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Strategies for Slowing the Growth of Health Spending

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Health spending in the United States is high relative to other countries and rising rapidly, but many Americans perceive they are not getting their money's worth, and tens of millions are not covered by health insurance of any kind. As chapter 1 illustrated, federal health spending, especially spending on Medicare and Medicaid, is clearly on an unsustainable track. But cutting Medicare and Medicaid benefits and restricting eligibility will shift the financial burden of health care to other payers and increase the ranks of the uninsured without improving the effectiveness of care or slowing the growth of total health spending significantly.

In this chapter we focus on how federal programs could provide leadership that will bring about positive change in the whole health system. What reforms would slow the growth of total health spending and move the whole health care system in the direction of greater efficiency and effectiveness, broader coverage, and better health outcomes? This is a tall order!

Is Comprehensive Reform Necessary to Slow Spending Growth?

Many health policy analysts believe that the United States will have little success in slowing the growth of health spending until it undertakes comprehensive reform of its complex and fragmented health system. Advocates of a strong government role in health care believe that slowing the growth of health care spending would be a far more feasible task in a simpler, more unified system covering most or all of the population. In that view, a universal system with a single payer—or even a small number of competing payers—would be in a far stronger position to cap spending, negotiate payment rates with providers, insist on efficient delivery, or refuse to pay for marginally effective services. In contrast, supporters of competitive reform argue that efficiency can be achieved by giving consumers choice and financial incentives, providing the tools for informed decisionmaking, and providing subsidies to those in need. Such an approach would reduce unnecessary spending, promote high quality care, and better meet the demands of individuals for a health system that works.

However, comprehensive reform of any sort will take either a crisis that forces widespread recognition of the need for sweeping change or national leadership willing to invest enormous political capital in working out the necessary compromises among diverse vested interests. Neither will happen quickly. In the meantime, rising health spending will likely put increasing upward pressure on federal and state budgets and cause retrenchments in public spending and employer health coverage that will leave more people uninsured.

The authors of this volume believe comprehensive reform is necessary—although they may differ on what form it should take. They also believe that the nation cannot wait for comprehensive health reform to address the problem of rising spending in as many ways as possible. Squeezing waste and inefficiency out of the system and putting in place mechanisms to make health spending more effective can set the stage for more comprehensive reform. We believe that many different approaches to improving efficiency and slowing health spending growth should be tried simultaneously. In the rest of this chapter we offer a comprehensive menu of specific reforms, all of which merit attention.

We have not attempted to estimate the potential cost savings of the options described below. Many of the policy options are in early stages of development and their likely impact on health spending cannot be gauged. Many proposals would interact with others, sometimes reinforcing and sometimes reducing their impact on cost, quality, and access to care. The net impact of any policy reform depends on the specific options that are adopted and how well they are implemented. In addition, we have not prescribed a single best course of action to reform federal health programs. As we argue below, the health system is a mix of market and regulatory elements. A realistic reform strategy would include both market-oriented and regulatory policy initiatives.

No Easy Answers

The debate on health care reform sometimes sounds like a contest over which “silver bullet” will solve the whole problem—or a big part of it—by offering better health care at lower cost for everyone. For example, the impressive contributions of information technology to reducing cost and improving quality in other sectors have generated a widely held hope that information technology can greatly increase productivity in the health sector. The common sense observation that avoiding illness saves a trip to the doctor has been translated into the hope that a nation of couch potatoes can adopt healthier lifestyles, resulting in billions saved because disease has been prevented. Multimillion-dollar awards in malpractice cases that seem out of proportion to the actual harm have raised hopes that legal reforms could substantially reduce the cost of health care. Evidence that treatment of the same diagnosis varies greatly in intensity and cost among providers—without observable differences in outcomes—has generated enthusiasm for “evidence-based medicine” and “pay-for-performance” and created a hope that aligning health reimbursement to outcomes can result in higher quality at lower cost.

All of these prescriptions have merit, but none is a silver bullet. Information technology does have potential to reduce errors and save costs in health care, but the required investment is high, and much of the benefit would come from revolutionizing the way hospitals, physicians, and other providers organize their work—not a quick or easy task. Prevention

is, indeed, better than cure, but people cling tenaciously to bad health habits such as smoking and overeating. Moreover, healthier folks use medical care over a longer lifetime and do not necessarily spend less in the long run. Limits on damage claims can reduce malpractice premiums significantly in certain specialties, but their effects on overall health costs are marginal. Similarly, while evidence-based medicine and pay-for-performance are promising approaches, the needed evidence and performance measures do not now exist. A major multiyear effort will be necessary to move the health system toward rewarding performance.

In short, the prospect of a simple solution to the health spending crisis is dim. Slowing the growth of health spending will require multiple policy interventions and persistent effort to address the serious problems of our health system. Everyone—patient, provider, employer, taxpayer—will ultimately be involved in the difficult decisions necessary to slow the growth of spending to a sustainable rate.

The Problem of Third-Party Payment

When spending on video games or espresso drinks soars, no one tries to design policies to second guess consumers and slow such spending. Society relies on the price mechanism to keep supply and demand in balance and ensure reasonably efficient production. But health care is often necessary to life and health. Denying care to someone who needs it but cannot pay is widely regarded as cruel and unconscionable, especially in an emergency or with respect to a life-threatening condition. Moreover, the need for health care is often unpredictable and comes in large lumps, for example, when the patient suffers a heart attack, stroke, or serious accident. People naturally want protection from sudden, involuntary bills that could bankrupt them.

These characteristics have led to third-party payment for most health services. Many countries have national health programs paid out of tax revenues. The United States has a complex system of private and public health coverage. Many workers and their families obtain health insurance through their employers, an arrangement that is subsidized through the income tax. Seniors and the disabled are covered by Medicare, and many of the poor are eligible for Medicaid or the State Children's Health

Insurance Program (SCHIP).¹ Some people purchase their own insurance without employer help, but about 16 percent of Americans go without health insurance, either paying for care directly, receiving charity care, or going without care.

When a third party—whether the government or a private insurer—is paying for care, the patient has little incentive to consider the price or find the most efficient provider. Providers who know that the patient is not paying the bill also have little inducement to economize. This phenomenon, known as moral hazard, results in higher spending for health care than would have occurred if the patient had paid the full cost directly.²

Moral hazard can be diminished by requiring that patients pay more of the cost of their care out of their own pockets or by limiting the use of health services through administrative mechanisms. Raising the deductible amount that must be paid before insurance kicks in, or increasing the co-payments or coinsurance that patients pay when they receive a health service, increases cost-awareness on the part of patients and discourages the use of health services. However, even modest co-pays and deductibles may cause hardship to low-income people. If they subsequently stop taking their medications or seeking care, chronic conditions may worsen, leading to more aggressive treatment and higher costs.

Alternatively, health plans may reduce the impact of moral hazard by directly limiting access to services. Managed care plans often require patients to get a referral from a “gate-keeper” physician before accessing specialist services. Direct limits on the use of services can be effective in controlling spending, but they are unpopular with patients and providers. During the early 1990s many employers turned to managed care plans because they offered comprehensive coverage for lower premiums. Complaints from workers coupled with a booming economy and tight labor markets caused a backlash against managed care, with employers shifting back to less-managed types of insurance coverage.

Public subsidies have encouraged the purchase of private insurance or provided public health coverage to millions of people, but they have also contributed substantially to the rapid growth of health spending. Only about 25 percent of seniors had comprehensive hospital insurance in 1963; virtually all seniors gained that coverage with the implementation of Medicare in 1966.³ Similarly, many low-income persons were given

expanded access to care when Medicaid was enacted. Those programs have helped to improve the health status of seniors and the poor, but they also have added a large and rapidly growing burden on federal and state budgets.

The tax system provides generous subsidies for the purchase of private health insurance. In 2006 more than 170 million people will take advantage of federal and state tax preferences for employer-sponsored insurance worth \$225 billion in reduced income and payroll taxes.⁴ Tax expenditures for health care are essentially entitlements, growing automatically every year without any necessary intervention by Congress. However, they receive less attention than the spending-side entitlements, Medicare and Medicaid.

Nearly the entire amount of that tax expenditure comes from the exclusion of employer premium contributions from the taxable income of workers.⁵ Although the tax exclusion helps millions of people buy health insurance, it also leads to higher spending on health insurance and promotes insurance that covers more services with lower out-of-pocket cost to be paid by consumers. Employer contributions to premiums also reduce the apparent cost of insurance even though such contributions are ultimately paid by the workers, whose wages grow less rapidly than they otherwise would. Consequently, employer-sponsored insurance tends to offer more generous coverage, which blunts the consumer's sensitivity to health care prices and encourages greater use of services.

Consumers directly paying only a fraction of the cost of their care are apt to use services that are not worth as much as they cost. The cost of additional care induced by this moral hazard effect of insurance is reflected eventually in higher insurance premiums. By promoting generous coverage, tax incentives help fuel the escalation of health care costs and insurance premiums.

The tax exclusion does not help people who are not working or who work for a firm that does not offer health insurance coverage, regardless of their income or health status. Among workers who benefit, those with higher incomes stand to gain more from the exclusion than lower-income workers. After income and payroll taxes, a high earner could save as much as 50 cents for every dollar spent on health insurance premiums, at

the margin. In contrast, a low earner might save as little as 3 cents on the dollar for employer-sponsored insurance.⁶

Combining program spending for Medicare and Medicaid with the health tax expenditures, federal and state governments will devote over \$875 billion to health care in 2006 and substantially larger amounts in the future. Much of that money is not spent efficiently, resulting in health care that does not return full value for the investment.

Seeking Efficient and Effective Care

Despite enormous advances in scientific knowledge, medicine remains more an art than a science. Diagnosing a patient can be difficult if he or she has multiple conditions or uncommon diseases. The choice of treatment can be complicated because different patients with a particular disease may respond well or poorly to the same therapy. Physicians may well disagree about the best treatment approach for a challenging patient. Since physicians share experience and influence each other, it is not surprising that there are substantial variations among locations and providers in how particular diagnoses are treated.

Nonetheless, the variation in medical practice across the country is much larger than one might expect to arise purely from different mixes of patients or traditions of practice. Dr. Jack Wennberg and colleagues at the Center for Evaluative Clinical Sciences at the Dartmouth Medical School have long experience analyzing Medicare data to uncover variations in resources used to treat the same diagnoses among regions, states, and providers, as well as the outcomes associated with those treatments.

Three robust results emerge from this body of research and analysis. First, the variations in resource use are huge. For example, Medicare spending for the average patient living in Miami is about two and a half times larger than it is in Minneapolis, even accounting for health and demographic differences between the two populations.⁷ A study of Medicare patients suffering from one or more serious chronic diseases showed that in the last six months of life such patients averaged more than sixteen days in the hospital in New York and Hawaii, but less than eight days in Utah and Oregon. In the last two years of life, Medicare

spent an average of \$40,000 on such patients in New Jersey and only \$25,000 in Ohio.⁸

Second, resource use is sensitive to supply. In areas with more hospital beds per capita, Medicare patients were more likely to be hospitalized, and in areas with more cardiologists per capita, Medicare patients with heart disease had more cardiologist visits.

Third, and most surprising, more aggressive treatment styles and higher spending levels do not result in better patient outcomes. One study that followed three cohorts of Medicare patients (who were hospitalized for hip fracture, colorectal cancer, and heart attack) found that greater care intensity was associated with increased mortality rates.⁹ However, all is not well in low-spending areas: both high- and low-cost areas underutilize effective services, such as mammography or vaccination for pneumonia.

These findings reflect a disturbing variability in efficiency in the health system. They suggest that finding ways to make practices of the least efficient providers more like the most efficient would save large amounts of resources, both in Medicare and in the rest of the health system.

The challenge is moving from documenting inefficiency to reducing it without doing more harm than good. Information on what works in health care (and for whom) is inadequate, and providers often fail to use available information on effective medicine. Fee-for-service payment encourages greater resource use and rewards excessive treatment and even medical errors. Medicare, for example, will pay for the readmission of a patient to a hospital to treat an infection acquired in that hospital.

Major efforts are under way to address the lack of information on effective treatment. New data sources are being developed, including information from insurance claim records and patient registries that can provide evidence of how well medical interventions work in day-to-day practice rather than under the more carefully controlled (and less realistic) conditions of clinical trials. Comparative effectiveness studies analyze the body of scientific literature to draw conclusions about which of several treatment strategies are the most promising. Medicare has modified its coverage process to permit payment for certain treatments (such as implantable cardiac defibrillators) on a provisional basis, contingent on the development of evidence on the success of the treatment among Medicare patients.

It is sometimes said that only 15 percent of what doctors do is backed by hard evidence.¹⁰ That may be an exaggeration, but it is clear that the medical profession's ability to treat patients has greatly outrun its knowledge of what works best out of a growing range of options. Efforts to improve the knowledge base must become an ongoing and substantial part of the health system.

Despite the lack of clear evidence for much of what is done in medicine, the wealth of treatment options can be overwhelming even for well-trained physicians trying to keep up with medical progress. Methods being developed to help physicians manage information overload include:

- Practice guidelines based on evidence rather than subjective judgment or professional consensus;
- Disease management and other patient management methods that rely on evidence-based protocols and improved coordination among providers;
- Improved Internet access to the latest scientific studies; and
- Computer-based decision support tools.¹¹

Many physicians may not make the best use of such information tools, however. Accessing computer-based information can interfere with face-to-face interaction between physician and patient. Computers are typically not available in examining rooms, for example, although hand-held devices may reduce this problem for physicians willing to use them. Although younger physicians are more comfortable with such technology, the practice style of many older physicians is incompatible with its use. In addition, most physicians typically see patients with common diseases that may be easily diagnosed, diseases that the physician has long treated in conventional ways. Conventional practice may therefore lag behind the best evidence unless new findings are brought to the physician's attention.

The business realities of running a medical practice also inhibit physician adherence to evidence-based standards. Fee-for-service payment combined with low negotiated reimbursement rates from insurers promote the use (and overuse) of health services. The patient is unlikely to object to treatment that does not meet evidence standards since he or she is largely shielded from the direct cost of care by insurance and is far less knowledgeable about treatment alternatives than the physician. The

insurance system has a bias in favor of treating rather than preventing disease, even though prevention might be less expensive.

To improve the efficiency and effectiveness of health care, the knowledge base necessary for sound medical decisionmaking must be built and that knowledge made accessible and usable to patients, physicians, and payers. The financial incentives must be redirected toward more prudent use of care while also finding mechanisms that ensure that patients seek necessary care.

The Problem of the Uninsured

The American health financing system leaves about 45 million people without health insurance at any given time and larger numbers without coverage for some part of the year.¹² Perhaps as many as 60 million people are uninsured at any time during the year.¹³ Over the past two decades, the number of people without health insurance has grown by 50 percent.

People without insurance have limited access to health care through public hospitals and clinics and charity care offered by private providers. As a result, the uninsured often have untreated ailments and chronic conditions. Eventually they may require aggressive and expensive medical interventions that could have been prevented with more timely and routine attention from a health provider.

The rising cost of health care is pushing more and more people into the ranks of the uninsured. As insurance premiums rise, employers pare back benefits, increase the share of costs that must be paid by employees, drop coverage altogether, or decide not to offer it in the first place. Employment-based coverage is sensitive to the business cycle, declining during periods of economic slowdown and rising during expansions. Disturbingly, the share of the population with employer coverage did not grow much above historical levels even during the record boom of the 1990s. Medicaid has proven to be a safety valve, growing as a share of the total as private insurance enrollment fell off.

The rising numbers of uninsured also add to the total cost of health care. Uninsured individuals impose a cost on everyone else when they need health care and are unable to pay. Uncompensated care could amount to as much as \$35 billion annually.¹⁴ Moreover, people without

insurance tend to forgo preventive health care and delay treatment, which can cause them to suffer needlessly, lead to complications, and require more aggressive and expensive medical interventions. The uninsured tend to seek care in hospital emergency departments—an exceedingly expensive source of care.

Thus, the problem of the uninsured is not just a matter of fairness. Reducing health spending growth in ways that further adds to the ranks of the uninsured is not only inequitable; it tends to make the health system even less efficient.

Reform Strategies

Objectives of a broad system reform include slowing the growth of health spending by increasing the system's efficiency, ensuring that more people have access to health insurance, improving the availability of essential health services, providing consumers control over their health care, and promoting medical innovation. Some policy objectives are likely to be incompatible with others, requiring careful balancing of goals. However, it should be possible to make progress on a variety of objectives even as the nation works to slow spending in a \$2 trillion system.

Two basic approaches dominate the running debate among experts and policymakers about the best reform strategy for the health system. Market strategy proponents argue that promoting competition and consumer choice would establish appropriate incentives for greater system efficiency and ultimately lower growth in health spending. Regulatory strategy advocates believe that stronger government action is needed to control costs directly and to police an unruly marketplace to avoid risks that individuals should not be forced to bear. Both sets of beliefs are deeply held, causing a philosophical impasse that limits the scope of policies that can be seriously considered in Congress. We argue that a blended strategy that uses both market and regulatory approaches is most likely to be successful.

Market Reform Strategy

Proponents of a market strategy believe that if individuals had more direct responsibility for the cost of their care, they would weigh these

costs and the value they receive more carefully. Providers would be forced to compete for consumer dollars on the basis of price, quality, and customer service. This heightened competition would cause health care providers to adopt more efficient practice styles. Prices for services would be established in the market, reflecting both supply and demand conditions more accurately than government-set prices. Such pricing would provide incentives for continued medical innovation.

Giving consumers choices among competing health plans is not a new idea to the federal government. The Federal Employees Health Benefits Program (FEHBP) has offered federal employees and retirees a wide choice of health plans since its founding in 1960. While having a choice of health plans may make consumers more cost-conscious when they choose plans, it still leaves a third party (the plan) paying most of the bills.

Another approach that reduces the moral hazard problem would require consumers to pay out of pocket for most health expenditures, while protecting them only from the catastrophic losses that could accompany a major illness or accident. Such consumer-driven health plans typically offer insurance with a high deductible plus a savings account, to which the individual or his employer may contribute, designed to help the individual pay the out-of-pocket costs. Such plans encourage more prudent decisionmaking on the part of both patients and physicians by making both more aware of the cost of care and of the fact that consumers are using their own money to pay for that care. Congress introduced this idea into the discussion in 2003 when it enacted health savings accounts (HSAs), an idea that is discussed in more detail later.

Reliable information on the cost, quality, and appropriateness of care is needed if consumers are to make sound health care decisions. Such information is not readily available today, and the information that is available is fragmentary and difficult to interpret.

The price that the consumer will pay out of pocket for a service, for example, depends on who delivers the service and whether the consumer has satisfied his annual deductible. The cost of a full episode of care is a better indicator of cost for conditions requiring hospitalization or the services of more than one provider. However, since services are typically billed individually, ascertaining a price for the full bundle can be difficult.

Mortality rates, hospital readmission rates, and other commonly available quality indicators are inadequate assessments of provider quality and must be interpreted with care. Data comparing the effectiveness of alternative treatments are not readily available, and the typical consumer would need substantial medical knowledge or the advice of a physician to interpret the studies that do exist.

Insurers, providers, and government agencies are beginning to develop better consumer information. Many insurers have begun to experiment with ways to make price data available to consumers.¹⁵ Aetna, for example, gives its subscribers access to physician-specific rates for 25 common services in its Cincinnati pilot project. CIGNA focuses its pricing information on outpatient procedures, such as MRI (magnetic resonance imaging), where the variation in cost is substantial and members are more likely to consider choosing a provider based on cost. The White House has urged providers to make price and quality data available to consumers,¹⁶ and many states and the federal government make available quality indicators for hospitals, nursing homes, and other providers.

Nonetheless, critics are concerned that the average consumer is poorly equipped to interpret complex price and quality information and that high out-of-pocket costs will cause people, especially those with low incomes, to forgo both unnecessary and necessary care.¹⁷ That could worsen health outcomes and increase costs.

Moreover, much health spending is concentrated among a small number of people with very high expenses: 10 percent of the population accounts for 69 percent of the nation's health spending.¹⁸ Much of the spending for high-cost patients is above the deductible amount for a typical consumer-driven health plan and unaffected by financial incentives. Other methods of limiting inappropriate spending, such as care management for high-cost cases, may be more effective in controlling costs.¹⁹

The list of steps necessary to create a functioning health market is daunting. It includes insurance market reform, improved health information, better antitrust enforcement, malpractice reform, and restructured and better-targeted subsidies to individuals for private insurance.²⁰ Since such policies are controversial, and there are both political and technical disagreements over how to proceed, the task will not be easy.

Regulatory Strategy

Critics of market-based reform argue there is a social responsibility to make sure that everyone has access to good quality care when they need it. Third-party payment has become the norm precisely because consumers want, and deserve, to know that they will have the ability to pay for medical services when the need arises. Consumers, especially people who are ill, cannot become sufficiently informed on the technicalities of medical practice to make wise choices and thus are likely to be unduly influenced by providers.

Proponents of a regulatory strategy also argue that there is a social responsibility to ensure that good quality care is delivered as efficiently as possible. We cannot rely upon private companies to provide that care without regulation, as experience shows that insurers seek to avoid covering people with serious health conditions and drug companies charge substantially more than they need to cover their costs of production. Large companies will exploit their market power to the disadvantage of consumers. Moreover, large government programs have considerable market power that should be exercised on behalf of consumers and taxpayers. Proponents of stronger regulation assert that Medicare has been more successful than private insurers in slowing the growth of health spending, attributing that record to Medicare's ability to price services more aggressively.²¹ Many policymakers agree with that assessment despite some evidence to the contrary.²²

Admittedly, there are risks to setting lower prices for health services than would have prevailed in an unregulated market, since health providers may try to make up for the lower price by increasing the volume of services. For that reason, Medicare price cuts have typically resulted in less budgetary savings than might have been expected without the induced growth in the use of services.²³ Moreover, if prices are held to low levels over the long term, health providers and suppliers exit the market. The unwillingness of many providers to accept the low reimbursements under Medicaid reduces options for low-income people enrolled in the program, and some providers limit the number of Medicare patients they see.

Proponents of regulation argue that just because regulation has sometimes been carried out stupidly does not mean it cannot be done well.

They envision a system of universal health coverage in which the government uses its power to ensure that health services are effective and delivered efficiently. This could involve analyzing data to establish best practices, promulgating practice guidelines, and refusing to pay for care that did not conform to those guidelines, as well as imposing caps on total health spending and devising rules for enforcing those caps.

Blended Strategy

In fact, America's health system is a hodgepodge of market and regulatory elements that have accreted over decades. Replacing this complex, hybrid system with either a pure market system or pure regulated system seems both unlikely and unworkable. Realistically, moving the current health system toward greater efficiency as well as equity will take a blend of market-oriented and regulatory reforms.

An example of a blended strategy would be aggressive implementation of pay for performance by both public and private payers. Such a strategy would recognize the basic tenet of the market model that informed consumers will seek out providers who offer the best value in terms of price, quality, and customer service. But it also recognizes that, as long as a large fraction of health spending is covered by insurance, the most important decisions about what and where to buy are made by third-party payers, not individual consumers. Employers have taken steps to promote more informed purchasing by their employees. For example, the Leapfrog Group of large employers has received public acclaim for its efforts to reward doctors and hospitals for improving the quality, safety, and affordability of health care, and to help consumers reap the benefits of making smart health care decisions. Medicare also has begun experimenting with ways to provide stronger financial incentives for hospitals and physicians to provide high quality care under the rubric of P4P.

Regulation and markets are facts of life in the health system. Health reform is likely to nudge the system toward either greater regulation or more competitive markets, but a wholesale shift in one direction is implausible. Policy proposals should be evaluated for their likely impact on spending, access, and quality, as well as for their longer-term influence on the balance between government and individual control.

Using Federal Programs to Lead the Way

The size and impact of federal health programs suggest that well-designed reforms of these programs can serve as a catalyst for improvements of the whole health system. Of course, the reverse is also true: Poorly conceived federal policy can make matters worse for everyone, and it can be very difficult to reverse even the most misguided federal policy once it has been implemented.

Of all federal health programs, Medicare has the greatest leverage on the day-to-day operation of the health system. As the largest single purchaser of health care, Medicare policies directly affect virtually every provider.

Since Medicare's policies have the force of law, they have enormous influence over a vast industry. Record keeping, coding, and billing practices established by Medicare are the industry norm. Medicare has introduced innovations in payment methods, such as prospective payment systems, that have been widely adopted by private insurers. Changes in the way Medicare manages or pays for benefits, as with the prescription drug benefit, can cause health plans and providers to alter the way they manage both their Medicare and private business. Medicare's recent emphasis on price transparency and quality reporting, for example, is likely to lead to greater access to such information for all consumers. Initiatives to test new ways to manage high-cost patients, to promote the use of evidence-based treatment, and other innovations have stimulated interest among private insurers and health plans in such approaches.

Innovative approaches are also being tested by states seeking to improve the operation of their Medicaid programs, which together account for as much total health spending as Medicare. Efforts to make other federal health programs—including SCHIP, the Veterans Health Administration (VHA), and the Defense Department's TRICARE program—more efficient could pay off in terms of reduced growth in federal outlays. Lessons learned from such policies can often be applied more broadly (see chapters 4 and 5). Indeed, examples of efficient practices in VHA are already influencing other systems.

The federal tax system plays a major role in subsidizing employment-based private health insurance. Restructuring the tax preference, perhaps

by capping the amount that may be excluded from taxable income and providing a refundable tax credit for health insurance, could better target those in need and minimize the adverse incentives that promote inefficiency in the health system.²⁴

In addition, regulatory agencies, such as the Federal Trade Commission (FTC) and the Food and Drug Administration (FDA), establish and enforce “rules of the road” for the health sector. The FTC seeks to prevent anticompetitive business practices and to protect consumers against unfair, deceptive, or fraudulent practices. In the health sector, that has meant challenges to hospital mergers and other actions to discourage anticompetitive behavior or to improve consumer knowledge. The FDA regulates drugs and medical devices to ensure safety and effectiveness. The approval of new drugs, generic versions of brand drugs, and medical devices can have substantial impacts on the treatment of disease and the cost of health care.

Research agencies, such as the National Institutes of Health (NIH) and the Agency for Healthcare Research and Quality (AHRQ), contribute to the development of medical innovation and improvements in clinical practice and the delivery of health care. Research on health system improvements, including comparative effectiveness analysis, receives relatively little funding, however, despite the large potential payoff to such work.

Policy Options

In this section, we discuss policy proposals that show promise of mitigating the projected increase in federal health spending and leading the non-federal system toward greater efficiency at the same time (see table 2-1 for a brief summary of proposals). While substantial work would be required to implement any of them, they illustrate the many possible avenues to pursue.

Setting Prices or Payment Rates

The way in which health care products and services are priced or reimbursed can determine the type of services that are provided, the quality of the resulting care, and the cost of that care. Reimbursing providers on a fee-for-service basis is widely seen as creating incentives to produce more

Table 2-1. *Reform Options for Federal Health Programs and Health-Related Activities*

Improve price setting	
<i>Pay-for-performance</i>	Implement and evaluate reimbursement rates based on performance (P4P) in federal programs, especially Medicare.
<i>Bidding</i>	Design and implement bidding approaches to purchase of drugs, devices, and packages of health services in federal programs.
<i>Leverage market share</i>	Negotiate lower prices for medical products and services, using federal programs' market power and legal authority.
Develop information	
<i>Health information technology (IT)</i>	Develop standards for interoperable health IT for hospitals, physicians, and other health providers. Provide incentives and low-cost financing for adoption of systems that meet the standards. Use VA health system as laboratory to test improvements in health IT, including hardware, software, and work methods. Use incentives and requirements to meet target date for implementation of universal, portable, individual medical records.
<i>Data development</i>	Collect and make accessible data on cost and outcomes of health treatments by diagnosis and provider, starting with Medicare database.
<i>Research on outcomes and effectiveness</i>	Sponsor cost-effectiveness and comparative effectiveness studies of medical treatments and disseminate results widely.
Improve health care delivery	
<i>Guidelines</i>	Create evidence-based practice guidelines by using Medicare's "coverage with evidence development" to assess use of treatments and patients most likely to benefit Give providers information to compare their performance against their peers and measure their adherence to practice guidelines.
<i>Care management and coordination</i>	Increase incentives for Medicare beneficiaries to enroll in managed care plans and participate in disease management programs. Increase incentives for providers to cooperate with disease management programs and improve coordination of patient care.
<i>End-of-life care</i>	Promote greater public awareness of end-of-life health issues, including importance of advance directives and understanding of treatment options.
<i>Lower-cost delivery settings</i>	Increase incentives for use of lower-cost treatment settings.
<i>Health promotion and disease prevention</i>	Support studies on cost-effectiveness of preventive health services.

Promote consumerism and competition

<i>Premium support</i>	Introduce premium support in Medicare, modeled after Federal Employees Health Benefits Program.
<i>Premium assistance</i>	Encourage state experimentation in Medicaid to involve beneficiaries in decisions about their care, such as the “cash and counseling” demonstration.
<i>Health savings accounts</i>	Encourage high-deductible insurance plans tied to tax-favored health savings accounts.

Limit health outlays

<i>Transform Medicare and Medicaid</i>	Convert Medicaid to indexed block grant that rewards better health outcomes and lower-cost treatment. Convert Medicaid and Medicare to modified entitlements, requiring Congress to vote on total spending at least every few years.
<i>Limit tax exclusion</i>	Cap and gradually reduce tax exclusion for employer contributions to health insurance premiums.

Other options

<i>Drug approvals</i>	Streamline FDA approval process for new drugs and medical devices; develop standards for new types of generics, including follow-on biologics.
<i>Malpractice reform</i>	Reform tort system to reduce defensive medicine costs, improve patient safety, and promote appropriate redress for injury.

tests, procedures, and office visits, even if these services are likely to provide only minimal improvements in the patient’s health. Managed care plans can be more efficient, because they have an incentive to provide only the services needed to keep the patient healthy. Medicare has not required its beneficiaries to move into managed care (although they have the option of enrolling in Medicare Advantage). Medicare has been an innovator in developing more effective pricing methods within its traditional fee-for-service system, in which the vast majority of beneficiaries are enrolled.

Medicare’s first major pricing reform was the shift in 1983 from cost-based reimbursement to a prospective payment system (PPS) for hospital services. Paying a fixed amount for a given diagnosis gives hospitals an

incentive to reduce unnecessary costs.²⁵ Consequently, lengths of stay were reduced and hospital care became more efficient, although this approach also encouraged hospitals to discharge patients to skilled nursing facilities and other providers of postacute care that is billed to Medicare. Since then, Medicare has adopted prospective payment, or a predetermined schedule of fees, for most covered services. The program has analyzed ways to refine PPS, including payment adjustments for more acutely ill patients and a single payment for a larger bundle of services (such as the inpatient stay and some period of postacute care).

Pay-for-performance (P4P) is a promising tool for promoting high-quality care and reducing unnecessary costs, although implementing such a system poses major challenges.²⁶ To be effective, quality measures must identify real differences in provider performance, adjusting for the severity of illness of their patients and multiple dimensions of quality care. Mortality or hospital readmission rates and patient satisfaction measure only part of the broader quality concept that a well-designed P4P program would reward. Physician acceptance of both P4P principles and the specific quality measures is essential to making this approach successful on a sustainable basis. It is not known how much money must be at stake to promote improvements in provider performance. There are questions about the capacity of poor performing physicians and hospitals to improve the quality of their care when insurers reduce their reimbursements. Medicare has the clout to advance P4P, but it must move forward carefully to avoid institutionalizing an inadequate payment formula.

P4P has proven controversial among some conservatives.²⁷ They argue that Medicare has so much leverage over the market that the adverse consequences of any error in assessing provider performance would be magnified greatly. The fear is that Medicare's size and regulatory authority would create a de facto federal standard of care for private insurance that would be difficult to modify, even though the science of medicine continued to evolve. One solution, according to that argument, is to prevent the use of P4P in traditional Medicare while permitting smaller private plans in Medicare Advantage to experiment with such payment systems.

While allowing traditional Medicare to develop P4P carries risks, the program should not simply ignore the adverse incentives of its current payment methods that discourage quality and efficiency. Those incentives

influence medical practice regardless of who is paying the bill, and they must be addressed if systemwide improvements are to be made in care delivery.

Although a well-designed P4P system would provide financial incentives for high-quality care, even that advance would not ensure that the price level was appropriate. P4P, PPS, and other common formula-based payment systems used in Medicare may not accurately reflect the market conditions facing individual providers in local markets. At best, Medicare's payments approximate the average demand and supply conditions in each market. But that means some services and providers are overpaid, and others are underpaid. Consequently, exceptional growth in program outlays for some services appears to be motivated by distorted payment incentives.

Medicare has explored bidding approaches as an alternative to formula-based payment methods. By requiring all sellers to submit their best offer in advance, bidding approaches elicit prices that better reflect local market conditions.

Bidding has been tested for pricing durable medical equipment (such as wheelchairs, hospital beds, and oxygen equipment). Demonstration projects conducted between 1999 and 2002 in two locations found that bidding reduced program costs by about 20 percent.²⁸ A nationwide competitive bidding system for durable medical equipment is expected to begin in January 2007, although there are concerns that such a system will drive smaller suppliers out of business, ultimately driving prices up and reducing service to beneficiaries.

Greater controversy surrounds the decision to use bidding to set payments under the new Medicare drug benefit. Under this system, each prescription drug plan (PDP) submits a bid detailing the list of covered drugs (formulary), cost-sharing requirements (deductible, copayments, and coverage gaps), distribution network (retail and mail-order pharmacies), and the premium they propose to charge. Medicare pays an amount equal to 75 percent of the average premium, and beneficiaries pay the rest. This approach relies on the PDPs to negotiate their best price from drug manufacturers. Plans with lower costs can charge lower premiums and attract more enrollment; larger plans are in a better bargaining position to extract the greatest price concessions from manufacturers.

Critics argue that this approach fails to take advantage of Medicare's aggregate buying power. If the program negotiated on behalf of all of its beneficiaries, the resulting prices might be substantially lower than those obtained by the PDPs. The cost of producing an additional pill is generally low, which leaves room for downward price flexibility. However, drug manufacturers point out that the cost of research and testing a new drug is high and only a few drugs are financial successes. If aggressive government negotiation to lower prices to Medicare makes drug companies significantly less profitable, it could retard the creation of new pharmaceuticals.

Outside of Medicare, the government uses its market power and legal authority to extract lower drug prices than generally seen in the market. Congress requires drug manufacturers to provide rebates to state Medicaid programs, resulting in a Medicaid "best price" that is about 63 percent of the list price.²⁹ The Department of Veterans Affairs (VA) does even better, negotiating prices with drug manufacturers under the Federal Supply Schedule that average 53 percent of the list price, although some of the price difference is the result of not having to use retail pharmacies for distribution. Federal Supply Schedule prices are available to all direct federal purchasers of pharmaceuticals, including VA, the Defense Department, and the Public Health Service. Congress gave VA considerable leverage in its negotiations, and drug manufacturers must participate in the Federal Supply Schedule to sell their pharmaceuticals under Medicaid.

The challenge for policymakers is finding a balance between the short-term savings and the longer-term consequences of direct negotiations or other methods of setting prices administratively.

Developing Information

Any attempt to improve the efficiency of health services will require better information to be successful. Federal action can improve the knowledge base for clinical decisionmaking by promoting health information technology, developing comprehensive data on patient care, and sponsoring research on outcomes and effectiveness of care.

HEALTH INFORMATION TECHNOLOGY. More can be done to build on the health information technology (IT) activities already under way at

various federal agencies. Much attention has been given to the electronic medical record (EMR) system used by VHA, which is one of the pioneers in this area. Although that system can be improved to facilitate true interoperability across sites of care, it provides a solid demonstration of the value of health IT.

The Veterans Health Information System and Technology Architecture (VistA) provides comprehensive diagnostic and treatment information for each patient as well as financial and management information. The system allows providers not only to order various services (including medications, x-rays, nursing orders, diets, and laboratory tests) but also to review detailed information on the patient and his treatment. Although providers in one facility cannot currently access EMR information on care provided in another facility, VHA is working on a system upgrade that will establish a single systemwide record that is accessible to all VA providers (see chapter 5). The successful quality improvement initiatives undertaken by VHA to date have relied in large part on the patient data available through VistA.

The Department of Health and Human Services (HHS) is heavily promoting the use of EMRs that can be linked together to enable data sharing among doctors, hospitals, and other providers, as well as patients.³⁰ For example, the department is developing electronic standards in conjunction with the private sector to promote the exchange of data across computer systems. The Agency for Healthcare Research and Quality is funding projects to develop interoperable health information systems at the state and regional level. The CMS (Centers for Medicare & Medicaid Services) has several demonstration projects to test how health IT can improve the quality of care, and it is modifying the VA's EMR software for the physician office setting.

A recent executive order issued by the White House directs federal health care programs—Medicare, VHA, TRICARE, the Federal Employees Health Benefit Program, and the Indian Health Service—to transition to health IT that meets interoperability standards.³¹ In addition, the order requires a similar upgrading of health IT capability used by providers, health plans, and insurers who contract with those programs. Such requirements establish a more certain market for improved health IT systems and software that could spur more rapid development.

Recognizing that the cost of investing in health IT can be an insurmountable barrier for some providers, particularly small physician practices, Congress created a “safe harbor” that allows physicians to accept donations of software for EMRs or for electronic prescribing, or for information technology and training services.³² Such donations are likely to be made by hospitals, health plans, or insurers, who might offer help with health IT to providers in whom they have a financial interest. Previously, physicians could not accept such donations because of the potential for a conflict of interest.

Patients’ concerns about maintaining the privacy of their personal information, heightened after recent reports of unauthorized disclosures of patient data and other confidential information, are another barrier to the widespread use of health IT.³³ Greater technical safeguards and more enforcement are necessary.

DATA DEVELOPMENT. Sound medical decisionmaking requires a knowledge base of clinical research to ascertain what treatments are likely to be successful and under what conditions. In addition, patients need information about quality of care to make informed choices about which providers to see. Both objectives can be furthered by efforts to assemble data on the care of patients covered by federal programs.

Health IT, particularly EMRs, can provide a mechanism to efficiently collect information on patients and the course of their treatments. Ideally, a fully wired health system could monitor and analyze patient progress on a large scale, enabling more reliable judgments about the effectiveness of specific treatments and the value-added of providers. Until then, currently existing Medicare and Medicaid data offer a potentially rich source of patient information on which to base assessments of clinical effectiveness and quality of care.

The obstacles to developing a usable database from those programs are numerous. Medicare operates through regional carriers and intermediaries with access to billing records but not detailed patient records. Medicaid is operated through state agencies that do not currently share detailed information on billing and patient care with HHS. Assembling a longitudinal file that represents all of the health care a beneficiary receives through Medicare is a difficult undertaking, and combining data from Medicare and Medicaid is currently impossible. Desirable information is

often in paper records and not retrievable in any practical manner for a large sample of patients.

Despite these difficulties, it is feasible to begin constructing a comprehensive patient-level database using Medicare data without waiting for full adoption of health IT. Such a data source would be a powerful analytic tool, revealing the effectiveness of medical treatments for the entire elderly patient population rather than a small sample of patients (as in most research studies). In addition, such data would reflect the practical problems of providing health care (such as physician or patient failure to follow a strict treatment protocol, or treatment delivered to patients with multiple problems). Clinical trials are more tightly controlled (typically involving patients with one disease and tight adherence to protocols) and yield evidence of the effectiveness of care under best practices, but those results may not be found in actual care settings.

Less ambitious data development would also yield valuable information. The CMS has undertaken a variety of projects to measure the quality of care offered by providers, ranging from hospital mortality data first reported in the late 1980s to the recent release of information on the amount of Medicare payments and the volume of services for thirty common elective hospital procedures.³⁴

The federal government could also expand its data collection beyond Medicare and Medicaid. Federal insurance programs cover other large populations, including federal employees and retirees, veterans, and military personnel. Although there are legal, technical, and financial challenges, the government could explore partnerships with private insurers and health plans for the purpose of developing comprehensive health databases for a broad swath of individuals below the age of sixty-five.

Although it has several advantages in assembling health data, the government should provide other researchers, health plans, and insurers access to the resulting information so they can analyze the data and make judgments about effectiveness and quality.

RESEARCH OUTCOMES AND EFFECTIVENESS. The federal government spends little money on research to improve the quality, cost, efficiency, and effectiveness of our health care system. The lead federal agency for such research is the Agency for Healthcare Research and Quality, with an annual budget just over \$300 million. Other agencies support health

services research to some extent, but total federal outlays devoted to improving the delivery of health care are miniscule compared with the total amount spent for services.

Additional research could produce more evidence on the effectiveness of health services and knowledge of therapeutic approaches with the greatest chance of success given the patient's condition. Comparative effectiveness research can be difficult and expensive, particularly if the research uses clinical trials to test multiple treatment options. A far less costly approach synthesizes existing knowledge on a particular topic, identifying what can be concluded based on past studies while identifying gaps in knowledge.

Up-to-date analysis of a treatment's effectiveness, or the comparative effectiveness of a class of treatments, is an important input into a physician's decision to pursue a course of treatment. It is more difficult to assess whether a treatment is cost-effective.³⁵ That is, how good are the results likely to be and do they seem to justify the cost?

Cost-effectiveness could become an important consideration for insurers determining what services to cover. However, private insurers and public programs have been slow to adopt this approach, partly because of the paucity of reliable data on treatment effectiveness. An even greater challenge is cultural: the public and the medical profession do not seem eager to accept that resource constraints could be a reason to limit coverage for services. Whether an increase in life expectancy or quality of life is worth the cost of treatment, and who should pay for that treatment, are questions that must be viewed through the prism of personal and societal values.

The Oregon Health Plan systematically applied cost-effectiveness standards to Medicaid coverage.³⁶ Although that plan incorporated community views into the final list of covered treatments, the idea of making coverage decisions based on explicit resource constraints created a storm of protest about rationing health care.

More commonly, public and private insurers explicitly limit coverage to categories of medical services (such as dental services) as a contractual matter. Decisions about whether to pay for specific treatment within a covered category are typically based on the circumstances of the individual case, reflecting a medical necessity standard that may be based on

common practice in the community rather than on formal analysis of scientific evidence on effectiveness. Payment denials may be appealed in many cases, and insurers may decide to pay for a service they had previously denied.

Medicare recently adopted an approach that combines speedier access to new technologies with data on treatment effectiveness or its applicability to particular patient groups. Under “coverage with evidence development,” Medicare agrees to pay its share of the cost of a new treatment for patients who have a specific disease and other characteristics that make them good candidates for the treatment. Clinical evidence is collected over the course of treatment and evaluated to determine whether the coverage policy should be changed, either expanding access to the treatment or further restricting its use.³⁷

Improving Health Care Delivery

Beyond creating better information on health services’ effectiveness and quality of care, additional steps can be taken to improve health care delivery.

GUIDELINES. Clinical guidelines are an important tool in promoting appropriate, high quality care. They help physicians keep up with rapid advances in medical knowledge and incorporate the latest evidence into their decisions about the best course of treatment for a patient. However, even an ambitious program to develop clinical effectiveness information will leave large areas of medicine without a strong evidence basis.

The federal government can use its data development activities to generate more comprehensive clinical guidelines. Medicare and Medicaid could examine provider-specific patterns of service use to identify the outliers from local or national norms. Further investigation would be necessary to determine if providers failed to follow practice standards without clear justification. Enforcement actions could include mandatory continuing education to improve adherence to standards or financial penalties for providers whose performance does not improve.

Federal programs (and private insurers) could present providers with a scorecard benchmarking their performance against the average provider performance in their market. Learning that they are outside professional norms could be a strong incentive for individual providers to improve

their performance. In addition, AHRQ could direct resources for further study of methods to promote adherence to clinical standards.

CARE MANAGEMENT AND COORDINATION. Much of American health care is uncoordinated and inefficient, resulting in less than optimal care and higher costs.³⁸ Providers often do not share information that could reduce unnecessary services and avoid medical errors. Team approaches to patient care are uncommon in outpatient settings, and the patient's own role is often overlooked. Private and public health programs have started exploring ways to improve care coordination, including monitoring patient health status between visits and encouraging patient self-management.

Tightly managed health maintenance organizations (HMOs) might save 15 percent or more compared with plans that do not manage care.³⁹ Those potential savings led to growth of managed care plans during the 1990s, but such plans have proven unpopular with middle-class consumers.⁴⁰ Today, most people's plans offer little care coordination. Working-age people with employer-sponsored insurance primarily enroll in loosely managed preferred provider organizations, and most seniors are in traditional fee-for-service Medicare.

In contrast, Medicaid has long used managed care methods to control costs. Medicaid programs rely on direct management of health services to discourage unnecessary spending while maintaining reasonable access to care. During the 1990s Medicaid managed care grew rapidly as states used federal waivers to shift large numbers of beneficiaries out of fee-for-service programs.⁴¹ By 2002, more than half of all Medicaid beneficiaries were enrolled in HMOs or primary care case management programs. Case management coordinates care across multiple providers, helping patients with complex health problems to obtain services at the lowest level of care that is medically appropriate.⁴²

Many states also use disease management programs, which focus on specific diseases such as asthma, diabetes, high-risk pregnancies, and other conditions that account for substantial Medicaid spending. Although disease management programs vary considerably in their use of specific techniques, the programs have three common elements—they focus on the patient, providing education on managing their disease; they actively monitor the patient's condition and treatment protocols; and they

coordinate care across providers, facilitating the sharing of information during the course of treatment.⁴³

Medicare has several demonstration projects under way, and several completed projects, to test disease management approaches for patients with chronic conditions and complex health needs. Numerous interventions are being tried, including case management for high-cost beneficiaries, patient monitoring, data sharing, use of clinical guidelines, telemedicine, and patient support organizations.⁴⁴ However, more should be done to promote coordination between Medicare and Medicaid for low-income patients who often require a wide array of acute and long-term care services.

It is too early to determine whether disease management programs can reduce overall health spending.⁴⁵ Such programs incur additional costs for screening, monitoring, and educating patients, and it is unclear whether those costs are offset by savings from reduced use of other health services. More work is needed to determine the most effective combination of disease management tools and techniques for high-cost patients. When applied to a working population, disease management can also reduce absenteeism and increase work productivity.

One key to promoting coordinated care is financial incentives. Fee-for-service payments encourage physicians to see more patients for shorter office visits, and it is difficult to provide effective coordination in a fifteen-minute visit. Introducing a case manager, typically a nurse, reduces the demand on physician time but is resisted by some physicians as an imposition on their practice style. Alternatively, directly rewarding physician involvement could promote coordinated care. In addition, better patient management might be achieved if physicians were paid an additional amount for coordinating with case managers and other providers.

A variety of approaches should be tested to determine the optimal payment policy. P4P systems could include care coordination as one of the standards of performance. Medicare has experimented with a single bundled payment for hospital and physician services provided to cardiac patients and found that such an approach fosters efficiency. Recently, the CMS announced a gain-sharing project, in which hospitals would share with doctors some of the savings from joint efforts to improve care.⁴⁶

END-OF-LIFE CARE. Because they cover the major health expenses of elderly Americans, Medicare and Medicaid bear much of the cost of dying in the United States, paying for about three-fourths of the total cost of care for seniors in their last year of life. About a quarter of total Medicare and Medicaid outlays is spent on care of patients in their last year of life, though such patients account for only 5 percent of the elderly population.⁴⁷

Although many seniors prefer not to die in the hospital, inpatient hospital services account for more than 40 percent of the total paid by public and private insurance and out-of-pocket spending for seniors in their last year of life.⁴⁸ An alternative for some Medicare patients is hospice care, which provides palliative services (including skilled nursing care, medications for pain management, social services, short-term inpatient care, and other services) to those expected to live no more than six months. During the mid-1990s, hospice services accounted for only about 2 percent of total spending for seniors in their last year of life. The use of Medicare's hospice benefit has grown in recent years, with program outlays rising from \$6.7 billion in 2004 to \$9.8 billion in 2006.⁴⁹

Much of the high cost of dying is from treating severe disease and functional impairment.⁵⁰ Greater adherence to evidence-based medical guidelines would help minimize unnecessary spending. Coordination between acute care and long-term care providers, and between Medicare and Medicaid, should also be improved. End-of-life care involves the full spectrum of acute- and long-term care services and financing streams that are not well coordinated today.

LOWER-COST DELIVERY SETTINGS. Visits to hospital emergency departments (EDs) increased 26 percent over the past decade, to about 114 million visits annually by 2003.⁵¹ Close to one-third of those visits were classified as nonurgent or semi-urgent. Routine care in the ED is expensive, with charges estimated at two to five times higher than a typical office visit.⁵²

A number of factors contribute to high ED use, including a growing uninsured population that is dependent on the ED for care. The Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 requires hospital EDs to screen all patients and stabilize them if necessary, regardless of their ability to pay.⁵³

Many people with insurance coverage also use the ED for routine care. Medicaid patients are significantly more likely to use ED services than the uninsured or those with private coverage.⁵⁴ That may be due to their greater need for medical services, little or no cost sharing, and lower access to office-based physicians. Federal health insurance programs could encourage their beneficiaries to use lower-cost sites of care, perhaps by charging a fee to beneficiaries who habitually use the ED for routine care.⁵⁵ Other policies would improve access to lower-cost sites of care. For example, states might allow Medicaid patients to use walk-in health clinics operating in major retail chains, or federally financed health clinics might expand their hours to accommodate patients after most physician offices are closed.⁵⁶

HEALTH PROMOTION AND DISEASE PREVENTION. The poor health habits of average Americans—smoking, inappropriate use of alcohol and drugs, poor diet, lack of exercise, and failure to seek timely help for illnesses—add significantly to the cost of health care in the United States. According to one analysis, 40 percent of deaths are the result of such poor health habits.⁵⁷ Chronic diseases, including diabetes, cancer, and cardiovascular diseases, account for 70 percent of deaths in the United States, and the cost of caring for people with these chronic diseases accounts for more than three-fourths of the nation's medical care costs.⁵⁸

Although the concepts of health promotion and disease prevention have gained popularity among policymakers and the public, it is unclear whether such policies would yield substantial cost savings. A study published in 2000 found that increased participation in regular moderate exercise among the more than 88 million inactive adults might reduce national medical costs by as much as \$77 billion annually, or almost 5 percent of national health expenditures.⁵⁹ However, wide-scale behavioral change is unlikely even with the most ambitious health promotion campaign.

The obesity “epidemic” illustrates this challenge. Almost one-third of the U.S. adult population is obese, and approximately two-thirds of adults are obese or overweight. Excess weight is a risk factor for type 2 diabetes, high blood pressure, coronary heart disease, stroke, and many types of cancer. Obese individuals are estimated to have inpatient and ambulatory care costs up to 36 percent higher than the general population.⁶⁰

Much of this problem is preventable—poor diets and sedentary lifestyles are major contributors to obesity. However, despite widespread knowledge that proper diet and exercise can reduce the risk of expensive and debilitating disease, many people remain unwilling or unable to change their behavior. In some cases, environmental or social conditions compound the problem. For instance, lack of supermarkets in low-income areas and the pervasiveness of “supersize me” fast food restaurants offering cheap, high-calorie food make it more difficult to maintain healthy eating habits.

Some interventions, including childhood vaccination campaigns and smoking cessation programs, have been successful in preventing disease and generating cost savings. Researchers for the Centers for Disease Control and Prevention estimate that routine childhood immunizations reduce direct medical costs by \$9.9 billion.⁶¹ California estimates that its statewide tobacco prevention program resulted in overall cost savings of \$8.4 billion between 1990 and 1998.⁶² Nationwide, about 22 percent of adults are smokers today, compared with 33 percent in 1979.⁶³

Greater use can be made of proven methods to reduce the cost of preventable disease. In particular, not all state Medicaid programs cover smoking cessation treatments even though smoking is more prevalent among low-income populations. In 2003 thirteen states did not cover such treatments despite the availability of funds earmarked for that purpose through the multistate tobacco settlement reached in 1998.⁶⁴

Even successful health promotion and disease prevention activities may not reduce health care spending over the long term. Efforts that extend healthy life spans might only defer the need for expensive health care to later ages. Some interventions, such as medical screening, may not be cost-effective since a large number of people may be screened to identify the few who might have a disease, the screening and follow-up investigations and treatment can be expensive, and individuals incorrectly diagnosed as having the disease will incur both the cost and the physical consequences of unnecessary follow-up treatment.

Another impediment to better health is the failure of many people to adhere to their treatment regimens or to obtain care in an efficient manner. Recently, several state Medicaid programs have taken steps to encourage their enrollees to use health benefits more appropriately. West Virginia, for example, will offer enrollees enhanced coverage if they

formally agree to take their medications, adhere to health improvement programs and health screening, not miss appointments, and use the hospital emergency room only for emergencies.⁶⁵ Those who choose the enhanced package will receive an array of preventive health services (including tobacco cessation, nutritional education, diabetes care, and chemical dependency/mental health services).

Promoting Consumerism and Competition

Numerous policy changes are required to introduce effective competition and informed consumer and provider decisionmaking into the health care market. Beyond prerequisites for effective market reform already discussed, such as payment methods that better reflect local market conditions, price transparency, and better information on the clinical effectiveness and quality of care, other possible steps include implementing premium support and related consumer-directed purchasing models and capping the exclusion of private health insurance premiums from taxable income.

PREMIUM SUPPORT. The Federal Employees Health Benefits Program is often cited as a model for the reform of Medicare and the broader health system. Under FEHBP, federal employees and retirees have a wide choice of competing health plans. About three-quarters of the insurance premium is paid by the government based on the average bid from the plans, with the remainder paid by enrollees.⁶⁶

All plans in FEHBP are required to offer coverage for hospitalization, physician services, and other essential care, but they can augment the basic package of benefits. An enrollee willing to pay the extra premium may choose a health plan that is more expensive than average. This arrangement, often referred to as “premium support,” limits the financial exposure of the federal government without unduly restricting consumers. It also fosters competition among the health plans, providing an incentive for the plans to manage their costs and improve their benefits as a way of gaining market share.

Several experts have proposed a premium support reform for Medicare.⁶⁷ The core of such a reform already exists in Medicare Advantage, which offers beneficiaries a choice of health plans as an alternative to traditional Medicare. Under full premium support, traditional Medicare would be placed on the same competitive footing as Medicare

Advantage plans, adjusting its premium and benefits to meet the competition from other plans.

Traditional Medicare would be given the same risk-adjusted subsidy for a beneficiary's care as the private plans receive. This is a controversial change from current practice. To be successful, traditional Medicare would need expanded authority to manage its costs, improve efficiency, and become a better purchaser of health services.

The Medicare Modernization Act (MMA) of 2003 used the premium support concept in designing the outpatient prescription drug benefit, which pays a subsidy based on the average premium offered by competing private plans. Narrowing competition to a single health benefit substantially reduces the scope for efficiency improvements, however, since the private drug plans cannot realize the potential savings from a well-managed pharmacy benefit that reduces use of inpatient and other services.

The MMA also included a voluntary test of premium support that would introduce direct price competition between traditional Medicare and Medicare Advantage plans. Scheduled to begin January 2010 in a limited number of local markets, the "Comparative Cost Adjustment Program" would charge a higher (or lower) Part B premium to enrollees in traditional Medicare if the cost of that program was higher (or lower) than the average cost of all plans in a market area. This would encourage enrollment in more efficient plans that charge lower premiums and put market pressure on both private plans and traditional Medicare to seek greater efficiency. The demonstration is unlikely to be implemented, however; previous attempts to test competitive pricing during the 1990s were halted because of opposition from health plans and local politicians.⁶⁸

PREMIUM ASSISTANCE AND OTHER DEFINED CONTRIBUTION APPROACHES. Both Medicaid and SCHIP programs may provide premium assistance to beneficiaries who are offered insurance by an employer. Buying into an employer's health plan can be cost-effective, although states generally must supplement the private policies to ensure full coverage for services and to pay deductibles and copayments that are typically higher than allowed in Medicaid.⁶⁹

The CMS introduced the Health Insurance Flexibility and Accountability (HIFA) initiative in 2001, which allows states to restructure their

Medicaid and SCHIP programs—including limiting enrollment, changing benefits, and increasing beneficiary cost sharing—and encourages the use of premium assistance.⁷⁰ The 2005 Deficit Reduction Act gave states even more flexibility to redesign their Medicaid programs, including the ability to customize benefits for different groups of beneficiaries.

Florida is implementing fundamental changes in its Medicaid program.⁷¹ Instead of receiving a fixed set of benefits, enrollees will be given a fixed subsidy to meet their likely use of health services. The risk-adjusted premium can be used to enroll in a Medicaid managed care plan or to buy into an employer plan or individual coverage. Managed care plans will have new authority to determine the benefits they will provide. Adults, except for pregnant women, will be subject to a limit on the total cost of benefits allowed each year. Individuals who opt out of the Medicaid program by purchasing private insurance will receive no subsidies from the state other than their risk-adjusted premium.

There are a host of uncertainties associated with a reform as sweeping as Florida's.⁷² Accurate risk adjustment is essential to ensure beneficiaries retain access to necessary care, but even the best estimation methods will have difficulty accurately predicting future use of services. Rising health costs may erode the beneficiary's purchasing power unless states raise subsidy levels over time. Medicaid beneficiaries will need assistance with their health plan choices, and most states are not equipped to provide that level of consumer protection.

States have implemented other reforms that provide Medicaid beneficiaries with individual budgets for care, giving them more control over how that money is spent. There is considerable interest among states in using this approach for the provision of personal care services.⁷³ Cash and Counseling gives Medicaid beneficiaries who are eligible for personal care services a consumer-directed allowance in lieu of traditional agency services. Beneficiaries (or their family caregivers) can choose the combination of goods and services that they prefer, including hiring a relative to provide assistance rather than relying on a home aide. This approach improved patient satisfaction without increasing program costs.⁷⁴ Twenty-two states have established or are actively planning programs for the frail elderly using this model, and the CMS has encouraged further state experimentation in this area.⁷⁵

HEALTH SAVINGS ACCOUNTS. Congress authorized high-deductible insurance tied to tax-favored health savings accounts (HSA) in 2003, eliciting substantial interest among employers. Increasing the deductible makes beneficiaries more aware of the cost of their routine care and generally lowers the insurance premium. Many employers contribute a portion of the premium savings to the HSA, which helps their employees with the higher out-of-pocket cost.

The FEHBP introduced the option of high-deductible insurance coupled with HSAs for federal employees and retirees in 2005.⁷⁶ The new plans generally cover the same services as traditional FEHBP plans.⁷⁷ Enrollee deductibles are about twice as large as under traditional plans, but premiums are lower and contributions to the enrollee's HSA by the health plan are substantial. In 2005 enrollees in the three largest high-deductible plans saved an average of \$90 a month for individual coverage and \$200 a month for family coverage, compared with the average premium charged by traditional plans.

It is too early to assess the impact of high-deductible coverage on the use of services or the cost of the federal program. The new FEHBP plans provide online access to decision support tools that could help beneficiaries assess their treatment options. Information on cost and quality is limited, however, reflecting the paucity of such information in the health system as a whole. Enrollees in the new plans were younger and earned higher federal salaries than the average FEHBP enrollee, raising concerns that such plans might disproportionately attract younger and healthier people. Although risk selection could raise the cost of traditional plans, that is not an issue for the foreseeable future because enrollment in those plans is very low—7,500 out of a pool of 8 million federal employees, retirees, and family members.⁷⁸

High-deductible health plans with a tax-favored savings account were first authorized for Medicare in 1997.⁷⁹ However, such plans have never been offered to beneficiaries. The CMS recently announced a new initiative to test more flexible approaches.⁸⁰ If employers adopt HSAs widely, future generations of seniors may want a similar option when they become eligible for Medicare.

TAX EXCLUSION. Reforming the tax treatment of health insurance would promote greater cost consciousness on the part of both consumers

and providers. Capping or eliminating the tax exclusion for employer-sponsored insurance would also increase federal revenue. A gradual reduction in the value of this tax break would give the market a chance to accommodate the shift in demand toward less generous benefits and greater cost-sharing requirements.

A capped exclusion would tax employees on any contributions for health insurance or other tax-preferred health spending that exceeded some limit, such as the average premiums paid by employers. Allowing the cap to grow less rapidly than the growth in average premiums would phase in the restriction on the tax break over time. If a cap set at average employer contributions made in 2004 was not indexed, the Joint Committee on Taxation estimates that federal revenue would increase by about \$700 billion between 2006 and 2015.⁸¹

A cap on the private insurance subsidy would initially increase the cost of coverage for high-income individuals, but eventually everyone would be affected. Loss of the tax subsidy would raise the cost of health coverage, encouraging the purchase of less generous policies. It could also cause some people to drop their coverage altogether. This reform is politically unpopular but holds great potential for health system reform.

Other Options

Beyond the considerable influence of the major health entitlement programs, other government entities contribute to the legal, institutional, and scientific structure in which public and private health programs operate. We focus on two policy options: improving the Food and Drug Administration's approval process for prescription drugs and restructuring the tort liability system to promote better quality of care.

DRUG APPROVALS. One of the many functions of the Food and Drug Administration is to protect consumers from unsafe or ineffective drugs while ensuring that the regulatory process does not unduly impede the introduction of innovative new products to the market.⁸² This delicate balancing act has been the subject of intense public scrutiny after the FDA failed to detect rare but serious side effects that emerged with some popular medications, including increased risk of cardiovascular disease associated with the Cox-2 painkiller Vioxx.

The limited size and narrow focus of clinical trials in the drug approval process make them unlikely to identify problems that occur very rarely or arise because of interactions with other medical treatments or in patients with multiple conditions. Lengthening clinical trials would add to the cost of drug development without significantly adding to the safety of approved products.

Clinical trials typically measure the safety and effectiveness of a new drug against a placebo rather than against alternative therapies. Head-to-head trials of pharmaceuticals might yield insights about their comparative effectiveness. However, such trials would be substantially longer and more expensive. Drug approvals would be slowed significantly to the disadvantage of some patients who could benefit from a new treatment, but uncertainties about the benefits and risks of the new product would remain. This argues for paying greater attention to the health effects of new drugs once they are on the market.

The FDA is taking steps to beef up its postmarketing surveillance of new drugs.⁸³ Broader investment in health IT, including electronic medical records, would give the FDA real-time access to information on adverse events. New tools are being developed that would more rapidly detect a pattern of clinical results that needs investigation. Data collected under the Medicare drug benefit should also be used to identify safety problems.

Requiring labels that identify drugs as being in their first two years on the market would increase consumer awareness of their use of a newly approved therapy, which could prompt patients to report possible adverse effects to their physicians.⁸⁴ An advertising ban during that period would reduce consumer demand for new drugs and slow their diffusion into medical practice. This would give the FDA more time to deal with any safety issues that arise, but it would also delay some patients' access to the therapeutic benefits of the new drug.

A slowdown in drug approvals has raised concerns about the complexity and adequacy of the approval process. In 2005 the FDA approved twenty new drugs, down from thirty-six in 2004.⁸⁵ The development and review process is not keeping pace with drug discovery, to a great extent because scientists test new discoveries using inefficient tools and techniques.

The FDA's Critical Path Initiative is an effort to modernize the process through which basic scientific discoveries translate into new medical

treatments.⁸⁶ By implementing standards for clinical trial design and uniform statistical methodologies, early warnings could predict failure before advanced clinical trials take place. Helping pharmaceutical companies “fail faster” on drugs that eventually would not be approved could significantly reduce the cost of drug development. For example, shifting 5 percent of clinical failures from Phase III to Phase I trials would reduce costs by \$15 million to \$20 million.⁸⁷ In addition, clearer guidance for product approvals and better communication between FDA and pharmaceutical companies can smooth the development process and reduce the cost of multiple reviews by the agency.

The FDA can promote price competition in the drug market by introducing close substitutes for brand name products more quickly. Some of that competition comes from other brand name drugs in a therapeutic class, the “me-too” drugs that are different molecules designed to treat a common disease. Even stronger price pressure is exerted by the entry of generic drugs. Generic drugs have the same active ingredients as the brand name version, and usually cost 60 to 90 percent less.⁸⁸ The price drops the most with the first generic alternative to a brand-name drug and continues to fall as each new competitor reaches the market.

With many blockbuster drugs going off patent, the FDA faces a growing backlog of applications to bring new generic products to the market. The strong demand for lower-cost pharmaceuticals has attracted competition within the generic market, resulting in multiple applications to sell generic versions of many drugs. To manage the backlog, the FDA gives priority to the first application for a generic equivalent of a branded product. Better funding for the FDA’s Office of Generic Drug Approval, perhaps through user fees levied on the manufacturers, could speed the approval process.

Brand-name manufacturers have used a variety of techniques to reduce generic competition, such as paying generic manufacturers to stay out of the market.⁸⁹ Brand manufacturers also may threaten to launch their own authorized generics, reducing the market share available to generic manufacturers. The Federal Trade Commission is investigating actions that could limit these techniques.

Biologics—complex molecules, such as proteins, derived from living organisms and used as medical treatments—represent a significant part of

the U.S. drug industry, with sales expected to top \$57 billion by 2010.⁹⁰ The FDA approval process for biologics is complicated because their manufacture involves living organisms. The Hatch-Waxman Act provides a clear path for approval of generic drugs, but not for generic, or “follow-on,” biologics.⁹¹ Moreover, there are difficult scientific questions about what constitutes bioequivalence for these products. Consequently, the potential for price-reducing competition in the biologics market is sharply attenuated.

MALPRACTICE REFORM. The medical liability insurance system is in upheaval, with rapid increases in insurance premiums and the exit of major insurance carriers from the medical liability market. Between 2000 and 2002, malpractice insurance premiums rose by 15 percent on average for all physicians.⁹² High-risk specialties faced even larger premium hikes: 22 percent for obstetricians-gynecologists and 33 percent for internists and general surgeons. A general surgeon in Miami could expect to pay at least \$174,000 a year for liability coverage in 2002.⁹³

As premiums rose, the availability of malpractice insurance diminished. The St. Paul Companies, which was the largest malpractice insurer during the 1990s, dropped out of that market in 2002.⁹⁴ Other large insurance carriers have also exited the market.

These problems and heightened public awareness of patient safety problems have prompted a feverish debate over capping malpractice awards and attorneys' fees. Physicians and liability insurers argue that such caps would slow the growth of malpractice premiums and reduce overall health spending. Trial lawyers argue that this unfairly penalizes patients who have suffered from a medical mistake and have no other recourse.

Capping malpractice awards would lower the cost of malpractice insurance, but the impact on overall health costs would be modest. California was one of the earliest states to impose such a cap through the Medical Injury Compensation Reform Act (MICRA) of 1975, which restricts noneconomic damages to \$250,000 and limits attorneys' fees.⁹⁵ Federal legislation modeled after MICRA would lower malpractice premiums by 25 to 30 percent.⁹⁶ However, malpractice premiums amount to less than 2 percent of overall health spending, resulting in only a 0.5 percent reduction in national health expenditures.

Additional savings are possible from reducing “defensive medicine,” where physicians use tests and procedures that have little therapeutic value but that provide a legal defense against a malpractice claim. The adoption of caps on awards reduced spending for heart disease and heart attack patients by about 4 percent with no adverse effect on mortality rates or complications.⁹⁷ However, the Congressional Budget Office (CBO) found no evidence that tort reforms reduced medical spending when considering a broader set of ailments.⁹⁸

Tort reform could be part of a broader effort to improve patient safety and provide appropriate redress for injured patients. More attention should be placed on preventing medical errors. Reengineering medical workplaces can make errors less common and improve the response of the system when errors do occur.⁹⁹ Focusing blame on those involved with an error is a poor strategy for improving patient safety, as most errors are the result of mistakes by competent people working in stressful situations. More could be done to improve provider performance through training, guidelines, performance measurement, and research on patient safety.

When an injury does occur, patients need better access to a fairer liability system. Few patients who have experienced medical negligence bring lawsuits, and few receive compensation.¹⁰⁰ Claims are resolved slowly, on average four to five years from the date of an incident.¹⁰¹ Injured patients receive only about 40 percent of the malpractice insurance payments, with the rest going to legal and administrative fees. Awards can be inequitable. Many patients with meritorious claims receive nothing, while others are granted judgments that seem disproportionate to the severity of their injury.

More structured payment rules and the use of alternative methods for resolving malpractice claims would make the system more equitable. One proposal would tie disclosure of the circumstances of patient injury with an offer to pay for out-of-pocket losses in exchange for an agreement not to pursue claims for pain and suffering.¹⁰² Other proposals include automatic payment for avoidable events that are identified in advance, replacing the tort liability system with an administrative compensation system (similar to workers compensation), and the creation of specialized health courts that could be more systematic in their evaluation of malpractice cases.¹⁰³

Capping Health Spending

Even if an efficient health system can be achieved, that does not dictate either the level of health spending or its rate of growth. Consequently, policymakers must consider whether to limit directly the growth of health spending. Spending limits take the regulatory approach, which tends to favor social judgments over individual preferences, to an extreme. As a society, we have never directly confronted the question of how much, in a resource-constrained world, we are individually and collectively willing to devote to health care, and how much to all other goods and services. However, there have been sporadic attempts to limit spending in Medicaid and Medicare.

During the mid-1990s, the Oregon Health Plan expanded Medicaid coverage to most low-income residents. To hold down budgetary costs, the state prioritized health care services based on their clinical effectiveness as judged by medical experts and reviewed through a series of town meetings. This process was intended to establish both a scientific basis and a community standard for acceptable care, bringing the public's views regarding adequate care to bear on the budget process. The goal was to pay for the most appropriate care for each patient. The experiment has not continued, however. Fiscal pressures and a slowing state economy essentially halted the project by 2003, with the Oregon Health Plan reverting to a more traditional Medicaid program.¹⁰⁴

Congress imposed several methods of limiting the growth of Medicare payments for physician services during the 1990s. The current formula, called the sustainable growth rate (SGR), ties physician spending to growth in the economy. Medicare adjusts its physician payment rates annually to allow for increases in the cost of providing care. If Medicare physician outlays grow faster than the SGR, the annual update is reduced. That lowers the *prices* paid for physician services across the board to account for excess growth in *expenditures*, which reflect increases in the volume and complexity of services as well as price increases.

The SGR has generated a difficult political problem for Congress. Medicare physician spending, like other health costs, is growing more rapidly than GDP (gross domestic product). As a result, the formula automatically imposes 4 to 5 percent reductions in Medicare's payment rates

virtually every year for the foreseeable future. Fee reductions of this magnitude are untenable and, if sustained, would reduce access to care as doctors take fewer Medicare patients in favor of more lucrative business.

However, permanently restoring the payment reductions would cost several hundred billion dollars over the next decade. Any payment relief granted to physicians also increases beneficiary premiums for Medicare Part B, which are set at 25 percent of program costs. As a result, policy-makers have resorted to one-year fixes, deferring the fee reduction and providing a small increase in most years rather than establishing a new permanent payment policy.

The SGR illustrates the challenges of broad efforts to cap the growth of health spending. Without great care in their application, the government's budgetary savings might result in less access to necessary care or higher private spending without substantially lowering the growth of overall health spending.¹⁰⁵ Any limitation on spending will ultimately entail difficult choices about what care is to be delivered to whom under what circumstances. Such decisions might be made through a political process, but they might also be made by consumers facing higher out-of-pocket expenses for their care.

Conclusion

A plethora of policy options is available that could help ameliorate the federal health spending crisis. Many of those options are likely to produce one-time savings rather than a permanent reduction in the growth of outlays—not an ideal solution to the fiscal problem, but one that at least buys time for further policy innovation. Every option requires development and testing to be implemented in a way that balances reducing costs, ensuring access to care, promoting high quality, and other objectives. Society does not lack ideas to test, but it may lack the political will to proceed.

This volume focuses on the major federal programs that finance the cost of health care through insurance or the direct provision of services. Medicare and Medicaid are the largest of those programs, and both face immediate financing problems that will only worsen with the aging baby boom generation and the continuing trend toward the use of more services and greater complexity of care. Other programs (SCHIP, VHA, and

TRICARE) are smaller and pose less of a fiscal threat, but they are also subject to rising cost pressures.

The succeeding chapters explore in greater depth the performance of those programs and the steps that could be taken to improve their efficiency, better serve their beneficiary populations, and slow their spending growth. Lessons from such policy initiatives can help policymakers—and society as a whole—work toward a high-value health system.

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