Congress was willing to appropriate. So he simply refused to spend the money Congress had earmarked for its own priorities. In budget lingo, he "impounded" it. By 1973, Nixon had held up about $15 billion in spending. ***Congress was not amused, and it passed a bill called the Congressional Budget and Impoundment Control Act of 1974.*** The legislation outlawed Nixon's gambit and, as a further gesture of disgust with the administration's chicanery, vastly strengthened Congress' institutional capacity to influence the budget.

Until then, Congress' role in the annual budget was responsive. The president proposed, and Congress critiqued. In 1974, that changed. The bill created the Budget Committees, ensuring, for the first time, that Congress would build a yearly budget of its own, asserting its priorities

directly. That meant Congress would need to determine the cost of its own programs. Thus, it created the Congressional Budget Office.

Alice Rivlin, now a senior fellow at the Brookings Institution, was the first director of the CBO. But it wasn't an easy hire. "The Congress did something that was not very smart," Rivlin says, "and that they never did again. They had two search committees for the director, one in the House and one in the Senate." Rivlin was the Senate's choice. The House preferred Sam Hughes, then the deputy controller at the Government Accounting Office. "The chairman of the House Budget Committee was a congressman from Oregon named Al Ullman," Rivlin recalls. "And he was very committed to Sam Hughes, and I think rather sexist. He said over his dead body was a woman going to run this organization. People said things like that in those days."

A months-long standoff ensued, with the Senate refusing to back down from Rivlin, and Ullman refusing to let go of Hughes. "Finally it got settled in a very bizarre way," Rivlin laughs. Wilbur Mills, the powerful chairman of the House Ways and Means Committee, became involved with an Argentine stripper named Fanne Fox. One night, the police pulled over Mills and Fox for speeding. Fox fled the vehicle and jumped into the Tidal Basin. Mills still managed to win re-election the next year. But soon after, he was spotted stone drunk at Fox's burlesque show, and the resulting uproar forced him from Congress. Ullman ascended to chair of the Ways and Means Committee, and his successor on the House Budget Committee, Brock Adams, lacked his strong attachment to the CBO search process. Rivlin was confirmed.

It was an important personnel decision. Embedded in the standoff between the House and the Senate were two different visions of what the agency should do. The House wanted the CBO to focus almost exclusively on scoring policies and creating budget programs. "More number crunching," Rivlin says. The Senate agreed but wanted the CBO to go further: Rather than acting as a passive producer of cost tags, the organization the Senate envisioned would use its considerable analytical expertise to help legislators build cost-effective programs that would, as Rivlin puts it, tell Congress "what the options are, what it would cost, and what [it would] accomplish."

This small change in mission -- allowing the CBO not only to evaluate programs but also make suggestions on their architecture -- has given the CBO a quiet but firm influence on the congressional process. How much a bill costs is central to whether it gets enacted. And not just how much it costs but *how much the CBO says it costs*. The Number.

The CBO's most famous -- or infamous -- intervention in a legislative battle was its estimate of the 1994 Clinton health-care proposal. "The major issue," recalls Robert Reischauer, then director of the CBO, "was not how much it cost but whether the premiums that you were charged as an individual were governmental in nature and would thus be in the budget." Reischauer and the CBO decided they were. The premiums paid by every American would be included in the Number. ***This meant the Number was huge -- vastly larger than the price tag previously affixed to the proposal by the Clinton administration***. Hearing the news, one senior administration official moaned *to The Washington Post, "The Republicans will jump all over this and say we're increasing the budget by 25 percent and putting through the biggest tax increase in history." The New York Times editorialized that "the opponents of President Clinton's health care bill think they have struck political gold in an analysis of the bill just released by the Congressional Budget Office."*

They were right. Donna Shalala, Clinton's secretary of health and human services, called the ruling "devastating." But through all of this, Clinton's bill never changed. Nor did the amount individual Americans would pay. Only the Number changed. And it wasn't an obvious decision that the CBO made. Indeed, even some of the CBO's leading lights questioned the judgment. "In all honesty," says Rivlin, who by that time was head of the White House Office of Management and Budget, "I wasn't sure my colleagues had done it right. I mean there are mandated expenditures such as if you have to put a handicap ramp in front of your building. That's a mandatory *expenditure*, but that's not a *tax*." But it didn't matter. That was the Number, and it

helped kill the bill.

The CBO, however, can help a congressman change the Number. The office can offer program analysis to guide congressmen toward more cost-effective policy options. The Clinton plan entered the CBO process late in its lifecycle and couldn't be changed. But another model was on exhibition last May, when Sen. Wyden held a press conference to announce that his bill, the Healthy Americans Act, had undergone "preliminary analysis" by the CBO (and the Joint Tax Committee) and was found to be revenue neutral in two years and revenue positive in four. When his staffers passed out the analysis, it came with a sheet stapled to the back detailing changes to the legislation. Wyden, in consultation with the CBO, had rebuilt portions of the bill in order to achieve the Number he needed. And he got it. "It was extremely valuable for our efforts to have [such a favorable] CBO score," he told me.

This process is informal but important. "We've always tried to be pretty open with staff," Reischauer says. "CBO won't commit to anything, but they'll offer helpful advice, and they've always tried to do that. They've probably gotten better through time. At the beginning of CBO, there wasn't a lot of communication with congressional staff. There did seem to be an element of gotcha. They'd send a bill, and we'd nail them."

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Peter Orszag turned 40 in December, and he looks 10 years younger than that. He has black hair, clear glasses, and pointed ears that lend his face an elfish quality. He's a country music enthusiast, and he has a sly sense of humor: He once quoted an Oliver Wendell Holmes poem in the footnotes to a CBO analysis of infrastructure spending, because David Brooks complained that budget analysis lacked sufficient "romance."

Orszag made his name in the late years of the Clinton administration as a hotshot staffer for the Council of Economic Advisers. *He was soon tapped to run the Hamilton Project, which was understood by most to be former Clinton Treasury Secretary Robert Rubin's government-in-exile.* He is, in other words, a member in good standing with D.C.'s economic elite. ***It's the sort of background usually associated with self-appointed wise men who advise that fiscal responsibility requires that we cut Social Security benefits, means-test Medicare, and limit our ambitions to expanding children's health insurance***.

Orszag, however, has been leveraging his establishment credentials to wage a quiet war on this limited vision of "fiscal responsibility."

In 2005, he was a key economist in the fight to protect Social Security against George W. Bush's privatization scheme.

In December 2006, he was nominated by a bipartisan search committee to direct the Congressional Budget Office, replacing the outgoing director, Doug Holtz-Eakin.

From his perch at the CBO -- which is to say, as one of the few individuals charged with safeguarding the federal budget -- he's been arguing that fiscal responsibility means, above all, serious health-care reform. This is a surprisingly subversive point.

Fiscal responsibility has come to mean something very specific. As Robert Samuelson wrote in a *Washington Post* column last October, we face a "heavily mortgaged future," ***and the only answers are to reduce Social Security and Medicare costs.*** And you can do that in three ways: "*Increase eligibility ages; trim benefits; and require recipients to pay more for their Medicare benefits (higher premiums, co-payments or deductibles)."* ***The problem, in other words, is overly generous spending. And the answer is austerity.***

In testimonies, speeches, and blog posts (yes, he kept a blog at the CBO), Orszag has emphatically rejected that premise. **He says that comprehensive health reform is the "key to our fiscal future."** He says that Social Security is not the problem and neither are the baby

boomers. The impact of aging is only a small slice of the increase in health costs. The real driver is technology: We spend more because we're buying more expensive stuff. Left unchecked, this trend will eventually consume the federal government, with federal spending alone growing to 37 percent of gross domestic product by 2050.

The answer is to reduce health-care costs, but you won't get there by cutting benefits. The political system isn't set up for that.

Orszag, however, sees another path. He emphasizes a striking chart from the Dartmouth Atlas Project that shows that spending on Medicare beneficiaries varies by tens of thousands of dollars across the states but that *higher spending is not connected to better outcomes*. Spend more, get the same*. In this, he says, there is a substantial "embedded opportunity" to reduce costs without reducing the quality of care*. "There is a huge amount of care that is provided that is unnecessary," Orszag says. "The Dartmouth folks say as much as 30 percent, others say between 15 percent or 10 percent, and fine, that's huge. The question is how we get out of that."

As the bailout was winding its way through Congress this fall, it became common for columnists and news anchors to argue that the presidential candidates would have to trim their agendas in response. At the first presidential debate in Mississippi, moderator Jim Lehrer asked, "What are you going to have to give up, in terms of the priorities that you would bring as president of the United States ... to pay for the financial rescue plan?" A few weeks later, at the third presidential debate, moderator Bob Schieffer said, "We found out yesterday that this year's deficit will reach an astounding record-high $455 billion. Some experts say it could go to $1 trillion next year. Aren't you both ignoring reality? Won't some of the programs you are proposing have to be trimmed, postponed, even eliminated?"

But Orszag was having none of it. "Many observers have noted that addressing the problems in financial markets and the risks to the economy may displace health care reform on the policy agenda," he wrote on his blog.

Orszag went on to argue that rising health costs threaten the nation's very solvency. If they continue to grow, investors will no longer be willing to buy Treasury bonds at low rates. And if that happened, the government would lose its ability to mount the sort of costly rescue operations that have kept this crisis from turning into a calamity. "*So if you think the current economic crisis is serious," concluded Orszag, "and it is, imagine what it would be like if we didn't have the ability to undertake aggressive and innovative policy interventions because creditors were effectively unwilling to lend substantial additional sums to the Federal government*."

Behind Orszag's economic jargon was a startlingly aggressive message. He was essentially accusing those who would delay health reform of bringing a Zippo and a can of kerosene to the federal budget. "I have not viewed CBO's job as just to passively evaluate what Congress proposes," he tells me shortly before his appointment to the OMB, "but rather to be an analytical resource. And part of that is to highlight things that are true and that people may not want to hear, including that we need to address health-care costs." *Orszag also quietly worked to make the CBO a more surefooted ally of those who would attempt health reform*.

This meant beefing up its analytical capabilities on the issue by adding 20 full-time health analysts (bringing the total number to 50) and aggressively reorganizing the division's management structure so more experienced supervisors are overseeing the health-policy analyses. It also meant addressing the CBO's occasionally dysfunctional relationship with Congress.

Thinking back to the furor over the Number on Clinton's health-care plan, Orszag says, "I think there were two things about that decision. One was the decision itself, which was viewed as being the final nail in the coffin. The second was that it was a surprise. It may well still be the case that you, senator, or you, congressman, don't like the answer we give. But we can try [to] make sure you're not surprised by it."

Erasing the element of surprise means ripping the curtain back from the CBO's scoring process.

"The goal is to provide more guidance to policy makers," Orszag says. "When I took office, one of the complaints that people had was that the CBO process was like a game of Battleship. They'd say 'A14,' and we'd say 'hit!' And they'd say 'B42,' and we'd say 'miss!' And they had no idea why. So I'm trying to take that shield down and provide a bit more information on what the dials are." **That impulse lies at the heart of two books of heath-care policy options the CBO released in December. The books will serve as a guide to the assumptions the CBO will build into its health-care scoring model**. They will be how-to guides, in other words, for achieving the perfect Number.

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If the CBO was formed to strengthen Congress' hand on the budget, the Office of Management and Budget is the president's weapon -- not just against Congress but against the federal bureaucracy. The OMB predates the CBO, and in many ways, served as its precursor. But under **Ronald Reagan, the OMB became more than a simple budget analysis agency: It became the vehicle by which the executive wielded authority over all the elements of the federal government that he could affect without congressional approval.** With the help of OMB Director David Stockman and a few executive orders, Reagan used the office not only to radically restructure the federal budget but to act as the government's regulatory gatekeeper. The OMB's Office of Information and Regulatory Affairs (OIRA), which was established a month before Reagan's inauguration, assumed additional powers and was soon "reviewing" 2,000 to 3,000 regulations a year. (By contrast, OIRA only reviewed 500 to 700 regulations a year under Bill Clinton.) It was an arrogation of power so sweeping that a nonprofit organization called OMB Watch was formed just to, well, watch it, which is what it does to this day.

But Stockman's efforts also discredited the OMB as a neutral source of budget analysis. When Stockman plugged Reagan's tax-cut proposal and defense-spending increases into the OMB's economic model, the computer projected yawning deficits. So Stockman reprogrammed the computer. The new model deployed the absolute cutting edge in supply-side fantasizing. Reality disagreed, and the expected deficits quickly manifested. The lesson most observers took was that the OMB, by virtue of serving a single master (the president), is more vulnerable to politicization than is the CBO, which serves the many masters of Congress, even though the CBO's director is effectively appointed by the majority party.

If the OMB's analyses aren't sacrosanct outside the executive branch, however, the agency is still responsible for the Number inside the executive branch. The president must propose a budget to Congress, and that budget must be built out of the priorities and recommendations of dozens of competing agencies. The OMB assesses the cost of all those items, giving each its Number, and makes recommendations to the president on which to choose. In that, it differs sharply from the CBO.

The CBO's influence on policy is indirect, as members of Congress work to understand its guessing formula and construct their bills accordingly. But the CBO never makes recommendations among competing options. A chairman cannot ask the director to identify the best path forward. **Conversely, the OMB, and its director, offer explicit advice to the president**. If the CBO is like using the software Quicken to better understand and manage your finances, the OMB is like a financial adviser who simply tells you what to do with your money. "***Some OMB budget directors*** might meet every morning with the president," says Reid Cramer, a former OMB analyst. "It's a very inner-circle position."

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On Nov. 25, Barack Obama held a press conference to announce that Orszag would be leaving the CBO and ascending to that inner circle. ***The promotion came because of, not in spite of, Orszag's crusade on behalf of health reform.*** "Peter has been one of our nation's leading voices

on budgetary issues," *Obama said. "As director of the Congressional Budget Office, he re-energized and reinvigorated the agency, while shifting its focus to confront the health-care crisis that is not only a cause of so much suffering for so many families but a rapidly growing portion of our budget and a drag on our entire economy*."

Implicit in the announcement was that the elevation of Orszag represents a rare opportunity to align two of the government's most powerful agencies in service of major reform. "*Peter doesn't need a map to tell him where the bodies are buried in the federal budget. He knows what works and what doesn't, what is worthy of our precious tax dollars and what is not*," Obama said.

Orszag knows, in other words, how the CBO will make its guesses. Thus, he can advise Obama on how to construct the legislation most likely to pass unscathed through the CBO's scoring process.

"It is said that a nation's budget reflects its priorities," Obama continued. "I believe that is true. And I know that Peter will bring to his work at the OMB a set of priorities that I -- and the American people -- share." If Orszag can make Congress share those priorities, too, that will indeed be a story worthy of the headlines. It will even have a hero.

"How Health Care Can Save or Sink America." *Foreign Affairs*. 17 June 2011. Web. 27 May 2014. <http://www.foreignaffairs.com/articles/67918/peter-r-orszag/how-health-care-can-save-or-sink-america>.

Rising health-care costs are at the core of the United States' long-term fiscal imbalance. The Congressional Budget Office (CBO) projects that between now and 2050, Medicare, Medicaid, and other federal spending on health care will rise from 5.5 percent of GDP to more than 12 percent. (Social Security costs, by comparison, are projected to increase from five percent of GDP to six percent over the same period.) It is no exaggeration to say that the United States' standing in the world depends on its success in constraining this health-care cost explosion; unless it does, the country will eventually face a severe fiscal crisis or a crippling inability to invest in other areas.

The problem is not limited to the federal government. Over the past 25 years, cost increases in the national Medicare and Medicaid programs have roughly paralleled (and actually been slightly below) cost increases in the rest of the health-care system. These trends drive a wide range of problems. State governments have had to divert funds from education to health care, which is partly why salaries for professors at public universities are now often 15 to 20 percent lower than those at comparable private universities. Meanwhile, the rising cost of employer-sponsored health insurance has squeezed take-home pay for most U.S. workers at the same time as median wages have stagnated and income inequality has increased.

Another dimension of the problem involves the variation of health-care costs across the United States. A recent analysis by the Medicare Payment Advisory Commission found that spending in higher-cost areas of the United States (that is, those in the 90th percentile ranked by cost), even after controlling for various factors, was 30 percent higher than in lower-cost areas (those in the 10th percentile). This substantial variation is undesirable both because the high-cost areas unnecessarily drive up total costs and because the results are often haphazard for patients. Indeed, higher costs typically do not equal better care -- and sometimes they mean the opposite.

In March 2010, the United States attempted to address these problems by passing a historic health reform act. The new law set up health exchanges through which individuals can purchase insurance, required those without health insurance to buy it, and created subsidies to offset part of the cost of insurance, especially for moderate-income households. The bill also reduced payments from Medicare and Medicaid to providers, imposed a new tax on high-cost insurance plans, and created a set of new institutions intended to bolster quality and reduce costs throughout the system.

Even before it passed, the health act became mired in political controversy, and its future remains at risk. Opponents have filed legal challenges to the law, the House of Representatives has voted to repeal it, and the funding necessary to administer it is in jeopardy. To be fair, the new law has many shortcomings -- including its failure to seriously reform the medical malpractice system. It does, however, create new infrastructure that can improve the quality of treatment and cut costs. For this infrastructure to succeed, though, the tools created by the health act must be applied forcefully, rather than undermined or abandoned. Even then, more drastic measures may ultimately be needed. The United States must make a fundamental change to its health-care system, transforming it into one that emphasizes evidence and quality, one in which providers have better tools and much stronger incentives to deliver value.

STRATEGIES FOR SAVING

Health-care costs rise for a variety of reasons, and there are essentially four conceptual

approaches to constraining them. The first approach is to simply reduce payments to providers -- hospitals, doctors, and pharmaceutical companies. This blunt strategy can work, often quite well, in the short run. It is inherently limited over the medium and long term, however, unless accompanied by other measures to reduce the underlying quantity of services provided. If only Medicare and Medicaid payments were reduced, for example, providers would shift the costs to other patients and also accept fewer Medicare and Medicaid patients. This would make the approach politically nonviable.

The second approach is direct rationing, whereby the government decides which services will be offered and which will not. This approach is not remotely politically viable in the United States, where people have grown accustomed to access to new technologies and procedures and where antigovernment sentiment is strong.

The third approach -- consumer-directed health care -- could be a useful component of a cost-reduction strategy, but its benefits are often exaggerated. This approach emphasizes giving consumers more information and control over their health care and stronger financial incentives to reduce their own spending. The goal is to ensure that patients have a greater stake in keeping costs down through increased copayments and other forms of cost sharing.

If most health-care spending were driven by discretionary decisions among relatively healthy people, this approach could cut costs dramatically. But health-care costs are instead heavily concentrated among a small number of relatively sick patients. The top five percent of Medicare beneficiaries ranked by cost, for example, account for more than 40 percent of total Medicare spending, and the top 25 percent account for more than 85 percent of total costs. Financial incentives can have some effect on these people's decisions, but under virtually all consumer-directed proposals, these patients would still be covered by generous third-party insurance for their high-cost procedures -- which is, after all, the whole point of insurance.

Consumer-directed measures would have a substantial impact only if they lowered the cost of the care delivered in the most expensive cases. Yet some research suggests that consumer-directed health approaches could make high-cost cases even more expensive, because chronically ill patients facing copayments for their medicines would skip some doses, requiring even more expensive treatment later on. (Ironically, those who advocate consumer-directed reforms often oppose advance directives that spell out individuals' care instructions for late in life -- tools that might be more effective than any other consumer-directed change.) Since the share of total costs most affected by consumer-directed health-care incentives is relatively modest, no one should expect this approach to dramatically reduce overall health-care spending.

Nonetheless, the consumer-directed approach is at the heart of a reform of Medicare put forward in April by Representative Paul Ryan (R-Wis.), chair of the House Budget Committee. Under Ryan's approach, Medicare would be transformed into a "premium support" plan, whereby the government would pay the premiums for private health insurance plans chosen by beneficiaries. Ryan's plan appears to save substantial sums for the federal government, but it is far less clear that it would substantially reduce overall health-care costs because it may not do enough to affect high-cost cases. Indeed, a preliminary analysis of the Ryan plan by the CBO found that total costs would actually increase -- by an astonishing 40-67 percent by 2030 -- because the benefit of having more consumer "skin in the game" is limited and because private plans would have higher administrative costs and less negotiating leverage with providers than Medicare. The goal should not be to simply move costs around; it must be to reduce them overall.

The fourth approach, the provider-value approach, is more promising. Instead of reducing costs indirectly by having patients put pressure on doctors, the provider-value approach focuses on giving doctors more information and making changes so that payment is based on the quality of the services they provide -- not the quantity. The goal is to boost the use of evidence-based medicine and narrow the variation in treatment methods across the United States, improving outcomes and lowering costs by reducing the number of expensive but unnecessary procedures.

Data from the Dartmouth Atlas of Health Care suggest that the variation in treatment is greatest when there is little consensus about the appropriate treatment for a given condition, such as whether a patient with lower back pain requires surgery. The variation is much smaller when evidence-based guidelines exist, such as the recommendation that a hospital administer aspirin to a person suffering a heart attack. The underlying premise behind the provider-value approach is that in high-cost and chronic cases, which account for the bulk of overall costs, the patient typically agrees to the care recommended by the provider -- so that the provider's recommendation is most often the care that winds up being delivered. In the end, therefore, fundamentally reducing health-care costs requires that providers alter their recommendations. (Emphasizing prevention and wellness may also help reduce the incidence and severity of high-cost cases, but the evidence to date suggests limited success in reducing costs from such measures. Besides, a shift toward prevention and wellness requires many of the changes in information and incentives embodied in the provider-value approach.)

The potential for a better combination of cost and quality is not theoretical. The United States already has examples of institutions, such as the Mayo Clinic, that deliver high-quality health care at substantially lower costs than do other institutions. Such exemplary institutions tend to use information technology intensely, examine best practices rigorously, pay attention to doctors' financial incentives, and focus on the nitty-gritty of management and the use of procedures such as checklists to minimize mistakes. All of which is easy to say and hard to do.

CONTAINING COSTS

The health-care legislation aimed to address various gaps in insurance coverage, especially for those who were uninsured. And it aimed to do so without increasing (and, ideally, along with reducing) the budget deficit under conventional accounting methods -- while putting in place the infrastructure to reduce long-term growth in health-care costs through the provider-value approach. The legislation includes three basic categories of measures aimed at containing costs. The first category involves blunt reductions in Medicare reimbursements. The legislation reduces the growth rate in provider reimbursement rates (by $196 billion over ten years), reduces payments to private insurance companies through the Medicare Advantage program (by $136 billion), and reduces payments made to hospitals for treating uninsured low-income patients (by $36 billion). These changes save money for the federal government, but they do not represent the type of structural cost containment necessary for the long term.

The second category of cost-containment measures involves private insurance. For example, the legislation made changes aimed at reducing unnecessary paperwork and moving toward uniform electronic standards to be used by all insurers (so that coding and other tasks are easier), which should yield an estimated savings of tens of billions of dollars a year. More important, the health bill includes an excise tax on "Cadillac" insurance plans -- plans that will cost more than $27,500 for families or $10,200 for individuals in 2018, when the tax comes into effect. Plans exceeding these thresholds will face a 40 percent tax on the excess cost, creating a strong incentive to redesign them to be more efficient and come in under the threshold. Since the tax rate is effectively punitive, the vast majority of the tax's projected revenue will not come from the insurance companies (who are ostensibly responsible for paying the tax). Instead, it will accrue as companies shift their compensation packages away from tax-advantaged health plans and toward taxable wages, which then generate income and payroll taxes. And since the threshold is indexed to increase with the consumer price index, which tends to rise more slowly than health-care costs, the tax will exert strong pressure on private insurance companies to keep their costs down so their premiums stay below the threshold.

The legislation's third and arguably most important category of cost containment involves a variety of structural measures to prod Medicare to lead the way toward the provider-value model of health care. Some private insurance firms would like to move in this direction to save money, but the private market remains too fragmented for any individual firm to engineer a wholesale change in provider incentives. Given Medicare's prominent role in the health system,

it is necessary to put the program at the center of the effort to control costs. The act does so through both specific measures (such as imposing penalties through Medicare on hospitals with high rates of infection) and institutional changes (such as the creation of new bodies with the power to reduce cost growth over time without the need for new legislation).

THE MISTAKES

The legislation was an impressive, perhaps even improbable, achievement, passed in an era of intense political polarization. It lays the basis for future structural cost containment while expanding coverage to tens of millions of Americans. But it is not perfect. The act's shortcomings fall into two categories: those that have to do with appearance and those that have to do with substance.

The first mistake of messaging was made during the summer of 2009. At the time, the only bill in the public domain was the House legislation, which, although it expanded coverage substantially, did very little to contain structural costs. (It had plenty of reductions in reimbursements to providers, but again, that approach is ultimately not sustainable.) The administration nonetheless applauded the bill. The final legislation improved on the House bill's efforts to contain structural costs, but by the time the act was passed the next year, it was too late. The damage had been done, and it proved difficult to shift the prevailing public and elite opinion that the measure failed to reduce spending.

The second such mistake involved the CBO, which is the official body charged with assessing the budgetary and economic impact of legislation. Given the complexity of reducing health costs, the CBO has been understandably reluctant to conclude that any individual measure would be hugely effective in doing so. As a result, there is essentially no policy that the CBO will score as exerting powerful downward pressure on aggregate health-care costs. (It is willing to score some policies as reducing federal health spending substantially, but mostly because they shift costs to other parts of the health-care system.) Barack Obama's presidential campaign had promised massive cost savings from reform, including $2,500 a year per family. But such savings were never going to be confirmed by the CBO under any scenario. And since the House bill was relatively weak on cost containment anyway but was the first version to receive a public CBO analysis, the contrast between Obama's campaign promises and the CBO's forecast proved something of a shock to the public. These two mistakes of image may have been an inevitable part of the process of enacting the legislation; after all, getting the act passed was extraordinarily difficult. But they nonetheless fed the widespread impression that the act will do little to reduce cost growth.

The biggest substantive shortcoming of the legislation involves tort reform. The academic literature generally concludes that medical liability laws do little to raise costs, although some recent studies suggest modestly larger effects. The literature also suggests that variation in the medical malpractice laws across the United States explains very little of the variation in health-care costs. What this literature largely misses, however, is the fundamental problem with the laws' standard of "customary practice" -- the norm that protects doctors if they can be found to have treated their patients the way most other doctors in the area do. This basis for malpractice creates a strong contagion effect among doctors, because a doctor's legal liability is minimized by doing what the doctor down the hallway is doing.

The traditional approach to tort reform involves imposing some limit on damages. The problem with such an approach, however, is that it does nothing about the customary-practice problem. A far better strategy would be to provide a safe harbor for doctors who follow evidence-based guidelines. Under this approach, a doctor would not be held liable if he or she followed the recommended course for treating a specific illness or condition under guidelines put forward by professional associations such as the American Medical Association or the Institute of Medicine. By failing to move forcefully in this direction, the health reform act missed a major opportunity.

CRITICISMS AND CONCERNS

Much of the criticism that the health legislation has attracted, however, has been misplaced. For example, one prominent critic, former CBO Director Douglas Holtz-Eakin, complained in a *New York Times* op-ed, "Gimmick No. 1 is the way the bill front-loads revenues and backloads spending. That is, the taxes and fees it calls for are set to begin immediately, but its new subsidies would be deferred so that the first 10 years of revenue would be used to pay for only 6 years of spending." But the only reason one should be concerned about such an imbalance is if it created a fiscal hole in the tenth year and thereafter. That is not what the legislation does: it reduces the deficit not only over one decade but also in the tenth year alone. A more legitimate concern is that the legislated savings may be undone by a future Congress.

Another concern is that employers will drop coverage for certain employees and force them into the health insurance exchanges created by the act, thereby raising costs for the government, since coverage subsidies are available in the exchanges but not through employer-sponsored plans. The CBO has predicted that this will rarely happen: it estimated that by 2019, the legislation will reduce the number of people with employer-provided coverage by only three million. But critics have charged that the penalty the law imposes on firms that do not offer coverage ($2,000 to $3,000 per worker per year) is too small to act as a real disincentive.

Two factors suggest that this concern may be exaggerated: first, most firms consider coverage to be an important part of their compensation packages, meant to attract good workers, and second, the simple analysis ignores the effect of the tax subsidy for employer-sponsored insurance. In effect, if firms drop their coverage, they lose the tax preference on that component of their compensation packages, and that is often large enough to overcome the other incentives to drop coverage. Indeed, Massachusetts, which adopted a similar approach in order to expand coverage, saw a net increase in employer coverage. Nonetheless, how social norms develop among employers will be important. A July 2010 survey by Fidelity Investments found that two-thirds of large employers were not seriously considering eliminating their health plans because of the new law. But 36 percent of those firms said they would consider eliminating coverage if other firms did.

Although employers may not eliminate health-care plans en masse, they could start dropping high-risk workers by designing health plans that encourage these employees to purchase insurance on the exchanges. This is a legitimate concern. If employers altered their plans, this could create a spiral effect, in which those employees buying insurance on the exchanges would be disproportionately high-risk patients, raising premiums and defeating the purpose of risk sharing. The cost to the federal government of subsidizing coverage in the exchanges, in turn, could become unsustainable.

Another substantial concern involves the effect of the legislation on local hospital markets. Over the past two decades, these markets have become increasingly concentrated, raising prices as competition among providers has been reduced. The health legislation, if anything, will exacerbate this trend by inducing a new round of mergers among clinics, hospitals, and practices. According to Thomas Greaney of Saint Louis University School of Law, this process has already begun. "The risk that dominant providers and dominant insurers may exercise their market power, individually or jointly, has never been greater," Greaney warns. Hospitals and other providers are already engaged in significant lobbying to relax a variety of older rules limiting health-care monopolies, especially in conjunction with the so-called accountable care organizations (ACOs) encouraged by the act. ACOs are meant to band doctors and hospitals together to provide comprehensive treatment for patients. In the words of Jon Leibowitz, chair of the Federal Trade Commission, "If accountable care organizations end up stifling rather than unleashing competition, we will have let one of the great opportunities for health care reform slip away." The Justice Department and the Federal Trade Commission are trying to minimize this risk by instituting a mandatory review process to evaluate the largest proposed ACOs.

A final concern involves the CLASS Act, a voluntary national long-term-care insurance program created by the bill. There is a serious risk that healthy people may be reluctant to join the

program, whereas those who most need long-term care will be eager to do so, jeopardizing the idea of a broad and stable risk pool. The only solutions may be to make the purchase of such insurance mandatory or to require employers to provide it by default unless employees opt out -- a strategy that has worked well in boosting participation rates in 401(k) plans.

MOVING TO QUALITY

The health-care system of the future must be much more quality-oriented than today's is. As the economist Victor Fuchs has underscored, accomplishing that requires changes in three areas: information, infrastructure, and incentives. When it comes to information, the U.S. health-care system is on the cusp of a dramatic development that could substantially expand evidence-based care. Over the next decade, hospitals and doctors will begin to adopt more information technology than ever before -- a breakthrough that has been promised for many years and whose time is finally coming. Although many doctors still find it awkward to make the leap to electronic medical records, today's systems based on tablets are less disruptive to their work than laptop-based ones. At the same time, the stimulus bill contains subsidies for the meaningful use of new information technology in medicine, which will be followed by penalties after four years for a failure to adopt such technologies. Systems like these give doctors more accurate and timely data on patients, protect against adverse drug interactions, and reduce paperwork.

The data produced by that technology could also expand medical knowledge about which treatments do and do not work. A new marketplace of data should develop. Promising steps toward this future have already been taken, including efforts such as the Health Data Initiative, a partnership between the Institute of Medicine (a part of the National Academies) and the U.S. Department of Health and Human Services that aims to boost the use of health data across public and private providers. In 2014, Medicare will begin releasing de-identified claims and data about doctors that will help patients more effectively select physicians and hospitals.

If the true potential of these data is to be realized, appropriate privacy protections must be put in place and the research itself must be funded. To lead the effort, the legislation created the Patient-Centered Outcomes Research Institute, a nonprofit organization that will help prioritize and fund new research into the comparative effectiveness of various treatments. It will disseminate the results of these studies to help doctors and patients make better-informed health-care decisions. Ideally, professional medical societies will increasingly rely on this research to issue more evidence-based protocols. The data gathered and the protocols based on them could then flow back into the health system through software that helps doctors make clinical decisions. Such a setup would be substantially more potent if it were combined with the type of evidence-based safe harbor under the tort laws discussed earlier: if the software could tell doctors not only what the best practices were but also that a malpractice safe harbor existed for those following such guidelines, the practice of evidence-based medicine would become much more common.

The second way to move the health-care system forward involves infrastructural reform. The most pressing need is to encourage providers to increase the coordination of care, and the leading idea for driving such coordination is ACOs. ACOs are designed to tie doctors and hospitals together financially and give them incentives to deliver better care to their patients on a coordinated basis. Many questions remain about how exactly ACOs will work, but the draft regulations governing ACOs issued by the administration in the spring of 2011 have begun to provide some of the answers. The Premier QUEST initiative, a voluntary project among hospitals focusing on evidence-driven improvements in their performance,* has highlighted the promise of information and incentives. By emphasizing evidence-based medicine and coordination across providers, the project has succeeded in narrowing the variation in practice norms, improving quality, and reducing costs.

The final prong involves incentives. The health-care system today is dominated by fee-for-service payment; the health-care system of the future needs to be dominated by fee-for-value payment. The difference is crucial: one payment system drives up quantity; the other, quality.

The health bill takes some steps, albeit modest ones, toward creating a system based on paying for quality. For example, it creates penalties for hospitals with high rates of hospital-acquired infections and other avoidable conditions by reducing Medicare payments for hospitals in the top 25 percent of the distribution for such problems. It includes a variety of pilot programs involving bundled payments, which provide incentives to coordinate care for patients with chronic illnesses by paying a fixed sum for treating a specific condition rather than paying for each individual treatment. The legislation also imposes a penalty on hospitals with high rates of readmission; roughly 20 percent of Medicare patients are readmitted within 30 days after a hospital discharge. The lack of coordination in handoffs such as hospital discharges drives up costs (by increasing readmissions) and reduces quality (patients rarely prefer an unnecessary stint in the hospital).

All these measures will never be enough to substantially constrain the growth of health-care costs on their own. It would be shocking if they were, since the provider-value approach necessarily involves an ongoing, evolutionary process of continuous adjustment. That process is even more challenging in the United States' polarized political environment, which makes it harder for legislation to respond nimbly to new developments and information. The success or failure of the health legislation in constraining costs will therefore hinge on how well a number of new institutions created by the law will work, that is, whether they can respond flexibly but forcefully to changes in the health-care system over time -- and without requiring new legislation to do so.

One of those institutions is the Patient-Centered Outcomes Research Institute, which was designed to analyze drugs, medical tests, and other treatments and provide updated information on them for physicians and patients. The bill also created an organization called the Center for Medicare and Medicaid Innovation, which will develop and evaluate approaches to making Medicare and Medicaid beneficiaries' care higher quality and less expensive. The act gives the U.S. secretary of health and human services the authority to scale to the national level pilot projects conducted by the center that prove successful, without the need for new legislation.

The new institution with the most potential by far, however, is the Independent Payment Advisory Board. President Obama fought hard for IPAB, over strong opposition from Congress, which saw the board as usurping its power. When IPAB starts up in 2014, it will comprise an independent panel of medical experts charged with devising changes to Medicare's payment system. In each year that Medicare's per capita costs exceed a certain threshold, IPAB will be responsible for making proposals to reduce this projected cost growth to the specified threshold. The policies will then take effect automatically unless Congress specifically passes legislation blocking them and the president signs that legislation. In other words, the default is that policies to constrain cost growth and improve quality will take effect.

These three new institutions -- the Patient-Centered Outcomes Research Institute, the Center for Medicare and Medicaid Innovation, and IPAB -- represent a powerful constellation in theory, especially in conjunction with ACOs. The question is whether they will prove to be so in practice -- a question with critical implications for the fiscal future of the United States.

A FISCALLY RESPONSIBLE FUTURE

Despite popular impressions to the contrary, the new health legislation would significantly bend the curve of Medicare spending over the next several decades -- assuming it is implemented in full. Medicare is only part of federal health spending, however. What about overall federal health expenditures, including the new subsidies to offset the cost of coverage for moderate- and middle-income families? Projections from the CBO suggest that the added cost of covering millions more Americans will initially exceed the cost reductions included in the legislation but that eventually the pattern will be reversed. The CBO projects that the transitional year will be 2028, after which the legislation will begin to modestly reduce overall health spending by the federal government.

And what about the budget deficit, including both spending and revenue? The bill includes a

variety of measures that increase revenue, such as the excise tax on high-cost insurance plans. Altogether, if fully implemented, the legislation is projected to reduce the long-term fiscal gap facing the United States by roughly two to three percent of GDP, or about one-quarter to one-third of the underlying fiscal imbalance. Much of this effect will be driven by the excise tax on high-cost insurance plans and the impact of IPAB, measures that were excluded from the initial House bill. As the International Monetary Fund recently concluded, "The effects on the fiscal gap of the final healthcare legislation depend on the IPAB's success at controlling excess growth in health spending going forward. If the IPAB is successful, the fiscal gap could be about 2 percent [of GDP] smaller. . . . However, if the IPAB fails to contain excess growth, the recent health reform will on net worsen slightly the fiscal gap, according to our estimates."

In other words, if the legislation is implemented effectively -- and especially if IPAB and the excise tax on high-cost insurance plans live up to their promise -- it could significantly reduce the nation's long-term fiscal imbalance. A big gap would remain, but the gap would be even larger without the health bill. Major challenges remain for the health bill. The Supreme Court might find the individual mandate unconstitutional, Congress might underfund the implementation of the bill, and entities such as IPAB might have difficulty finding individuals willing to go through the Senate's confirmation process. If implemented aggressively, however, the health bill holds the promise of moving the United States toward a better health-care system -- one that not only leaves many fewer people uninsured but also, through the provider-value approach, improves quality and constrains costs. There are still many obstacles, and even stronger medicine may ultimately be necessary to limit future cost growth. And there is still room for much-needed improvements to the health bill, especially on tort reform. But much of the debate in the United States is still about the core approach adopted in the bill, not how to improve it.

The only prominent alternative that has been proposed is the consumer-directed one, and there is no doubt that this approach could supplement the provider-value one. Many opponents of the health legislation, however, are either implicitly or explicitly banking on a consumer-directed approach's ability to fix health care by itself. That is not a plausible path forward, since such an approach would likely do little to address high-cost cases and therefore do little to contain overall costs.

In the end, there is no credible path to reducing the long-term fiscal imbalance in the United States other than directly addressing high-cost cases in health care. The best bet, then, is to implement and improve the provider-value provisions in the health legislation, not abandon them.

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ABOUT PETER

Peter Orszag is an economist who worked for the Clinton and Obama administrations. He has focused particularly on efforts to reform healthcare, by improving the value we receive for the money we spend on health.

While serving as the director of the Office of Management and Budget for President Obama, Orszag was praised for his part in the stimulus package negotiation, which included research and support for information technology systems crucial to the future of American healthcare. He consistently pushed while working on the Affordable Care Act for creating a tax on high-value insurance plans and an independent commission to aggressively reform Medicare, both of which were included in the enacted version of the bill.

As director of the Congressional Budget Office prior to joining the Obama Administration, Orszag significantly expanded the agency's focus on health care. He invested in the organization's analytical abilities to assess health care reforms, and put together a two-volume set of health reform options.

Orszag is encouraged by recent trends in health costs, which have decelerated substantially over the past few years. He has argued that the slowdown in Medicare cost growth is the most encouraging, since Medicare should not be significantly affected by the broader economic slowdown. And he has argued that the Medicare deceleration is being caused by expectations of a shift toward a value-based payment system, in which hospitals and doctors are paid based on how well they care for their patients rather than how many tests and procedures they do.

But Orszag also believes that much more needs to be done. On malpractice laws, for example, Orszag believes that the right solution is to protect doctors who follow evidence-based guidelines when treating patients. Such a safe harbor approach would help to provide clarity to doctors while improving care for patients.

Orszag has also focused on growing gaps in life expectancy by education and income. Life expectancy is rising rapidly in the United States for those with higher levels of income and education; it is roughly flat for those with lower levels of income and education. Orszag is co-chairing a National Academies of Sciences panel on the causes and implications of these trends.

Orszag is an author and co-contributor to several books and papers, and is regularly invited to appear on television to discuss healthcare as well as a range of other topics of American politics. He is currently a regular contributor to Bloomberg View.

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The Looming Showdown

Come next January, our dysfunctional system will have to function. Here's one possible path toward an outside-the-box budget deal.

Peter Orszag

It's January 2013. The treasury secretary has warned that we've run out of maneuvering room to avoid hitting the debt limit again, bringing back memories of August 2011. This time, though, the debt-limit drama is happening at exactly the same time as contentious debates over the massive spending cuts triggered by the 2011 debt-limit deal and over the 2001 and 2003 tax cuts, which were allowed to expire at the end of 2012 due to political stalemate but are likely to be replaced or resurrected in some form.

This trifecta—debt limit, sequestration on spending, tax cuts—is occurring right at the beginning of a new presidential term, the brief but auspicious honeymoon period for legislative action. Furthermore, even if the rest of 2012 turns out relatively well for economic growth, the labor market will remain weaker than normal in early 2013—which should further motivate legislators to avoid the substantial and immediate fiscal contraction that would occur if the tax cuts and spending cuts were to be implemented in full. If ever there were a time for a big legislative package, early 2013 would be it.

And yet there's reason to question whether meaningful legislation will emerge from this maelstrom, especially if the President is not from the same political party as the majority in the House and the Senate. Despite mythology to the contrary, divided government has never been particularly conducive to important pieces of legislation—and more importantly, the rise of polarization and the decline of moderates in Congress makes the hurdles of divided government

more challenging than they've ever been during the postwar era. As a result, it's entirely possible we'll have another placeholder or "framework" deal in early 2013—embodying the false hope that with just a bit more time, we could finally reach a more substantial agreement.

The situation in early 2013 is thus a microcosm for examining a new and fundamental dilemma of our political economy, one that is driven by the disappearance of moderates in Congress. National elections continue to be won by appealing to the swing voters in the middle of the political spectrum. (Indeed, because the rise of polarization creates safer bases for each side, it makes centrist swing voters ever more crucial to winning presidential elections.) And yet, after winning national elections by appealing to centrists, politicians quickly learn that actually governing from the center is less and less feasible given the hyperpolarization now reflected in Congress.

Instead, major legislation is more likely to succeed on a partisan basis. But that's only possible in the rare instances in which one party wins the political trifecta—the White House, the House of Representatives, and close to 60 votes in the Senate. Furthermore, a party that uses those rare moments of political supremacy to enact significant legislation on a partisan basis will typically suffer enough backlash to destroy the temporary dominance.

The United States will thus spend significant periods of time with divided government. And the rise of polarization and the associated decline in congressional moderates means that the harm from such periods is likely to be higher than in the past, since divided government was less debilitating when the center in Congress was more heavily populated.

We need not, however, lose all hope, even with divided government. After all, and however improbable it seems right now, it's possible that the drama of early 2013 will produce an agreement that avoids undue immediate fiscal austerity while modestly reforming the tax code and entitlement programs.

Imagine, for example, the following scenario that I describe in more detail at the end of this essay: The Administration, having tried valiantly but failing during the lame-duck session to extend the tax cuts only for those with incomes below $250,000, allows all the tax cuts to expire at the end of the year. Taxes rise, the debt limit looms, and commentators on CNBC say the world is about to end.

Rather than continuing the unproductive debate over extending part or all of the tax cuts, though, the Administration then steps forward with an entirely new tax cut, which could take many forms. One example would be a substantially larger payroll-tax holiday, combined with an increase in the standard deduction. The Administration also offers modest entitlement changes while dialing back the immediate spending cuts. Amid all the external demands for a deal that lifts the debt limit and resolves the uncertainty, it then dares the Republican House to vote against a large tax cut and some modest entitlement changes. Stranger things have happened.

The Divided Government Myth

The 1983 Social Security reform bill, the 1990 Andrews Air Force Base budget deal, and the 1996 welfare-reform deal have created an impression, especially among policy-makers and pundits in Washington, that divided government in the United States has historically been more conducive to significant legislative undertakings than unified government. In a 2004 piece in The Atlantic extolling the virtues of divided government, Jonathan Rauch wrote, "Divided control…draws policy toward the center; and by giving both parties a stake in governing, it can lower the political temperature so that even daring changes (tax reform, welfare reform) *seem* moderate." Rauch is not alone in suggesting that divided government may not be problematic, and indeed may be more productive than the alternative. The evidence from the political science literature, however, shows that impression is misleading.

No serious political scientist appears to agree with the punditry that divided government has been integral to producing major legislation in the past. At best, the evidence assembled by David Mayhew of Yale in his landmark book *Divided We Govern* suggests that divided

government is about as productive as unified government. Yet even that assessment is likely too optimistic. As Sarah Binder of George Washington University and others have shown, the most rigorous analyses find that divided government is harmful to legislative productivity.

Binder also shows that moderates in Congress are crucial: the fewer the moderates, the bigger the hurdle to enacting significant legislation, a finding consistent with research by Princeton professor Nolan McCarty on legislative productivity during periods of congressional polarization. The decline of moderates, furthermore, is changing the nature of governing even during periods of unified government. Until the past 20 years or so, even when one party controlled the White House and the Congress, major pieces of legislation were traditionally bipartisan. The 1965 legislation creating Medicare is one example; Democrats controlled the White House, House, and Senate, but almost half the Republicans in Congress also voted for the legislation. The 1993 budget deal and the 2010 health-care reform act, by contrast, are likely to represent the new model: major legislation enacted on a partisan basis. Both bills passed without a single Republican vote.

Most of the policy-making and punditry world still yearns for the days of the Medicare deal, but they are largely if not entirely gone. When I became director of the Office of Management and Budget, I was lucky because I had just come from being director of the Congressional Budget Office—and since the CBO is a nonpartisan agency, I had good relationships with many Republicans. At my confirmation hearing, one of those Republicans said that even his Republican friends seemed to like me—and then asked how long I thought this feeling of bipartisanship would last in my new job. He was prescient: Many of those relationships quickly frayed. Indeed, although a few agencies like CBO operate on a nonpartisan basis, there are now remarkably few people in Washington who work well with members of both parties, a reflection of the polarized environment.

The broader lesson for presidents is clear: Unless they have sufficient votes to legislate only with members of their own party, they're much less likely to enact major legislation—that is, without surrendering key policy objectives to the opposite party.

Where Have the Moderates Gone?

So what's happened to the moderates? As the data assembled on Voteview.com (a website maintained by political scientists Keith Poole and Howard Rosenthal that contains data on congressional voting patterns) demonstrates, the most conservative Democrats in Congress 50 years ago often voted together with the most liberal Republicans. That common ground was dwindling by the 1980s; today, it is almost non-existent. Much of the shift has occurred because Republicans have become substantially more conservative.

A popular explanation among pundits for the rise of polarization and the decline in moderates is gerrymandering—that districts have been redrawn to make them safe for one party or the other, allowing more partisan representatives. But it's mostly wrong. One study by Sean Theriault of the University of Texas at Austin showed that only a tenth to a fifth of the rise in polarization since the 1970s can be attributed to redistricting (other estimates are even lower). Nor is polarization just an inside-the-Beltway phenomenon, as some have suggested. From 1996 to 2008, most state legislatures also experienced striking increases in polarization, according to data assembled by McCarty and Boris Shor of the University of Chicago. If anything, over that period, most state legislatures polarized even more rapidly than Congress did.

Indeed, the polarization of our elected officials partially reflects the growing polarization of the public. We are increasingly surrounding ourselves physically and virtually with like-minded people, who then reinforce our biases and drive us further apart. In *The Big Sort*, for example, Bill Bishop documents increased residential segregation by political party. Over the past several decades, we have voluntarily separated ourselves into Republican and Democratic neighborhoods. Americans are also increasingly choosing to live near people in their own income bracket. Sean Reardon and Kendra Bischoff of Stanford University found that nearly two-

thirds of American families lived in middle-income neighborhoods in 1970; by 2007, only 44 percent did. Since income is strongly related to voting patterns, this phenomenon may help explain the rise in residential segregation by political party.

The residential segregation by party, in turn, is reinforced by a splintered media market. Research suggests that Americans only tune in or log on to a small share of the media choices available to them, and they often pick the ones that fit their beliefs. The consequences are far-reaching. As Cass Sunstein emphasized in his book *Going to Extremes*, "When people talk to like-minded others, they tend to amplify their preexisting views, and to do so in a way that reduces their internal diversity."

Governing in the Age of No Moderates

One obvious victim of this rise in polarization is the centrist legislating that has been the norm for most of postwar history. So what can be done? We can take on the problem on three different levels: encouraging less polarization in the population, increasing the number of moderates in Congress, and finding ways to govern effectively given a smaller number of moderates in Congress.

The first level involves dampening the degree of polarization in the population itself. To the extent that polarization is being driven by increased income inequality, one pathway to constraining it is to pursue policies (such as a more progressive tax code) that narrow after-tax income gaps. Another pathway is to highlight the importance of diversified interactions, both physically and virtually, to avoid the extremist tendencies that occur with self-reinforcing views. In speeches on college campuses, for example, I've been trying to communicate to students the importance of reading and listening to arguments from those with wildly different political views—because doing so will not only better inform their own thinking, but may also provide a broader social benefit by mitigating polarization. We should also remember that polarization has occurred in long waves in the past. Epochal shifts, such as world wars and the Great Depression, have brought Americans together and attenuated schism. It is possible, though not pleasant, to imagine similar catastrophic events that would offset the intensifying polarization among the public and in Congress.

The second level focuses on the gap between elites and the population. Whatever the degree of polarization in the population, what can be done to dampen the signal by the time it reaches Congress? Changes in districting laws could help, even if much more modestly than the punditry believes, to mitigate the loss of moderates in Congress compared to the underlying population. The greater degree of polarization in Congress than the population also suggests an opportunity: focus on electing moderates to Congress from districts where polarization is least severe. It is not in the interests of either party to do so, which means the effort would need to be driven primarily by non-party leaders, including from the business community. Indeed, efforts to elect centrist candidates such as Americans Elect would do much better to focus on Congress rather than trying in vain to elect a third-party candidate as president.

The third and final level addresses the problem of how to govern assuming a given level of polarization and a general absence of moderates in Congress. Within this category, two approaches suggest themselves. The default approach is for both parties to aim for partisan dominance and unified government, and then to legislate on a partisan basis. This partisan legislative approach represents an understandable and potentially effective response to polarization (at least from the perspective of legislative success). If you can't govern in the middle, might as well govern, even if it is from one side.

Placing our bets on a partisan legislative model has substantial downsides, however. For one thing, political dominance across the White House, House of Representatives, and Senate is a relatively rare phenomenon, so the approach will often be frustrated in practice by some degree of divided government. Furthermore, even when political dominance occurs, the model represents a fundamental shift from the bipartisan norm that has dominated American policy-

making during the postwar era. Finally, the model is inherently unstable, as the 1993 budget deal and the 2009 and 2010 stimulus and health-care examples suggest, since it is likely to create a backlash so strong as to eliminate the political dominance that allowed it. That backlash, in turn, risks making the underlying polarization even more extreme.

What to do during those periods of divided government (which is likely to be most of the time) with few moderates? As I have argued elsewhere, the best we can do to avoid gridlock may be to expand the degree of "automaticity" in the legislative process while retaining full congressional prerogatives to unwind such automaticity. For example, rather than requiring specific affirmative votes in Congress to extend stimulus measures, a better approach is to tie the stimulus measures to an objective indicator, like the share of the population working, and have those measures continue as long as the indicator (in this case, unemployment) is above a specified level. That way, the measures remain in effect as long as they are necessary, without the need for new legislation (though Congress can retain full authority to undo the measures at any time).

Similarly, even a divided Congress is often able to agree upon a process with uncertain outcomes, such as the creation of commissions tasked with finding solutions that take effect unless voted down by Congress. The base realignment and closure (BRAC) process provides a powerful example. It seems implausible that Congress would be able to agree upon which military bases to close through the normal legislative process. But through the BRAC process, first enacted in 1988, Congress delegates the job of choosing which excess military installations to close down to an independent commission, whose recommendations go into effect unless specifically voted down by Congress. The BRAC process—and others like it—works because it creates sufficient ambiguity about specific outcomes that objections are muted at the time of creation; the power of inertia then explains why the specific outcomes are allowed to take effect. For that second stage to work, it is essential that the proposals take effect automatically unless they are voted down by the Congress. This logic is reflected in the Independent Payment Advisory Board that was created as part of the health-care reform legislation to determine Medicare rates and rules.

Back to the Future, 2013 Version

So now back to our early 2013 hypothetical, in which we assume President Obama is re-elected and the House remains Republican. I say early 2013 on purpose, since I suspect the impediments to a deal will be more extreme during the lame-duck session at the end of 2012, before any of the tax expirations or sequestration cuts actually occur and while there may still be some maneuvering room to avoid the debt-limit bind. To the extent there is a serious attempt to get a deal done during the lame-duck session, the argument below still holds—albeit with a bit more force. (One factor that could change the dynamic substantially is if the debt limit turns out to be binding well before the end of the year—forcing a deal to occur in some form in 2012 rather than 2013.)

Given the overwhelming case for a major deal in early 2013, the difficulty of seeing how it could come together at this point only underscores the new political economy. It is not impossible to imagine, given the difficulty of passing bipartisan legislation and the distance between the Obama Administration and the House Republicans over tax policy in particular, that we will wind up with another "framework" agreement that leaves out specifics and delays decisions again, or alternatively a series of rolling temporary extensions of the debt limit and other provisions. That type of just-in-time governing would create unnecessary anxiety and uncertainty in an economy that is likely to remain weak relative to its potential.

In the grand negotiation to come (assuming that Obama and the House majority win re-election), supporters of the Obama Administration correctly note the leverage the Administration will have because all the tax cuts are scheduled to expire at the end of 2012. Note that if the middle-class tax cuts had been made permanent in 2010, this leverage would not exist, and the Administration would thus be facing another debt-limit dynamic similar to the one it faced in the

summer of 2011. With the tax-cut expiration, by contrast, each side has leverage over the other—a fundamentally different dynamic, and one more likely to force both parties to the table. In other words, precisely because the Administration did not get what it wanted in 2010, the prospects for a significant deal in early 2013 are brighter—and that deal could well be broader in scope than anything that was possible in 2010. (In addition, the economy will have enjoyed some very modest benefit in the meantime from the meager additional stimulus provided by extending the high-income tax cuts for two years.)

The challenge is nonetheless that House Republicans will have to vote in favor of a debt-limit increase. The Administration's success in pushing an extension of the payroll-tax holiday this past spring should not be seen as predictive of the 2013 mega-negotiation's prospects, since the reason for that Administration win was that Republicans had somehow boxed themselves into a position—of appearing to oppose a tax cut—fundamentally contrary to their core views. In early 2013, by contrast, Republicans will again be fighting for tax relief—the ground they typically like to occupy.

One path through this brick wall for the Administration would be to allow all the tax cuts to expire and thereby escape the intractable debate over those extensions. In the cacophony that follows, the Administration could then come back in early 2013 with a tax-reform proposal that reduces taxes (compared to the level with the expired tax cuts) disproportionately for middle- and low-income families. If the tax cuts are designed to be universal, even if they are much more progressive than the Bush tax cuts, it would presumably be harder for Republicans to vote against them. One example of this strategy would be to combine a much larger payroll-tax holiday with an increase in the standard deduction. This would provide a substantial tax cut for everyone who works, but the effect would be progressive since payroll taxes represent a larger share of income for low- and middle-income workers than for high-income workers. As with the structure in place for the current payroll tax cut, general revenue would backfill the Social Security and Medicare Part A trust funds, so that the programs would not be harmed by the tax cut.

The problem with simply cutting payroll taxes is that it leaves out nonworkers, like the elderly. Therefore the second component of this proposal would raise the standard deduction, which is claimed by almost two-thirds of elderly filers. This component would also be progressive, since almost all high-income taxpayers itemize their deductions and therefore would not benefit from an increase in the standard deduction, and it would simplify the tax code by removing the need to itemize for more taxpayers.

By changing the discussion to a new tax proposal, it may be a bit easier to perpetuate a higher level of taxation on high-income families rather than continuing to debate the issue within the four corners of the Bush tax cuts. The tax cuts would be designed to avoid or minimize the fiscal contraction at the beginning of 2013, since the economy will remain too weak to handle a substantial fiscal tightening at that point. Ideally, however, even the middle- and lower-income tax cut within this strategy (the payroll tax holiday) would not be a permanent one, since over the medium term the federal government's revenue base is inadequate for the tasks that have been assigned to it. So the significantly larger payroll-tax holiday could phase out as the labor market recovers. Middle- and lower-income families would be more severely affected by excessive reductions in existing government programs (like Medicare and Social Security) than a modest revenue increase to finance those programs.

That core tax package could be combined with other features. For example, we should reform the itemized deductions themselves. Many deductions are intended to promote socially beneficial activities, such as saving for retirement, purchasing health care, or owning a home. Yet with a deduction or exclusion approach, the tax benefit from spending $1 on one of these activities depends on the person's marginal tax bracket. A person in the 15 percent marginal tax bracket who spends $1 on mortgage interest, for example, enjoys a 15-cent tax reduction from doing so; a person in the 35 percent marginal bracket enjoys a 35-cent tax cut for that same $1 in mortgage interest paid. This structure makes little sense from either a fairness or an efficiency

perspective (as Lily Batchelder, Fred Goldberg, and I have argued in a *Stanford Law Review* article). A better approach would be to give each of these taxpayers, say, a 20-cent tax credit for each $1 in mortgage interest paid. Adopting this type of progressive approach to itemized deductions may require adding some less desirable policy—such as a second round of a corporate tax holiday on repatriated profits—to make the overall package legislatively feasible.

That broad approach may resolve the tax issue, albeit at the cost of some temporary turbulence, but it leaves open the debt limit and sequestration components of our early 2013 trifecta. Raising the debt limit and waiving the immediate spending cuts associated with sequestration will undoubtedly require entitlement changes. The question becomes whether the House Republicans accept the more modest entitlement changes discussed during the negotiations over the debt limit in 2011, or try to demand something more dramatic and problematic, such as block-granting Medicaid. The Administration would do well to aggressively combat the more radical proposals during the lame-duck session, lest it find itself boxed in unnecessarily in early 2013.

Before the critics start pointing out all the flaws in this strategy, it is worth emphasizing that none of the alternatives, including the one I sketch above, has an easy path to enactment. And that in turn underscores the key point: In a moderate-free Congress, it is much harder to govern—especially in a divided-government scenario. ***If nothing else, the likely drama later this year and early in 2013 will highlight the challenge of legislating in the new era of hyperpolarization***.