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FORGING A NEW PLAN FOR HEALTH CARE: Principles and Priorities for Sustainable Reform

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Executive Summary

The U.S. stands poised to enact dramatic and far-reaching changes to health-insurance markets in the name of expanding insurance coverage to the more than 45 million uninsured and controlling rapidly rising health-care costs in both the public and private sectors.

Early signals from Congress and the administration indicate that many of these changes will involve expansions of existing government programs like Medicare and Medicaid, massive new regulation of private insurance providers, and trillions of dollars in new federal spending that will have to be financed through new taxes or substantial rationing of patient access to health-care goods and services.

In this paper, former CBO director Douglas Holtz-Eakin makes the fiscal and political case for bipartisan health-care reform that: addresses dysfunctions in the existing health-care-delivery system; expands access to affordable private health insurance in an incremental and fiscally responsible manner; and improves market-based options for consumer access to information on health-care quality.

Principles and their matching reforms:

Principle 1: It's about value (stupid). Any reform that does not address low-value care and cost growth will fail. Suppose, for example, that the "reform" consisted of a mandate to purchase insurance, thereby achieving "universal" health insurance. In the absence of changes to the growth in health-care spending, this insurance would become increasingly expensive and ultimately force families to evade the mandate as a matter of economic necessity. At the same time, those dollars that were devoted to health care would purchase care that was of no greater overall effectiveness than at present. In short, the reform would fail to address the policy problems.

Anticipated reform: Medicare and Medicaid payment reforms to pay for prevention, bundle payments to accountable care organizations, reduce payment for readmissions and other low-quality care, and reduce the subsidy in Medicare for high-income individuals; medical malpractice reform; and the development of a pathway for follow-on biologics. The reforms recognize that the federal government has a powerful lever to reform the practice of medicine in the United States: Medicare payment policies. Recent reports also suggest that Medicare fraud may be approaching $60 billion per year—roughly 10 percent of total Medicare expenditures—and a similar situation exists with Medicaid. This fraud is unacceptable, and stopping it should be a top priority that will help finance targeted private insurance coverage expansions.

Principle 2: A rising tide of quality insurance. Health insurance is a valuable financial product that protects families against the financial devastation of costly medical expenses. A steady rise in insurance is very different, however, from an immediate move to universal coverage or other massive expansion. Assuming a round number of 50 million uninsured for simplicity, providing coverage at the typical level (say, $7,000) would cost $350 billion per year. Reforms to the delivery system could generate system-wide savings that could be funneled to expanding coverage, and opportunities within government programs could generate savings as well. But it is implausible that these savings would be sufficient for an immediate, large-scale coverage expansion. Instead, the focus should be on a process that leads to increasing insurance.

Principle 3: Private money, private insurance. Increasing coverage does not mean larger government programs. Instead, it should mean better and broader private health insurance for the U.S. population. Accordingly, there should be a firewall that does not permit new taxes or other private resources (fees, costs of complying with mandates, etc.) to be devoted to a "tax and spend" government-centric health-care reform.

Anticipated reforms for Principles 2 and 3: The federal government should reform the subsidy for private health insurance. In a policy dating back to World War II, the value of insurance that employers provide to employees is not treated as taxable income for the employee. (In contrast, if the employee were given cash to buy health insurance, the cash would be taxed.)

This subsidy—referred to as the employer exclusion—has several defects. It is fundamentally unfair because it provides a subsidy to those who receive their insurance from their employer but no subsidy to those who purchase their own health insurance. Moreover, the subsidy is of greater value to the more affluent (who have a higher tax rate and thus avoid more taxes) than to the less affluent. It also distorts decisions about health insurance and, by implication, health care. Subsidizing additional coverage can lead to overuse of insurance and medical services.

With appropriate attention to phasing in the policy to avoid disruptions, the exclusion should be eliminated and replaced with a flat credit of $4,500 (indexed for CPI inflation) for those who have private health insurance, regardless of its source. This credit will preserve existing health insurance for those in the employer system and provide incentives for coverage to those outside it.

However, it will not be a panacea. In particular, the credit would not be refundable, so those with no tax liability would require other sources of assistance. As detailed in this paper, for states that sign "Health Insurance for All" (HIA) agreements, the federal government would provide the income-tax resources to each state that was meeting its coverage objectives in proportion to the uninsured population, using sliding-scale, income-based subsidies for private insurance. This would provide additional resources to meet coverage objectives. Also, states should be permitted to allow Medicaid funds to be used for enrollment in private health insurance. Many eligible individuals do not participate in Medicaid because of the personal stigma, an outcome that could be avoided by including private health insurance as an option.

Principle 4: No more blind leading the sick. Families, providers, device manufacturers, hospitals, drug companies, and other participants in the U.S. health-care system interact in a complex and often baffling fashion. We must ensure that all participants understand their options, the cost implications of their options, and the likely health or economic consequences of their decisions.

Anticipated reform: Information should flow more smoothly and inexpensively through the system. There is now a wide appreciation of the potential to increase the penetration of health information technologies throughout the system. Indeed, the recently passed "stimulus" bill contained funding for such an initiative. However, unless there is a business model that supports the *use* of such technologies, no amount of funding (and the amount to date is modest) will succeed. Transforming the payment system to reward coordination, quality, and low cost will create a business model for health information technology, for private-sector incentives to invest in these technologies, and for greater diffusion of information throughout the system.

These reforms will gradually expand access to affordable, private health insurance; reduce waste and improve access to high-quality health care; and commit policymakers to fiscally sustainable health-care reforms.

Message from the Director

The conservative case for health-care reform begins with the recognition that health care is heavily regulated by both state and federal authorities and that many current health-care challenges can be traced to arbitrary or expedient political decisions rather than true market failures—such as the tax deduction for employer-provided health insurance, the result of WWII-era wage and price controls.

Employment-based insurance has many benefits, but it also disadvantages the self-employed and workers at small firms, who may not be able to afford to buy insurance. State insurance mandates also require insurers in the small-group and individual markets to cover many benefits—such as infertility treatments and chiropractic care—that drive up the cost of insurance. At the same time, one-size-fits-all coverage expansions that depend on expensive new federal entitlements modeled on Medicare or Medicaid will run into the same problems that are leading those programs to slowly implode, along with state and federal budgets.

Still, health-care "reform" and insurance coverage expansions are often thought of as synonymous; some advocates even argue that universal coverage will pay for itself by adding more young, healthy (and formerly uninsured) individuals to insurance pools.

In his proposal for the Manhattan Institute, Douglas Holtz-Eakin, distinguished scholar and former director of the Congressional Budget Office, makes clear that reform of our dysfunctional health-care-delivery system—particularly, the byzantine payment system for Medicare providers—must be the first priority; without reforms that provide incentives for better health outcomes and coordinated patient care, expanding coverage will merely add to our fiscal woes. Expanding coverage is a valuable goal, but it should build on these reforms, not precede them.

It should also be clear that Holtz-Eakin's proposal recognizes the vital necessity of health-care reform and that he shares President Obama's analysis of the problems facing the system. Thanks to his tenure at CBO, Holtz-Eakin is intimately familiar with the crushing burdens that rising health-care costs can impose on American families and employers. He is also acutely aware of the political realities that have led policymakers from both parties to delay needed reforms and to rely on fiscal gimmicks—IOUs for the Medicare "trust fund" and annual votes to delay cuts to Medicare physician payments—to keep a floundering entitlement system afloat until it becomes someone else's problem.

Where Holtz-Eakin emphatically differs with the administration is in his prescriptions for reform, and here he outlines a plan that builds on the conservative principles of limited government, federalist experimentation, market-based innovation, and patient-centered care to expand coverage incrementally in a fiscally responsible manner.

There are many things about which fair-minded people are allowed to disagree, and the right prescription for health-insurance expansion is one of them. Even critics who may not agree with Holtz-Eakin's approach should recall that our uninsured are not a homogenous group and that state-based approaches—whether "blue-state" reforms as in Massachusetts or "red-state" reforms as in Utah—are better and more accountable laboratories for experiment than new bureaucracies based in Washington, D.C. As in the case of welfare reform, sustainable approaches are more likely to emerge over time from the bottom up than from the top down.

Finally, we hope that Holtz-Eakin's call for bipartisanship is taken seriously. For the first time, as Holtz-Eakin explains, the Republican Party has pressing political and institutional reasons to embrace health-care reform at the national level. Democrats should also welcome a robust and serious debate and be open to compromise because a truly bipartisan process is more likely to produce durable reforms than a partisan process that marginalizes the opposition.

Unique—one is tempted to say exceptional—qualities of the American polity have long included its commitment to pragmatism over ideology; a prudent federalism that recognizes the validity of state and regional differences; and optimism regarding the powers of well-run markets to produce medical innovations that improve the quality of life and extend longevity for all Americans. Holtz-Eakin's vision for health-care reform embodies these qualities, and we hope it is a vision that will galvanize productive policy discussions in the days and months to come.

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About the Author

DOUGLAS HOLTZ-EAKIN is president of DHE Consulting, LLC. He served most recently as director of domestic and economic policy for the John McCain presidential campaign. He has also recently been a senior fellow at the Peter G. Peterson Institute for International Economics, the director of the Maurice R. Greenberg Center for Geoeconomic Studies, and the Paul A. Volcker Chair in International Economics at the Council on Foreign Relations. Previously, Dr. Holtz-Eakin was the sixth director of the Congressional Budget Office, where he was appointed for a four-year term beginning February 4, 2003.

Dr. Holtz-Eakin served for eighteen months as chief economist for the President's Council of Economic Advisers. Prior to that, he was a trustee professor of economics at the Maxwell School, Syracuse University, where he served as chairman of the Department of Economics and associate director of the Center for Policy Research.

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CONTENTS

Forging a New Plan For Health Care: Principles and Priorities for Sustainable Reform

Douglas Holtz-Eakin

INTRODUCTION

The president has called upon Congress to enact health-care reform this year. And he has correctly identified the problems: we spend too much, cover too few people, and do not get enough for our money. Unfortunately, his reforms reflect the problems with American health care: the right diagnosis is not leading to effective treatment.

The Democrats support massive new spending, draconian regulation, and a new entitlement that is likely to hamstring the private insurance market, threaten employer-sponsored insurance, and diminish the choices that the president has promised to Americans.

Effective health-care reform will be bipartisan; Republicans have an equal stake in effective reform. Health-care reform emerged as a potent issue in the 2008 Republican primaries: for the first time, every candidate had to have a plan for health-care reform. Republican constituencies are eager for new ideas. Health-care reform can contribute to their political revitalization. The 2008 election cycle disclosed a party that was unable to win outside of the South and unable to win in large cities. It is unable to poll majorities among all minorities—notably, Hispanics—and loses across the educational spectrum. It has now lost the youth vote in three successive elections, threatening the loss of this generation for its lifetime.

Most significant, the Republican Party was unable to generate an effective message on how it would help the middle class. Traditionally, it has relied on a tax-cut message to generate this support, but it now requires proactive solutions to the problems facing the middle

class: education; energy and the environment; and, especially, health care and insurance. The party can appeal to a broader spectrum of Americans by actively seeking conservative solutions to these problems. Health-care reform is more than a political imperative; health-care spending now accounts for over one-sixth of the economy, and it is badly underperforming. Republicans are the party of economic growth, and policies that reduce the bloated and inefficient health-care sector will support stronger growth.

Health-care reform is a budgetary imperative. Under current trends and policies, the nonpartisan Congressional Budget Office projects that by 2050 federal spending on Medicare and Medicaid could exceed 12 percent of GDP, and the combined cost of Social Security, Medicare, and Medicaid will be as large (20 percent of GDP) as the entire federal budget. Health-care reform that moves in the wrong direction—namely, increased government insurance with no reforms of cost growth—will transform this threat into a crisis that no advocate of small, contained government could endure.

There are compelling reasons for Republicans to do more than simply obstruct the Democrats on health-care reform. Debating new approaches in the legislative arena is the route to genuine, bipartisan reform that will be more effective. It begins with the recognition that the tax code distorts the private insurance market; that state regulation of health-insurance markets often handicaps competition; and that the existing "public options" of Medicare and Medicaid are fiscally unsustainable and rely heavily on unsustainable price controls. Worse yet, Medicare's reliance on fee-for-service payments distorts the entire health-care system by fragmenting care. Until and unless we prioritize reforms that incentivize competition and pay for quality, we will be left with the same dysfunctional, expensive system we have today.

POLICY PROBLEMS

One of the most important issues facing the United States is its underperforming health-care sector. There are three major problems. First, it costs too much. In 1970, national health expenditures were $1,300 per person and consumed 7 cents of every national dollar—7 percent of GDP. For the past three decades, health-care spending per person has grown roughly 2 percentage points faster every year than income per capita. That is, in the race between costs and resources, costs have been winning. The result is that health-care spending now exceeds 17 cents of every national dollar—and will rise to 20 percent by the end of next decade. Within the federal budget, the rising cost of Medicare and Medicaid threatens a tsunami of red ink in the decades to come.

A dominant characteristic of health care in the United States is its fragmentation and focus on acute-care episodes. This system feeds the growth in spending per capita outlined above. The Medicare program itself is illustrative in this regard. It has programs for "hospital" (Part A), for "doctors" (Part B), for "insurance companies" (Part C), and for "drug companies" (Part D). These compartmentalized programs are dedicated to ensuring that various providers receive their payments in a fee-for-service system. Doctors and hospitals are paid for doing things to patients; and the more they do, the more they are paid. This system is focused on payments to providers, not on the health of families. This system is not centered on quality of care and gives scant regard to coordinating the decisions of the various medical providers, and it does not reward preventive care.

It is hardly surprising that a medical system focused on paying for acute-care episodes has rewarded the innovation, adoption, diffusion, and utilization of new technologies for these episodes. Because the system is not oriented toward quality outcomes—particularly, paying for quality outcomes—a key feature of rising health-care spending is that it has not generated improved outcomes: the U.S. spends a greater fraction of its income on health care but does not have comparably superior longevity or health quality. The trends are most pronounced in Medicare, but the same broad characteristics prevail for the private system serving those younger than sixty-five. Also, in both cases (but again larger for Medicare) in the United States, there are large regional differences in spending

that do not lead to apparent differences in the quality of outcomes.

Second, because health care is becoming more expensive, the cost of health insurance is skyrocketing. Over the last decade, insurance costs have increased by 120 percent—three times the growth of inflation and four times the growth of wages. With higher costs has come reduced insurance coverage: over 45 million people are uninsured. It is important to solve the first problem—rising costs—before committing to large-scale coverage expansions. Dealing with the problems in the wrong order will be prohibitively expensive and will likely cause the reform effort to unwind.

Finally, health insurance and health-care systems underperform. A job loss typically also means loss of health insurance. High spending has not yielded comparably high outcomes for infant mortality, longevity, or treatment of chronic disease.

PRINCIPLES AND POLICIES FOR HEALTH-CARE REFORM

Numerous proposals will address the policy problems of spending growth, subpar coverage, and low-value care and insurance. What criteria will permit policymakers to distinguish between desirable and undesirable proposals? Four principles should guide the debate:

Principle 1: It's about value (stupid). Any reform that does not address low-value care and cost growth will fail. Suppose, for example, that the "reform" consisted of a mandate to purchase insurance, thereby achieving "universal" health insurance. In the absence of changes to the growth in health-care spending, this insurance would become increasingly expensive and ultimately force families to evade the mandate as a matter of economic necessity. At the same time, those dollars that were devoted to health care would purchase care that was of no greater overall effectiveness than at present. In short, the reform would fail to address the policy problems.

The reforms in this area are: Medicare and Medicaid fraud efforts; Medicare and Medicaid payment reforms to pay for prevention, bundle payments to accountable care organizations, reduce payment for readmissions and other low-quality care, and reduce the subsidy in Medicare for high-income individuals; medical malpractice reform; and the development of a pathway for follow-on biologics.

These reforms can produce concrete improvements that can be augmented by strong public information efforts and the bully pulpit to encourage people to take care of themselves and prevent chronic diseases when possible. Childhood obesity, diabetes, and high blood pressure are increasing in their prevalence and severity; it is important to teach children about health, nutrition, and exercise. This is a financially cheap, but potentially valuable, effort.

The reforms recognize that the federal government has a powerful lever to reform the practice of medicine in the United States: Medicare payment policies. The fraction of the nation's bills that Medicare and Medicaid are paying is rapidly approaching 40 percent. The Medicare payment mechanism supports—indeed, produces—the flaws of fee-for-service medicine in the United States.

To begin, the federal government should institute a zero-tolerance policy toward fraud. Recent reports suggest that Medicare fraud may be approaching $60 billion per year—roughly 10 percent of total Medicare spending—and a similar situation exists with Medicaid. This fraud is unacceptable, and stopping it should be a top priority.

Medicare payment policy must be oriented away from paying for anything that is done to a patient and toward paying for cost-effective, coordinated care that yields high-quality outcomes. The first step is: Do not pay for bad care. Already, the federal government has taken steps in not paying for events that should "never" happen; a more aggressive approach would include not paying for treatment if readmission occurs too soon—say, within a month—for the same problem.

Next, payment policy should explicitly incentivize the use of low-cost care and coordination of care among providers, leading Medicare to become a more accountable health-care system that rewards efficiency

and good clinical outcomes. Medicare reimbursement now rewards institutions and clinicians who do more and provide more complex services. We need to fundamentally change how physicians are paid and to focus more on chronic diseases and managing their treatment, as this is where the money goes for an aging population.

In the short term, Medicare can start paying physicians on an annual basis for treating patients with chronic disease or multiple chronic diseases rather than on a per-service basis. Medicare could also make a single payment for all the care of the most complex types of cases. As reporting of quality information continues, these measures should become part of the payment process.

These supply-side approaches to changing the use of medical services can be complemented by legal reforms to eliminate frivolous lawsuits and excessive damage awards and to provide a safe harbor for doctors who follow clinical guidelines and adhere to patient-safety protocols. Focusing on the patient provides a business model for much-needed improvements in electronic medical records and twenty-first-century information systems. Until all providers have financial incentives to lower the cost of care via coordination and to produce quality outcomes, there will be no natural incentive for health information technology and its productivity-enhancing benefits.

Finally, reform should include a process for follow-on, or "generic," versions of biologics. Optimal policy recognizes the importance of incentives to innovate but recognizes that without widespread utilization, there is insufficient social benefit. Greater penetration of these therapies will improve value in the health-care system.

Principle 2: A rising tide of quality insurance. Health insurance is a valuable financial product that protects families against the financial devastation of costly medical expenses. It is desirable to have it more broadly utilized and to provide many quality options. It is a political reality that Democrats seek to reduce the ranks of the uninsured; so Republicans must be committed to sensible policies that expand coverage over time.

A steady rise in insurance is very different, however, from an immediate move to universal coverage or other massive expansion. Assuming a round number of 50 million uninsured for simplicity, providing coverage at the typical level (say, $7,000) would cost $350 billion per year. Reforms to the delivery system could generate system-wide savings that could be funneled to expanding coverage, and opportunities within government programs could generate savings as well. But it is implausible that these savings would be sufficient for an immediate, large-scale coverage expansion. Instead, the focus should be on a process that leads to increasing insurance coverage.

Principle 3: Private money, private insurance. Increasing coverage does not mean larger government programs. Instead, it should mean better and broader private health insurance for the U.S. population. Accordingly, there should be a firewall that does not permit new taxes or other private resources (fees, costs of complying with mandates, etc.) to be devoted to a "tax and spend" government-centric health-care reform.

The policy strategy that matches Principle 2 and Principle 3 involves a partnership that encompasses federal efforts, state-level reforms, and employer participation. At the heart of this approach is the recognition that states differ greatly in their rates of uninsurance, their demography, existing mandates to provide benefits (ranging from nineteen in Alabama to more than sixty in Minnesota), rates of participation in Medicaid, and previous efforts at reform. Thus it makes sense to assign roles so that the federal government provides a base of uniform national support, states tailor assistance to the conditions of their populations, and employers continue as a mainstay of the U.S. health-insurance system.

Federal government steps. The federal government should reform the subsidy for private health insurance. In a policy dating back to World War II, the value of insurance that employers provide to employees is not treated as taxable income for the employee. (In contrast, if the employee were given cash to buy health insurance, the cash would be taxed.)

This subsidy—referred to as the employer exclusion—has several defects. It is fundamentally unfair because it provides a subsidy to those who receive their insurance from their employer but no subsidy to those who purchase their own health insurance. Moreover, the subsidy is of greater value to the more affluent (who have a higher tax rate and thus avoid more taxes) than to the less affluent. It also distorts decisions about health insurance and, by implication, health care. Subsidizing additional coverage can lead to overuse of insurance and medical services.

With appropriate attention to phasing in the policy to avoid disruptions, the exclusion should be eliminated and replaced with a flat credit of $4,500 (indexed for CPI inflation) for those who have private health insurance, regardless of its source. By transforming the tax subsidy to private insurance from the form of an exclusion to the form of a credit, two objectives are accomplished. First, the subsidy is fairer, as the same amount is available regardless of income or the source of private insurance. Second, the subsidy is fixed and capped, eliminating the reward to excessive use of insurance and care. Notice that a $4,500 credit is a generous subsidy, equivalent to an exclusion of $45,000 of health insurance for an individual in the 10 percent tax bracket and over $12,800 for a family in the top bracket of 35 percent.

This credit will preserve existing health insurance for those in the employer system and provide incentives for coverage to those outside it. However, it will not be a panacea. In particular, the credit would not be refundable, so those with no tax liability would require other sources of assistance. As detailed below, for states that sign "Health Insurance for All" (HIA) agreements, the federal government would provide the income-tax resources to each state that was meeting its coverage objectives in proportion to the uninsured population. This would provide additional resources to meet the coverage objectives.

As a final contribution to reform, the federal government should make two changes to Medicaid. First, it should incorporate Medicaid expenses for long-term care into Medicare. Many services required for long-term care are best provided in the home, and many are close complements to the care of chronic disease among elderly patients. Medicare is due for a massive overhaul—steps that will improve care and save money are outlined above—and it makes sense to develop an effective and cohesive, all-round policy toward elderly needs. It will also free up some state-level resources to meet the coverage objectives.

Second, states should be permitted to allow Medicaid funds to be used for enrollment in private health insurance. Many eligible individuals do not participate in Medicaid because of the personal stigma, an outcome that could be avoided by including private health insurance as an option. For those who do participate, states can reduce the risk of losing insurance when individuals leave Medicaid; and states can provide greater choice and competition and improve overall coverage. Finally, if individuals choose the private option, they will be able to keep their insurance in the future and not return to the Medicaid rolls. Of course, some states may choose not to pursue this option.

State government steps. States will be given the opportunity to sign HIA agreements with federal government, setting specific timelines and targets on the path to universal coverage. As noted above, in exchange they will receive budget resources to provide sliding-scale, income-based subsidies for private insurance, have additional resources for costly patients, and have the option of using Medicaid funds for private insurance.

Deploying resources at the state level enables states to "risk-adjust" the basic tax credit so that higher-cost individuals or individuals in high-cost states receive greater resources. Money alone, however, will not be enough. Some states have already chosen to mandate coverage, and others may follow. States will need to enact insurance reforms to provide coverage options for costly patients.

HIA states will also establish state-level insurance exchanges to simplify insurance shopping for individuals and small businesses by providing comparison of insurance options, enrollment, and real-time price quotes. Individuals and small businesses would have the option of purchasing private products

through the exchange, thereby providing a readily available, portable form of insurance. The insurance needs of employees of small businesses is among the most pressing issues, and these exchanges can fulfill this need.

These exchanges will encourage greater competition in the market through greater price and product transparency as well as provide a market-driven alternative to simply creating another federal bureaucracy. If desired, states could partner with like-minded states to create regional and contiguous-state health-insurance exchanges.

Employer contribution. An important element of any plan must be a mechanism to ensure that coverage goals are met. Democrats have featured the creation of a national-level insurance plan that competes with private insurance—a step that Republicans must reject. Instead, I propose a "private-sector fallback" approach. Specifically, in HIA states that are failing to meet their coverage objectives, employees would be permitted to demand 40 percent of their salary in a health-insurance match. This roughly corresponds to the average contribution paid by employers for those with employer coverage.

Why this approach? First, and most important, it engages private employers in every state in the effort to meet coverage goals—the best fallback plan is one that is never used. Second, it makes a contingent commitment of private resources to solve the private insurance failure and puts control into the hands of employees.

Principle 4: No more blind leading the sick. Families, providers, device manufacturers, hospitals, drug companies, and other participants in the U.S. health-care system interact in a complex and often baffling fashion. We must ensure that all participants understand their options, the cost implications of their options, and the likely health or economic consequences of their decisions.

A central flaw of the current health-care system is the inability of providers or patients to make value judgments regarding alternative drugs and therapies. One reason for this flaw has been the absence of efforts to identify high-quality care, a void rapidly being filled by a plethora of private-sector-driven efforts to identify best practices and to set quality benchmarks. Any reform should embrace—not replace—these efforts.

In addition, information should flow more smoothly and inexpensively through the system. There is now a wide appreciation of the potential to increase the penetration of health information technologies throughout the system. Indeed, the recently passed "stimulus" bill contained funding for such an initiative. However, unless there is a business model that supports the use of such technologies, no amount of funding (and the amount to date is modest) will succeed in adoption and use of health information technologies. Transforming the payment system to reward coordination, quality, and low cost will create a business model for health information technology, for private-sector incentives to invest in these technologies, and for greater diffusion of information throughout the system.

We need to be able to compare the relative effectiveness of alternative approaches. Comparative effectiveness (CE) is now seen as a centerpiece of reform. But how should it be implemented? I suggest that the federal government has a clear role in certifying which studies and trials meet the standards of science and operational integrity. The government also has a clear role in summarizing and disseminating the results of research that is conducted according to high standards. These roles could be met by a small research agency devoted to the certification, analysis, and dissemination tasks. Importantly, it would not be necessary for the agency to conduct intramural research or to make coverage decisions. The goal is to establish standards and disseminate information.

CONCLUSION

The U.S. health-care system is a global leader in medical science and innovation of medical technologies. But the foundation of the system—the tax exemption for employer insurance, the quality of state health-insurance markets, and the fragmentation supported by federal payment

policies—encourages a system of low value and poor performance. Fixing those problems without crippling medical innovation should be our first priority.

Fiscally responsible and durable reform must be a genuinely bipartisan process. The U.S. would be well served by a robust health-care debate that covers the areas of broad bipartisan consensus (largely, the delivery-system reforms) as well as the areas of sharp disagreement (notably, the strategy for coverage expansions).

Democrats and Republicans alike should develop strategies to support bipartisanship. The president and Democrats must not overreach and muscle through expensive coverage expansions—in particular, using the legislative protections provided by the "reconciliation" process that would permit Democrats to pass major reform on essentially a party-line vote—that will ultimately fall under their own fiscal weight.

Worse, the quick and easy way to achieve expansion would be through larger government programs—a Medicare buy-in at younger ages, Medicaid expansions, or a new public insurance program. That approach would exacerbate, not solve, the worst problems of the health-care system. First, it would inevitably be a budgetary drain as politicians fall victim to the pressures to charge too little and cover too much. Second, it would centralize power in Washington, which is surely at odds with providing competitive, low-cost, quality care in flexible treatment models for Americans. Finally, it would lead to the poor provider-payment policies that plague the system today.

Perhaps my most depressing moment as director of the Congressional Budget Office was being asked during congressional Medicare testimony, "Mr. Director, what is the right price for inhalation therapy in [name of senator's state]?" That question reflects everything that is wrong with Medicare: it is riddled with price-fixing on a political basis that determines the therapies available to beneficiaries and the incomes of doctors and other providers. Reform must move away from those approaches.

Republicans should work with Democrats to demonstrate bipartisanship of the outcome at every stage. When a bill is considered in committee, at least one prominent Republican should be willing to vouch that the bill, while perhaps not perfect, represents the kind of compromise that bipartisan efforts require. If not, Republicans should depart the process.

The strategy should involve engagement with all stakeholders, especially the states. States have made numerous efforts at significant reform. "Blue" states such as Massachusetts and "red" states like Utah have passed bipartisan reform. The agreement of these stakeholders will raise the legitimacy of any federal reform as well as avoid undercutting their own efforts.

Each side should be permitted a key objective at the outset. Republicans should veto any new federal government insurance plan and demand fiscally responsible reforms to existing programs. In return, they should acknowledge the need to expand coverage in the near term and include a path to broad coverage.

The United States is in need of deep reforms to the health-care sector of its economy: it spends too much, covers too few people, and gets too little for the money. Bipartisan reforms that stress a reformed delivery system, better value in care, respect for state-level reform efforts, more efficient insurance markets, and better tools can address the deep problems of our health-care system in a fiscally responsible way. These reforms should be in the interest of Democrats and Republicans alike.

Fellows

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The Center for Medical Progress (CMP) is dedicated to articulating the importance of medical progress and the connection between free-market institutions and making medical progress both possible and widely available throughout the world. The research and writing of CMP senior fellows David Gratzer, Regina Herzlinger, Paul Howard, and Thomas Stossel encourage the development of market-based policy alternatives to sustain medical progress and promote medical innovation.

CMP fellows are published in prominent publications such as the Wall Street Journal, the Washington Post, National Review, and the Weekly Standard. Regina Herzlinger is widely recognized throughout the business and policy communities for her innovative research in health care and in 2007 released her latest book, "*Who Killed Health Care?: America's $2 Trillion Medical Problem—and the Consumer-Driven Cure*". David Gratzer, who's work focuses on consumer-driven health care, Medicare and Medicaid, drug reimportation, and FDA reform, released "*The Cure: How Capitalism Can Save American Health* " in 2006, which received nationwide acclaim.

Paul Howard, director of the CMP, has a focus on medical malpractice, FDA reform, and Medicare policy initiatives. Thomas Stossel has written extensively on physician and researcher interactions with private industry. Peter Huber writes on a wide range of topics from drug development to the future of pharmaceuticals

In Fall 2008, CMP launched Project FDA, an initiative designed to advise the Food and Drug Administration on ways to accelerate the drug approval and drug development process while maintaining drug safety. The Project FDA committee, chaired by Tomas Philipson, PhD, is composed of nine practicing physician-scientists, economists, medical ethicists and policy experts who will explain how 21st Century technologies can help develop better FDA regulations and a faster and safer drug and medical device pipeline.

CMP also publishes MedicalProgressToday.com, a blog that provides a daily commentary of the best published research and analysis of health-care issues from a free-market perspective. In addition, MPT solicits original spotlight op-eds on critical health-care topics, and convenes policy forums where leading scholars exchange views on important health-care issues. Contributors to MPT have included Richard Epstein, Newt Gingrich, Scott Gottlieb, and J. Edward Hill.