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Schroeder Center for Healthcare Policy

RISING COSTS FOR HEALTHCARE: Implications for Public Policy

A REPORT PREPARED FOR THE NFIB RESEARCH FOUNDATION

Author

Louis Rossiter

“Liberty is to the collective body, what health is to every individual body. Without health no pleasure can be tasted by man; without liberty, no happiness can be enjoyed by society.”

Thomas Jefferson

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The National Federation of Independent Business is the nation's leading small business association, with offices in Washington, D.C., and all 50 state capitals. NFIB's powerful network of grassroots activists send their views directly to state and federal lawmakers through our unique member-only ballot, thus playing a critical role in supporting America's free enterprise system.

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Special acknowledgement goes to the people in small businesses across the country who labor everyday to pay for the rising cost of healthcare.

Executive Summary

- The problem with rising costs for healthcare is that it takes an ever larger share of the economy

Healthcare System Produces Enviably Quantity and Quality of Life

- Despite the problem, the U.S. healthcare system is enviable in many ways
- Life expectancy has increased significantly and age-adjusted death rates have dropped remarkably for eight of the top ten diseases
- More progress on health outcomes need to be achieved, especially in terms of disparities by racial/ethnic background
- Comparisons to other countries in terms of life expectancy and death rates must be done cautiously because of data sources and other issues
- As people in any country experience higher income, consumption of healthcare increases at the expense of all other goods and services
- As people in any country age, consumption of healthcare increases at the expense of all other goods and services
- The preponderance of American's across all characteristics perceive themselves to be in good or very good health
- Waiting lists are rare for most healthcare services in the U.S.

What Share of the Economy Should Be Healthcare?

- The share of the U.S. economy devoted to healthcare is 16.4 percent and expected to rise to nearly 20 percent before 2020
- No one knows the right share of the economy devoted to healthcare, but the demand for healthcare must be throttled by an true willingness to pay for whatever the larger share becomes

Finding Balance between Freedoms and Moderation

- People in the U.S. value choice of health insurance and choice of provider very highly
- Approximately 68 percent of the population have private health insurance coverage primarily through their employer and mostly with managed care companies
- The employment-based market is not performing well with higher health insurance premiums and declining percent covered
- Managed care companies help to moderate costs by establishing select networks of providers and innovative benefit designs
- In order to enhance the competitiveness of their businesses in terms of attracting good employees and delivering low-cost products and services, employers attempt to control their health insurance costs with managed care companies
- Employer contract renewal negotiations with managed care companies are the core of the competitive influence in containing costs in the U.S. today

Underpaying Public Programs

- Medicaid covers low income women, children and disabled persons and uses government administered prices to pay providers
- Medicare covers aged and disabled persons and uses government administered prices to pay providers

- Because of administered prices for public programs, costs are thought to be shifted to private payers such as employers
- The burden of cost shifting is especially heavy for small employers who are less well positioned than large employers to address market power from managed care organizations
- The rising cost of healthcare is more burdensome for small employers because it is complex to attempt to manage
- No national market for health insurance puts all business, but especially small business, at a disadvantage
- Efforts abound to slow the growth of health spending with real but limited impact
- The problem with the rising cost of healthcare mean new and serious efforts are needed now while safeguarding freedom of choice and ensuring equity
- Healthcare spending, unlike almost any other segment of the economy, gets criticized when spending increases primarily because we do not understand what we are paying for

Money for Technology Innovation

- Healthcare appears to be largely immune from the market forces dubbed “creative destruction” by the economist Joseph Schumpeter
- In a largely fee-for-service healthcare system, the volume and intensity of services receive relentless pressure to increase
- Managed care organizations are able to place some limits on provider ability to freely prescribe
- Employers have been in the vanguard of managed care adoption for many years

Money for More Effective Treatments

- The added spending for technology innovation suggests the added benefits for at least four major conditions exceed the added cost
- Increased spending on an array of new treatments for heart disease appears to have had a significant impact on age-adjusted mortality trends
- Increased spending on a array of new treatments for cancer, and breast cancer specifically, appears to had less than dramatic effects on age-adjusted mortality
- Importantly, chronic disease are growing rapidly in prevalence and account for half the increase in healthcare spending in the U.S. in recent years

Money for More Care at Older Ages

- Older adults are the most frequent users of health care and the services they use are costly
- Medicare secondary payer shifts the burden of paying for healthcare costs to private employers with healthcare retirement benefits
- Medicare accounts for three percent of spending in the entire economy, thereby playing a major role in demand for health services
- The population age 65 years or older is approaching 40 million today and will rise to 71 million in 20 years
- All groups by racial/ethnic background, sex and age are living longer at birth and at age 65
- The frail elderly with significant chronic disease, including Alzheimer’s Disease and related dementia, are the most costly and rapidly growing group

Money Spent for Poorly Understood Services

- Healthcare stands apart from all other personal consumption expenditures because it is not valued for its own sake -- it is a very personal service -- and it has distributional aspects which prompt public policy involvement
- Inefficiency, fraud, waste and abuse are a major portion of healthcare costs without effective tools to arrest future growth, especially for public programs
- Many providers, particularly specialist physicians, have some of the highest incomes in our society
- Administrative costs, including medical malpractice, are a significant source of higher health care costs
- With healthcare taking a larger share of the economy and technology innovation, more effective treatments, older costly adults and lack of understanding what we pay for driving costs, serious action on health care costs is needed

Policies to Change Government-Induced Incentives

- As the largest health program in terms of number of people covered, Medicaid must be utterly transformed to a national eligibility standard based on federal poverty level
- The federal government should finance cost of new eligibility and establish a 5 percent hold back of funding for pay for performance goals of reducing Medicaid cost, improving quality, and initiatives to cover the uninsured
- As the largest health program in terms of dollars expended, Medicare must be utterly transformed to a new benefit package with four parts: Medically Necessary Care, Long-term Care, Experimental Care, and Lifestyle Care
- The federal government should swap long-term care coverage (currently under Medicaid in the states) for state initiatives to cover the uninsured
- A ten-year effort should be undertaken in Medicare to enroll all beneficiaries in managed care organizations by 2019
- Medical malpractice insurance should be reformed to establish health care courts, cap awards at \$500,000, pursue mandatory arbitration
- The largest group of uninsured – young, largely healthy people working for small employers – must be brought into the health insurance system through market-based pooling, health savings accounts, and national rules for the provision of health insurance

Policies to Change How Care Is Delivered

- New and expanded medical groups and hospital and health systems should be encouraged to develop further through federal grants and loans in ways that promote competition
- Investment in standard medical language for health information technology should be made
- Global pay for performance from public payers to individual providers should be throttled and replaced with renewed emphasis on pay for performance toward process goals, such as implementing health information technology
- Public policy should foster pay for performance at the organizational level of the medical group and hospital and health system

Policies to Change the Actions of Individuals

- Disease management for chronic disease should continue to be a public policy priority

- A better understanding of all the alternatives for end-of-life care should be promoted by public policy

Policies to Reduce Demand for and Raise Supply of Health Services

- Employers have long recognized the importance of striking the right balance between health coverage and cost sharing in benefit design
- Work-site health promotion should be given tax incentives by federal and state government
- Demand management should become a public policy priority
- Competitive markets and competitive bidding should be encouraged
- The tax exclusion for employer-provided health insurance should be reduced or eliminated
- A standard deduction for personal health insurance premiums and out-of-pocket costs should be made available for everyone up to \$15,000 for a family and \$7,500 for an individual
- Tax deductibility for health care costs should be contingent upon purchase of a health insurance plan
- Refundable tax credits up to a maximum amount are the best solution for rising health care costs and fair government assistance in the purchase of health insurance
- Free clinics and referral networks should be subsidized with government funds by redirecting to them the disproportionate share of payments hospitals receive
- Spur the development and diffusion of innovations that reduce costs, including new regulations, methods of payment, insurance benefit design, competition policy, and tax incentives
- Support research on health outcomes and effectiveness of medical treatment alternatives with government funding

RISING COSTS FOR HEALTHCARE: Implications For Public Policy

By Louis F. Rossiter

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OVERVIEW

What are the real problems facing the healthcare system in the United States today and how can legislators and policymakers address them? What policy actions must be taken to strengthen a service that touches the lives of every American?

The purpose of this monograph is to address these issues – to define more clearly the actual problem with the healthcare system. This document also prescribes urgent remedies that must be taken to provide each citizen with a greater sense of security when it comes to their health care, while helping our leaders manage more skillfully a vital component of our economy.

As this monograph explains, the actual problem with the healthcare system is the high cost of care, not the lack of coverage. In fact, the lack of coverage is a consequence of high cost. If healthcare costs were in check, it would be possible to expand coverage. And if those issues and factors that drive healthcare costs were moderated, many fewer people would be without health insurance.

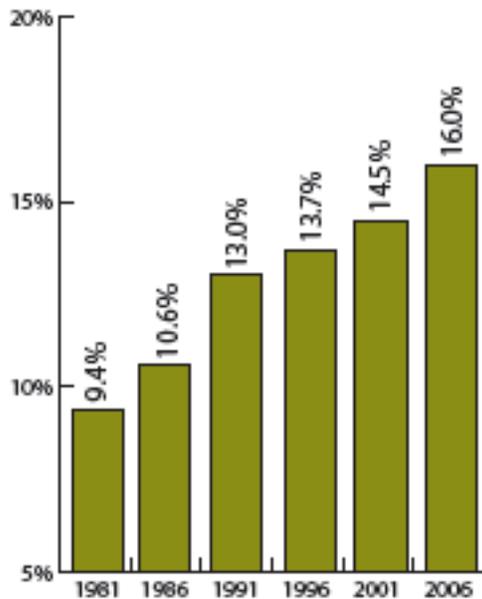
Is comprehensive coverage for all Americans possible? Yes, it is, but only if the rising costs for healthcare are addressed through bold public policy. Any attempt to enact reforms that will provide comprehensive coverage will not work unless cost containment provisions are first put in place.

Rising Costs for Healthcare: Implications for Public Policy focuses on the costs of healthcare, the forces behind those costs, and the most effective ways to control cost increases so that we can expand coverage and reduce the number of uninsured Americans.

The Problem

The first section of this monograph, “Healthcare Expenditures Drive the Economy,” describes many of the usual problems cited about healthcare in this country, and it explains the real problem we face. That share of the economy devoted to healthcare is growing too fast and must be stopped before comprehensive changes are possible.

The basic problem is not simply that we are spending more on healthcare in terms of how much we use and the price of that care. The problem is the accelerated rate of the increase when compared to other components of the economy. As each year passes, healthcare consumes an ever-larger share of expenditures, increasing from 9.4 percent in 1981 to 16 percent in 2006. Today, that figure is even higher.



Source: U.S. Centers for Medicare and Medicaid Services

Much of the spending problem derives from Medicare for the elderly and Medicaid for the poor. Under current policies, the Congressional Budget Office (CBO) projects that federal spending on Medicare and Medicaid will rise from about 4 percent of gross domestic product (GDP) in 2009 to nearly 6 percent in 2019, reaching 12 percent by 2050.

Legislators and policymakers who seek coverage for the uninsured must come to grips with the fact that we will never achieve the goal of providing people with affordable health care as long as a larger share of the economy must be devoted each year to merely paying for those who already have coverage. In these adverse conditions, making comprehensive coverage a reality means denying those already covered or finding sensible ways to arrest costs for everyone.

The Cause

Four powerful forces affect healthcare and explain why it consumes such a disproportionate share of the economy. The second section of this monograph, “High Costs, Unchecked Freedoms, Demographics, and the Demand for Quality,” describes how these forces account for rising costs and then offers insight on possible solutions. Mitigating these powerful forces requires powerful policy.

This monograph also addresses the issue of competition and the vital role it plays in making care affordable. Healthcare is an intensely competitive industry in the U.S., affecting not only hospital systems and health plans, but also the private practices of physicians and allied professionals. What accounts for this competition? Consumer choice. “Am I getting my money’s worth?” is a question that is just as vital to the healthcare industry as any other industry. When the system is structured to undermine choice or avoid answering this question, the competitive market does not work as it should. This monograph focuses on

the role of competition in healthcare and how the problems facing the industry are largely tied to inadequate competition.

The Solution

“Governmental Policies and Incentives Must Guide Supply and Demand,” the third section of this monograph, reviews the expanse of current literature to explain how public policy can address the issue of rising costs for healthcare. This section provides real solutions that legislators and policymakers can enact and then implement to remedy the problems associated with healthcare costs.

THE PROBLEM: HEALTHCARE EXPENDITURES DRIVE THE ECONOMY

The U.S. healthcare system is actually enviable for a variety of reasons, and because of this, carrying out revolutionary changes in health policy has been difficult. While we might feel as though too much of our spending goes toward healthcare, both the quantity and the quality of life in the United States are headed in the right direction. We also enjoy the many freedoms our healthcare system offers—from choosing our own doctors to picking our favorite hospital—and we want to preserve these freedoms, even going so far as to fight for them. But we cannot ignore the fact that these freedoms come with a price, and they must be moderated if we expect to contain costs. As this section describes, employers and managed care organizations have been moderating these freedoms for some time. This section also covers the practice of cost shifting in healthcare, which is one of the most important public policy issues surrounding rising healthcare costs.

Healthcare System Produces Enviably Quantity and Quality of Life

Our satisfaction with the U.S. healthcare system is largely determined by two factors: the quantity of life (life expectancy) and the quality of life (consumption). People generally accept the expense associated with healthcare because they know it translates into longer, better lives (Hall and Jones 2007). Yet they also know that the more money spent on healthcare, the less money spent on goods and services that can also contribute to better lives. This substitution effect is probably why people complain – and probably always will complain – about spending on healthcare. Still, the U.S. healthcare system is enviable in the quantity and quality of life it gives, and it is revealing to examine some of these enviable aspects before turning to the root cause of the cost problem.

The Quantity of Life

Healthcare as a percentage of U.S. gross domestic product has been rising for years – from just 9.4 percent in 1981 to 13.0 percent in 1991. That figure reached 14.5 percent in 2001 and 16.4 percent in 2007. While all this spending has apparently improved quantity of life, as recent trends in life expectancy and death rates illustrate, it is revealing to compare these findings against international trends.

Most Measures Are in the Right Direction. The quantity of life has improved in the U.S. In 1950, life expectancy at birth was 68.2 years. From 1975 to 2000, life expectancy increased from 72.6 years to 77.0, and it is on target to reach 80 years or more in 2010. As Exhibit 1 shows, deaths from eight of the ten leading causes dropped significantly between 2005 and 2006, the last year with available data. Double digit declines in age-adjusted death rates occurred for influenza/pneumonia (12.8 percent) probably because of a lighter flu season. Some of the most costly chronic diseases in the U.S. also showed declines.

Exhibit 1: U.S. Deaths Were Down Sharply in 2006

Cause of Death	Percent Decline in Age-Adjusted Death Rate from Previous Year
Influenza/pneumonia	-12.8

Chronic lower respiratory disease	-5.3
Hypertension	-5.0
Chronic liver disease/cirrhosis	-3.3
Suicide	-2.8
Septicemia or blood poisoning	-2.7
Cancer	-1.6
Accidents	-1.5

Source: National Center for Health Statistics, CDC 2008

While both the long- and short-term trends for life expectancy are enviable, disparities persist between income levels and racial/ethnic backgrounds. Between 1960 and 2002, 14 percent of premature deaths among whites and 30 percent of the premature deaths among populations of color would not have occurred if people died at the same rate as the highest income white person (Kreiger et al. 2008).

Beware of International Comparisons. As favorable as these trends are, most complaints about U.S. healthcare surface when our system is compared to international models. These complaints often begin with the rate of infant mortality, a measure that any country in the world would strive to keep lowest. While the U.S. has substantially reduced its infant mortality rate in recent decades, it is still ranked below many industrialized nations in 2008 with a rate of 6.3 deaths per 1,000 live births. For comparison, the infant mortality rate for the United Kingdom is 4.9 deaths per 1,000 live births.

There are several explanations for differences in infant mortality rates among industrialized nations. First, both healthcare and social behavior explain infant mortality. The differences in infant mortality rates certainly reflect disparities in the health status of women before and during pregnancy or the quality and accessibility of primary care for pregnant women and their infants. But differences in infant mortality are also tied to the prevalence of social behaviors that may be related to income and other cultural norms, and not the healthcare system.

Second, some of these differences have long been known to be the result, in part, of international variation in the definition, reporting, and measurement of infant mortality, especially regarding early infants and fetal deaths.

Third, differences between U.S. and international systems depend on whether the inequality is measured using the rate ratio or rate difference (Moser 2007). For example, Exhibit 2 shows an estimated rate of infant mortality in 2008 for France and the U.S. Measured as a ratio or difference, these estimates of infant mortality lead one to conclude that France has a superior rate and that the U.S. could achieve the same infant mortality by adopting the French healthcare system. That point is even more compelling when using the rate ratio, in which the disparity is a difference of 85 percent (the U.S. has an infant mortality 85 percent higher than France). But the message is diluted with the rate difference, which is less than three infant deaths per 1,000 live births. Certainly, even one infant death is too many. But the point is clear. Imputing conclusions about the effects of an entire healthcare system is far more complex than many simple international comparisons might suggest.

Exhibit 2: Relative and Absolute Disparities in Infant Mortality Are Not the Same (Measured Using Rate Ratios and Rate Differences, 2008)

2008	Deaths per 1,000 Live Births	Rate Ratio	Rate Difference
France	3.4	1.00	0.0
United States	6.3	1.85	2.9

Source: Rate calculations based upon data from The World Factbook, 2008.

When compared to international systems, the U.S. healthcare system excels on some measures of performance and lags on others. Some of the laggards are serious, such as costs and the percent of people without insurance, but many others are of a relative magnitude that is neither clinically nor policy relevant. Thus, it should not be a surprise that international comparisons have rarely led to marked change in U.S. healthcare policy.

The Quality of Life

In most markets, consumers are typically able to get what they want and can afford. While they may protest the costs, they usually are resigned to balance their pursuit of satisfaction with the cost of satisfaction and their budget.

Healthcare Satisfies More and More. Healthcare may be unique when it comes to reconciling the desire to be satisfied with the cost of achieving that satisfaction. For most everyday goods and services we buy – coffee, laptop computers, new automobiles – the level of satisfaction we feel when making a purchase diminishes as we consume more. This is not the case when it comes to purchasing healthcare, especially when the reason for doing so is to extend our lives. Our ability to purchase something that helps insure a longer life does not reveal the same sort of diminishing return. People around the world seek longer life, and the older they get, the longer they want to live. Moreover, their willingness to pay for anything that alleviates pain and anxiety increases as the average age distribution of the population rises. We are not becoming a nation of hypochondriacs, but people clearly recognize the benefits of a healthcare system that prolongs their life.

As the nation as a whole gets older and average incomes rise, we value additional years of life more than we value those goods and services we buy at the store, from coffee to computers to cars. In fact, the U.S. may be experiencing an historic shift toward higher value for more years of life as the boomer generation ages in such large numbers and people begin to face their own mortality.

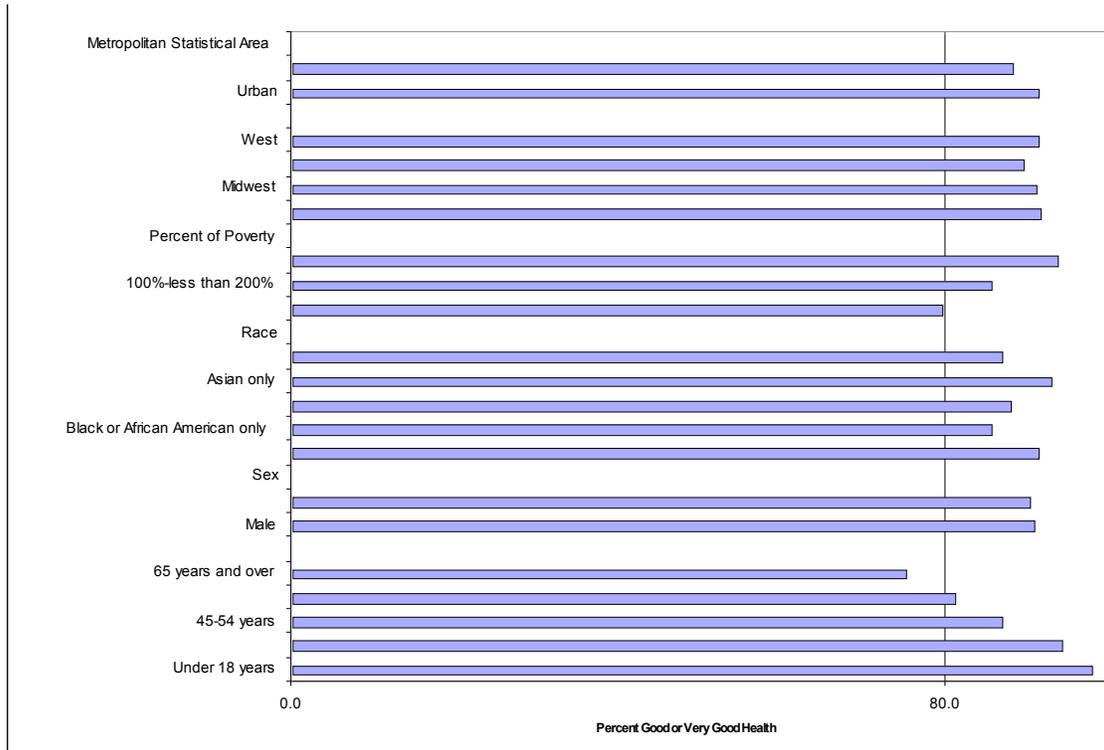
The relationship between the desire to live longer and the amount we will pay to do so shows in the numbers. As people earn higher incomes, consumption rises, and individuals devote an increasing share of their budget to healthcare (Reinhardt, Hussey and Anderson 2004). One recent quantitative analysis projects that the share of the GDP devoted to healthcare will increase from the current 16 percent to more than 30 percent by the middle of the century (Hall and Jones 2007). Will people complain about the expense? Yes. But

the average age in years and higher incomes will largely explain the growing share of GDP devoted to healthcare.

Most Citizens Are Healthy. While too many people in the U.S. are without insurance and experience chronic illness, Exhibit 3 shows that most generally assert they are in good or very good health. These people represent a wide demographic, which includes the elderly. Most of the time, people will say they are in “good” to “very good” health. The rest are in “fair” or “poor” health. On any given day, most people do not visit a physician and incur healthcare costs. In fact, costly hospital stays are actually fairly rare events, involving fewer than 10 percent of the population in any year. The cost of healthcare is primarily derived from a small proportion of people with expensive and often persistent chronic diseases.

If “very good health” could somehow be attained by everyone, demand for health services would plummet, and the share of the economy devoted to healthcare would likewise fall. Healthcare costs rise when more people perceive they are in poorer health. It makes sense, therefore, that health promotion and disease prevention can help lower the share of our economy devoted to medical expenditures.

Exhibit 3: Most Individuals Self-Assess Their Health Status as Good or Very Good



Source: Health United States, 2008.

Of course, health promotion and disease prevention programs themselves cost money, and spending on them does not yield unlimited returns.

An aging population will also make it more difficult for everyone to achieve the highest levels of health. While an aging population has a crucial affect on the financial health of the Medicare Trust Fund, it has a persistent but only gradual effect on overall spending (Stunk, Ginsburg and Baker 2006). A related and, perhaps, more overlooked trend, is the gradual shift in the medical conditions we experience and their related costs. Trends in hospital discharges suggest we will see double digit increases in costly conditions such as heart failure, pneumonia, joint and limb procedures, and moderation in lower-cost normal deliveries, psychoses, and cesarean section (Thorpe et al., 2006).

Waiting Lists Are Rare For Most. Because of the mixed, predominantly private health system in the U.S., waiting lists for primary care or specialist care physician services are rare for most people. In predominately public health systems around the world, waiting lists for physician care generally serve as a rationing device, and they are the subject of numerous investigative studies in Canada, Great Britain, and other counties with comprehensive health coverage. Waiting lists are not a major characteristic of the U.S. health system except in several very specific areas of treatment.

One such area is mental health, especially those services provided by states through community mental health centers and state mental health hospitals. These centers have a long history of waiting lists. Delays for mental healthcare result in increased psychiatric hospitalizations, complications, and risk for suicide (Williams, Latta and Conversano 2008).

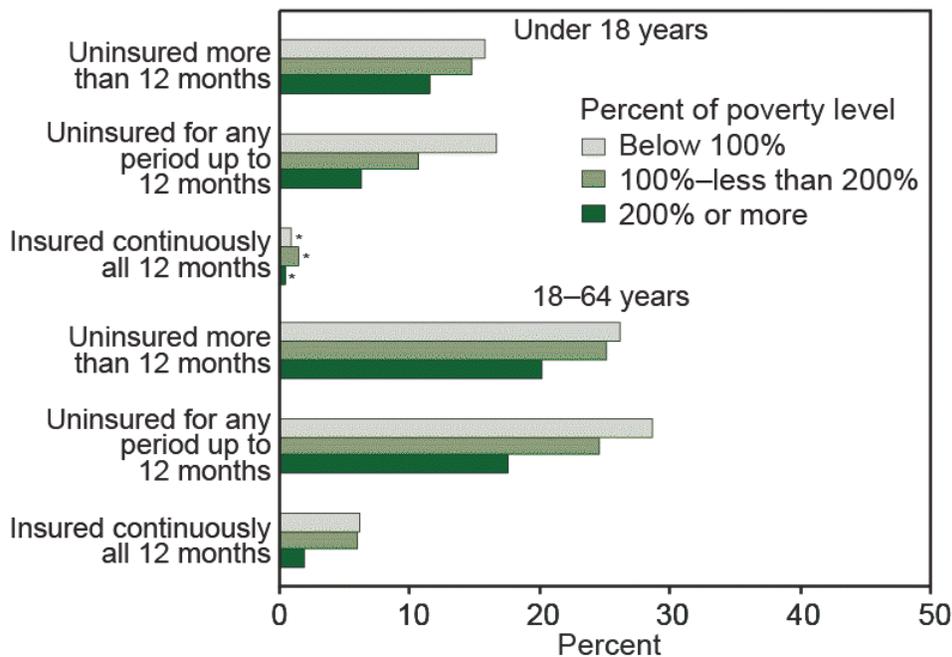
Another area of treatment is organ transplantation. Patients seeking a kidney, pancreas, liver, heart, lung, or intestine transplant can be on a national waiting list with as many as 100,000 people, and the list is managed by contract under federal auspices.

Hospital emergency departments in the U.S. are increasingly overcrowded and subject to lengthy waiting times. While not strictly a waiting list, the overall average waiting time to see a physician in the hospital emergency department is nearly 56 minutes. Excessive hospital emergency room visits are thought to indicate problems with access to care in the physician office. When it is difficult to access physicians in their offices, people turn to the costly hospital emergency department. For example, low income patients with Medicaid use the emergency department more frequently than patients with private insurance – 82 per 100 persons for Medicaid as compared to 21 per 100 for private insurance. Low-income patients have few alternatives when it comes to gaining access to care because of lower Medicaid payments to physicians and the unwillingness of some physicians to accept Medicaid.

Problems with travel and waiting times exist in the U.S., but they are not a ubiquitous feature of our health system. In fact, the National Center for Health Statistics no longer collects data on travel and waiting times as it once did. The access to care problems of the 1960s involving travel and waiting time have been replaced by the problem of access to care due to cost.

Exhibit 4 shows different categories of uninsured and the percent most likely not to get needed medical care. Lack of insurance and problems with the cost of care affect access to care. People who have health insurance continuously all twelve months of the year are most likely to get the medical care they need. Children with continuous health insurance almost always get needed care, and fewer than 10 percent of adults did not get needed medical care. Those who fall below 100 percent of poverty and lack insurance are the ones most likely to have problems related to cost when trying to get the care they think they needed.

Exhibit 4: The Uninsured Were Most Likely Not to Get Needed Medical Care in the Past Year Due to Cost, 2005

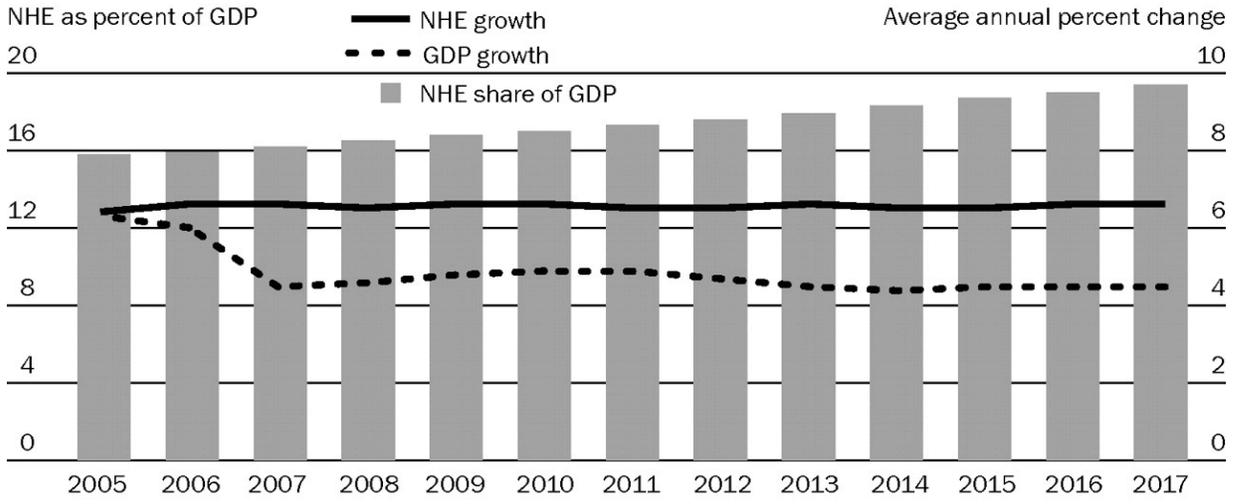


*RSE 20%-30%.
 SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*, Figure 33.
 Data from the National Health Interview Survey.

What Share of the Economy Should Be Healthcare?

The share of GDP going to healthcare is expected to increase from 16.4 percent in 2007 to 19.5 percent by 2017 (Keehan et al. 2008). No one knows if this latter figure for healthcare represents an appropriate share of our GDP. But as Exhibit 5 illustrates, the 2007 recession will end, GDP is expected to rise, and healthcare expenditures are expected to increase. The only difference is that the growth in the healthcare sector will go up faster than GDP. These increases are unrelated to crisis we are currently experiencing with troubled assets. Instead, this is what we expect to happen due to a wealth effect. People demand more healthcare as they have higher income and higher wealth. Because of the demand for care, roughly half the increase in healthcare growth over GDP growth stems from increases in prices, and one-fourth the growth results from increases in service use. The final one-fourth growth is split between the general growth of our population and the increased distribution of elderly in that population. Clearly, the elderly use more healthcare than the younger members of the population.

Exhibit 5: National Health Expenditures (NHE) Are Projected to Grow As A Share of Gross Domestic Product (GDP), 2005-2017



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

NOTES: The left axis (NHE share of GDP) relates to the gray-shaded bars. The right axis (percent change in GDP and NHE) relates to the two line graphs.

Source: Keehan et al. 2008.

The search for solutions to rising healthcare costs must begin with finding a way to govern the demand for healthcare and ensure sufficient supply of health professionals. All the factors that have driven up costs in the past and promise to do so in the foreseeable future largely revolve around demand. The next few sections of this monograph discuss how consumers in the U.S. value choice and enjoy the freedom to determine their own health insurance and the way in which they receive healthcare. By reviewing specific drivers and modulators such as choice and freedom, we can explain how the demand for healthcare affects price and quantity and begin to discuss possible solutions.

Finding Balance Between Freedoms and Moderation

People place a high priority on having the freedom to choose their own health care plan and the providers who deliver their care. They also tend to favor employers that offer them these same freedoms. It is clear, however, that having the freedom to choose without somehow moderating that freedom creates problems in terms of the cost, availability, and quality of care.

Freedom to Choose: Recent Example

When the U.S. Congress passed the Medicare Modernization Act (Pub.L. 108-173) in 2003, coverage for prescribed medicines under Medicare was made available only through a wide selection of private health insurance companies and health maintenance organizations. The federal government did not take direct control of managing benefits or paying pharmacies through a monolithic health plan. The Congress and the President recognized the value of choice, as well as the fact that ability to choose is what people want.

At first, critics said that private health plans would not sign up with Medicare to offer the coverage. That assumption turned out to be false. Then, when the number of prescription drug plans was more than adequate and even proliferated, critics said there were too many choices.

In 2008, most Medicare beneficiaries of all income levels and geographic areas have chosen either a health maintenance organization or a prescription drug plan to obtain their drug coverage. There are 10 million Medicare beneficiaries in over 700 prepaid health plans, as well as another 27 million beneficiaries in 102 prescription drug plans. The magnitude of choice these beneficiaries enjoy is one of the most popular features of the program. However, choice also serves as a source of complexity for older persons trying to sort out the best hospital and doctor networks and prescription drug formularies.

The point of this description is that people place a high value on the freedom to choose a health plan and a provider. In a recent survey of Americans about health reform, one demand of any future national health plan was the ability of people to keep their current health insurance if they choose (Consumer Reports 2008). However, the results of the survey suggest that the ability to choose healthcare providers is more important to people than the ability to choose health plans. Adult respondents to the survey were more than twice as dissatisfied if they had no choice of provider than if they had no choice of health plan.

People also place a high value on employers that offer choice when it comes to health plans and providers. Two of three respondents preferred an employer-selected set of plans over an account funded by employers that employees can then draw from to find coverage on their own. While health policy makers and employers may value health savings accounts and other consumer-directed health plans, they must pay special attention to supporting employees and their family as they make decisions about their healthcare coverage. Those with employer-based coverage have become accustomed to employer sponsorship and value the role employers play when it comes to helping them understand and manage their benefits.

Choice Moderated: Employers

While offering freedom of choice among providers and health insurance plans is a major feature of employment-based coverage, employers have successfully moderated unbridled fee-for-service freedom to choose because of cost concerns. The structure is complicated because employment-based coverage is not the same for all companies and employees. Consequently, the structure bears some explanation in order to understand the current problems.

Who Has What Health Coverage?

Approximately 68 percent of the U.S. population has private health insurance. Of that figure, approximately 60 percent obtain health insurance through their employers as part of their employee benefits packages. The remaining 8 percent purchase it on their own just as they would other types of insurance, such as homeowner's insurance or car insurance (DeNavas, Proctor and Smith 2007). Approximately 27 percent of the population has coverage provided by the government (primarily the elderly, through the Medicare program,

and the poor, through the Medicaid program). Approximately 16 percent have no health insurance.¹

Because health insurance is typically a component of a benefit package, employers play an important role on behalf of their employees, functioning primarily as intermediaries among individuals, health insurance companies, and healthcare providers. There is nothing inherent about the provision of healthcare that requires employers to get involved; it just happens to be the way the process of purchasing and paying for health insurance and healthcare evolved in the United States.

Employment-Based Market Is Not Well

How effectively has employer-based managed care balanced choice and costs? Regrettably, the market for health insurance has not performed well. From 2000 to 2006, the percentage of the population with employer-based health insurance declined from 64.2 percent to 59.7 percent, and the percentage of uninsured Americans increased from 13.7 percent to 15.8 percent (DeNavas-Walt 2007). These changes are due primarily to the increasing costs of providing health benefits. While employers have successfully moderated demand with an eye toward costs, all is not well. The following section describes how managed care organizations have worked to moderate the rising cost of health benefits.

Choice Moderated: Managed Care Organizations

Health insurance products purchased by employers from health insurance companies are structured around two broad types. In one, 45 percent of employees are fully-insured; in the other, 55 percent are self-insured (Employee Benefit Research Institute 2008). With a fully-insured plan, the health insurance company, which is typically a managed care organization, serves three primary functions. The company provides contractually obligated access to its network of healthcare providers, and it also manages benefits and pays providers.

Select Network of Providers

A managed care organization builds a network by entering into contracts with healthcare providers. Each provider in the network refers to other healthcare providers with whom the managed care organization has contracted to provide its members with healthcare services at negotiated rates, or prices.² These providers set rates for the services to be covered under the health insurance. These rates are usually fixed charges for each procedure, or a percentage of the provider's list charges, but they can be formulated in other ways as well. The important point is that the managed care organization negotiates with healthcare providers to offer services to members of the managed care organization at a negotiated rate

¹ Health insurance coverage figures are not mutually exclusive and add up to more than 100 percent because people may have multiple coverages. For example, a person may be eligible for Medicare but also have private coverage.

² When an insured member goes "out-of-network," it means the insured is seeking care from a healthcare provider who has not entered into a contract with the insured's health insurance company (at least for the provision of those particular services under that insured's particular health insurance plan). Depending on the terms of the health insurance plan, the insured may or may not be reimbursed by the health insurance company for a portion of those out-of-network services.

(Hurley et al. 2002). This is an important function because the managed care company strives to offer the widest network at the lowest negotiated price.

Select Design of Benefits

Managed care organizations also manage benefits. This means that the organization might design the structure of the benefits plans offered, deciding on what is and is not covered, as well as co-payment schemes. It also might perform medical management, which involves determining whether a particular treatment is medically appropriate and whether it should be covered, and support an employer's human resources department by providing it with supplemental benefits information. In a fully-insured plan, the managed care organization also administers the claims made by employees and directly pays healthcare providers – hospitals, doctors, medical labs – for any charges incurred.

By providing all these services, the managed care organization takes the risk that the health insurance premiums it receives from employers and employees will be insufficient to cover the costs of the healthcare services provided. Given this risk, managed care organizations have strong incentives to obtain the lowest prices possible from providers, especially hospitals. They can achieve this goal only if they have the ability to offer their members alternative providers in their network, which can occur in markets with active provider competition.

Self-Insured Health Plans

Similar to fully insured plans; self-insured plans also involve managed care organizations. These organizations typically negotiate contracts with healthcare providers. In addition to giving individuals access to a provider network, managed care organizations manage benefits and facilitate the payment of providers on behalf of the employer.³ Managed care organizations then charge employers a fee for providing these services. Unlike the situation with fully insured plans, employers in self-insured plans – and not the managed care organizations – bear the risks associated with paying providers. The self-insured employer pays healthcare providers directly out of its pocket at rates negotiated by the managed care organization.

In self-insured plans, the managed care organization bears no risk that health insurance premiums will be insufficient to cover the charges incurred by the insured. The reason for this is because there are no premiums to speak of. Instead, healthcare providers are paid from the employer's account, not from the account of the managed care organization. Consequently, employers have a strong interest in lower prices through competition among managed care organizations. Self-insured plans are the domain of medium to large employers. Almost no small businesses are self-insured.

³Occasionally, an employer will seek only the contracting services from the managed care organization (a process often referred to as “renting” the provider network) and will perform the claims administration on its own.

Employers and the Selection of Managed Care Organizations

Employer benefit plans can vary significantly because employers compete for employees, in part, by offering benefits packages (Abraham 2006-07). The higher the quality of an employer's health benefits package, and the lower the cost of those health benefits to employees, the more attractive that employer's health benefits will be to potential and actual employees (Cooper and Vistnes 2003). Of course, there are costs to employers associated with providing health benefits. These costs appear in the form of health insurance premiums in fully-insured plans. For self-insured plans, these costs take the form of fees associated with contracting, managing benefits, administering claims, and paying for services. In fact, averaged across both types of health plans, the average cost in 2007 for family coverage was \$12,680. The worker's contribution to this amount was \$3,354, and the employer contribution was \$9,325 (Kaiser Family Foundation 2008).

Core of the Competitive Influence

In order to enhance the competitiveness of their businesses, employers attempt to control the costs of their employee benefits programs. It is an important issue to employers, as health insurance premiums, driven by healthcare costs, have continued to rise faster than wages and inflation (Kaiser Family Foundation 2007). To cope with these increases, employers typically initiate competition among health insurance companies in an effort to identify the lowest cost, highest quality plans. Employers rely on the managed care organizations as their agents to negotiate with hospitals and doctors because the managed care organizations better understand the competitive dynamics that exist among hospitals (Morrisey 2005). Indeed, this is the very expertise employers buy when they contract with a managed care organization to provide a health benefits plan for employees.

It is common for employers to offer no more than one or two health insurance plans (often from the same health insurance company) to their employees. In fact, just under half of employers offer their employees a choice of three or more plans (Kaiser Family Foundation 2007). Each time its contract with a health insurance company comes up for renewal, the employer is able to consider and compare offers from competing health insurance companies. The employer is then able to choose the plan or plans it thinks has the best cost-to-value ratios for its employees.

Competition Even for the Largest Employers

Although most employers have no more than one or two health benefits plans, some major employers offer a large variety of plans. The federal government, for example, offers employees the Federal Employee Health Benefits (FEHB) program. The very design of the FEHB program sets up a competitive market among health insurance companies by effectively allocating a fixed sum (approximately 60 percent of the average premium for all plans) for each federal employee to use when selecting coverage from among multiple health plans. This defined contribution methodology means that employees themselves are responsible for any differences in premiums among the plans. Thus, just as with single-plan employers, the plans in the FEHB with the best cost-to-value ratios are likely to be the ones that are selected by greater numbers of federal employees and receive a greater volume of business. Switching plans is not uncommon, with 12 percent of employees switching plans annually (Atherly, Florence and Thorpe 2005).

Underpaying Public Programs

While employers grapple with coverage for their employees, the prices employers pay to hospitals and physicians are influenced noticeably by what public programs pay the same providers. The next section briefly described the two largest public programs, followed by a discussion of cost shifting – a phenomenon that has public programs underpaying providers.

Which Public Programs Cause Problems?

One of the most significant problems with healthcare in the U.S. is the absence of market forces when operating or monitoring public programs that provide health coverage for 26 percent of the population. These programs – Medicaid, Medicare – are huge, but they can be easily modified by public policy. This section explains how and why these programs cause problems.

The Challenges Presented by Medicaid

Medicaid is the largest public healthcare program based on the number of people covered. Serving low-income people, the program pays for hospital and physician services, as well as drugs and long-term care for more than 55 million individuals. Most are women and children. Many elderly and disabled depend on the program to fill in cost sharing gaps in their Medicare coverage left by deductibles and coinsurance. While the elderly and disabled account for 70 percent of the program's expenditures, three quarters of those eligible for Medicaid are adults or children.

The federal government pays more than half the costs of Medicaid, but the program is operated in each state by a single state agency that sets the payment amounts for all the services it covers. States have gone the same route as employers. More than 60 percent of Medicaid-eligible people are enrolled in managed care organizations that establish provider networks, administer benefits, and negotiate provider payment rates. The single state agency negotiates take-it-or-leave-it monthly payment rates with the managed care organizations based upon sound actuarial principles. Providers serving those in fee-for-service Medicaid agreements receive administered prices. These payments, set by the single state agency, are often based on nothing more than what was paid last year or what the state legislature allows for budgetary purposes.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) was enacted in 1997 as a block grant program. SCHIP provides matching state funds to cover uninsured children and some parents with incomes too high to qualify for Medicaid. Covering over six million children, SCHIP is also administered by the single state agency that sets the Medicaid payment amounts for all the covered services. Eligible children in each state have three enrollment options. They can be enrolled in the regular Medicaid program (Medicaid Only), a separate program that is more like private health insurance (Separate Only), or a combination of these two (Combination). Managed care organizations dominate coverage in SCHIP and operate as described above.

The Challenges Presented by Medicare

Medicare is the largest public program in terms of spending for health coverage for older and disabled persons. It pays for hospital and physician services, as well as drugs and some

long-term care (after a hospital stay), for more than 45 million individuals. Medicare is facing serious fiscal challenges over the next few years. From 2010 to 2030, the number of people on Medicare is projected to rise from 46 million to 78 million. At the same time, the number of workers is projected to decline from 3.7 workers per beneficiary to 2.4 workers per beneficiary.

Congress and the federal agency that operates Medicare (Centers for Medicare and Medicaid Services, or CMS) face enormous pressure to control the Medicare payment rates that they set. Fees for hospitals are paid out of a separate trust fund. The inflows from payroll taxes into this fund is currently projected to fall below outflows in 2011, and the fund will remain in a cash flow deficit for many years. The method for paying doctors in this program is particularly troubling. While the premiums paid by beneficiaries cover less than 30 percent of a physician's cost, the money used to pay the remaining 70 percent comes from current federal general revenue dollars, not from a trust fund with earmarked tax revenues. To increase the payments to doctors under Medicare, the Congress is basically taking from other federal programs or increasing the federal budget deficit. With broad authority from Congress, the CMS sets administered prices to pay hospitals and doctors.

Losing Ground

Public programs, especially Medicaid, have long been thought to shift the costs of care for Medicaid recipients to private payers and employers because public programs are habitually the lowest payers compared to private payers. Public payers have administered prices and just dictate to providers the payment rates. If payments are lower than costs, the rest of the cost of care is shifted to everyone else.

Medicare is the best example. Congress has been enacting annual spending limits on physicians, and these are thought to shift costs and misallocate resources. Normally the spending limits take Medicare to the brink each year of forcing payment cuts, and then new funding is found at the last minute to avoid a reduction in Medicare physician payments.

Medicaid operates on a slightly different track. Local and state hospital associations and medical societies have the most interest in influencing Medicaid payments. Essentially from the inception of Medicaid in 1967, healthcare associations in each state have complained – and justifiably so – about low payments. Medicaid administers prices; it does not arrive at them through normal market negotiations.

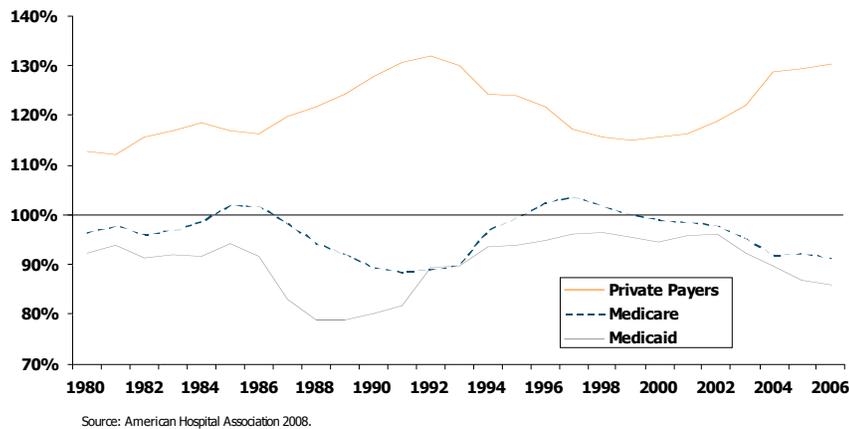
Cost Shifting by the Numbers

Data from the American Hospital Association annual survey of hospital charges, costs, and sources of revenue show the picture as the hospitals see it. Exhibit 6 shows the ratio of average costs to revenue by private payers, Medicare, and Medicaid without making any adjustments for case mix or promptness of payment among payers (public payers are prompt, reliable payers). The top line shows the cost shifting.⁴ Over the years, prices paid by private payers have always yielded revenues that are more than 110 percent of average costs. That ratio of revenues to costs (on average) increased in the early to mid 1990s when

⁴The term “cost shifting” refers to the shift in the cost of doing business private payers incur in reaction to the reduced prices paid by public payers.

the revenues of public payers, especially Medicaid, fell relative to costs. Public payments increased in the late 1990s and Medicare was even providing revenues above costs from 1995 to 1999. More recently, cost shifting has returned, with private payers at or exceeding 130 percent of costs and public payers around 80 percent of costs. Medicare paid \$48.9 billion less and Medicaid paid \$39.9 billion less than they would have if all payers paid equivalent rates (Fox and Pickering 2008).

Exhibit 6: Cost-Shifting Seems Apparent from the Trend Toward Low Hospital Payments Compared to Costs by Source of Revenue. 1980-2006



Ginsburg (2003) and Morrissey (2003) describe the views on cost shifting held by most economists. They find that healthcare cost shifting is an uncertain concept because hospitals and doctors should be able to maximize revenues or profits without regard to what public payers may be paying. If cost shifting is going to occur, we must assume that hospitals and doctors have some market power to exploit it once they see what the public payers are going to pay. In other words, why should hospitals and doctors cost shift when public payments fall? Hospitals should already be obtaining the highest prices their market power will allow through their negotiations with private payers.

Yet as the chart of revenue to costs in Exhibit 6 clearly displays, a cause and effect appears to be at work. The lines for Medicare and Medicaid seem to move together below the zero ratio line probably in response to the cycles in the economy that influence budget shortfalls for federal and state governments. Further, when the lines in the graph for Medicare and Medicaid are falling and bottoming, the lines for private payers are rising and peaking.

Over 75 percent of physicians accept new patients with Medicare or Medicaid. Most health economists assume that a phenomenon exists in the U.S. in which changes in administered prices from public payers are associated with compensating changes in prices charged to private payers. Thus, if Medicare reduces payments to doctors in order to reach pre-established spending limits, doctors will tend to engage in more exacting negotiations with

private managed care organizations and demand higher prices. Whether the compensating differential is complete – that is, a one-dollar cut by public payer leads to a one-dollar boost of private payers higher prices – is unclear. Empirical evidence in the published literature shows that cost shifting is not complete, but it does exist.

The Burden for Small Employers

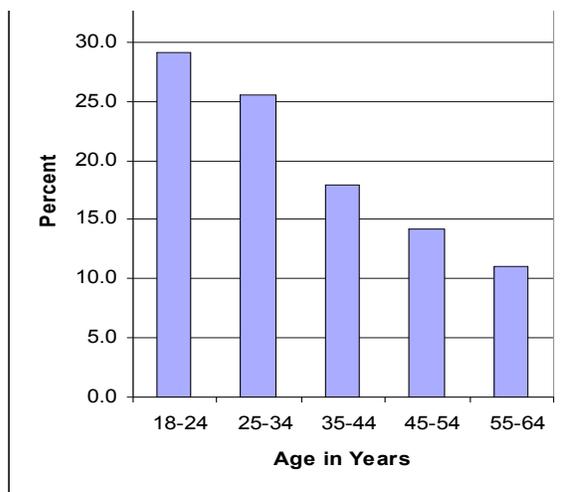
Cost shifting has important implications for the cost of private health insurance, employers, and the ability to cover the uninsured. There is evidence that the cost burden is not evenly distributed across employers. Small employers shoulder a greater burden than large employers. For small employers, the costs of health insurance have increased 129 percent over the last eight years, and small employers pay an average of 18 percent more in health insurance premiums for the same benefits as large employers (Kaiser 2008, Gabel 2006).

There are three reasons small employers carry the heavier burden of rising healthcare costs than large employers:

1. Managed care organization direct their marketing to large employers.
2. Small employers are ill-equipped to handle the complex process of managing benefits.
3. There is no national market for health insurance that covers small employers.

These three reasons for the rising cost of healthcare for small employers stem from a couple factors. First, small employers face a natural disadvantage in the market for health insurance when compared to larger employers. Second, small employers employ a greater percentage from that group of people called “the young immortals.” As Exhibit 7 illustrates, not having insurance is strongly linked with age. Fully 30 percent of those between 18 and 24 have no health insurance compared to just 10 percent among the oldest age group. These are

Exhibit 7: Young Immortals Are Most Likely Not to Have Health Insurance, 2005



Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National health Interview Survey, 2005.

relatively healthy employees, who rarely see a physician or hospital, and they often do not believe they need health insurance, even though many can afford it. Young immortals place a cost burden on the entire healthcare system. While on average they are correct in their thinking about not needing much medical care, a certain number of uninsured young immortals need physician services and costly inpatient hospital care, which they cannot afford to pay. The rest of the population with insurance winds up paying a higher premium for coverage in part to pay for the cost of the young immortals.

The majority of young immortals work for small business, which has the most difficulty providing low-cost health insurance. Unlike large businesses, small employers are not large enough to be an important customer for a managed care company. With little bargaining power, small business is faced with take-it-or-leave-it health insurance premiums. They face high administrative costs in dealings with insurance companies and few options for coverage. Finally, even a minor illness, but especially a major illness among the small employer group, can lead to remarkable swings in annual premiums. These unreliable year-to-year premiums for health insurance frequently send small employers into the market looking for alternatives. It is a struggle for a small business to meet all government requirements and filings, carry out the day-to-day responsibilities of a small business, and manage health benefits for even one employee. Yet the core of the problem is the affordability of the coverage.

A small business may be able to find an insurer willing to provide coverage, but the premiums are high and rising faster than wages are rising. Youthful employees, perhaps at the early part of their career, are not highly compensated and thus do not take up coverage unless the employer pays most or the entirety of the premium. The market is local for a couple reasons. Restrictive state health insurance regulations govern who can sell insurance in the state, and mandatory benefits must be covered under commercial health insurance policies. These provisions eliminate easy competition from outside the state and increase the costs of coverage by nearly 20 percent according to some estimates. Again, there is no help here for young immortal employees who may or may not be offered coverage, but who cannot afford coverage, especially in light of the fact that they face low odds of experiencing illness, injury, or disability.

Summary

The problem with rising costs for healthcare is that it takes an ever larger share of the economy.

U.S. Healthcare System Enviably for Many Reasons

- Life expectancy has increased significantly and age-adjusted death rates have dropped remarkably for eight of the top ten diseases.
- More progress on health outcomes needs to be achieved, especially in terms of disparities by racial/ethnic background.
- Comparing the U.S. to other countries in terms of life expectancy and death rates must be done cautiously because of noncomparable data sources and other issues.
- As people in any country experience higher income, consumption of healthcare increases at the expense of all other goods and services.
- As people in any country age, consumption of healthcare increases at the expense of all other goods and services.
- Most people in the U.S. across all characteristics perceive themselves to be in good or very good health.
- Waiting lists are rare for most common healthcare services and most people in the U.S.

The Share of the Economy Devoted to Healthcare Is High and Rising

- The share of the U.S. economy devoted to healthcare is 16.4 percent and expected to rise to nearly 20 percent before 2020.
- Under current policies, CBO projects that federal spending alone on Medicare and Medicaid will rise from about 4 percent of GDP in 2009 to nearly 6 percent in 2019 and 12 percent by 2050.

Balancing Freedoms and Moderation is Difficult

- People in the U.S. place a high value on being able to choose health insurance coverage and providers.
- Approximately 68 percent of the population have private health insurance coverage primarily through their employer and mostly with managed care companies.
- The employment-based market is underperforming as indicated by higher health insurance premiums and declining percentage of people covered.
- Managed care companies help moderate costs by establishing select networks of providers and innovative benefit designs to negotiate lower payments.
- In order to enhance the competitiveness of their businesses in terms of attracting good employees and delivering low-cost products and services, employers attempt to control their health insurance costs with managed care companies.
- The process of negotiating contract renewals with managed care companies has the competitive effect of containing costs.

Public Programs Underpay for Coverage and Small Business Bears the Primary Burden

- Medicaid covers low-income women, children, and disabled persons and uses government administered prices to pay providers.

- Medicare covers aged and disabled persons and uses government administered prices to pay providers.
- Because of administered prices for public programs, costs are thought to be shifted to private payers such as employers.
- The 25-year trend toward low hospital payments relative to hospital costs is associated with declines in payments for Medicare and Medicaid.
- The burden of cost shifting is especially heavy for small employers, who, unlike large employers, are unfavorably positioned to take advantage of managed care organizations.
- The rising cost of healthcare is more burdensome for small employers because managing benefits is a complex process.
- Not having a national market for health insurance puts all business, but especially small business, at a disadvantage.
- Small businesses struggle to meet government requirements and filings when they provide health insurance.
- Youthful employees and low-income employees do not enroll in health insurance programs, even when it is offered, because of affordability.
- The problem with the rising cost of healthcare means new and serious efforts are needed now while safeguarding freedom of choice and ensuring equity.

THE CAUSE: TECHNOLOGY, MORE EFFECTIVE TREATMENTS, AGING, AND POORLY UNDERSTOOD INEFFICIENCIES

Most people would probably agree to spend more on healthcare if it becomes demonstrably more effective over time at preventing and curing disease. In reality, however, much of what costs more is only modestly more effective. For this reason, most people are displeased with any level of increase in the cost of care.

Seeking healthcare is, for most people, an unusual event – something they experience infrequently. Unlike the process of purchasing consumer goods, which we do regularly and, as such, understand the value of what we are buying, we have a poor sense of worth when we spend money on healthcare. And when persistent cross-subsidies or cost shifting complicates the process and obscures the true cost, those who pay more for care become increasingly dissatisfied.

These concerns help explain why the cost of healthcare is a major concern and prompt calls for policy intervention. There are many reasons for rising costs. But to develop public policy solutions that will cure the ill of rising healthcare costs, we must assign priority to treating those factors that cause the problem.

The next sections of this monograph explain four key reasons for the rising cost of healthcare.

Reason 1: We have increased our investment in technological innovation.

Reason 2: People are willing to pay big money for more effective treatments.

Reason 3: Our aging population will engender an unsustainable force.

Reason 4: The system is rife with inefficiency, fraud, and overcharging.

These four reasons are the basis for the health policy solutions we must follow if we intend to control healthcare costs. Once we understand the impact of these issues and how to implement the solutions, the path we need to take toward expanding coverage will be clear.

Reason 1: Money for Technological Innovation

Joseph Alois Schumpeter (1883-1950) was a famous economist who wrote extensively about technology’s impact on an economy. His ideas said a lot about how technology can change an entire economy, improve productivity, and gradually lower costs. Unfortunately, the ideas do not seem to have any relation to the cost of healthcare in the U.S.

Innovation by entrepreneurs, said Schumpeter, leads to gales of "creative destruction" as changes in technology make old ideas, inventions, labor skills, and equipment obsolete. As Schumpeter saw it, the question is not "how capitalism administers existing structures . . . [but] how it creates and destroys them." This creative destruction causes continuous progress and improves standards of living for everyone.

For reasons no one has really explained, U.S. healthcare seems to be exempt from creative destruction. One of the top cost drivers for healthcare is the apparent unrelenting impact technology has on the volume and intensity of services. While there is creative destruction in the sense that new drugs and procedures replace old ones in our still predominantly fee-for-service system, there is a persistent, almost viral, tendency toward more volume and intensity of services, not less. Rarely does creative destruction lead to productivity gains in healthcare. Unless this significant driver of health costs is broken, we will be unable to control costs.

Volume and Intensity of Services

For decades, innovation in healthcare through technological change has been perhaps the most important driver of rising healthcare costs. This cost driver has been the source of numerous efforts in public policy to control technology and its impact on costs.

One of the first efforts to control the impact of technology on cost came in the form of the Health Planning and Resources Development Act of 1972. This act expected all states to set up agencies for reviewing, approving, and limiting capital spending for beds and technology. The prevailing view was that under cost-based reimbursement, hospitals and doctors faced strong incentives to acquire more costly capital and encourage patients to use it.

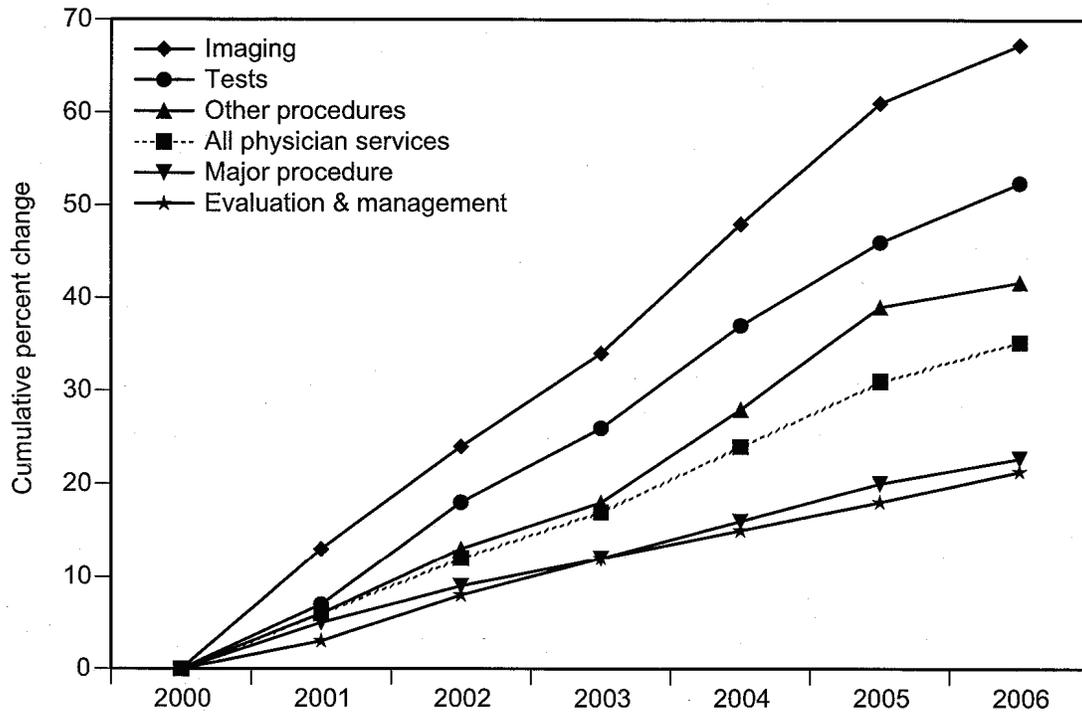
The second effort occurred with an attempt to reduce incentives brought on by fee-for-service medicine that increased the volume and intensity of services. The Health Maintenance Act (HMO) of 1973 was passed to make grants and loans that would foster the development of HMOs and remove state restrictions for new federally qualified HMOs. This act also required businesses with 25 or more employees to offer federally certified HMO options whenever they offered traditional indemnity insurance. While this act created many HMOs and fostered the beginning of the managed care organization, it did not work as completely or soundly as originally hoped.

However, the HMO Act of 1973 did lead to the third effort in which public and private payers launched a now 26-year movement toward bundled payments. The most notable bundled payment system is diagnosis-related groups (DRGs). Rather than reimbursing hospital costs, DRGs pay a predetermined amount of dollars for each hospital admission, though it is adjusted for the case mix of the patient and other factors. The same sort of bundled payments adjusted for case mix now applies to nursing homes, home health, ambulatory surgery, and other types of health services. While bundled payments should have had a restraining effect on healthcare costs, the volume and intensity of services continued to swell apace. Proof of this is seen in a recent examination of all fee-for-service claims from Medicare.

Epidemic of Imaging, Testing and All Physician Services

Exhibit 8 shows the cumulative increase between 2000 and 2006 of the per capita spending on imaging and testing services. To calculate the impact on total spending, the growth in volume of services shown must be multiplied by the growth in the number of beneficiaries from 2000 to 2006. There is an epidemic of imaging, testing, and all physician services occurring in the traditional fee-for-service side of the Medicare program.

Exhibit 8: Imaging Costs Have Risen Faster Than Any Other Test or Procedure, 2000-2006



Source: MedPAC 2007.

During this period, the cumulative volume of physician services delivered grew about 35 percent per beneficiary. Imaging (x-rays) increased 67 percent, and tests increased 52 percent over seven years at a time when physicians were requested to restrain the volume of services or face a congressionally mandated cut in payment rate. For just the last year available (2005 to 2006), tests and imaging grew most compared to all Medicare’s services. Tests grew 6.9 percent, and imaging grew 6.2 percent per capita.

The technology innovations driving these sorts of increases are unique to fee-for-service medicine. In the spirit of Schumpeter’s creative destruction notion, technology innovation in healthcare covers a broad array of expensive activities, including basic research, clinical trials, regulatory approval, product development, marketing and sales to health professionals and patients. The National Institutes of Health and DHHS are the prime drivers of basic research either through the work they do themselves or the \$27 billion in funds they provide for this effort. Companies of all sizes in the areas of pharmaceutical research, biotechnology, and medical devices conduct the necessary activities for gaining approval to market products and disseminate innovations through their distribution channels. This is a complex and risky process, and both regulatory and market forces affect results at every step along the way. The question is whether the push to innovate drives creative destruction or merely raises costs with unknown effects on quality, patient safety, and health outcomes.

New Spending on Technology

One recent study (Baker et al., 2003) evaluated the impact of technological innovation on healthcare costs, depending on the point at which new equipment is placed into service. The authors examined everything from outpatient diagnostic imaging to inpatient radiation oncology facilities, linking measures of technology supply to spending for both elderly and non-elderly populations. They used extensive claims databases over time to see whether changes in availability are related to changes in use and spending.

This study found that expanding the supply of technology tended to be associated with higher service use and greater spending on the service in question. In some cases, notably diagnostic imaging, a rise in availability appears linked to incremental utilization, rather than substitution for other services. They concluded that public policy needed to focus on assessing and managing the availability of new technologies. This practice would avoid spending money on innovative technology that is not associated with strong quality improvements. Technology that enhances productivity should be encouraged and rewarded.

Limiting the Freedom to Prescribe

Despite the growth in the volume and intensity of services, physicians and hospitals do not have unlimited freedom to prescribe whatever they wish to drive up health costs and their own incomes. While fee-for-service medicine holds the strongest incentives possible to drive up the volume and intensity of services, utilization management programs are ubiquitous in the system and provide a check on unbridled service use. Managed care organizations are the primary purveyors of utilization management programs, and they do not all view utilization management in a standard way.

The Institute of Medicine (IOM) narrowly defined utilization management as a case-by-case outside review sponsored by purchasers. There are a variety of ways to manage utilization. One is to use limited networks of providers who meet expectations about the use of services for standard treatments. At one point, managed care organizations used primary care gatekeepers to channel patients to specialists. In addition, electronic medical records are also making it possible to manage utilization. Computerized physician order entry programs concurrently check for contraindicated medications or procedures and can prod physicians to consider lower cost alternatives as they order tests and procedures. In the broadest terms, utilization management is anything that influences physician autonomy by inserting cost concerns in the medical decision making process.

Mark Schlesinger (1997) has described how utilization management might limit physician autonomy on four levels.

First, utilization management challenges the traditional authority of the medical profession. The spread of utilization review undermines a physician's ability to establish the rules for practicing medicine.

Second, while generally understood to be effective at reducing costs, utilization management increases paperwork and other bureaucratic requirements. These outcomes, in turn, often raise the cost of operating a practice. This, in turn, affects morale and impacts net income. Physicians frequently complain of intrusive tactics from utilization management that siphon

time away from their patients and force them to incur the expense of more office staff. All of this ultimately subtracts from time and attention to patient care.

Third, substituting utilization management over clinical decisions encourages a style of medical practice in which the needs and circumstances of individual patients are overlooked. Physicians often complain that any standardization of their recommendations is “cookbook medicine.” Quality of care experts would say driving out variation in the practice of medicine based upon sound medical evidence is quality improvement.

Fourth, the traditional sensibilities of physicians for scientific decision making and beneficence toward patients are undermined by corporate concerns about the costs of care.

Reason 2: Money for More Effective Treatments

It may carry risks, the results may be uncertain, and the costs are certainly high, but innovative health technologies must convey value or they would not be pursued either by government or corporate research and development. Sometimes the value is high, as it was in the case when someone discovered that stomach ulcers are caused by a virus. But too often, the value is low, which occurs when me-too drugs are marketed. The real issue is whether the benefits of innovative health technologies exceed the costs. When they do not, healthcare costs increase and people think they are not getting their money’s worth. Ineffective or inappropriate treatments that translate into low-quality care is just one of the key drivers of higher healthcare costs.

The question of whether innovative health technology is cost effective has been the subject of thousands of case studies (Neumann 2007). But several teams of researchers have tried to tackle the question of the value of technological change more broadly. Cutler and McClellan (2001) analyzed technological change in five conditions: They looked at the benefits of technology in terms of survival, improvements in disability, and substitution for older less effective technologies. In four of conditions—heart attacks, low-birth weight infants, depression, and cataracts—the estimated benefit is much greater than the cost. In the fifth condition, breast cancer, costs and benefits are approximately of equal magnitude.

The question of value for money, or benefits exceeding costs, is a major theme in the fight against higher healthcare costs. This concept of benefits exceeding costs should be distinguished from cost reductions. Simply cutting the prices paid or limiting the budgets for healthcare services could easily generate cost reductions. We could likewise reduce costs by not paying for or denying expensive treatments. But that type of cost reduction is usually unacceptable for those who are denied the services.

What we are really after is cost-effective healthcare, or healthcare in which the added benefits exceed the added costs. This concept is critical, and it merits further discussion for three important diseases: heart disease, cancer, and chronic disease.

Demonstrable Impacts on Acute Heart Disease

Heart disease is the leading cause of death and is associated with more than one million heart attacks annually, especially among older adults. This statistic makes heart disease Medicare’s most frequent and costly reason for a hospital stay. The past 30 years have seen great

improvements in the efficacy and effectiveness of therapies, procedures, and interventions for heart disease. A remarkable number of variable treatments exist, including some that are controversial, yet patients and their insurance companies still pay for them.

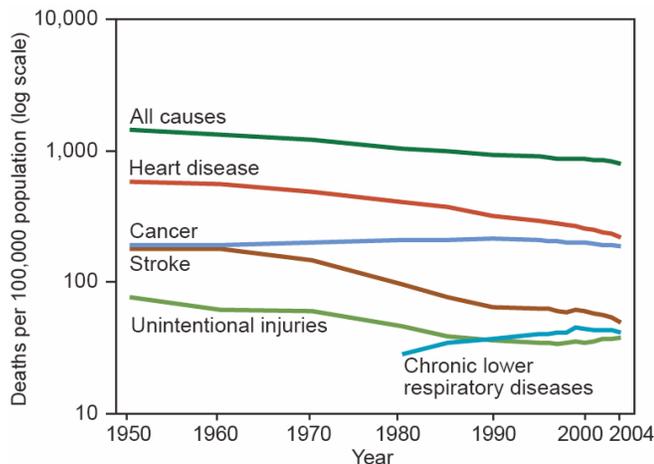
Medical treatment combined with changes in diet and exercise seems to be effective. Surgical treatment with invasive medical procedures also seems to help with heart disease, as do many new drug therapies. Medicines, diet, daily activities, exercise, lifestyle and health habits, and family as well as social supports are all elements of managing the disease even in the acute phase. But to be effective, all these treatments require patients to adhere to a regimen. With proper management, patients can return to normal lives after an acute episode of heart disease and avoid future costly hospital events for many years.

Long-term Outcomes and Cost of Heart Disease

Alison Rosen, David Cutler, and colleagues (Rosen 2007) examined national trends in the costs and benefits of care for heart disease from 1987 to 2002. They looked at the long-term outcomes and costs of care. They also examined the impact of a costly and invasive procedure called revascularization, and they compared it with drug therapy after a heart attack. With a creative twist, they also examined the impact of primary prevention on the cost and benefits of treating heart disease. They put together all their findings to formulate a picture of what the enormous cost of heart disease actually gets us.

Naturally, as the number one disease in the country, heart disease consumes a great deal of money. But as Exhibit 9 reveals, age-adjusted mortality trends are clearly down. In 1950, mortality from coronary hearth disease was nearly 600 per 100,000 (about 0.5 percent per year) across the entire population. The death rate for the elderly was nearly 4 percent per year. Over the last 50 years, mortality fell 1.7 percent per year in the overall population and 1.5 percent per year among the elderly. In 2004, only 217 per 100,000 Americans died from heart disease. This trend reflects a remarkable achievement, all believed to be tied to the host of treatments, prevention, and lifestyle changes mentioned at the beginning of this section.

Exhibit 9: Death Rates Fall for Major Diseases with Heart Disease as the Leading Cause of Death for All Ages, 1950 – 2004



SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*, Figure 20. Data from the National Vital Statistics System.

Array of Therapies for Heart Disease

Rosen, Cutler, and colleagues associated the changes in deaths per population to the changes in a number of therapies for heart attack alone. From there, they tried to determine the effectiveness of each therapy, the cost of that therapy, and which therapies would be effective to use going forward. Exhibit 10 summarizes their analysis. This exhibit focuses on the increased use of all the therapies shown from earlier periods to later periods and, only by implication, reveals the increase in costs associated with these shifts. There is no single consistent source of data on the use of these therapies, so some of the earlier and later time periods do not match. Yet the authors did the best they could with the data available.

Exhibit 10: Nearly All Therapies for Heart Disease Have Increased in Usage Over Time

Therapy ^a	Percent of Patients with Use Earlier	Percent of Patients with Use Later
Medical Therapy Aspirin	41	45
Statins	8	46
Beta Blockers	21	49
ACE or ARB inhibitors	22	51
Revascularization Thrombolytics	34	21
Coronary Artery Bypass Graft CABG	8	15
Primary PTCA	2	13
Nonprimary PTCA	3	15

Source: Rosen et al. 2007.

^a Briefly, the therapies include the following: aspirin (an over-the-counter paid medication that tends to thin blood and reduce harmful clotting); statins (a class of drugs used to lower cholesterol levels); beta blockers (a class of drugs often used for irregular heart beat); ACE inhibitors (a class of drugs for hypertension); revascularization thrombolytics (a surgical procedure for the provision of a new, additional, or augmented blood supply to a body part or organ); coronary artery bypass graft surgery (CABG); primary percutaneous transluminal coronary angioplasty, or PTCA (a technique of mechanically widening a narrowed or totally obstructed blood vessel six to twelve hours after a heart attack; and non-primary PTCA (a PTCA done electively more than 12 hours after a heart attack).

Aspirin use is thought to be a very low cost, yet effective therapy after a heart attack, and its use has increased modestly. The use of statins is up nearly seven fold. Use of beta blockers has more than doubled, as has the use of ACE inhibitors. Revascularization of all types has actually fallen. The highly invasive coronary artery bypass graft (CABG) surgery has doubled. The incidence of percutaneous transluminal coronary angioplasty (PTCA) procedures, which involves a widening of a blocked blood vessel, has increased remarkably at great expense to the healthcare system.

Studying the rate at which these therapies are used and the effect of each on survival, the authors attempted to assign a therapy to a mortality benefit. They did this by deconstructing the downward trend in heart disease mortality for heart attack. They concluded that the increased use of revascularization procedures is associated with a 2 percent reduction in mortality. The increased use of medications is associated with an additional 15 percent reduction in mortality: Statin use accounts for 6 percent of that reduction, and ACE inhibitors and beta-blockers each account for 5 percent reduction.

Next, they determined lifetime healthcare costs using a database for a large number of people over many years of data. They estimated that lifetime spending increased nearly \$50,000 (from \$77,000 to \$127,000) for a person with a heart attack.

For persons with a heart attack, the increase in all the therapies made an incremental change in life expectancy of nearly one year of life at a cost of \$24,000. This is thought to be very cost effective. Revascularization did not fare as well, with the incremental cost of another life-year pegged at \$55,000. Medical management was relatively cost effective, adding another year of life for just under \$16,000.

In sum, all our therapies for treating heart disease cost more, some more than other, but they have demonstrable impacts on life expectancy. The question is clear. Are we willing to

spend an additional \$16,000 to \$55,000 for sometimes costly therapies that add another year to the life of a patient with acute heart disease?

Demonstrable Impacts on Cancer

Patients newly diagnosed with cancer represent a significant opportunity because this disease is a major driver of costs. As Exhibit 9 shows, cancer is the second leading cause of mortality at 559,000 deaths. It is a more complex disease than heart disease, however, because the numerous tested and experimental processes of therapy depend on the many types and stages of cancer.⁵ With many cancers, there is not widespread agreement regarding the course of treatment, and the outcomes can be poor no matter what is done for the patient. The number of living Americans who have been diagnosed with cancer is 10.7 million, and 1.4 million new cases are reported each year.

Breast cancer is selected here to illustrate the cost effectiveness because there is fairly wide agreement on the treatment process depending on the state of the disease. On the other hand, evidence-based medicine changes all the time, primarily because of advances in the genetic basis for breast cancer for some patients.

Prevention and Early Detection Most Cost Effective

The most cost effective approach to treat breast cancer is to detect it as early as possible and quickly return the patient to normal activities free of cancer. Treatment has undergone significant changes over the years. In the 1970s, chemotherapy for cancer required hospitalization, and patients had difficulty tolerating its effects. Mastectomies were much more common, if not the norm, and few effective drug therapies existed. Prevention of any kind, such as breast self-examination and mammography, were hardly used or even known.

Today, 90 percent of chemotherapy is accomplished on an outpatient basis, and new drugs have been developed that specifically help with side effects such as nausea. Breast conserving surgery is performed routinely with breast reconstruction as an integral part of the treatment regimen. Most encouraging is the growth in new drugs being developed that frequently offer total remission over a five-year period with less toxicity. Investment in cancer prevention and breast cancer awareness has been enormous with widespread and routine use of mammography.

There have been improvements in adjuvant chemotherapy. This type of chemotherapy is a secondary treatment that controls side effects such as infection or pain and discomfort. In some instances, adjuvant chemotherapy is used to remove any remaining cancer after the primary treatment is complete. Hormonal treatments are now the norm and better tolerated than in the past, and these can be linked to genetic tests that are used to target therapies.

Long-Term Outcomes and Cost of Breast Cancer

Brian Luce and colleagues (Luce, Sloan and Muskopf 2007) examined national trends related to the costs and benefits of caring for breast cancer from the 1970s to 2000. They looked at

⁵ Some of the major cancers, for example, are colorectal, prostate, skin, hematologic (blood), ovarian, gynecologic, cervical, and lung.

the long-term outcomes and costs of care. They also examined the impact of costly and equivocally effective drugs when compared to surgical therapies.

Unlike heart disease, overall cancer mortality is down, but not dramatically (Exhibit 9). In 1950, the mortality from all cancers was nearly 193 per 100,000 across the entire population. Today, all cancer mortality is 185 per 100,000. However, like heart disease, breast cancer has seen improving trends (not shown in Exhibit 9). In 1950, the mortality from breast cancer was approximately 31 per 100,000 females of all ages. Today, the breast cancer mortality is 24.4 per 100,000 females of all ages, which represents a less than a one percent reduction per year. Five-year overall survival rates increased from 76.9 percent to 86.6 percent. Moreover, the risk of developing meta-static disease declined from 40 percent to 15 percent. These trends are notable.

Luce and colleagues associated the five-year cost of Medicare claims for breast cancer with changes in treatment costs from new therapies. They compared the increased costs to the gain in life expectancy over the same period. Life expectancy was estimated to improved 8 percent and treatment costs increased \$4,676. Calculating the cost effectiveness, the incremental cost of another life-year was \$103,000. Many other therapies for other diseases have superior cost effectiveness ratios per life saved.

Treatment for breast cancer specifically and cancer generally changes rapidly primarily because we continue to learn more about complementary therapies that attempt to expand the effectiveness of standard cancer treatments. All costing great sums of money, new efforts to help those with cancer focus on symptom control, rehabilitation, the quality of life, and especially cancer surveillance and prevention. Our therapies for treating cancer cost more with favorable but less dramatic effects on life expectancy compared to heart disease. To balance the cost with the effectiveness, we need cancer therapies that are based on the best evidence of outcome with attention given to quality of life for patients.

The Impact of Heart Disease and Cancer on Other Chronic Diseases

Acute heart attacks and periods of treatment of cancer with chemotherapy are not chronic diseases.⁶ But the broad spectrum of heart disease and cancer that lasts a very long time or are recurrent are chronic diseases. Recurrent means the course of the disease follows a path of ill health, followed by remission, and then ill health over many years.

Chronic Disease Growing and Driving Costs

While much is made of just how costly it is to treat deadly diseases such as heart disease, cancer, and stroke (especially among the elderly), other chronic diseases actually drive the cost of healthcare in this country. These chronic diseases require constant physician care and sometimes costly medications, as well as frequent and costly trips to the emergency room and the hospital for treatment. And as Exhibit 11 shows, they are also becoming more prevalent.

⁶ Because of the advances made in detecting and treating cancer, more people are living longer after a cancer diagnosis. Because survivors often face a range of health challenges, cancer has become more like a chronic disease, rather than a death sentence. Over 10 million living Americans have received a cancer diagnosis, making cancer a way of life for many.

Using two sources of large databases over several years, Ken Thorpe evaluated this information. Exhibit 11 lists the top ten most costly chronic diseases and the change in percentage points of the incidence for two broad points in time approximately 15 years apart. The ranking is based on the total number of people with the disease at a particular time.

Exhibit 11: The Prevalence of Treating Disease Is Up Sharply for Top Ten Chronic Diseases Among US Adults 18 and Older, 1987 – 2003

Condition	Percent		
	2003	1987	Point Change
Mental disorder	17.4	5.3	12.1
High cholesterol	10.7	1.4	9.3
Pulmonary conditions	17.6	9.4	8.2
Back problems	11.8	5.2	6.6
Arthritis	13.8	7.7	6.1
Upper Gastrointestinal	9.8	3.8	6.0
Hypertension	19.1	13.4	5.7
Lupus and Related Conditions	8.5	4.8	3.7
Diabetes	7.0	4.0	3.0
Other central nervous systems	7.4	4.7	2.7

Source: 1987 NMES and 2003 MEPS from Thorpe 2006.

The results have been sorted according to the prevalence of a disease from highest to lowest. All ten of the most costly diseases increased in the last 15 years. The chronic disease with the double digit increase was mental disorder. Six diseases increased 5 percent or more – high cholesterol, pulmonary conditions, back problems, arthritis, and upper gastrointestinal. The top-ten list is rounded out by hypertension, lupus and related conditions, diabetes, and other central nervous systems. If trends continue, the costs for the top-ten list would more than double in 10 to 15 years.

According to the Thorpe analysis, increases in the prevalence of these top ten diseases combined with the per patient cost of treating them accounted for half of the increase in spending on healthcare in the U.S. during this period. Several factors that account for the enormous growth in spending:

- Patients and physicians are more adept at recognizing and then reporting a disease.
- The increased longevity of people creates more opportunity for the onset of disease.
- Medical services are being provided in greater volume and intensity.
- Our population has experienced a rise in obesity.

The fourth reason deserves further discussion. A recent multinational study called the Prospective Obesity Cohort of Economic Evaluation and Determinants reported the baseline relationship between obesity and chronic conditions. People were segmented by body mass into one of three groups: non-obese subjects with a low body mass index (BMI 20-24.0 kg/m²), overweight subjects (BMI 25-29.9 kg/m²), and obese subjects (BMI

$\geq 30 \text{ kg/m}^2$). Abdominal obesity was defined by waist circumference (WC) $>102 \text{ cm}$ for males and 88 cm for females.

Overweight and Obesity a Culprit

Across the board, chronic disease symptoms were associated with obesity and higher costs. Symptoms associated with weight were hypertension, diabetes, and sleep apnea. Diabetes risk factors increased with weight. Among the overweight class, subjects with abdominal obesity had significantly more reported respiratory, heart, nervous, skin, and reproductive system symptoms. Most telling is the fact that mean healthcare costs were significantly greater in the higher weight classes: lower weight was \$456, overweight was \$1,084 and obese was \$1,186.

The trends are not good, especially for children (Wang 2008). The prevalence of being overweight (BMI ≥ 95 th percentile, 30%) among children will nearly double by 2030. Total healthcare costs attributable to obesity/overweight would double every decade, accounting for between 16 and 18 percent of total US healthcare costs.

Reason 3: Money for More Care at Older Ages

Another driver that has a significant effect on health costs is our aging population. Why are a larger number of older adults an issue for healthcare costs? Are they just a problem for Medicare since that is the source of their coverage?

First, as the following section shows, older adults use healthcare most frequently, and the services they use are very costly. In any country, if the population is aging, the demand for health services will increase and raise healthcare costs. Good health for older people declines with age, so they use more health services to maintain good health. For a high-income country such as the U.S., the fact that we have an older population probably interacts with higher income to exacerbate the problem, and people demand even more health services than they would otherwise.

Second, while it is true that Medicare covers much of the increasing costs of an older population, there is one place it does not. Medicare Secondary Payer is a program mandated by the Congress for private insurance to pay first when a Medicare beneficiary also has employer-based retiree coverage or other private health insurance paid by someone else. Private insurers call this coordination of benefits when assigning responsibility for first and second payment. Employers are required to do the following:

1. Identify beneficiaries with health coverage for which Medicare Secondary Payer applies.
2. Provide for proper primary payments when Medicare Secondary Payer applies.
3. Enforce nondiscrimination against employees and disabled Medicare beneficiaries.
4. Submit Data Match regular reports on identified employees.

This secondary payer program affects all employers who pay for retiree health benefits and saves Medicare – or costs corporations – approximately \$200 million annually.

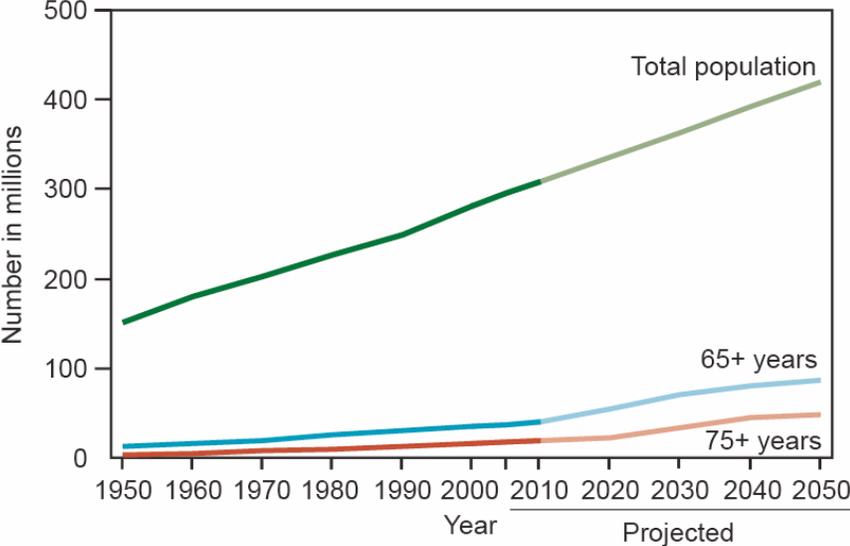
Third, older adults covered by Medicare are about 14 percent of the U.S. population, and Medicare accounts for about one-fifth of spending on personal healthcare in 2004. To put a

finer point on it, Medicare accounts for 3 percent of spending in the entire economy. Medicare is the largest single payer of health services in the U.S. The share is even larger for large classes of services. In 2004, Medicare accounted for 20 percent of hospital services, 38 percent for home health services, and 28 percent for durable medical equipment. Medicare is a formidable source of demand for resources in the healthcare sector. All other demanders, primarily employers working on behalf of their employees, must compete with Medicare. As the number of beneficiaries grows markedly in the future, Medicare will put unprecedented pressure on prices.

Demographic Shifts

Exhibit 12 shows the past, current, and projected total population of the U.S. in millions. The population has roughly doubled since the 1950s from 150 million to over 300 million, and the number of elderly has gradually increased from 8 percent to 12 percent of the total population. All that is about to change. The number of people age 65 years or older today is approaching 40 million, and that figure will rise to 71 million in 20 years. In other words, the number of people age 65 and older will increase from 13 percent in 2010 to 19.7 percent in 2030.

Exhibit 12: Population Growth Among Elderly Will Affect Demand for Healthcare Through 2050.



SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*, Figure 1. Data from the U.S. Census Bureau.

The most costly older-old population, those 75 and older, rises equally as fast, and this has serious implications for Medicare and the rest of the health services sector. The number of people age 75 years or older today is just fewer than 20 million, and this figure rises to 33 million in 20 years. As a percentage of our total population, this represents an increase from 6 percent in 2010 to 9 percent in 2030.

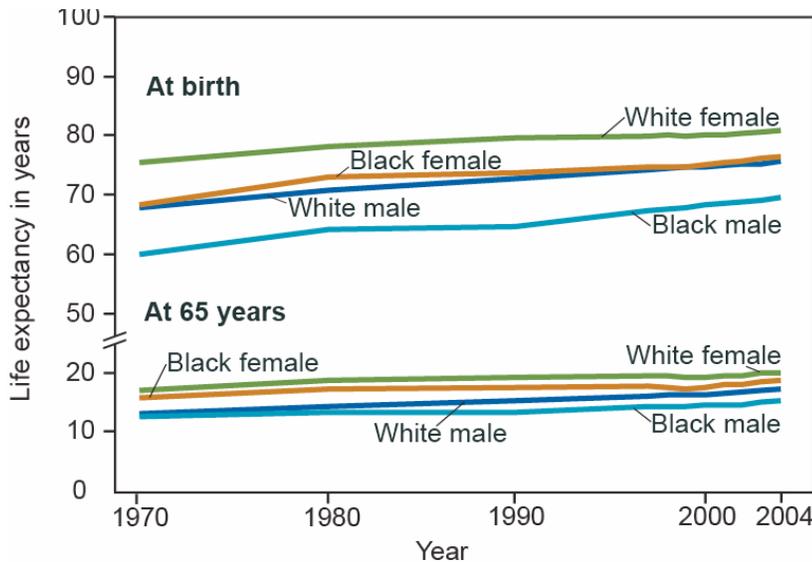
People Living Longer

The total population growth combined with the rapid growth in the older population and the old-old population all conspire to drive up healthcare costs. Another way to look at the demographic imperatives is through life expectancy, or the expected years of life remaining at any particular age or for any particular group of people. The estimates of life expectancy are statistical or actuarial measures taken from Social Security databases for the entire population, so they are thought to be accurate. Yet they are based on past experience and could change as time goes on.

Trends in Life Expectancy

Exhibit 13 shows current estimates of life expectancy at birth and at age 65 in the U.S. by sex and race. As the exhibit reveals, all groups are living longer at birth and at age 65. White

Exhibit 13: Lengthening Life Expectancy Will Affect Cost of Healthcare, 1970-2004



SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2007*, Figure 18. Data from the National Vital Statistics System.

females over the last nearly 40 years have the highest life expectancy at birth and at age 65. Black males have the lowest life expectancy at birth and at age 65. White males and black females have a similar (and rising) life expectancy at birth, but when they reach age 65, a white male has a shorter life expectancy than a black female.

These differences are called disparities in life expectancy, and they persist over many years. Government policy at all levels aims to reduce or eliminate them (Secretary of DHHS, 2001). One of the major determinants of overall life expectancy is the difference in infant mortality, which is why one of the most effective ways to reduce disparities is to equalize and improve prenatal care and increase the odds of a normal delivery. Another important determinant of disparities is exposure to accidents, such as workplace or automobile accidents. Better workplace and driving safety are the second-best way to increase life expectancy.

Knowing What Works without Knowing How to Make It Work

Healthy People 2010 is a scientifically-based program of national health objectives designed to recognize the most significant and preventable threats to health and to reach national goals to reduce them. All DHHS agencies are charged with helping to reach the Healthy People 2010 goals. Since the enactment of the Disease Prevention and Health Promotion Act of 1978, the federal government has spent 30 years and millions of dollars to prevent disease through screening and treatment programs and promotional programs that encourage healthy behavior and lifestyle.

We know that good diet, effective exercise, not smoking all have favorable effects on health, and they reduce disparities in life expectancy and prolong life. Yet despite years of research and public health programs, we do not know as much about what compels people to adopt healthy behaviors. No one has evaluated the total cost effectiveness of all the disease prevention and health promotion efforts, and there is little evidence that their use has significantly reduced disparities, except in targeted cases. We need to understand what works and then redouble efforts to integrate programs and processes into our system. That, of course, will increase costs.

Reducing disparities in the use of health services or the services that are prescribed should have an impact on disparities in life expectancy. Whether they are enough to reduce or eliminate life expectancy disparities remains to be seen, but we need to try. While these efforts will cost money in the short run, they should lower costs in the long run.

Demanding the Most Care at Older Ages

Chronic disease is a major driver of health costs. Embedded among the population with chronic disease is one particular group that requires costly, long-term care: the frail elderly. These people are typically 65 years or older who need assistance in several activities of daily living. They are at high risk of needing nursing home care. Activities of daily living include bathing, dressing, grooming, eating, transferring, and toileting.

Frail Elderly Cost the Most

The definition of frail elderly continues to evolve, given the more than ten-year decline in the use of nursing home care. This decline has occurred, in part, because states pay for most nursing home care through the Medicaid program for people who have spent their assets. States have been assertive in trying to develop alternatives to costly nursing home care. Most alternatives have focused on services that help people stay at home or age in place, such as home healthcare or adult day services. Despite these efforts, the frail elderly are the most costly and vulnerable group with expensive healthcare needs.

Available data from Medicare highlights the issue the healthcare system must face in the future as millions of additional frail elderly wind up on Medicare and, becoming poor, qualify for Medicaid. Exhibit 14 shows three categories of beneficiaries according to frailty and their components of care.

Exhibit 14: Percent Distribution of Medicare Beneficiaries Using Medicare Services, 1995

Type of Service	Beneficiaries in Traditional Medicare	Frail Beneficiaries in the Community	Frail Beneficiaries in Nursing Home
Durable Medical Equipment	18.0	53.0	33.1
Home Health Agency	9.5	50.0	8.9
Rehabilitation Facility	0.9	5.0	0.5
Inpatient Hospital	18.4	43.1	33.8
Outpatient Hospital	62.5	72.3	85.3
Physician	92.8	97.1	99.5
Skilled Nursing Facility	2.9	9.6	16.4

Source: Medicare Payment Advisory Commission, 1999.

Most beneficiaries see a physician during the year, and a large percentage goes on to receive outpatient hospital services. Although the frail elderly are more likely to have these two services than all other beneficiaries, the pattern is close. But for durable medical equipment, home healthcare, rehabilitation, hospital, and skilled nursing care, the percentages are markedly different. Frail beneficiaries are two to three times more likely to use durable medical equipment. The frail elderly in the community use five times the home health services, experience twice the average rate of hospitalization, and consume a multiplier of three to five times the average rate of skilled nursing home use.

If the average cost of a year in a nursing home is \$55,000 to \$80,000, depending on geographic location, the combined cost of long-term care, physician services, and hospital stays cost approaches between \$120,000 and \$140,000 annually. Unless new technologies are developed to address the needs of the frail beneficiary, the shift toward supportive services will drive up healthcare costs at a remarkable pace.

Reason 4: Money Spent for Poorly Understood Services

The fourth reason that costs are rising is because we really do not understand what we pay for when we buy healthcare. This section explains that point, beginning with a short discussion of the way the federal government views healthcare in terms of personal consumption expenditures.

Other Goods Are Easy – Healthcare is Not So Easy

The Bureau of Labor Statistics has 26 categories of items of personal consumption expenditures. These include durable goods such as furniture, nondurable goods such as food and beverages, and services such as housing. Because we spend money on these items, they have value in exchange, meaning they can be obtained by paying a price in a free

market. They also have value in use because we are willing to give up something else in order to include that item among our personal expenditures.

The category that does not neatly fit this concept of value is medical services, and for this reason we do not understand what our money buys when we purchase healthcare. We all come into this world and move through life with a stock of health. Because of our genetic makeup or what happens to us in life, but definitely over time, that stock of health declines and then we die. We purchase health services as part of personal consumption expenditures for a couple primary reasons. We think our purchase will help return our stock of health to previous levels when we are sick, or it will help us cope with disease (dis – ease, or the lack of ease) when we have a chronic condition, experience pain, or express anxiety because of a medical condition.

Not Direct but Derived Satisfaction

Healthcare is rarely valued or desired simply because of the satisfaction we might get from using it. In a sense, we do not value healthcare at all. Except for the rare hypochondriac or older adult with nothing else to do, who would want to go to the hospital for surgery or visit the physician to have a needle stuck in their arm for blood tests? Almost no one views healthcare the same way they might view furniture, food and beverages, and housing. We almost force ourselves to include healthcare in our household budget in the form of health insurance premiums and out-of-pocket costs because we know acute or chronic disease will occur at some point. We spend money on healthcare in an effort to return to good health or cope with chronic disease, not because it offers something that might be fun.

Not Open but Personal Service

Healthcare is very personal, too. You can send another family member or a friend to purchase furniture, food and beverages, and housing for you, but you cannot send someone else to see the doctor or visit the hospital for you. Consequently, the value of care is very personal and not easily measured. Nearly all the other items the Bureau of Labor Statistics measures as personal consumption expenditures are easy to measure, whether in terms of their features and quality or their price.

Not Favorable but Unfavorable Viewpoint

Furthermore, it is universally viewed as good for the economy when 25 of the items listed as consumption expenditures are sold in the market and take up a larger share of our household budget. The exact opposite is true for healthcare. Nearly everyone can agree – even most physicians, nurses and hospital administrators – that when we spend more of our household budget on healthcare, the effect on our economic wellbeing is unfavorable.

Not Individual but Collective Social Issues

These nearly unique features of healthcare shape our willingness to pay for healthcare versus all other goods. There are also distributional dimensions to this feature of healthcare because the choices society makes about how much healthcare to provide and who pays for it depend on how each one of us values it for ourselves and for others.

Ultimately, allocative efficiency is the goal of any economy, which simply means the economy supplies what people want. Since almost no one inherently wants healthcare the

way we do all other goods and services, it is the ultimate personal service, and the fairness of distributional issues abound. We have a great deal of difficulty understanding what our money buys and how to value it for healthcare. These factors may also explain why it is so difficult to collect data, define useful measures, and broadly report the value of healthcare. For furniture, food and beverage, housing, and almost every other consumption good, it is relatively easy to know more is better, and it carries a higher value. Healthcare is different, and it is this difference that explains, in part, what drives costs higher. We do not understand what part of healthcare costs should be eliminated to increase the value.

Inefficiency, Fraud, Waste, and Abuse

Compounding our lack of understanding of what we pay for in the healthcare sector is the loss that comes from inefficiency, fraud, waste and abuse. Stolen or borrowed social security numbers are used at a clinic to submit false claims for services not provided; mills turn out thousands of look-alike pills to be sold on the street and resold to pharmacies; wheelchair suppliers and home health agencies file millions of dollars in claims when nothing was actually delivered or done. These are all examples of healthcare fraud and abuse. It is no wonder the public is suspicious of public and private payers and their ability to prevent, detect, and enforce corrupt activities.

Fraud Recoveries Only Scratch the Surface

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) promised to do something about fraud and abuse for public and private insurers. A new office in the DHHS Office of the Inspector General cost \$160 million per year to operate and has returned approximately \$11.2 billion to the Medicare Trust Fund. The new office and the Justice Department have had more than 5,000 criminal convictions for healthcare fraud. For every dollar spent enforcing laws on healthcare fraud, the system recovers \$4.50 of funds

The Centers for Medicare and Medicaid Services estimates that more than \$100 billion is lost annually due to fraud against public and private payers. That would be approximately 5 percent of all healthcare spending and probably represents the level of fraud in private insurance companies. Another CMS study (Becker 2005) puts fraud in the largest government program, Medicare, at between 7 and 14 percent. Medicaid, with each of the states operating its own program, is thought to have even higher levels of fraud and abuse.

Despite the billions recovered since HIPAA was enacted and the thousands of perpetrators who have been convicted, the best estimate is that only 5 percent of fraud is stopped. The pace of electronic billing both helps and hurts the fraud effort. Electronic claims can be audited before they are paid and examined easily for obvious indicators of fraud. But once perpetrators find vulnerability, electronic claims enable them to easily replicate the false claims and obtain even more funds. No one knows whether fraud is increasing or decreasing.

Abuse Could Be the Greater Portion

Abuse refers to care given inappropriately or not in accordance with medical treatment guidelines. One study, for example, looked at 439 indicators of quality of care for 30 acute and chronic conditions, as well as preventive care. Investigators found that 11.3 percent of adult patients received care that was not recommended and was potentially harmful. The

study focused on 12 cities in the U.S. that represent the typical mix of payers in both fee-for-service programs (with the strong financial incentives to overuse) and managed care programs (with the strong incentives and procedures to restrain overuse).

Healthcare service use is known to vary across geographic areas, almost without reasonable explanation. It is likely that abusive overuse also varies across the country. But an implied level of abuse that exceeds 11 percent means that over \$200 billion of healthcare spending is abuse. Combined with the estimate of fraud, over \$300 billion or 15 percent of total health spending could be lost to fraud and abuse. This problem serves as one of the major drivers of healthcare costs.

Many Providers Reimbursed Generously

An emerging trend that does not bode well for healthcare costs is the declining number of medical students choosing to enter primary care specialties. Primary care physicians are an important cost-conscious factor in the health system. Not only are they the first-contact physician, but they also can serve as the medical home for coordinating all specialist care. In addition, they are generalists. Specialists, who tend to see conditions in terms of their own specialty, believe that higher volume in that specialty is good for everyone.

Recent figures from the American Academy of Family Practice show that training in family practice dropped by 50 percent between 1997 and 2005. Most general internal medicine trainees are deciding to go on to subspecialty practices or to become hospitalists who specialize in inpatient care with better hours and backup.

The ability to have a predictable lifestyle, interesting patients, and a pride in specific expertise in a complex medical specialty account in part for the interest in becoming a specialist. However, marked differences in physician income by specialty more readily explain the drop in primary care specialist physician trainees in the U.S. Exhibit 15 shows the remarkable differences in physician income in 2006 dollars. Radiologists receive the highest income after practice expenses but before taxes. The lowest, by a factor of 2.25, is pediatrics. General practice/family practice (GP/FP) is not very far ahead. The average physician made \$233,041, and all the primary care specialties were below the average: internal medicine, GP/FP, and pediatrics. Primary care makes up around 40 percent of all physicians. If the demand for physician services continues to increase and the supply of primary care physicians remains the same or increases as little as 2 percent (as projected), the foundation of the health system will be threatened. A bias toward more specialist physicians will certainly not help stem the growing volume and intensity of costly services if the system continues to have a major fee-for-service component.

Exhibit 15: Physician Income by Specialty

Specialist	Income in 2006 Dollars
All Professions	\$62,138
All Physicians	233,041
Radiology	351,284

Anesthesiology	277,206
Surgery	311,189
OB/GYN	257,099
Pathology	279,248
Internal Medicine	222,069
Psychiatry	165,053
GP/FP	163,924
Pediatrics	156,116
All Other	236,708

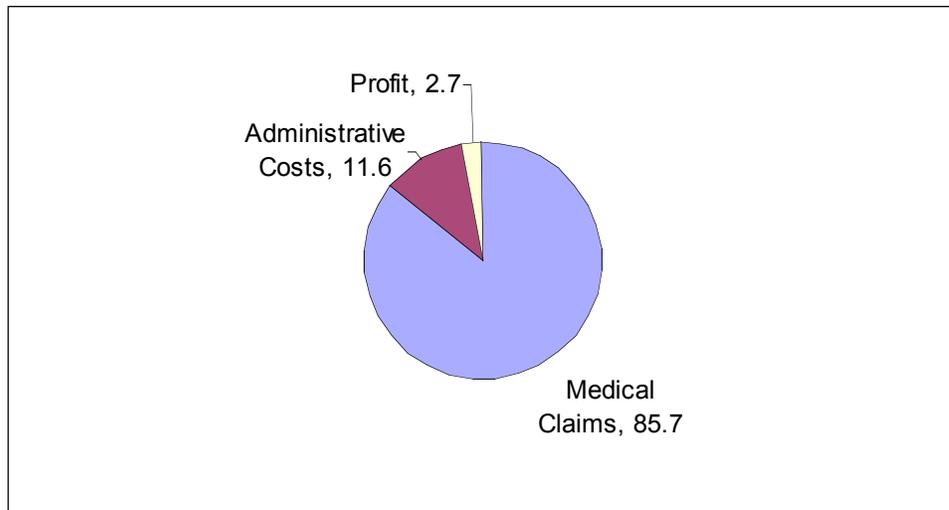
Source: Scheffler 2008.

Administrative Costs Including Medical Malpractice

With a predominantly fee-for-service healthcare system, hundreds of millions of claims are filed by providers of services to public and private payers. The payers also bear the administrative cost of organizing, explaining, and marketing health insurance coverage, as well as defining and managing provider networks. They are also responsible for managing finances and underwriting, along with information technology. All administrative functions of health insurance cost money and drive healthcare spending.

A 2003 study found that the administrative costs of health insurers were nearly 12 percent of premiums as Exhibit 16 shows. Administrative costs for Blue Cross and Blue Shield plans were somewhat lower than commercial insurers (Milliman 2003). The average share of health insurance premiums paid out for health services was approximately 86 percent, and average profits were 2.7 percent of premiums.

Exhibit 16: U.S. Health Insurance Industry Average Premium Dollar, 2001



Not included in these expenses are a variety of other costs: managing health benefits (for employers), staffing for hospital and nursing home administration, operating offices for physicians and clinicians, and administering home care (Woolhandler 2003). No doubt, skillfully managing all these administrative costs would produce efficiencies and these, in turn, would have a positive impact on healthcare costs. But unless the employer-based health insurance system in the U.S. is replaced, it would be difficult to change the costs employers incur when managing health benefits. The other provider-related costs could be modified by health information technology, but how these modifications would affect the system is unclear.

The cost of medical malpractice insurance also drives overall healthcare spending. The link between this expense and overall healthcare costs or the cost of employment-based health insurance premiums is not apparent from the studies that have been done. There are two parts to the relationship between overall healthcare costs and medical malpractice insurance. The first is the direct effect that high medical practice insurance costs have on physicians and hospitals and whether these costs get reflected in the prices for health services. The second is the indirect effect of so-called defensive medicine in which physicians in training are taught to practice in a way that overuses services just in case a medical malpractice claim could be lurking. Once learned in training, physicians hold onto these defensive medicine tendencies throughout their careers.

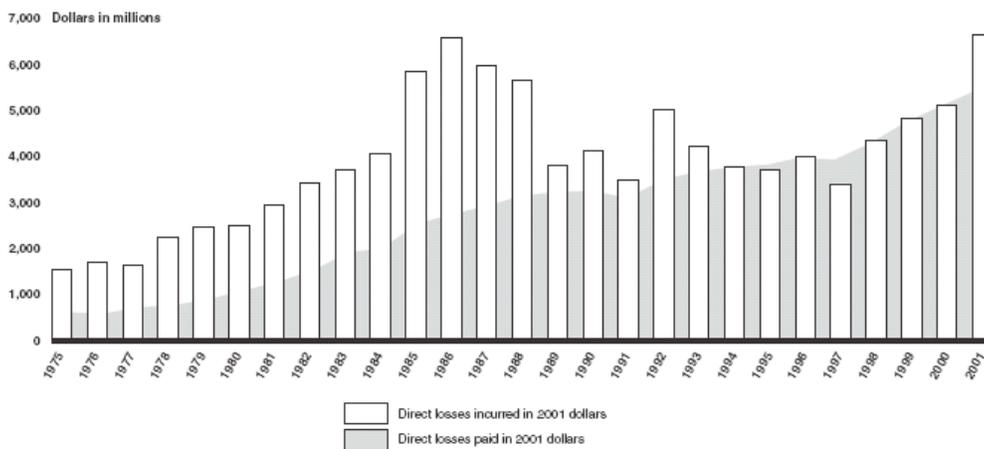
One detailed study of medical malpractice cases specifically examined whether the fear of being sued without cause were true (Studdert et al. 2006). This issue is crucial. If frivolous lawsuits are the norm, the rationale physicians use to explain the costly practice of defensive medicine is clear. The authors had a panel of physician reviewers conduct standardized medical record checks of nearly 1,500 closed malpractice claims from five medical malpractice insurers to determine whether a medical injury had actually happened and if it was linked to medical error. They analyzed the prevalence, characteristics, litigation outcomes, and costs of claims that lacked evidence of error. There were no verifiable medical injuries for 3 percent of the claims, and 37 percent did not involve errors. Thus, it would appear there is some rationale for practicing defensively. The twist to the study was that these apparently unwarranted claims were the ones to have the lowest settlement costs or awards. Nevertheless, administrative costs for paying attorneys, experts and courts constituted a remarkable 54 percent of compensation to those injured. This is a remarkable dead weight loss on the healthcare system that has an unknown impact on quality or trends in quality.

What is more clear is that premiums for medical malpractice insurance are cyclical and linked to the returns that the medical malpractice insurance companies earn domestically and overseas. Important segments of the medical malpractice market are covered by overseas financial institutions, and what is happening around the world in financial markets has clear impact on medical malpractice premiums.

Exhibit 17 shows the last two recent cycles of losses – one in the mid 1980s and the other between 2001 and 2003. Both include payments to plaintiffs to resolve claims and the costs associated with defending claims. Two measures of malpractice insurance costs are depicted. The first shows direct losses incurred, which means the losses that must eventually be paid now or in the future. The second is losses paid, which means actual dollar paid in the year

shown. When these cycles come around, the affected states pass reforms make changes to how these conflicts are resolved legally. Some of the changes include limiting damage awards, modifying rules regarding pretrial expert certification, limiting attorney contingency fees, changing joint and several liability, shortening periods of statute of limitations, and stiffening penalties on bad faith claims. If history is any guide, medical malpractice insurance cycles have not gone away. The murky effects they have on overall healthcare costs do not match their likely minimal impact on quality of care.

Exhibit 17: Inflation-Adjusted Paid and Incurred Losses for the National Malpractice Insurance Market, 1975 - 2001 (2001 Dollars)



Source: GAO analysis of A.M. Best data.

Summary

Healthcare spending, unlike almost any other segment of the economy, gets criticized when it increases primarily because we do not understand the true value of what we are buying.

Money for More Technology Innovation

- Healthcare appears to be largely immune from the market forces dubbed “creative destruction” by economist Schumpeter.
- In a largely fee-for-service healthcare system, there is relentless pressure to increase the volume and intensity of services offered.
- Managed care organizations are able to place some limits on a provider’s ability to freely prescribe treatment.
- Employers have been in the vanguard for years, encouraging managed care techniques and demanding accountability in healthcare.

Money for More Effective Treatments

- Providers are inclined to spend more on technological innovation, and studies of four major conditions (heart attacks, low-birth weight infants, depression, and cataracts) suggest that the added benefits of care exceed the added cost.
- Increased spending on an array of new treatments for heart disease appears to have had a significant impact on age-adjusted mortality trends.
- Increased spending on an array of new treatments for cancer, and breast cancer specifically, appears to have had less than dramatic effects on age-adjusted mortality.
- Importantly, chronic diseases are becoming more prevalent, accounting for half the increase in healthcare spending in the U.S. in recent years.

Money for More Care at Older Ages

- Older adults are the most frequent users of healthcare, and the services they use are costly.
- Medicare secondary payers shift the burden of paying for healthcare costs to private employers with healthcare retirement benefits.
- Medicare accounts for three percent of spending in the entire economy, thereby playing a major role in demand for health services.
- The number of people who are 65 years or older is approaching 40 million today and will rise to 71 million in 20 years.
- All groups categorized by racial/ethnic background, sex, and age are living longer at birth and at age 65.
- The frail elderly with significant chronic diseases, including Alzheimer’s Disease and related dementia, are the most costly and rapidly growing group.

Money Spent Yet Poorly Understood

- Healthcare is different from all other personal consumption expenditures because it is not valued for its own sake, is a very personal service, and has distributional aspects, prompting the need to involve public policy in finding solutions.
- Inefficiency, fraud, waste, and abuse consume a major portion of healthcare costs, and we lack effective tools to arrest future growth, especially in public programs.

- Many providers, particularly specialist physicians, have some of the highest incomes in our society and the disparity between specialists and generalists is causing a flight from primary care.
- Administrative costs, including medical malpractice, are a significant source of higher healthcare costs.

THE SOLUTION: GOVERNMENT POLICIES AND INCENTIVES MUST GUIDE SUPPLY AND DEMAND

The primary point thus far is that in the years most people today have been alive, healthcare has taken a larger share of the economy year after year, and this trend is projected to continue for quite some time. The main reason for this problem is that we do not get our money’s worth for all that we spend on healthcare. As they aim to tackle this problem, policymakers must focus on developing real solutions.

Over time, the U.S. spends more for technology innovation. We spend more for effective treatments. We spend more for healthcare at older ages. We do not understand what we pay for because healthcare is delivered so inefficiently. Fraud, waste, and abuse are enormous. Payments to some healthcare providers are overly generous. And administrative costs, including medical malpractice, are too high. Public policies must be enacted to address each of these problems.

The following sections of this monograph recommend specific public policy solutions for addressing the reasons behind rising healthcare costs. These solutions require immediate and fearless changes in policy at several levels, particularly in the areas of government-induced incentives, how care is delivered, the actions of individuals, and the demand for and supply of health services.

Policies to Change Government-Induced Incentives

This section covers the kinds of policy changes government can achieve easily in an effort to address the very perverse incentives to use healthcare that government creates in the first place. For one thing, federal policy makers should transform Medicare and Medicaid from their 1970s features to modern programs for managing medical costs. In addition, medical malpractice insurance should be modified to lower costs and do more good. The market for primary care providers should be made more competitive to increase the supply and lower prices. And young, healthy people who can afford insurance should be prodded to purchase it through changes in federal regulations

Utterly Transform Medicaid

Any serious effort to address rising healthcare costs must start with Medicaid. As discussed above, more people have Medicaid than any other health coverage. This program drives up costs because it cannot seem to provide people with adequate access to care. Instead, people flood emergency rooms. In addition, Medicaid is the primary culprit of cost shifting. The rate of growth in Medicaid costs is much higher than other programs.

Medicaid is financed by the federal government at the level of nearly one-quarter trillion dollars (\$250 billion) plus a matching share from the states at nearly \$200 billion. This kind of fiscal federalism is actually one of the strengths of the program, although the formula for financing should be significantly modified, as described below.

Medicaid is actually a variety of programs wrapped into one. Medicaid offers healthcare coverage for all categories of people, including pregnant women, low-income children, poor parents, and the physically and mentally disabled. No two states are alike in the eligibility

determination – a source of significant geopolitical unrest whenever healthcare reform discussions are launched at the federal level. Medicaid covers some people for some services such as mental healthcare and others for other services such as long-term care. The program is also a source of direct financing to many hospitals that treat large numbers of patients without insurance.

Exhibit 18 summarizes the real transformation that Medicaid needs, and it begins with a change in one key concept: the definition of eligibility (Etheredge and Moore 2003). Medicaid is means tested and an entitlement, which denotes that those without the means to pay for health coverage are free to obtain Medicaid coverage.

Exhibit 18: Policies to Change Medicaid

	Old Medicaid	New Medicaid
Key concept	Arcane categories define and limit eligibility differently in each state for a state-run program	National financial needs-based eligibility for subsidy for health coverage
Federal-state roles	Federal minimum eligibility for mothers and children; most aged, blind, and disabled, but not for others; state options to exceed federal minimum	Federal minimum eligibility tied to poverty level for all
Children and Pregnant Women	Children up to age 6 and pregnant women at 133 percent of poverty; older children at 100 percent of poverty	No change
Adult singles and couples (no children)	Not eligible	Eligible to 100 percent of poverty
Adults in families (with children)	State option, national average below 45 percent of poverty	Eligible to 100 percent of poverty
Aged, blind, disabled	SSS (75 percent of poverty in most states)	100 percent of poverty
Spend-down eligibility	State option	National, income related
Asset tests	Required, state option	None, except for long-term care
Buy-ins, high risk pools, reinsurance	Limited buy-in options for cost effective employer plans, no provisions for high-risk pools and reinsurance	Federal financing for all to cover cost of Medicaid eligible
Immigrants	Post 1996 immigrants excluded for 5 years	Legal immigrants covered like anyone else
Financing	Federal matching formula based on state per capita income and state spending	No change except 5 percent hold back across the board to fund incentive rewards to states based on performance toward reducing Medicaid costs, improving quality, and initiatives to cover the uninsured
Financing sources	General revenues	No change

Source: Adapted from Etheredge and Moore (2003). SSI is Supplemental Security Income. SCHIP is State Children’s Health Insurance Program.

A new Medicaid would be designed to eliminate the variety of programs described above and have one definition of eligibility nationwide. Medicaid coverage should be available to anyone with a need as defined by household income in relation to federal poverty guidelines. With some grandfathered exceptions, the national eligibility standard should be Medicaid coverage at 100 percent of poverty. It does not matter whether or not someone has disabilities or if the patient is a child or an adult or a legal immigrant (illegal immigrants would continue to be excluded). It does not even matter what services someone needs. Everyone at or below 100 of the federal poverty level and showing appropriate documentation for legal residence should get Medicaid coverage for six months, and they must renew that coverage every six months.

The new Medicaid coverage would be managed through a state-run program. Eligible persons would receive either traditional Medicaid fee-for-service, as about 30 percent of eligibles do today, or they would be enrolled in a Medicaid managed care organization, as about 70 percent of eligibles do today. Conceptually, this approach represents a shift away from a patchwork of state-specific eligibility rules with arcane requirements concerning income, assets, disability, or type of illness. This approach also moves the program toward coverage based on one standard: an individual's need in terms of the federal poverty level. Such a change would need to be phased in to allow the states time to adjust. But those who might lose coverage could be grandfathered in states with generous Medicaid eligibility. There is another major benefit to this simplified concept of nationwide eligibility. This approach enables providers to experiment with and develop Medicaid buy-in and buy-out programs that will use Medicaid financing to leverage other partners like employers and the individuals themselves to obtain coverage.

A Medicaid buy-in program is an arrangement that allows the state to receive a monthly payment from someone not on Medicaid who wants to receive coverage for some or all of Medicaid services. A Medicaid buy-out program is a voucher, defined contribution, or premium support that the state can use to make a monthly payment on behalf of someone not on Medicaid who would like to receive coverage through private insurance. Both the buy-in and buy-out programs are normally for people above the poverty level. These individuals either have the resources to make the buy-in payment, or they have the resources and access to private coverage that enables them to receive the buy-out payments. Maintenance of effort in retaining insurance on the part of employees and employers are a concern about Medicaid buy-out programs.

Under this new Medicaid program, the federal and state roles are amended, but they do not change fundamentally. The current federal minimum requirements regarding eligibility are replaced with one national, simplified standard tied to the federal poverty line. Ideally, the traditional Medicaid program should be combined with the SCHIP program, and all of it should be converted to a block grant to states. A block grant is a lump sum of money determined in advance through a formula. Federal requirements regarding covered benefits and provider payment rates could be preserved or eliminated. The current baseline level of spending could serve as the initial block grant, but over time differences in changes of cost of living should be incorporated. The obvious benefit of a block grant for the federal government is that it provides complete budget predictability and a simple lever for controlling future spending. States would need to know how they would benefit in return, the level of the grant the first year, and which factors would be used to increase/decrease the grant over time.

A block grant for a combined Medicaid SCHIP program would definitely change state conduct. Under current law, states receive an unlimited federal match for any increase in provider payments they unilaterally decide to make. They also receive a match for any costly inefficiencies that may emerge, and they are covered for most changes in eligibility or services offered. There is zero benchmarking of standard performance measures, no reward for having a better performing Medicaid program, and no penalty for having a worse performing Medicaid program. It is exactly like two friends going to a restaurant and deciding to split the check. One person orders the most expensive item on the menu, gets

two desserts, and sends a bottle of wine to a friend at another table, while the other eats a light dinner. At the end of the night, the two friends split the check evenly.

With a new concept of eligibility, Medicaid would have to address old categories of eligibility. There would be no change in the way the program currently covers all children and pregnant women at 133 percent of poverty. Many states provide coverage above this poverty level, and they would be grandfathered in. Single adults and couples with no children are not eligible today, but they would be eligible up to 100 percent of poverty. Adults in families with children would be eligible to 100 percent of poverty. The aged, blind, and disabled would also be covered up to 100 percent of poverty.

Medicaid has a unique eligibility feature called “spend down.” On the surface, this concept seems simple. People with assets and income that exceed the cut off for eligibility must spend down those assets and eligibility in order to qualify. But the feature is really more complicated because the state will look back five years, according to federal rules, to see if any of assets or income were gifted to others in order to reach the poverty level to qualify for Medicaid. For years, people have not spent down. Instead, they have given away their assets to family or friends and gone on Medicaid. Now all states are expected to recoup those gifts to pay for care for up to five years. Those provisions would stay in place but only for long-term care in a nursing facility. In other words, there would be no examination of assets except for someone going on Medicaid to receive nursing home services. Otherwise, only income would be counted for eligibility.

Medicaid coverage today is inflexible in that it does not work well with employer-based or other private coverage. The reason is that the Medicaid recipient is entitled to coverage and all the services included in that coverage. This feature does not make it easy for states to redeploy the actuarial value of Medicaid coverage and, for example, help a working Medicaid recipient purchase coverage with their employer. The employer-based benefits do not normally match the Medicaid covered services, and federal rules would not allow any variation across the state for the services available to someone who qualifies for Medicaid. The state can seek a waiver under current law of federal provisions, and many states have, but progress has been slow.

Federal financing should be little changed from the current system of variable funding based upon state per capita income and state spending. States with high per capita income receive the current minimum federal cost sharing of 50 percent of the cost of a state’s program paid by the federal government. States with lower per capita income receive a sliding scale of as much as 80 percent of the cost of a state’s program paid by the federal government.

One other major change under a new Medicaid program would be to establish a Pay-for-Performance (P4P) Fund equal to 5 percent of total federal Medicaid funding. The P4P fund would be used to pay for incentive rewards to states based upon performance measures toward reducing Medicaid costs and improving quality. They would pay rewards based on a state’s effort to cover the uninsured.

Create a New Medicare

Medicare is not organized well for cost containment, and it emphasizes acute care over health promotion and disease prevention for a population faced with primarily chronic disease. As stated earlier, Medicare covers principally hospital services, physician services, and drugs. It suffers from unrelenting shortfalls in funding, especially for physician services, which force the U.S. Congress to reduce payment levels. These reduced payment levels lead to cost shifting and waning participation by providers in the program.

Medicare should restructure its benefits in an effort to curb rising costs, as well as the program's impact on the rest of the healthcare sector. Instead of offering three broad categories of coverage organized by type of service, Medicare could offer four broad categories of coverage organized by purpose as Exhibit 19 illustrates.

Exhibit 19: Policies to Change Medicare

	Old Medicare	New Medicare
Key concept	Illogically divided categories of service benefits with little attention to chronic care	Common deductibles, coinsurance and maximum with explicit recognition of experimental and lifestyle care
Federal-state roles	Federal Medicare coverage for hospital, physician and drugs; state Medicaid coverage for nursing home facility (low income only)	Federal Medicare covers nursing home facility for all Medicare beneficiaries
Part A	Separate inpatient hospital and skilled nursing facility deductibles, per day coinsurance after minimum days and no maximum	Replace Part A with Medically Necessary Care with common deductible, 20 percent coinsurance and maximum for: Inpatient hospital Home healthcare Physician and other medical services Outpatient hospital care Ambulatory surgical services X-rays, durable medical equipment Physical, speech, and occupational therapy Clinical diagnostics laboratory services Outpatient mental health services Bone mass measurement and diabetes monitoring Medically necessary prescription drugs
Part B	Separate physician and other medical services, outpatient hospital care, ambulatory surgical services, x-rays, durable medical equipment, physical, speech and occupational therapy, clinical diagnostic laboratory services, home healthcare, outpatient mental health services preventive services, bone mass	Replace Part B with Long-term Care with common deductible, co-pay and maximum for: Skilled nursing facility Home healthcare Hospice Program for all-inclusive Care for the Elderly (PACE)

	measurement and diabetes monitoring	
Part D	Medically necessary prescription drugs	Replace Part D by incorporating medically necessary prescription drugs in Medically Necessary Care
Experimental Care	Medicare option based upon local medical director decisions and eventual review by the The Medicare Evidence Development & Coverage Advisory Committee (MEDCAC)	Add coverage for Experimental Care with 50 percent coinsurance with sponsors and patients for: Schedule C cancer drugs New cell and gene therapies Other experimental procedures
Lifestyle Care	Not covered except at option of Medicare Advantage Plans	Add coverage for Lifestyle Care with 20 percent coinsurance and rebate for: Preventive services Lifestyle drugs (e.g. Botox)
Financing	Part A from Medicare wage tax to Medicare Part A Trust Fund, Part B from beneficiary premium and general revenues, Part D from general revenues	Medically Necessary Care from wage tax to Medicare Part A Trust Fund, beneficiary premium and general revenues; Long-Term Care, Experimental Care and Lifestyle Care from general revenues
Medical Management	Standardized and minimal	All beneficiaries enrolled in Medicare Advantage plans by 2019
Fraud and Abuse	Healthcare Fraud and Abuse Program	

In the first new category, the traditional Part A and part B of Medicare established nearly 40 years ago should be combined, and only medically necessary services should be covered: inpatient hospital services and physician services along with uniform cost-sharing provisions. For example, the program could manage payment for services with a common deductible and 20 percent coinsurance that includes an annual maximum, rather than a lifetime maximum based on hospital days. Medically necessary prescription drugs could fall within this category as long as they are part of a program that manages drug interactions and adheres to the treatment regimen.

In the second category, skilled nursing facility care and hospice would be placed under a new coverage called long-term care. Some forms of cost-effective home and community-based health services, including professional all-inclusive care for the elderly (PACE), also would be captured under this coverage. Again, different cost-sharing provisions would apply, but these would have a common deductible and coinsurance where appropriate.

Medicare suffers from a 1970s model of traditional major medical insurance coverage. This means that the program generously covers acute medical services to the exclusion of preventive and lifestyle drugs and services. The new Part D coverage for prescribed medicines opens up the program to more treatments that help prevent or control chronic disease, rather than merely covering the results of years of neglect and the associated expensive acute services. Experimental and lifestyle coverage under this proposal would make up the new categories. Experimental coverage would pay for promising new treatments in approved clinical trials on a cost-sharing basis. Medicare would pay 50 percent of the cost with the sponsors of the trial or the patients paying the other 50 percent. The trials would require Food and Drug Administration approval and meet new rigorous standards for producing scientific findings regarding quality of life and cost effectiveness. This arrangement would avoid a costly new bureaucracy that would conduct lengthy, possibly inconclusive studies at government expense, to gauge the comparative effectiveness of alternative medical treatments.

The final category should emphasize the important role behavior plays in achieving good health and maintaining low health costs, and it can do this by helping pay for lifestyle services and drugs such as assistance for weight loss, smoking cessation, and other types of conditions. The cost sharing should be 20 percent Medicare and 80 percent beneficiary responsibility, which highlight the need for patient responsibility when it comes to self-care. Beneficiaries achieving pre-established preventive care guidelines should receive an annual rebate on their out-of-pocket costs for preventive services. This category is likely to include relatively inexpensive services for largely already lower-cost beneficiaries to keep them healthy. They could include exercise programs, effective weight-loss programs, and other interventions that affect lifestyle and ultimately the course of health while aging. An alternative would be to heavily subsidize such lifestyle care as part of a so-called value-based approach to benefit design. In this scenario, cost effective preventive interventions are strongly encouraged through generous benefits (Chernew 2004).

Finally, the financing of the program will require additional general revenues to absorb the long-term care from the state Medicaid programs. The taxes for Medicare this year will no longer cover the payments from the Medicare Trust Funds. By 2019, the Medicare Trust Funds will be depleted. Something must be done to interject more medical management into fee-for-service Medicare. Managed care organizations have successfully served the Medicare population for 25 years. Enrollment in Medicare managed care is approaching 30 percent. The U.S. Congress should make it a goal to have all Medicare beneficiaries enrolled in Medicare managed care organizations by 2019. It will take some work to encourage the development of managed care plan options in rural areas, but this can be accomplished and should be in order to stem the rise in Medicare expenditures.

Reform Medical Malpractice Insurance

The problems discussed previously about the rising cost of medical malpractice insurance tell us that the current government rules need to be scrapped. The current structure encourages defensive medicine through unnecessary tests and procedures. The majority of the medical malpractice premium goes toward attorney fees, expert witnesses, and court costs, and dramatic cost increases run in crisis cycles and threaten to disrupt access to care. There are three public policy changes needed to help address the negative impact medical malpractice has on costs: create healthcare courts, cap malpractice awards, and require arbitration.

Create Healthcare Courts. One of the reasons more than half the cost of medical malpractice awards goes to attorneys, expert witnesses, court costs, and the significant number of frivolous lawsuits is the fact that these suits are taken to regular courts for a typical tort trial. The last time the judge heard a medical malpractice case might have been years ago. The jury is likely to bring almost no medical expertise to bear on the case.

Several years ago, some states started drug courts in which specialized and experienced judges, attorneys, criminal justice officers, and mental health professionals dedicated themselves to hearing substance abuse cases. Their purpose was to dispense justice but with attention paid to avoiding recidivism and getting the accused off of drugs. Drug courts, which operate at a lower cost than regular courts, have significantly reduced drug use and crime. Drug court recidivism is between 4% and 29%, compared to 48% traditional courts.

The federal government should enable states to follow this example and establish healthcare courts, given the highly technical nature of medical malpractice. In fact, drug courts could be expanded and converted to healthcare courts in which they would hear cases on drug abuse, mental health detention, and medical malpractice. Rather than medical experts who are flown in from out of state by the plaintiff and the defendant at great expense, the court would empanel a list of objective medical experts from all specialties and rely on their expertise to find the best outcome for the patient.

Attorneys debate whether the federal government or a state can constitutionally replace the current system of common-law tort trials that occur in front of judges and juries. Given the precedent of drug courts in many states and the multi-billion cost of the current medical malpractice system, an alternative such as healthcare courts is worth trying.

Cap Awards at \$500,000. Federal legislation has passed the House, but not the Senate, that would attempt to control the cost of malpractice insurance by placing a cap of \$250,000 on subjective, non-monetary losses such as pain and suffering. There would continue to be no Federal cap on economic losses such as the cost of health services, lost wages, or income. The cap on non-monetary damages should be set higher, at \$500,000, which is closer to the average award nationally. A new federal law should remove the disparity across the country on awards and smooth changes in malpractice premiums that cause a new medical malpractice crisis approximately every seven years. The cap would stabilize the entire market and allow insurers to better predict their losses.

Insurers and medical societies, including the American Medical Association, have promoted such a cap to control losses on medical malpractice claims and curb premium rate increases.

A limit certainly would reduce the number of claims as well as the number of frivolous claims. The reason for so many frivolous claims is that attorneys for the plaintiff are paid a quota share (percent) of the award. Firms that specialize in plaintiff suits start with huge reserves from previous awards in the millions of dollars, which give them the ability to take a chance on winning another enormous award if they can get in front of a jury and appeal to their sensibilities in the case of an injured person. It does not matter if there were a medical error. Non-economic awards are difficult to quantify, and juries have granted enormous sums of money in some cases. Attorneys will be less like to represent injured patients if non-economic damages are limited.

Opponents of federal caps on damages, including trial lawyers and patient advocate groups, argue that lawsuits have minimal or no bearing on the rise in premiums and that several other factors are to blame for the rise. These groups also argue that caps on damages might preclude just compensation to patients injured by medical malpractice. Another issue of contention is the shift of jurisdiction of malpractice from the states to the federal government.

Require Mandatory Arbitration. Another solution to the problem of malpractice costs is mandatory arbitration. Arbitration is a formal, legal process that attempts to settle disputes without going to court. A professional arbitrator with significant experience in disputes listens to both sides, who are usually represented by attorney, and then decides on an award that both parties agree is binding. Arbitration can be mandatory or not, and it can be binding or non-binding.

Florida offers an example of how this works. Florida's last medical malpractice insurance crisis led to new arbitration requirements for medical malpractice cases. Rather than enforcing a blanket cap on non-economic losses, the state limits non-economic damages to \$250,000 when the defendant and plaintiff agree to binding arbitration. The defendant must admit fault. When the plaintiff refuses to arbitrate, the non-economic damages are limited to \$350,000. The 2003 changes have benefited policyholders and the industry by improving the solvency of medical malpractice carriers, and it also directly contributed to lowering the cost of defense (Florida Office of Insurance Regulation 2007).

Mandatory arbitration for medical malpractice claims would require certain protections. The arbitration would need to meet standards of fair arbitration in medical cases. The patient would need be informed of the entire process and understand that there is no court trial. But in the context of a large number of states with non-economic damage caps, mandatory arbitration makes sense because it avoids the greater cost of going to court over a dispute.

Legislation has been proposed in the U.S. Senate to prohibit mandatory arbitration for any dispute, including medical malpractice. Many consumer and attorney groups believe it is important not to circumscribe a person's constitutional right to access the courts in the event of a dispute. They do not oppose voluntary, non-binding arbitration. They oppose mandatory, binding arbitration because it eliminates a final legal option in court.

Deal Directly with Young Immortals

As discussed above, a serious free-rider problem exists in healthcare in that too many relatively young, healthy people forgo the purchase of health insurance because of its costs. This behavior is not entirely irrational. They do so because experience tells them that they are healthy and will not need to see the physician or go to the hospital. Why would they need health insurance? Moreover, their employer is likely to be a small business that struggles with obtaining competitive premiums from managed care organizations. These small businesses also have trouble coping with the complexity of health insurance benefits. And not only is it difficult for them to avoid restrictive state laws that limit national firms from entering the market, these firms are required to offer expensive mandatory benefits that drive up premiums.

Market-Based Pooling. One solution for encouraging young immortals to enroll in a healthcare plan is market-based pooling. A little more than one-half of all private sector workers are employed in small businesses. Because many young immortals work for small business, market-based pooling arrangements sanctioned and encouraged by the federal government should be a tremendous help.

Health insurance is currently regulated by the states, and this should not change. The federal government should pass legislation that would encourage states to adopt regulatory provisions friendly to health insurance companies. In turn, these companies must meet standardized options and submit proposals to an organizing entity that would help create competition in the health insurance market. These proposals would address the issues of coverage and premiums.

One state, Massachusetts, has recently attempted market-based pooling through a new private-sector entity called the Commonwealth Connector. This program is sanctioned by the state to organize health plans in a manner that allows them to offer coverage to people without insurance. The state also has an individual mandate, requiring adults to have health insurance. Consequently, those who do not have access to affordable insurance can go to the Commonwealth Connector and join the market-based pool of people who choose from a variety of plans retained by the state.

The Commonwealth Connector addresses several of the problems faced by small businesses. It helps them overcome the market power of managed care organizations by pooling potential members and negotiating favorable rates, and it takes over the complex problems faced by small employers in administering health insurance. After one year, Commonwealth Connector reduced the number of uninsured working adults by almost half. The percent of persons with no insurance was 13 percent before and 7 percent afterward. In household surveys, working adults reported that they “supported the program” by more than 70 percent before and after the reforms.

The Massachusetts Commonwealth Connector program is an example of market-based pooling organized by the state. There is no reason that business owners could not achieve the same thing on their own, except to do so state by state is daunting. Consequently, the federal government should encourage market-based pooling that allows groups to pool across state lines. This can be achieved either by pre-empting state insurance laws or

providing incentives to state insurance commissioners to adopt model reforms that foster market-based pooling. In any case, the federal government has a role to play in reducing the market power of managed care organizations for small business, simplifying the administration of health benefits, and reducing costs.

Health Savings Accounts. Yet another simplification for small employers and an excellent option for the young immortals is the health savings account (HSA). These plans allow workers and anyone who pays taxes to set aside funds in a separate account held by a bank or other entity without paying wage or income taxes on the funds. Money from this account is then used to pay for healthcare. The funds in the account roll over year to year and are able to earn interest tax free. There are two major requirements. First, the holder of a health savings account must also hold a high-deductible health policy of \$2,900 for an individual and \$5,800 for a family in 2008. That means you must have a health insurance policy that does not pay anything until the high deductible limits are met. Second, you may not have any other coverage.

There are numerous benefits to HSAs that help lower healthcare costs for everyone. Employers may contribute to the health savings account or the high-deductible health insurance on a pre-tax basis, which means neither the employer nor the employee pay the Medicare tax and FICA. Each party then saves 7.65 percent of tax on the amounts contributed. The healthy, like the young immortals, have high-deductible coverage and are no longer left outside the health insurance system. Those with high medical bills have a limit on their out-of-pocket expenses. The premium for a high-deductible health insurance policy is almost always less than traditional insurance. The person with a health savings account is more likely to seek lower prices for healthcare and take a strong interest in cost conscious care, thereby blunting the moral hazard of traditional insurance in which the insured facing no or low prices demands as much as possible in terms of covered services. Finally, HSAs can gather significant sums of money tax-free or tax deferred over a number of years.⁷

The critics of health savings accounts say that they help only those who pay taxes, which is true. People get no exclusions for their payments to a health savings account if they are not paying taxes. Critics also say that they leave healthier, younger people out of the general risk pool and leave older, sicker people to bear the burden of healthcare costs. But the current high-deductible requirements are really quite low. It seems better to have the young immortals in an HSA and at least holding a high-deductible plan than for them to be free riders with no insurance at all.

A first cousin to the HSA is the older health reimbursement account, which has the primary distinction of being funded entirely by an employer. A high-deductible health insurance policy is also required and the funds can be rolled over, but they remain with the employer.

Adopt National Regulations or Standards. Market-based pooling, HSAs and their cousins, and national regulations or standards for opening up insurance markets are all innovative tools that help lower healthcare costs. Innovative policy would either provide

⁷ The rules allow withdrawals for retirement or higher education under certain circumstances.

incentives or subsidize states to establish market-based pooling and provide commissions to brokers to sell policies from the pool. These could be private and voluntary associations of businesses, or they could be state sanctioned and funded as Massachusetts has done. The major policy change required to grow HSAs is to increase the maximum amount that can be contributed in a year. As pointed out above, the average employment-based policy for family coverage is over \$12,800 in 2008. If an individual with an employment-based policy receives a pre-tax remuneration of that amount, why should someone with a health savings account not receive the same? Small business would have more coverage options and lower premiums if there were national regulations or standards that states could adopt to open their markets to large insurers.

Policies to Change How Healthcare Is Delivered

The next subsections discuss the policy changes government can make in order to affect the way healthcare is delivered to patients. Health information technology offers promise for lowering costs by using medical treatment guidelines, performance benchmarking, and improved care management and coordination. But the widespread adoption of health information technology is not a question of computers and telecommunication equipment; it is more about organizational development, and this requires explanation.

The dominant form of medical practice in the U.S. is the medical group, four or more physicians sharing practice expense, income, or both. There are more than 20,000 medical groups in the U.S. with an average of over ten physicians. Approximately 500,000 or almost 60 percent of physicians in 2007 were in groups, and this figure has been growing for more than 20 years. Nearly all physicians in the U.S. are involved with managed care organizations, either receiving payment to serve members or through establishing contractual relationships.

The dominant form of delivery of acute hospital services is the health and hospital system. A hospital system is three or more hospitals sharing expenses, income, or both either through common ownership, board oversight, or contractual agreement. Approximately 2,700, or more than 50 percent of hospitals in 2007, were in hospital systems, and this figure has been growing for more than 15 years. This structure is primarily an urban phenomenon, but many rural hospitals benefit from being part of a hospital system. All hospitals have contracts or alliances with managed care organizations. Some even own their own managed care organizations. Most hospital systems also have physician affiliate organizations such as physician-hospital organization, independent practice association, a management services organization, and physician group practice without walls. These are equally likely to be with generalist and specialist physicians.

Physicians have been flocking for years, frequently on a salary basis, to organized systems of care -- medical groups or health and hospital systems -- because they are likely to provide backup coverage and offer more time off with regular office hours. The added benefit of all this clinical integration among physicians and between physicians and hospitals is that physicians work as a team with other health professionals, and they can better coordinate care for patients. Moreover, medical groups as well as health and hospital affiliated with physicians can more easily pay for new information technology, share expensive medical equipment, and create other business returns.

As a collection of professionals with common interest, the medical group offers great potential to improve care. Early studies found little evidence of economies of scale – that is, the group is more efficient or lowers cost as it gets larger. Economies of scope may be more likely – that is, the group is more efficient as it adds more specialties that smooth transitions between primary and specialty care. Patients can be handed off to another specialist physician more easily in a group compare to a solo practice when patients need to be referred for different types of care.

A multispecialty group and the physician group owned by a health and hospital system are natural responses to market demands for risk-bearing contracts with a health maintenance organization, for example. This type of vertical or horizontal combination is done to reduce coordination costs of operating under all-inclusive contracts that pay one flat rate for all covered services provided by the group.

That is why studies in the 1970s concluded that capitated group- and staff-model health maintenance organizations, paying physicians by salary, achieved cost savings of 30 percent to 40 percent relative to fee-for-service payment. A 1995 literature review found that group and staff model health maintenance organizations reduce services by 22 percent. Independent practice associations, which receive capitation payments from insurers but often pay physicians on a fee-for-service basis, have not yet been found to reduce costs (Bodenheimer 2005c).

Under the law, physicians are the sole professional group entrusted with diagnosing disease and prescribing medicine. They are the only avenue for admission to a hospital. For this reason, unless the law changes, physicians must now play a major role in changing the way care is delivered. There are policies that can be adopted to encourage the further development of clinical integration of physicians among themselves and with hospitals, improve the performance of health and hospital systems, and enhance payment systems to provide strong incentives for cost conscious care for all. The next sections discuss these policy changes.

Invest in Information Processing and Benchmarking Performance

Much has been made of health information technology, including electronic medical records, and its potential to improve care delivery and lower costs. In principal, the innovations offered by digital medical records versus paper are enormous. Electronic medical records have been shown to reduce medical errors and facilitate interventions that improve the quality of care. Information can be delivered to the point of service quickly and easily with greater accuracy. All this helps improve quality and make physicians and other health professionals more productive.

Medical groups are more likely to adopt health information technology because of the medical group administrative support they have compared to sole practitioners. Health and hospital systems are more likely to invest in health information technology because they have access to larger sources of capital and the necessary expertise compared to freestanding hospitals. The last federal administration viewed the slow adoption of health information

technology as a problem facing small, independent physician practices and invested accordingly.

An alternative approach is to assume that the technical aspects of health information technology – the purchase of equipment and software – evolve on their own in the market and are of little concern to public policy. It did not take public policy to bring computer technology to the nation’s factories and assembly lines. Financial institutions found the technology for automated tellers without government grants. The market should be allowed to work, but public policy for health information technology should focus on two activities. First, policy should set standards for common medical language. Second, policy should spur the clinical integration of physicians and hospitals in ways that allow innovation around information technology.

Set Standards for Common Medical Language. Even today’s newest electronic medical records resemble the traditional patient charts doctors have used for decades. Perhaps using electronic charts that look like paper charts is necessary for helping physicians make the transition. These charts may also be good for securing and maintaining privacy through a legal chain of authority that stores records such as family history, physical exam notes, progress notes, consultation notes, physician order, and laboratory and imaging results. But most electronic medical records are stored as free text, and this leads to data errors, ambiguous transfer of information between clinicians, and nearly impenetrable access for decision support and longitudinal monitoring of patient progress. They also make it difficult to benchmark one patient or provider to another.

The National Library of Medicine of the National Institutes of Health and others have long been proponents of standard clinical vocabularies. Aligned with electronic message standards that are mapped to billing codes, these standard vocabularies engender maximum interoperability (National Library of Medicine 2006). Interoperability refers to communicating and exchanging data between two information technology systems. Semantic interoperability means that the end result of the exchange is of value to the user. Public policy should aim to achieve semantic interoperability in the world of health information technology by creating a complete Unified Medical Language System that sets the standards for vocabulary in medical and hospital care.

The impact could be of tremendous value in lowering healthcare costs. With one standard for using medical terminology, health professionals would greatly enhance their ability to communicate. It would be easier and less costly to coordinate care. Most importantly, interoperable databases would allow data to remain in place. With proper permissions, a clinician of the future could conduct a patient visit and access the patient’s protected health information in real time wherever that data resided. That could be on the clinician’s server, in a competitor’s data across town, or in the database of a public clinic across the country. The data would be linked with relevant health education materials. The order for the follow-up care would be transmitted electronically before the visit concluded.

To accomplish this goal, public policy must first invest in and promote linked databases, using common medical terminology in practical settings. Second, next generation electronic records need to be promoted to enable interoperability. Third, so-called advanced electronic representations of medical treatment guidelines and evidence-based medicine need to be

imbedded into electronic medical records to support medical decision making. These might be in the form of artificial intelligence, clinical reminder and alert systems, decision rules, and easy queries of available data to answer questions about large sets of patients.

Spur Development of Organized Systems of Care. Although medical groups now encompass nearly 60 percent of physicians and health and hospital systems represent over 50 percent of hospitals, the U.S. healthcare system remains fragmented. Federal policy should explicitly endorse and promote further development of organized systems of care. There are a number of ways to do this that should be acceptable to the freestanding physician practices and hospitals that would be most affected. Integrating prepaid medical groups into local hospital systems is one of the most important steps the U.S. could take to lower the cost of delivering healthcare. But there are other approaches, too.

First, rigorously enforce the antitrust laws. While too many physicians remain outside the medical group and too many hospitals remain outside the health and hospital system, the groups and systems that do exist too often attempt to monopolize the market rather than compete on price and quality. Federal antitrust laws need to be update and clarified, making it perfectly clear that the market expects high-quality, cost-effective, and organized systems of care in both the for-profit and not-for-profit sectors. The pre-paid group practice is probably the best example of what is required to wring out costs in the system and turn clinicians toward more cost-conscious delivery. Competing groups of physicians that have achieved clinical integration with hospital systems should provide the kind of changes we need to make significant impact on the delivery of care.

Second, the federal government could offer grants and guaranteed loans over a ten-year period. Physicians can use the grant to form new medical groups, and hospitals can form new health and hospital systems. There could also be provisions for encouraging existing medical groups and health and hospital systems to grow through acquisition. States could also get involved by issuing tax exempt bonds to support consolidation.

The combination of investing in standards for health information technology and then spurring organizations to use it efficiently can change the way care is delivered in this country. The public policies required are straightforward and easily implemented.

Pay for Performance

A current public policy initiative that generates hope that healthcare costs might be contained is the notion of pay for performance and its cousin, pay for reporting. It is a sad commentary when public programs must pay hospitals not to have drug errors or avoidable infections, but this is the way pay for performance has evolved. While a number of private payers are also operating pay-for-performance schemes, the largest experiment stems from the pay-for-performance program established by the Medicare Modernization Act of 2003. The U.S. Congress specified a 0.4 percent reduction in Medicare payments to hospitals that did not “voluntarily” publicly report quality information. In a related development, the Centers for Medicare and Medicaid Services that operates Medicare announced plans to no longer pay for medical errors and anticipate no longer paying for so-called “never events” – events in the hospital that should never happen, such as an avoidable infection.

Pay for performance is based on the idea that payers should reimburse providers for the outcomes of care or the results of care, instead of the number of services performed. It is a way of blunting or perhaps repairing the perverse incentives of fee-for-service medicine to always do more with little regard to quality because payments are based on volume and intensity of services, not quality outcomes.

The Premier Hospital Quality Incentive Demonstration project started in 2003 and is still ongoing. Under the auspices of Medicare, this demonstration put in a reward and bonus system for common medical conditions, including heart attack, pneumonia, coronary artery bypass graft, and hip and knee replacement. Premier, Inc., is a loose-knit confederation of over 2,000 hospitals that primarily engage in group purchasing of hospital supplies and equipment. The hospitals that performed the best on standard outcome measures for these medical conditions received a bonus. The lowest performers had a penalty. The results were not overwhelming, but modest improvements in quality and efficiency were observed for most hospitals. One Congressional advisory board recommended expanding pay for performance to all hospitals, physicians, home health agencies, Medicare Advantage health plans, and dialysis facilities.

Pay-for-performance schemes operated by public payers are probably worthwhile, but they are not yet very effective. First, there is a long-data run out time to measure the performance. In other words, it can take a long time for any payer to see any results upon which to base pay-for-performance payouts while they wait for the claims data to be accumulated and analyzed. There are no agreed upon standards for formatting data to determine performance. Data for evaluation flows from multiple providers, and payers might have difficulty attributing results to specific providers or the provision of certain services. Data collection, validation, and analysis in a fair and open manner across a large number of providers burden everyone. Relatively small payouts for improvement efforts and burdensome data collection do not match the investment in pay-for-performance schemes. Sometimes the performance being gauged for payment is diffuse, and it is difficult to know exactly what organizational changes are required to reach the target for pay for performance. Finally, pay-for-performance schemes get what they pay for. Thus far, we have only been able to identify a miniscule set of measures out of the multitude of interventions done to patients. We could continue to obtain some modest improvement in a small set of relatively unimportant measures, while many other hard-to-measure significant items are ignored or even shortchanged. Alternatively, the next generation of improved and more consequential pay-for-performance measures should be a priority for development and implementation.

Foster Organizational Pay for Performance. Public policy should encourage pay-for-performance but not at the global payment level for Medicare and Medicaid. To overcome the shortcomings of global approaches described above, pay for performance should be targeted at medical groups and health and hospital systems, where they can be implemented at an organizational level. These programs should reward everyone who does well in the organization and only pay for improvement if a minimum performance threshold is achieved. The focus should be on core areas with high expenditures and patient volume. Hospitals should be allowed by Medicare rules to directly provide incentives to physicians to improve the quality of care.

Public Payers Stick to Process Improvements. Payers, Medicare, Medicaid, and managed care companies should pay for process improvements such as adoption of health information technology. In the California Statewide Pay-for-Performance Experiment medical groups were paid more when they adopted a number of innovations. These innovations included electronic prescribing, electronic check of prescription interaction, electronic retrieval of laboratory results, electronic access of clinical notes, electronic retrieval of patient reminders, and electronic messaging. Significant improvements were made across the board in medical groups that adapted improvements. Government needs to stay one level removed from the bedside and patient care and focus on pay for performance for process improvements that are easy to measure.

Policies to Change the Actions of Individuals

In this subsection of solutions, the changes recommended focus on encouraging patients to join the healthcare team and become more involved with their own care. For nearly 15 years, programs and policymakers have attempted to make disease management an important part of solving the cost crisis in healthcare. Moving forward, disease management for chronic disease should continue to be a priority of public policy priority because chronic diseases are the source of much of the problem when it comes to rising costs. Another important area to monitor is the role public policy plays in promoting a better understanding of alternatives for end-of-life care. What is clear is that any reform we undertake must change the way individuals view their own actions toward healthcare – what it is worth, how they use it.

Improve Care Management and Coordination

All ten of the most costly diseases are chronic diseases, and spending for them increased in the last 15 years. If trends continue, costs for the top ten will more than double in 10 to 15 years. Spending for the top 20 chronic diseases accounts for 30 percent of all healthcare costs and 53 percent of all adults have at least one top 20 chronic disease. We absolutely must find solutions for dealing with chronic disease, or it will be impossible to moderate the rising cost of healthcare.

Disease management represents a new way of thinking about patient care. It is not a quick fix or cook book or practice guidelines. It is not a fad, and it is not always a way for some companies to market their drugs or devices. Disease management encompasses four key activities:

1. Professional communication among multidisciplinary clinical teams

2. Collection of information on health outcomes
3. Application of cost-effective technology
4. Continuous analysis of relevant data on health outcomes

Traditional medical practice has always involved these four activities, so adopting a disease management approach to care management and coordination is a matter of emphasis.

Ultimately, disease management is a clinical activity, so it is not something that employers or payers can adopt or impose. Patients are central to the work of multidisciplinary clinical teams, and careful communication with patients is the most important work teams do. Patients provide information about their health outcomes to the managed care plan through numerous means, including self-administered questionnaires, face-to-face interviews that might be recorded in the patient's medical record, telephone interviews, internet web pages, or health exams. Cost-effective technologies are pushed out to patients, including state-of-the-art medical procedures and pharmaceuticals, or methods of encouraging health risk behavior change in patients. Patients are provided with an analysis of relevant information about health outcomes and the interdisciplinary team of providers reacts to the outcomes over time, adjusting the treatment regimen to get the best results.

Under the traditional medical model, the physician is referred to as “the captain of the ship.” The physician charts the direction of patient care, gives the orders for each patient, and provides the personalized attention. Disease management changes all this by converting the health professionals into a self-directed team. The roles of the nurse and the pharmacist are elevated from the old model. Pharmacists and nurses often initiate care directly with patients. Rather than merely requiring control over separate budgets for hospital, physician office, and drugs, disease management assumes that these components of care are interconnected. It is fruitless to attempt to control one component of care for cost reasons without understanding how it can affect other components. Finally, disease management clearly and doggedly focused on improving health outcomes, and that includes costs.

Disease management makes a great deal of sense for coping with the cost and outcome of chronic disease that lasts such a long period of time. On the other hand, critics say that the steps of disease management – patient identification and enrollment, treatment guidelines and intervention models, outcomes measurement and monitoring, medical devices – are additive costs to the system and must lead to big payoffs to save money. To date, the impact of disease management interventions on health outcomes and costs are more mixed than they should be. In principle, better organized, innovative care focused on improving outcomes should have a large effect. The field is still evolving.

Nevertheless, public policy should encourage employers, private payers, and public payers to pay for disease management programs and continue the search for programs that work. The methods for paying for disease management are still evolving, but those that pay per person per month for people with key chronic disease seem to be the most popular approaches. Quota share approaches in which the disease management company shares in any cost saving also have potential. Given the magnitude of the problem regarding the nation's growing healthcare bill for chronic disease, public policy should continue to support promising approaches like disease management.

Promote Greater Understanding of End of Life Care

End of life care is costly because the majority of people in the U.S. die in costly hospitals and nursing homes. Paradoxically, they would prefer to die at home – at a much lower cost. Public policy should promote greater understanding of end of life care and continue efforts to provide alternatives that people prefer. Prominent examples of policy trends supporting alternatives to institutional end of life care are the inclusion of hospice care under Medicare and the more recent development of private insurance coverage for palliative care. Hospice care is palliative care and more because it assumes the individual will not live past six months. Palliative care is geared toward relief of symptoms, most frequently pain for serious chronic disease such as cancer. The two terms overlap, although Medicare has rules and specifically covers hospice care. It does not do the same for palliative care.

Trends are driving the cost of end of life care in many directions. There has been a ten-year secular decline in the use of skilled nursing facilities, especially for Medicaid, which has lowered the cost of end of life care. The reason for moving away from skilled nursing care is that states have aggressively developed home- and community-based alternatives for people to remain in their home even at the end of life. Yet much of the cost of end of life medical care is borne by Medicare. The program disperses 25 percent of its funding to pay for medical care in the last two years of life. The total number of people who will soon be eligible for Medicare is increasing now and in the foreseeable future. The cost of end of life care falls with age, probably because costly, low-benefit medical treatments are less likely to be used.

People report that they would prefer to die at home or anywhere other than in a hospital or nursing home bed. For over twenty years, care givers have tried to accommodate these wishes with all sorts of local community programs, including home care, hospital-based palliative care units, and a combination of home and hospital care. There are even integrated teams of professions that provide hospice care wherever the dying person is located – at home, in assisted living, in a skilled nursing facility, or at a community hospice with its own accommodations. Research is mixed on the issues of family and patient satisfaction, relief of pain and discomfort, and costs (Higginson 2003). Yet patients and families increasingly seek hospice and palliative care.

More than 2,500 hospices in the U.S. accept Medicare. Approximately 25 percent of those with Medicare fee-for-service die using a hospice and approximately 35 percent die using Medicare Advantage. The number of hospices of all types continues to grow, as does the use of hospice. The number of palliative care units has grown from 632 in 2000 to over 1,000 in 2003. Veterans Affairs Medical Centers are also adding palliative care units. In the past 10 years, hospitals operated by the Roman Catholic Church were more likely to have a palliative care unit, along with larger hospitals and academic medical centers.

Public policymakers should research the benefits and costs of alternatives to institutional end-of-life care and develop more options for people who seek guidance through one of life's most predictable yet difficult periods. Whether dying in the hospital or at home, people rely on end-of-life care that is costly and probably not amenable to remarkable efficiencies. More information for families and dying patients about costly interventions at the end of life with little benefit should be a priority as well.

Policies to Reduce Demand for and Raise Supply of Health Services

The next subsections cover the kinds of policy changes government needs to adopt in order to affect the supply and demand of health services. Health promotion and disease management programs are popular with employers and hold promise for public programs. The tax exclusion for employer-provided health insurance premiums paid by employers needs to be eliminated or curtailed and replaced with numerous fairer and efficient tax standards. The supply of cost-reducing providers and technologies must be increased. Research on health outcomes and effectiveness can help us better understand what we are buying.

Reduce the Demand for Health Services

Why do we need to reduce the demand for health services? In a now landmark academic analysis, Martin Feldstein made the point long ago that people in the U.S. with health insurance actually have too much health insurance, which prompts them to demand too many health services (Feldstein 1973). Moreover, their over-insurance does not correspond to the level of financial risk involved. The excess health insurance means that out-of-pocket prices for medical care are too low. This situation leads to the excessive purchase of medical care, as well as higher and rising prices for everyone.

Rather than the average 15 percent of total personal healthcare expenditures paid out-of-pocket (36 percent private health insurance, 34 percent federal government, 11 percent state and local government), people could modestly increase their risk to sudden out-of-pocket medical care expenses. If they did, they would see greater benefits to themselves and others from lower demand for medical care and this, in turn, would foster lower prices for everyone.

Two recent policy changes illustrate this point. In 1973, the federal government subsidized and overtly endorsed managed care organizations. By the early 1990s, managed care – with its networks of required providers, incentives to reduce hospital services, and an albeit modest emphasis on preventive services – was growing very rapidly, and increases in healthcare costs actually leveled. In another example, the federal government instituted the “donut hole” in the new Medicare Part D coverage for drugs, which left people at the mid-range of drug expenditures paying entirely out of pocket until drug expenditures reached an even higher level. Both of these are examples of public policies designed to reduce the demand for health services. Such efforts, which should be encouraged, strike a balance between excess health insurance and out-of-pocket costs.

As discussed previously, employers have long recognized the importance of striking the right balance between health insurance and cost sharing. People need protection against the uncertainty of healthcare costs. But the healthcare system needs reasonable measures to reduce demand by having consumers come to understand the real price of predictable health costs. Healthcare policy needs to acknowledge the same principal.

Encourage Work-Site Health Promotion. We begin the discussion of reducing demand and increasing supply with a complementary approach to cost-sharing provisions of health benefits called work-site health promotion. Work-site health promotion incorporates health

awareness and education with behavioral change and other health initiatives. Health promotion programs are viewed favorably by employees and include weight loss, smoking cessation, low back pain management, nutrition education, work place safety, first aid, and employee assistance programs for substance abuse. These programs have long been thought to be cost effective, with paybacks of up to 300 percent from reduced absenteeism, presenteeism (being at work but not productive), emergency room costs, and hospital costs (Fries 1993).

Implement Demand Management. Another possibility is to implement demand management programs. These are run by managed care organizations on behalf of employers for the purpose of curbing the demand for inappropriate or unnecessary health services. Demand management programs sometimes go around the physician or other clinicians, and sometimes they operate with the full cooperation of the clinicians involved with the ongoing care of the patient. Three prominent demand management programs are telephone triage, emergency authorization, and discharge planning. Telephone triage programs have become especially popular because they have helped decrease demand for expensive emergency room and hospital services. Telephone triage can consist of several specific components: 24-hour access to registered nurses for advice and referral counseling; self-care guides in the form of audio or video tape libraries and Internet sites on various health topics; a process for referring clearly identified high-risk employees to more intensive monitoring programs; and services that provide after-hours telephone coverage for physicians. Most physicians are not paid for handling telephone calls from patients, so the telephone triage programs are established as an effective adjunct to any network of primary care physicians.

Efforts to reduce demand for services may be viewed as long-term strategies or short-term strategies. Demand management programs are short-term and integrated into the administration of benefits. Health promotion programs represent long-term strategies.

What should public policy be? The political responses usually involves giving people more, not less. Regulatory schemes or fiscal incentives to adopt efforts that reduce the demand for healthcare are politically complicated. Nevertheless, state or federal governments could provide tax credits to companies that adopt new demand reduction programs as part of their health benefits, just as tax credits are given for research or the purchase of new capital equipment. The offer of tax credits could be only for new programs and only for a limited time. It would be in the interest of government to see private sector employers adopt programs that reduce demand and control costs. They provide one of the best ways to offset the excess demand for health insurance.

Limit Tax Exclusion of Health Insurance Premiums. Health economists have pointed out for more than 25 years that current law for the tax treatment of health insurance premiums paid by employers on behalf of employees is unfair and increases costs for everyone.

Out-of-pocket spending on medical care for any uninsured or underinsured person comes from after-tax income. In other words, the low-income worker without employer-provided insurance must first earn income, and pay social security, Medicare wage taxes, along with

state and federal income taxes. Then, if there is any money left over, the worker must pay for medical care. What makes this unfair is that normally the higher income workers with employer-provided insurance first have their share of health insurance premiums deducted from gross wages. Their employer then adds a share to pay for health insurance premiums. Following that, taxes are paid. There is no tax on the employment-based portion.

Employees with employer-provided insurance are big winners compared to low-income uninsured workers. Not only does the employer subsidize their health insurance, but also employees and their employer incur no tax on this form of compensation. The same amount of money paid to an uninsured worker would result in higher taxes paid and tax revenue received by the government. Employees with employer-provided insurance receive substantial benefits. Employees without insurance – low income, many self-employed, unemployed, and working poor – have few or no benefits.

In keeping with the notion described above that there is an excess of health insurance in the U.S., this long-standing flaw in the tax code provides strong incentives for employers to offer, and employees to seek, health insurance and the type of plans that lead to coverage of the highest healthcare costs. Why should an employee have reasonable deductibles and coinsurance that require after-tax dollars for payment when first dollar health insurance coverage would get around having to pay taxes on those dollars?

In its recent, major report on key issues for major health insurance proposals, the U.S. Congressional Budget Office presented a clear example of how a tax subsidy affects two employees – one with no employment-based health insurance and another employee with coverage. Both employees are assumed to be unmarried, with no dependents and no other sources of income. Exhibit 20 shows the remarkable impact of current law on each employee.

Exhibit 20: Illustrative Tax Subsidy for Employment-Based Health Insurance, 2009

	Employee A Pays \$5,000 for Individual Health Insurance	Employee B Receives \$5,000 of Employment- Based Health Insurance	Difference
Compensation			
Wages	\$37,157	\$32,513	\$4,644
Premiums for Employment-Based Health Insurance	0	5,000	-5,000
Employers' contribution to Payroll Taxes	2,843	2,487	355
Total Compensation	\$40,000	\$40,000	0
Out-of-Pocket Premiums for Health Insurance	\$5,000	0	\$5,000
Income Tax			
Adjusted Gross Income	\$37,157	\$32,513	\$4,644
Minus personal exemption (\$3,650) and Standard Deduction (\$5,700)	9,350	9,350	0
Taxable Income	27,807	23,163	4,644
Total Income Tax	\$3,754	3,057	\$697
Payroll Tax			
Employee (7.65%)	\$2,843	\$2,487	\$355
Employer (7.65%)	2,843	2,487	355
Total Payroll Tax	\$5,685	\$4,974	\$711
Total Income and Payroll Tax	\$9,439	\$8,031	\$1,407
After-Tax Cost of Health Insurance	\$5,000	\$3,593	\$1,407
Subsidy Percent of Costs of Health Insurance	0	28%	-28%

Source: Congressional Budget Office (2008).

Both receive compensation of \$40,000. Employee B, however, has reduced wages that are used for health insurance entirely paid by the employer. Employee A is forced to use after-tax dollars to purchase health insurance out of pocket, probably in the individual insurance market. The effect on income taxes is shown in the middle of Exhibit 20. After the same personal exemption and standard deduction, there is a difference of \$697 in the incomes taxes paid. Both the employee and the employer save on payroll taxes for an added \$711 in tax savings for Employee B. Combined the tax saving is \$1,407 or 28 percent of the cost of the health insurance.

No one should underestimate the effect of the tax exclusion for health insurance premiums in this county. Cogan, Hubbard and Kessler (2005) estimate the combined effect of payroll taxes and income taxes leave the typical U.S. employee in the 30 percent tax bracket. Thus, a health insurance policy that costs \$1,000 more, because of low deductibles and unbridled fee-for-service, costs the employer and the employee only \$700. In this arrangement, the federal government loses \$300 in taxes. Assuming an average state income tax of 5 percent among states with income tax, another \$50 in taxes is avoided at the state level. The impact of this arrangement intensifies every year because health insurance premiums are growing

faster than wages. The Joint Committee on Taxation estimates the exclusion for employment-based health insurance was one-quarter trillion dollars in 2007, consisting of \$145 billion in individual income taxes and \$101 billion in payroll taxes that were not paid under current law.

Require Higher Deductibles and Coinsurance. Low deductibles and coinsurance are nice, but they sharply increase the demand for healthcare. A \$3,200 family deductible (in 2004 dollars) followed by first-dollar coverage after the deductible is met, reduces medical expenditures by about 30 percent. Recent work from the Netherlands suggests that a \$1,000 family deductible reduces medical expenditures by approximately 14 percent (Morrisey 2005).

Think of it this way. A typical family can easily spend \$1,000 on a family vacation and does not need vacation insurance, third party payers with their administrative costs, and employer contributions to take that vacation. Why should the first \$1,000 of medical care purchase be any different?

The current tax exclusion, which encourages low-deductible insurance, fosters the absence of cost-consciousness and encourages inappropriate use of physician visits and procedures. Not only is there a direct effect on consumer demand, but there is also an insurance-induced effect on physician recommendations when patients pay nothing out of pocket. Physicians are more likely to recommend a follow up visit or additional equivocal procedures when health insurance pays all. There is no evidence, after major and serious studies of the issue, that high deductibles have any measurable, negative impact on health outcomes.

Public policy solutions designed to address the unfairness and ill-effects on costs of the tax exclusion of employer-provided health insurance premiums are well known. They include, first, full or partial deductibility and, second, tax credits for health insurance capped at the level of a reasonable health insurance policy.

Create a Standard Deduction for Health Expenses. The easiest way to assure fairness and cost consciousness is to have a standard deduction for health insurance. Just as families are able to take a standard deduction for children, they should be able to take a standard deduction for health insurance. Families would receive a standard deduction for people buying health insurance on their own or paying a share of premiums through their employer. The standard deduction could be as much as \$15,000 for a family and \$7,500 for an individual, without regard to other deductions.

Full deductibility would allow everyone to deduct health insurance premiums and out-of-pocket medical care expenses if they purchased insurance, regardless of whether they itemized deductions. This approach would strongly encourage people to purchase insurance. It would simultaneously give everyone the same benefits and eliminate the unfairness. It would also create strong incentives to elect low-cost insurance premiums without penalizing high-deductible plans.

Cogan, Hubbard and Kessler calculate that full deductibility would reduce wasteful private health spending by 6.2 percent, or \$43 billion (in 2004). They further estimate that the

average coinsurance would rise from between 20 and 25 percent to between 30 and 35 percent. While politicians would object to this increase in coinsurance, a modest shift in bearing the expense would have an immediate impact on cost consciousness and the demand for medical care, especially equivocal medical care. Such an increase would also have an immediate effect on healthcare prices and costs.

For an uninsured person such as a young immortal who makes enough to purchase health insurance and works for a small employer, this approach would create an incentive to purchase insurance and, by doing so, turn out-of-pocket expenses into a tax deduction. To help the working poor who are ineligible for Medicaid and do not make enough to purchase health insurance, even with a full deduction, states could offer direct premium assistance to get them in cost conscious health plans. States could also create high-risk pools, or expand existing high-risk pools, for very sick individuals who are uninsurable because of pre-existing conditions or other reasons in the eyes of health insurers. Finally, states could foster market-based pooling either directly or with employer associations. The effort to achieve full deductibility would be the perfect reason to spur these activities at the state level and get everyone insured in cost conscious health plans.

This modest proposal for offering tax-deductible status to any and all health costs should sharply reduce the uninsured. At the same time, it would leave the current employer-provided health insurance system in tact and supported. The tax system could also be greatly simplified because flexible spending accounts and their complicated rules and health reimbursement accounts would no longer be necessary. With so many concerned about rising healthcare costs, instead of creating a new federal bureaucracy to address costs, the full deductibility of health costs would directly address the major concerns and do so fairly.

Create A Tax Credit for Health Expenses. Tax deductibility works only if you pay taxes. Tax credits should be used for low income persons who do not pay taxes. The Clinton Administration spearheaded welfare reform in the mid 1990s by requiring work in return for cash assistance and health coverage through Medicaid. Except for their children through the SCHIP program, adults with income too high to be eligible for welfare and Medicaid are left with no help. They are uninsured and clog the nation's emergency rooms, and they are the source of uncompensated care and cost shifting. More than 60 percent of the uninsured are working age (18-44 years), and 75 percent have incomes above the poverty level. In fact, more than 40 percent of the uninsured are above 200 percent of the poverty level.

If public policy could help cover the costs of low-income uninsured adults, cost shifting would fall remarkably. If the same policy could set a limit on first-dollar coverage, go-anywhere health insurance plans with high premiums, costs generally would be lowered. What policy change could accomplish this?

Offering refundable tax credits for health insurance up to a maximum dollar amount would sharply reduce the core source of cost shifting. At the same time, these tax credits would lower the current incentives to burden both small and large employers with health insurance premiums. In fact, they may have the effect of helping fund coverage.

There are many ways to do determine what is counted and how much is eligible for the tax credit, as well as the maximum amount that can be used toward a credit on federal taxes. States with income taxes could also get in on the act and help people with low incomes obtain health insurance, so extra help is available to get these costs under control.

One approach would be to offer a refundable tax credit toward 33.33 percent of individually or family purchased health insurance or out-of-pocket expenses for qualified healthcare. This credit could be limited to a maximum of \$300 per month for a family and \$120 per month for an individual. The maximum is equivalent to approximately one-third of the cost of the premium for health insurance from a managed care company. The credit should be there for everyone, regardless of whether they worked. It should be used to cover the costs of an employee-paid premium at work or to pay for out-of-pocket healthcare expenses for someone with insurance. As with the tax deductible policy option above, you must have health insurance to qualify for a tax credit.

The tax credit should be available for everyone without regard to income or to just low income persons, for example, who fall below 200 percent of poverty. Alternatively, the credit could be graduated so that those between 200 and 400 percent of poverty receive a portion of the tax credit that lower-income people receive. The point is that the federal government would be providing significant financial support to everyone or just low income persons to purchase health insurance either through their place of work or on the individual market. Because most of the uninsured and underinsured work for small businesses, the benefits for addressing healthcare costs for these entities would be the greatest. The benefits for the wealthy would be the lowest if the credit fell as income increased.

The use of tax credits is fair. Today, high-income people are at a substantial advantage because they get a tax exclusion for employment-based premiums. Under a tax credit system, they would receive the same monthly benefit that a low-income person would receive in the purchase of insurance, unless the tax credit were limited to low income persons. The cost shifting that ensues because of the way uninsured people use services would fall. Cost conscious plans would be the rule because the premium for an expensive plan would be entirely paid by after-tax dollars.

The goal is to discourage first-dollar coverage, go-anywhere health insurance plans that drive up costs for everyone. To really make a tax credit squarely address the cost issue, the tax exclusion for employer-provided insurance should be eliminated. Replaced by a tax credit for everyone, costly health insurance plans would no longer be favored. Alternatively, the tax exclusion could be capped and the cap gradually reduced over, for example, ten years. Johnathan Gruber (2008) estimates that the current tax exclusion of employment-based premiums is so large, eliminating it would more than pay for subsidies to cover the uninsured with \$50 billion left over.

Although changes in the tax treatment of health insurance premiums could be structured in a way that raises enough tax revenue to pay for the tax credit, experience shows such a proposal is politically unfeasible. It would mean expanding the annual Internal Revenue Service W-2 Form, the Wage and Tax Statement, to capture employer-provided health benefits (either health insurance premiums or out-of-pocket health expenses) and counting all the health benefits, or a portion up to a maximum, as taxable income. Employees

enjoying the tax exclusion, perhaps large employers with very generous employment-based health benefits, would object the most. To them, eliminating the tax exclusion would be like an increase in the costs of their overly generous health benefits, despite the help from a universal tax credit for health costs. Small businesses, currently most affected by the unfairness the tax exclusion, should be most supportive.

Increase the Supply of Cost-reducing Providers and Technology

Managing health care expenses is vital at all levels – whether the focus is on individuals and employers or the national economy – and one of the most cost-effective ways to accomplish this goal is to increase the supply of cost-reducing providers and technologies. It is also important that we understand what we are buying when we purchase health care services, and one of the ways we can reach this level of awareness is by conducting research on health outcomes and the effectiveness of various treatments.

Redirect Disproportionate Share Hospital Payments to Subsidize Free Clinics. One of the most mysterious and expensive federal health policy programs is disproportionate share hospital (DSH) payments. Hospitals can get a small increase in Medicare payments and a large adjustment in Medicaid payments if they qualify as a disproportionate share hospital. These are mysterious because of the odd way in which the payments are calculated and because they go only to hospitals. They are expensive because together, Medicare and Medicaid DSH payments account for more than \$22 billion of higher costs, and there is not much to show for the spending.

The Medicare DSH payment adjustment provision was enacted by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The primary method for a hospital to qualify is based on the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. This provision serves as a rough proxy for the number of low-income patients a hospital serves. Oddly, all the counted patients have either Medicare or Medicaid coverage, thus the formula is quite divorced from the number of uninsured patients.

The Medicare DSH payment adjustment is not small, accounting for over \$7 billion in added outlays to hospitals beyond their regular Medicare payment. Hospitals that receive DSH payments have much higher Medicare margins than those that do not receive the DSH payment adjustment. The uses of the additional funding are entirely up to the hospital and can be used to build a marble fountain in the hospital atrium or purchase new equipment for the pediatric unit. On a number of fronts, it is unclear how the program helps care for the poor and uninsured. But it does favor hospital care over primary care, and it raises federal spending.

At over \$15 billion, the Medicaid DSH payment provision is even more costly than Medicare DSH payments. The Medicaid payment adjustment is based upon the share of low-income or uninsured patients, so it is an improvement in terms of more directly gauging a hospital's service to the low-income and uninsured. Yet like Medicare, Medicaid DSH payments are made to hospitals to the exclusion of the primary care system and can be used for any purpose at the hospital. Imagine what could be done with DSH payments if they were

redeployed to provide access to primary care services. The amounts of money are not trivial. For example, 2005 DSH spending per low-income uninsured person was about \$3,800 in New Hampshire (Coughlin 2007), which is a high DSH payment state.

These funds should be redeployed away from costly hospitals to two types of volunteer organizations that provide healthcare to the poor and uninsured: free clinics and volunteer referral networks. According to Isaacs and Jellinek (2007), free clinics are private, nonprofit organizations supported by the local community. These organizations provide primary medical care and other services (for example, dental, pharmaceutical, or mental health services) at no cost or on a sliding scale fee-schedule to low-income or uninsured people. Rather than serving patients directly, referral networks maintain a list of volunteer specialists or primary care physicians and refer patients who would otherwise not receive care because of lack of ability to pay.

In 2003 there were over 1,700 free clinics in the U.S., and they provided medical care to 2.5 million people that year. They do not look alike, ranging from clinics open for several hours a few times per week working out of a church basement to large permanent structures with scores of volunteers open at all hours. No one knows how many referral networks exist, but they provide a very useful service in terms of helping people who are often very ill find specialists who will care for them.

Expanding the supply of free clinics and referral networks with over \$22 billion redirected from Medicare and Medicaid DSH payments would provide an immediate and direct impact on the use of primary care among the low income and uninsured patients. These two groups currently drive up costs by using the hospital emergency room as their primary care giver. As an alternative to directly funding free clinics and referral networks, the funds could continue to go to hospitals, but the hospitals would be required to support free clinics and referral networks. In some cases, the hospitals could provide low-cost health coverage through a managed care company that used free clinics and referral networks.

Spur Cost-Reducing Innovations. Technology and other innovations do not always have to be cost-increasing technologies. There are a few examples of cost-reducing innovations in healthcare (Robinson and Smith 2008). Public policy should be redirected to encourage the development and diffusion of innovations that are cost reducing, including new regulations, methods of payment, insurance benefit design, competition policy, and tax incentives that spur technology. Process innovations have paid off in other fields, such as the cargo container or the assembly line. These must be encouraged also.

First, there is the supply of drugs, tests, and devices that replace expensive alternatives. The use of generic drugs versus brand name drugs is a good example. Increasingly, the Food and Drug Administration (FDA) is approving home test kits for pregnancy, urinary tract infection, and blood glucose monitoring. The FDA's strict requirements to consider only safety and efficacy in clinical terms should be minimally modified to somehow fast track or more favorably assess technologies that reduce costs. The agency could do this without sacrificing quality.

Second, there are workforce substitution processes that could increase the supply of lower-cost, yet competent clinicians or other workers who could assist or replace the functions of more costly professionals. Physician generalists should substitute for specialists in some areas. Nursing personnel can be more flexibly employed to lower costs. And pharmacists, nurse practitioners, and physician assistants should be markedly increased to expand the supply of primary care capacity. Third-party payments should be extended or increased to substitute clinicians. Insurance policies could encourage the use of low-cost substitutes. Capitation payments to providers should be encouraged. These payments allow the health maintenance organization or large physician group practice to decide the lowest cost combination of clinicians and the way they can best work together to achieve quality care.

Third, tax policy could be used to encourage suppliers of cost-reducing technology innovations. Cost-effective alternative sites of care and innovative suppliers of innovative drugs, devices or other products could apply for rebates on federal taxes paid if they could demonstrate cost reductions.

Monitor Health Outcomes and Effectiveness. A recently completed experiment lasting seven years in Rochester, New York, used a common efficiency ratio to pay out as much as \$15 million to physicians who showed their cost effectiveness through a well-developed benchmarking and scoring process aimed at reducing overuse (Greene 2008). The program used a measure of actual costs to expected costs, which was adjusted for case-mix and severity.

While a seven-year experiment seems long in terms of trying to study ways to address overuse of health services and associated costs, it illustrates what we are up against in the effort to reduce costs. The leaders of this successful experiment have taken what they have learned and are now operating the next generation of pay for performance based on outcomes and effectiveness.

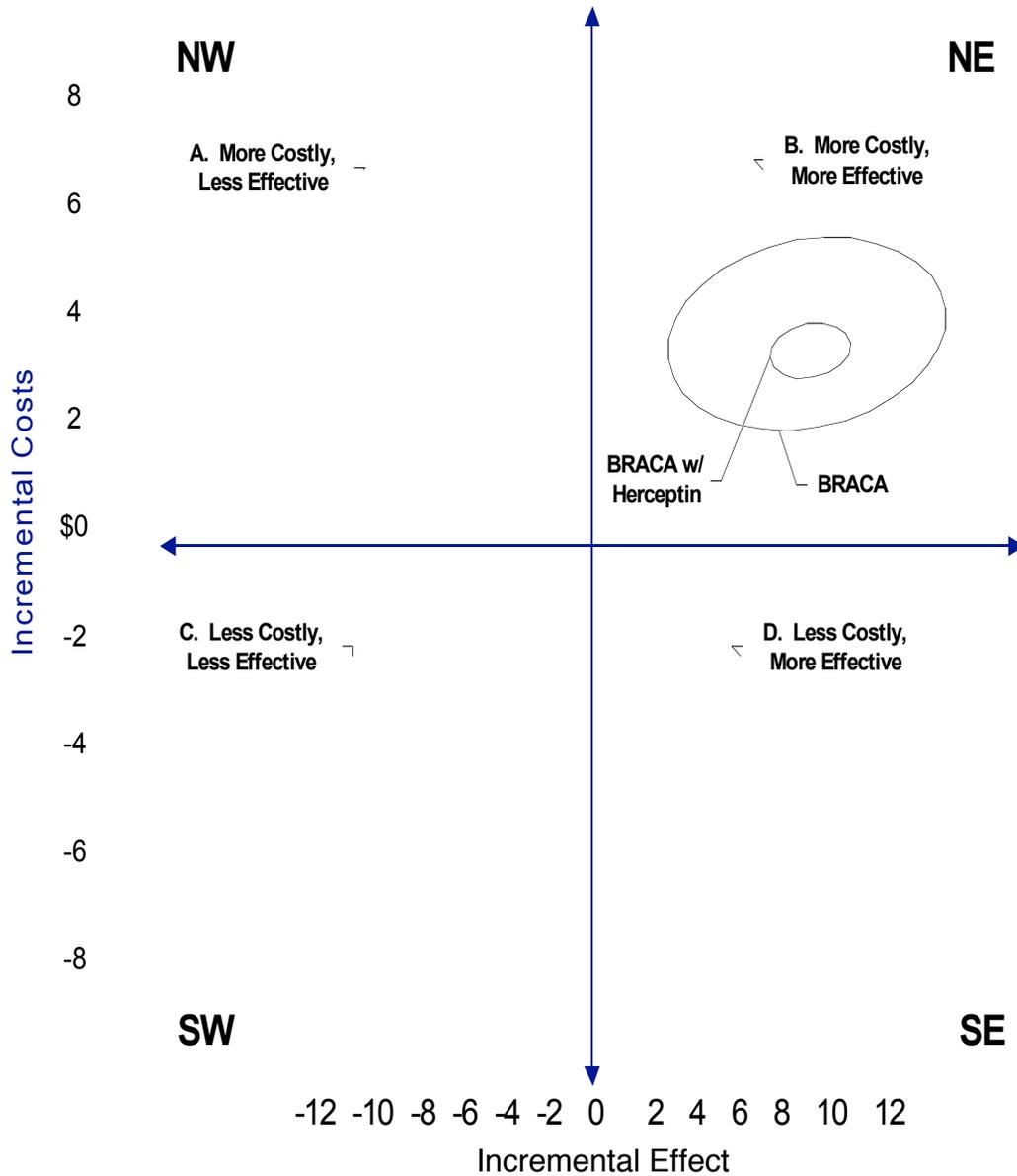
The delivery of healthcare is a very complex, personal, and sometimes life-and-death activity. We will probably never achieve perfect measurements in order to better manage the care that is given. But the science of health services research is trying to do so by studying what lowers costs and raises quality.

Exhibit 21 illustrates issues and factors that lower cost and raise quality. The left side of this diagram measures the incremental cost of a new healthcare service, device, or product. The lower axis measures the incremental effectiveness. Any change we make in healthcare can be incrementally more costly or less costly. It can also be incrementally more effective or less effective. Thus, the axes show positive and negative scales.

There are four possible outcomes, each labeled as the directions on a map. The NW quadrant represents changes that no one should want – more costly and less effective healthcare. Too frequently, new products and services are represented by the NE quadrant with more costly and more effective healthcare. The SW quadrant is possible but not always welcome because it represents less costly and less effective. Sometimes in order to reign in costs, products and services are adopted that fall in this quadrant. The SE quadrant is the best kind of change – something that is less costly and more effective.

To illustrate, Exhibit 21 indicates the likely placement on the cost-effectiveness matrix of a new drug herceptin (trastuzumab) as part of a treatment plan for the adjuvant treatment of patients with the BRACA gene and node-positive breast cancer. Traditional treatments for breast cancer for patients with the BRACA gene are both more effective and costly than no treatment at all. Thus, it would appear in the NE quadrant. We are not quite sure the range of cost and effectiveness, so it could be represented in a rather large circle as shown. If a patient has the right genetic makeup, herceptin can be made much more effective and targeted in a closer range of cost and effectiveness as indicated by the circle indicating BRACA with herceptin.

Exhibit 21: Cost-Effectiveness Matrix



Both public policy and private payers should continue to conduct research on health outcomes and effectiveness to improve our ability to identify changes and the quadrant they occupy. Doing so would make better use of the healthcare dollar and, ultimately, determine the best course of treatment for each patient.

More investment in health services research is needed for a variety of reasons. Thorough research would help us determine the next generation of payment mechanisms and provide the kind of clinically valid evidence required to show which treatments work best. It would also uncover ways to reduce the influence of emotion when making healthcare decisions,

especially at the end of life, and present providers and consumers with the information they need to feel that they are getting their money's worth.

Summary

- Healthcare costs are rising, and serious policy action is needed now to manage expenses. Policies may take the form of creating government-induced incentives, changing the way care is delivered, managing how individuals use services, and reducing the demand for and raising the supply of health services.

Policies to Change Government-Induced Incentives

- Medicaid is the largest health program in terms of number of people covered, and it must be utterly transformed to a national eligibility standard based on federal poverty level.
- To help Medicaid reduce costs, improve quality, and take initiatives to cover the uninsured, the federal government should finance the cost of meeting new eligibility standards.
- The federal government should establish a 5 percent hold back of funding to be used to reward states to meeting pay-for-performance goals.
- As the largest health program in terms of dollars expended, Medicare must be utterly transformed to a new benefit package with four parts: medically necessary care, long-term care, experimental care, and lifestyle care.
- The federal government should replace long-term care coverage (currently under Medicaid in the states) with state initiatives to cover the uninsured.
- The goal should be to enroll all Medicare beneficiaries in managed care organizations by 2019.
- Medical malpractice insurance should be reformed to establish healthcare courts, cap awards at \$500,000, and pursue mandatory arbitration.
- The largest group of uninsured – young, largely healthy people working for small employers – must be brought into the health insurance system through market-based pooling, health savings accounts, and national rules for the provision of health insurance.

Policies to Change How Healthcare Is Delivered

- We should encourage the development of new and expanded medical groups and hospital and health systems, and we should use federal grants and loans in ways that promote competition among these providers.
- Investment in standard medical language for health information technology should be made.
- Global pay for performance from public payers to individual providers should be replaced with pay-for-performance goals that focus on managing process. This includes capitalizing on efficient information technology that serves the healthcare sector.
- Public policy should foster pay for performance at the organizational level of both medical groups and hospital and health systems.

Policies to Change the Actions of Individuals

- Managing chronic disease should continue to be a public policy priority.
- Public policy should promote a better understanding of alternatives for end-of-life care.

Policies to Reduce Demand and Raise Supply

- Employers have long recognized the importance of striking the right balance between health coverage and cost sharing in benefit design.
- Work-site health promotion should be encouraged by federal and state government through tax incentives.
- Demand management should become a public policy priority.
- Competitive markets and competitive bidding should be encouraged.
- The tax exclusion for employer-provided health insurance should be reduced or eliminated.
- A standard deduction for personal health insurance premiums and out-of-pocket costs should be made available for everyone. These figures should be up to \$15,000 for a family and \$7,500 for an individual.
- Tax deductibility for healthcare costs should be contingent upon purchasing a health insurance plan.
- Refundable tax credits up to a maximum amount are the best solution for moderating rising healthcare costs and fair government assistance in the purchase of health insurance.
- Subsidize free clinics and referral networks by redirecting to them the disproportionate share of payments hospitals receive.
- Spur the development and diffusion of innovations that reduce costs, including new regulations, methods of payment, insurance benefit design, competition policy, and tax incentives.
- Support research on health outcomes and effectiveness of medical treatment alternatives with government funding.

CONCLUSIONS

As this monograph went to press, the Government Accountability Office released its annual *Citizen's Guide to the Financial Report of the United States Government* for 2008. With characteristic government agency restraint, the report finds the new fiscal state of the U.S. government “unprecedented.” The mortgage industry and the banking industry especially went through unprecedented reform. This past year saw the passage of the Housing and Economic Recovery Act (HERA) in July and the Emergency Economic Stabilization Act (EESA) in October, which included the unprecedented Troubled Asset Relief Program (TARP). Will the healthcare industry be next to go through unprecedented reform?

The federal government's net operating cost nearly quadrupled from \$276 billion in FY 2007 to just over \$1 trillion in FY 2008. As a result, the budget deficit jumped to \$455 billion in 2008 from a deficit of \$163 billion in FY 2007.

To provide the federal government and the economy with the kind of fiscal help it needs, we must implement healthcare reforms that lower unsustainable cost increases in the health care industry. If the federal government wants to retain the ability to manage the sort of financial crisis we are currently experiencing, it must address the long-term fiscal imbalance resulting from Medicare and Medicaid, not to mention Social Security.

Those who set public policy must be acutely aware of two highly relevant dates in terms of health care costs. The first is 2009. This year, Medicare Hospital Insurance benefits begin to exceed Medicare program tax revenues. Another date is 2019. The Medicare Trustees' Report shows that, under current law, the Hospital Insurance Trust Fund will not have sufficient funds to pay scheduled benefits beginning in 2019. At that point, trust fund income would cover only 78 percent of scheduled benefits. The country has a window of about ten years to enact major reform and lower the increase in healthcare spending at all levels of government and in the private sector.

This monograph contains approximately 40 specific recommendations for controlling the rising cost of healthcare. To help assign priority to these recommendations, we conclude with a list of the top ten solutions, starting with the federal government reforming its own costly programs.

Priority 1: Change Medicare. Totally redefine the benefit structure to emphasize health promotion and disease prevention for the population faced with primarily chronic conditions. Continue to grow enrollment in managed care organizations until everyone covered by Medicare is in managed care.

Priority 2: Change Medicaid. Totally redefine the eligibility categories to cover all families and individuals up to 100 percent of the federal poverty level. Convert the program to a federal block grant to the states with the addition of a Pay-for-Performance Fund equal to five percent of total Medicaid funding. This approach rewards states based upon performance measures related to how effectively they reduce Medicaid costs and improve quality.

Priority 3: Reform Medical Malpractice Insurance. Enact changes that will enable and encourage states to establish Healthcare Courts, cap non-monetary award at \$500,000, and require mandatory arbitration.

Priority 4: Establish Market-Based Pooling. Pre-empt state insurance laws or provide incentives to state insurance commissioners to adopt model reforms that foster market-based pooling. This process would allow health insurers to create new or larger pools of insured individuals across state lines.

Priority 5: Expand Health Savings Accounts. Remove the current maximum that can be contributed in a year based on the national average of the cost coverage (\$12,800 for family and \$6,400 for individual in 2008) and increase that figure each year so that it corresponds with the increase in the cost of family coverage.

Priority 6: Set Standards for Common Medical Language. Forget about government subsidies for new equipment and software. Rather, establish standards for healthcare providers, insurers, and patients for communicating and exchanging data between two information technology systems.

Priority 7: Spur Development of Organized Systems of Care. While rigorously enforcing the current antitrust laws, the federal government should offer grants and guaranteed loans over a ten-year period to form new medical groups that are clinically integrated with health and hospital systems.

Priority 8: Promote Greater Understanding of End-of-Life Care. Public policy should research the benefits and costs of alternatives to institutional end-of-life care and develop more options for people who seek answers when dealing with one of life's most predictable and difficult periods.

Priority 9: Limit the Tax Exclusion of Health Insurance Premiums Linked to a Standard Deduction for Health Expenditures. Just as families take a standard deduction for children, those buying health insurance on their own or paying a share of premiums through their employer would receive a deduction of up to \$15,000 for a family and up to \$7,500 for an individual. Everyone would be allowed to deduct health insurance premiums and out-of-pocket medical expenses.

Priority 10: Spur Cost-Reducing Innovations. Support the development and diffusion of innovations that reduce costs using new regulations, methods of payment, novel insurance benefit design, a policy favoring competition, and tax incentives.

By following and implementing these ten solutions with a sense of urgency, we can begin to slow the increases in spending on health care and help lower costs for everyone. We need to initiate and implement policies and practices that reduce or eliminate the government's worst current incentives, change the way care is delivered, involve individuals more in their healthcare, and, importantly, decrease the demand for health services while increasing their supply.

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Glossary

ADMINISTRATIVE COSTS—the costs incurred by a carrier, such as an insurance company or HMO, for administrative services such as claims processing, billing and enrollment, and overhead costs. Administrative costs can be expressed as a percentage of premiums or on a per-member-per-month (PMPM) basis (United HealthCare Corporation 1994).

BENCHMARKING—A process that identifies best practices and performance standards to create normative or comparative standards (a benchmark) as a measurement tool. By comparing against a benchmark, an organization can establish measurable goals as a part of the strategic planning or total quality management process (Menkin 1999).

BENEFICIARY—Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefit under the Medicare program or covered under a private health insurance plan.

BENEFIT—The amount payable by private health insurance, Medicare or Medicaid for a covered service on behalf of a beneficiary.

BLUE CROSS AND BLUE SHIELD ASSOCIATION (BCBSA)—The national non-profit organization to which the independent Blue Cross and Blue Shield member plans make up the Blue Cross and Blue Shield Association; however, all member plans function as independent, locally operated companies. BCBSA administers programs of licensure and approval for Blue Cross plans and provides specific services related to the writing and administering of healthcare benefits across the country.

CAPITATION—A set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include a physician's own services, referral services, or all medical services.

CARRIER—A private or public organization with which CMS enters into agreement to help administer the Part B benefits under Medicare. Also referred to as "contractors," the carriers determine coverage and benefit amounts payable and make payment to physician/suppliers or beneficiaries.

CASE MIX—the diagnosis-specific makeup of a hospital's workload. Each hospital has a Medicare Case Mix Index under the Medicare prospective payment system for hospitals.

CATASTROPHIC HEALTH INSURANCE—Health insurance that provides protection against the high cost of treating severe or lengthy illnesses or disabilities. Generally such policies cover all or a specified amount or percentage of medical expenses above an amount that is the responsibility of the insured himself.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) — The federal agency responsible for administering Medicare and overseeing the administration of Medicaid by the states. See www.cms.gov.

CLINICAL INTEGRATION--Clinical integration has two meanings. As a management concept it concerns the collaborative nature of a hospital and its medical staff. A large medical group, for example, which owns its hospital, is likely to be at the fully integrated end of the management meaning of clinical integration. A hospital that only holds quarterly medical staff meetings with its independent practitioners is at

the other end. The other meaning is newer and has a legal basis that stems from the increasing need to justify joint negotiations by competing providers that would otherwise be unlawful under the antitrust laws. Joint negotiations can bring significant efficiencies for both providers and managed care companies in negotiating and administering contracts. With the increasing digitized medical record and low-cost ability to share data with appropriate safeguards, hospitals and physicians can improve quality and safety and find efficiencies by working together.

COINSURANCE—A policy provision by which both the insured person and the insurer share in a specified ratio the covered losses under a policy. The most common coinsurance is 20 percent patient, 80 percent insurance.

COMPARATIVE EFFECTIVENESS RESEARCH—a type of health services research that creates, disseminates and applies evidence on the relative effectiveness of medical treatments. The research improves health care quality and patient outcomes, and reduces inappropriate and ineffective care.

COMPETITIVE BIDDING—A pricing method that elicits information on costs through a bidding process to establish payment rates that reflect the costs of an efficient health plan or healthcare provider.

CONSUMER PRICE INDEX (CPI)—An economic index prepared by the Bureau of Labor Statistics of the U.S. Department of Labor. It measures the change in average prices of the goods and services purchased by urban wage earners and clerical workers and their families. It is widely used as an indicator of changes in the cost of living, as a measure of inflation (and deflation, if any) in the economy, and as a means for studying trends in prices of various goods and services. The CPI is made up of several components including the medical care component.

COORDINATION OF BENEFITS (COB) — A method of integrating benefits payable under more than one group health insurance plan to so that the insured's benefits from all sources do not exceed 100 percent of his or her allowable medical expenses. Most insurers have a coordination of benefits department whose job is to find duplicate coverage and coordinate benefits.

COPAYMENT—A type of cost sharing whereby the insured or covered person pays a specified flat amount per unit of service or service of time (e.g., \$2 per visit, \$10 per prescription); the insurer pays the rest of the cost.

COST-BASED REIMBURSEMENT—Under this arrangement, a third party payer pays the hospital or other provider for the care received by covered patients at cost, not on the charges actually made for those services. The costs are often defined by the provider and are retrospective costs .

COST EFFECTIVE—Relative term, implying that the net benefits and outcomes of an intervention, service or program are worth the cost required. Interventions need not be cost saving to be cost effective—many cost-effective interventions do not save money but are still judged to be worthwhile.

COST –EFFECTIVENESS ANALYSIS—Method of economic analysis that assesses both the cost and the effectiveness of an intervention, service, or program. Costs are measured in monetary units, such as dollars. Effectiveness is measured in units of outcomes experienced such as number of years of improved survival, cases of disease prevented, or quality-adjusted life years (QALYs) gained.

COST SAVING—The absolute reduction in costs and expenditures resulting from the substitution of one intervention, service or program for another.

COST SHARING—A health insurance policy provision that requires the insured party to pay a portion of the costs of covered services. Deductibles, coinsurance, copayment, and the balance bills are the type of cost sharing.

COST SHIFTING—When a third party reimburses at an inadequate rate to cover actual costs and the hospital attempts to recoup the difference by charging other payers higher.

DEDUCTIBLE—The amount of covered expenses that must be incurred by the insured before the benefits become payable by the insurer.

DEFINED-BENEFIT COVERAGE—A sponsor provides funding for a specific package of medical services and is responsible for paying that package.

DEFINED-CONTRIBUTION COVERAGE—A sponsor provides funding for a specific dollar contribution toward the cost of coverage and is responsible for paying only that contribution.

DIAGNOSIS RELATED GROUP (DRG) —A system of classifying patients on the basis of diagnoses for purposes of payment to hospitals. Each DRG represents a broad clinical category based on body system involvement and disease etiology, which are similar in use and resources. They are now used by Medicare, most state Medicaid programs, and many private insurance companies to make hospital payments on a prospectively determined, per case amount.

DISEASE MANAGEMENT—Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. Disease management supports the physician or practitioner/patient relationship and plan of care, emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

DISENGAGEMENT—The termination of an enrollee's coverage under a health plan, either voluntarily or involuntarily. Voluntary disenrollment occurs when a member quits because he or she does not wish to continue coverage under that plan. Involuntary disenrollment might occur if a member changes jobs, will not comply with recommended treatment plans, or commits offenses such as fraud, abuse, or nonpayment of premiums or copays.

DISPROPORTIONATE SHARE HOSPITAL (DSH)—Urban hospitals with more than 100 beds that qualify for additional disproportionate-share payments from Medicaid, Medicare or both.

DONUT HOLE--A beneficiary who enrolls in standard prescription drug coverage under Medicare Part D generally will be responsible for a deductible, 25 percent coinsurance for covered drugs up to the initial coverage limit of \$2250, the full cost of covered drugs until the beneficiary has incurred a total of \$3600 in out-of-pocket costs, and, for drugs purchased thereafter, the greater of (a) a co-payment for a generic drug or preferred drug that is a multiple source drug or a larger co-payment for other drugs, or (b) 5 percent coinsurance. The period during which the beneficiary is liable for 100% of prescription drug costs is commonly referred to as the “donut hole.” Low-income beneficiaries will be subject to lower cost-sharing depending on their income and resources.

EFFECTIVENESS—The net health benefits and relative to costs provided by an intervention, service or program for typical.

EFFICACY—The net health benefits achievable under ideal conditions for carefully selected patients.

ENROLL—To agree to participate in a contract for benefits from a managed care company. A person who enrolls is an enrollee or subscriber. The number of people (including dependents) participating in a managed care company is its enrollment.

ENTITLEMENT AUTHORITY—In the federal budget, legislation that requires the payment of benefits or entitlement to any person or government meeting the requirements established by such law.

ERISA—The Employee Retirement Income Security Act of 1974. Landmark legislation that established federal standards of operation for qualified private employee benefit plans. ERISA preempts many state laws governing benefits (EBRI 1991).

EXPERIENCE RATING—A method of establishing premiums for health insurance in which the premium is based on the average cost of actual or anticipated healthcare used by various groups and subgroups of subscribers and thus varies with the health experience of groups and subgroups or with such variables as age, gender, or health status. It is the most common method of establishing premiums for health insurance in private programs.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (FEHBP) — The group health insurance program for Federal employees; the largest employer-sponsored contributory health insurance program in the world. It is voluntary for the employees, about 80 percent of those eligible being covered.

FEDERALLY QUALIFIED HMO—An HMO that has satisfied certain federal qualifications pertaining to organizational structure, provider contracts, health services delivery information, utilization review as well as quality assurance, grievance procedures, financial status, and marketing information, as specified in Title XIII of the Public Health Services Act.

FEE-FOR-SERVICE—A method of paying healthcare providers for individual medical services rendered, as opposed to paying them salaries or capitation payments. See Capitation.

FEE SCHEDULE—Schedule of insurance that specifies what the insurance plan will pay for a particular service or treatment.

FIRST-DOLLAR COVERAGE—Insurance plans that have no deductible or coinsurance.

GENERALISTS—Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Typically include family practitioners, general internists, and general pediatricians.

GROSS DOMESTIC PRODUCT—The total current market value of all goods and services produced domestically during a given period; differs from the gross national product by excluding net income that residents earn abroad.

GROUP INSURANCE—Any insurance plan by which a number of employees (and their dependents) of a given employer, or members of a similar homogeneous group, are insured under a single policy, issued to their employer or the group with individual certificates of insurance given to each insured individual or family.

HEALTH ECONOMICS—The application of the field of economics to healthcare. An assessment of the most efficient use of available resources, defined in terms of cost and outcome (University of Pittsburgh Medical Center 1995)

HEALTH MAINTANENCE ORGANIZATION (HMO) —A health delivery system that offers plan enrollees comprehensive health coverage for hospital and physician services for a prepaid, fixed fee. HMOs contract with or directly employ participating healthcare providers (i.e., physicians, hospitals, and other health professionals) and HMO members are required to choose from among these providers for all healthcare services or pay out-of-pocket (AMCRA Foundation 1994)

There are five standard models of HMOs:

1. The **Independent Practice/Physicians Association (IPA)** model HMO contracts with physicians in solo practice, and/or with independent practice/physician associations (**IPAs**) who, in turn, contract with their own member physicians. The majority of physicians in an IPA model HMO are in private practice and, in many cases, also have a significant number of patients who are not HMO members
2. The **Group Model** HMO contracts with a single multispecialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO often pays the group on a prepaid capitation basis for some or all of the covered services.
3. The **Network Model** HMO contracts with more than one medical group to provide services to its members.
4. The **Staff Model HMO** employs physicians directly. The physicians are employees of the HMO and deal exclusively with HMO members.
5. The **Mixed Model** HMO is any combination of the model types described above (AMCRA Foundation 1994)

The prototype HMO is the Kaiser-Permanente system, a prepaid group practice that dominates the markets on the West Coast. Rates of hospitalization and surgery are considerably less in HMOs than those occurring in the system outside such prepaid groups, although some feel that earlier care and providing fewer services maybe be better explanations.

HEALTH PLAN—an organization that acts as insurer for an enrolled population. See Fee-For-Service, Managed Care, Medical Savings Account.

HEALTH SAVINGS ACCOUNT (MSA)—A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals pay for their own healthcare up to the annual deductible by withdrawing from the savings account or paying out of pocket. A catastrophic insurance policy pays for most or all costs of covered services once the high deductible is met.

HEALTH STATUS— Information typically from individuals themselves, on domains of health such as physical functioning, mental and emotional well-being, cognitive functioning, social and role functioning, and

perceptions of one's health in the past, in the present, and for the future or compared with that of one's peers (also called health –related quality of life).

HOSPITAL INSURANCE (HI) (also known as Part A) —An insurance program providing basic protection against costs of hospital and related posthospital services for individuals covered by Medicare.

INDIVIDUAL (OR INDEPENDENT) PRACTICE ASSOCIATION (IPA) — An HMO composed of individual practices. Physicians are paid on a fee-for-service basis, and subject to quality assurance and utilization review.

INPATIENT HOSPITAL DEDUCTIBLE—A fixed payment for hospital care that must be paid by the beneficiary before the Medicare program pays any additional costs. By law, the inpatient hospital deductible is adjusted each year to reflect the average cost of one's day's hospital stay for all Medicare beneficiaries (EBRI 1991).

INSURANCE—the contractual relationship that exists when one party, for a consideration, agrees to reimburse another for a loss to a person or thing caused by designated contingencies. The first party is the insurer; the second party, the insured; the contract, the insurance policy; the consideration, the premium; the person or thing, the risk; and the contingency, the hazard or peril. Generally, a formal social device for reducing the risk of losses for individuals by spreading the risks over groups. Insurance characteristically, but not necessarily, involves equitable contributions by the insured, pooling of risks, and the transfer of risk by contract. Insurance may be offered on either a profit or nonprofit basis to groups or individuals.

INTENSITY OF SERVICES— The number and complexity of resources used in producing a patient care service, such as a hospital admission or home health visit. Intensity of services reflects, for example, the amount of nursing care, diagnostic procedures, and supplies furnished.

INTERMEDIARY— A private or public organization with which CMS enters into agreement to help administer benefits to institutional providers under the Hospital Insurance program. The intermediaries determine costs for Part A benefits and make payments to providers.

MANAGED CARE ORGANIZATION—Any system of health service payment or delivery arrangements wherein the health plan attempts to control or coordinate use of health services by its enrolled members. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan. Formal utilization review and quality assurance systems are involved. Enrolled members face financial incentives to use the defined delivery system of providers. See Health Maintenance Organization, Preferred Provider Organization, and Point-of-Service Plan.

MARKET-BASED POOLING—Enabling legislation that permits small and medium size employers to join together to form larger pools of people for health-insurance companies cover as one insurance group and thereby spread health risk. Private health-insurance companies compete for the right to cover the pool in return for competitive premiums. The employers gain bargaining power, lower administrative costs, increase coverage options, and reduce unexpected fluctuations in yearly premium increases. A key component to market-based pooling is to allow groups to pool across state lines.

MEDICAL MALPRACTICE EXPENSE—The cost of professional liability insurance incurred by physicians or other providers.

MEDICAID—Title XIX of the Social Security Amendments of 1965; federal/state welfare program that provides medical care assistance to the indigent and medically indigent. Medicaid is a healthcare financing program for low-income people. There are federal guidelines for which services are covered. Enrollment guidelines are based on state and territorial government guidelines. The program is funded jointly by both state and federal contributions (EBRI 1991).

MEDICARE—Title XVIII of the Social Security Amendments of 1965; federal/ Social Security insurance program that provides medical care assistance to elderly and disabled individuals.

MEDICARE ADVANTAGE—Part C of Medicare. Medicare pays approved managed care organizations to cover the services under Part A and Part B, usually combined with other supplemental services. These plans include:

- Health Maintenance Organizations (HMO),
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans
- Medicare Special Needs Plans
- Medicare Medical Savings Account Plans (MSA)

These plans may cover more services and have lower out-of-pocket costs than the Original Medicare Plan. Some plans cover prescription drugs. In some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals to get covered services.

MEDICARE MANAGED CARE—A method used to deliver health services and to pay hospitals and physicians caring for Medicare beneficiaries. This method attempts to control or coordinate the use of services to contain expenditures, improve quality, or both. It always involves beneficiaries making a choice to enroll in an alternative to traditional fee-for-service Medicare. The alternatives have a defined network of hospitals and physicians (NCHSR 1979), administrative systems for utilization management and quality assessment and improvement (HCFA 1982), and financial incentives for enrollees to use the network of hospitals and physicians (DHHS 1983).

MEDPAC (MEDICARE PAYMENT ADVISORY COMMISSION)—An independent federal body that advises the U.S. Congress on issues affecting the Medicare program (www.medpac.gov).

OUTCOMES—What happens to a person as a result of healthcare. Outcomes include measures of the individual's health status and quality of life (or health-related quality of life), as well as numerous other measures such as presence or absence of disease, readmission to hospital, repeat surgery, and death.

OUTCOMES MEASUREMENT—The process of systematically tracking a patient's clinical treatment and responses to that treatment using generally accepted outcomes measures or quality indicators such as mortality, morbidity, disability, functional status, recovery, and patient satisfaction (Menkin 1999).

OUTCOMES RESEARCH—A specialized branch of research that attempts to identify and develop standards for severity-adjusted clinical outcomes of medical service for large groups of patients (Menkin 1999).

PALLIATIVE CARE—medical or nursing care or treatment that concentrates on reducing the severity of disease, rather than striving to halt, delay, or reverse progression of the disease itself or provide a cure. The goal is to prevent and relieve suffering and to improve quality of life for people facing serious, complex illness.

PART A OF MEDICARE (Hospital Insurance Program)—Pays providers directly and covers inpatient hospital care with a large deductible and further cost sharing over 60 days. Part A also covers skilled nursing facility care following a hospital stay, home health care, and hospice care.

PART B OF MEDICARE (Supplemental Medical Insurance Program)—Has a monthly beneficiary premium and pays providers directly. Part B covers physician and other medical services, outpatient hospital care, ambulatory surgical services, laboratory services, outpatient mental health services, and some preventive services with a deductible, and coinsurance of 20 percent for most services.

PART C OF MEDICARE (Medicare Advantage)—Pays approved managed care organizations to cover the services under Part A and Part B, usually combined with other supplemental services.

PART D OF MEDICARE (Prescription Drug Program)—Private companies provide the coverage for approved prescribed medicines. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

PAYMENT RATE—The total amount paid for each unit of service rendered by a healthcare provider, including both the amount covered by the insurer and the consumer's cost sharing; sometimes referred to as payment level. Also used to refer to capitation payments to health plans.

PERFORMANCE MEASURE—A specific measure of how well a health plan does in providing health services to its enrolled population. Can be used as an indicator of quality. Examples include percentage of diabetics receiving annual referrals for eye care, screening mammography rate, and percentage of enrollees indicating satisfaction with care.

PHYSICIAN GROUP—A partnership, association, corporation, individual practice association (IPA), or other group that shares costs and distributes income from the practice among members.

PHYSICIAN-HOSPITAL ORGANIZATION (P110)—A legal entity formed and owned by one or more hospitals and physician groups to obtain payer contracts and to further mutual interests. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the PHO agreement. The PHO serves as a negotiating, contracting, and marketing unit (United HealthCare Corporation 1994).

PING-PONGING—The practice of passing a patient from one physician to another in a health program for unnecessary cursory examinations so that the program can charge the patient's third party for a physician visit to each physician. The practice and term originated and is most common in Medicaid mills.

POINT-OF-SERVICE (POS) OPTION—Offered by some traditional HMOs and PPOs to its enrollees to allow for out-of-network or "out-of-plan" coverage, but with economic incentives to enrollees to use network providers, such as lower copayments or coinsurance for their use. POS options are generally more expensive for purchasers (employers, etc.) of healthcare coverage (AMCRA Foundation 1994).

POINT-OF-SERVICE (POS) PLANS—Similar to PPOs in that they are characterized by a network of providers whose services are available to enrollees at a lower cost than the services of non-network providers. The difference is that whereas PPO enrollees are free to contact network specialists at their discretion, a POS participant must first receive authorization from a primary care physician (gatekeeper) to receive full benefits.

Also, the out-of-network benefits of a POS plan are typically less than those of a PPO (AMCRA Foundation 1994).

PORTABILITY—The requirement that insurers waive any preexisting condition exclusion for someone who was previously covered through other insurance as recently as 30 to 90 days earlier. See Preexisting Conditions.

PRACTICE GUIDELINES—Explicit statements about the benefits, risks, and costs of particular courses of medical action based on the medical literature and expert judgment. Intended to help practitioners, patients, and others make decisions about appropriate healthcare for specific clinical conditions.

PREEXISTING CONDITION—A physical or mental condition that existed prior to the effective date of the person's insurance.

PREEXISTING CONDITION EXCLUSION—A practice of some health insurers to deny coverage to individuals for a certain period, for example, six months, for health conditions that already exist when coverage is initiated. See Portability.

PREFERRED PROVIDER ORGANIZATION (PPO)—A healthcare benefit arrangement designed to supply services at a reasonable cost by providing incentives to its enrollees to use designated healthcare providers (those that contract with the PPO at a discount), while also providing a lower level of coverage for services rendered by healthcare providers who are not part of the PPO network. Financial incentives for individuals to use preferred providers include lower copayments or coinsurance, and maximum limits on out-of-pocket costs for in-network use. Unlike with HMOs, out-of-network usage is allowed by PPOs, though at a higher cost to the enrollee.

Most PPOs involve an arrangement between a panel of providers (physicians, hospitals, and other healthcare professionals) and the purchasers of care, for example, employers or insurance companies. The panel of preferred providers agrees to a specified fee schedule in return for preferred status, and is required to comply with certain utilization review (UR) guidelines.

PPOs are not insurers. They generally do not assume any financial risk for arranging medical services. In many cases, the risk is assumed by self-insured employers or by another underwriter (AMCRA Foundation 1994).

PREMIUM—An amount paid periodically to purchase health insurance benefits.

PREPAYMENT—Inconsistently used, sometimes synonymous with insurance, sometimes it refers to any payment ahead of time to a provider for anticipated services (such as an expectant mother paying in advance for maternity care). It is sometimes distinguished from insurance as referring to payment to organizations (such as HMOs), which, unlike an insurance company, take responsibility for arranging for and providing needed services as well as paying for them.

PRIMARY CARE CASE MANAGEMENT (PCCM)—A state-operated program wherein primary care providers contract directly with the state for the provision or coordination of medical services for Medicaid recipients. A key component of most programs is the payment of a case management fee to the primary care provider as compensation for coordination of care (Menkin 1999).

PRODUCTIVITY—The ratio of outputs (goods and services produced) to inputs (resources used in production). Increased productivity implies that an organization is producing more output with the same resources of the same output with fewer resources.

PROFESSIONAL LIABILITY INSURANCE (PLI) —The insurance physicians purchase to help protect themselves from the financial risks associated with medical liability claims.

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PROSPECTIVE PAYMENT SYSTEM (PPS) OR REIMBURSEMENT—Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for the coming year and the programs are paid these amounts regardless of the costs they actually incur.

PROSPECTIVE REVIEW—Review of necessity for hospitalization prior to admission to determine if it is medically necessary and if the hospital is the appropriate level of care.

QUALITY-ADJUSTED LIFE YEAR (QALY) — A common method for estimating the value of alternative outcomes in terms of a common nonmonetary unit, derived from the expressed preferences of patients for alternative states of health. QALYs integrate the quality of life experienced with the outcome obtained as a result of an intervention. States associated with decreased functional status are weighted less than states with improved function (University of Pittsburgh Medical Center 1995).

QUALITY ASSESSMENT—Measurement of technical and interpersonal aspects of healthcare including access to and outcomes of that care.

QUALITY ASSURANCE— A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies.

QUALITY IMPROVEMENT— Effort to improve the level of performance of a key process, which involves measuring the level of current performance, finding ways to improve that performance, and implementing new and better methods.

QUALITY OF LIFE— Assessment of patient functional status. A variety of methods may be used to estimate quantitatively such outcomes as cognitive, psychological, physical, role, social function, level of pain and general well-being. Quality-of-life scales may be generic or disease specific (same measured used regardless of the disease) (University of Pittsburgh Medical Center 1995).

REFERRAL SERVICES —Any specialty, inpatient, outpatient, or laboratory services that are ordered or arranged, but not furnished directly.

RETROSPECTIVE REIMBURSEMENT—Payment to providers by a third-party carrier for costs or charges actually incurred by subscribers in a previous time period. This is the method of payment used under Medicare Part B.

SELF-INSURED HEALTH PLAN—Employer-provided health insurance in which the employer, rather than an insurer, is at risk for its employees' medical expenses.

STATE BUY-IN— Term given to the process by which a state may provide supplementary medical insurance (SMI) coverage for its needy, eligible persons through an agreement with the federal government under which the state pays their premiums.

SUPPLEMENTAL MEDICAL INSURANCE (SMI) — SMI (also known as Part B) is a voluntary insurance program that provides benefits for physician and other medical services in accordance with the provision of Title XVIII of the Social Security Act for aged, blind, and disabled individuals who fall below specified income and resource thresholds and who elect to enroll under such a program.

SUPPLEMENTAL SECURITY INCOME— A federal income support program for low-income disabled, aged, and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions.

UTILIZATION REVIEW (UR) AND UTILIZATION MANAGEMENT (UM) —A formal assessment of the medical necessity, efficiency, or appropriateness of healthcare services and treatment plans on a prospective, concurrent, or retrospective basis (United HealthCare Corporation 1994).

UTILIZATION REVIEW ORGANIZATIONS (UROs) —are external reviewers who assess the medical appropriateness of a suggested course of treatment for a particular patient, thereby providing the patient and payer increased assurance of the appropriateness, value, and quality of healthcare services being provided. The most common form of UR, preadmission certification, is requested by the patient's physician for approval of any nonemergency admission to an inpatient facility. Other techniques include concurrent review, second surgical opinion, discharge planning, outpatient certification, and case management (AMCRA Foundation 1994).