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A SUSTAINABLE HEALTH SYSTEM FOR ALL AMERICANS

LEN M. NICHOLS

POLICY PROPOSAL

THE NEXT SOCIAL CONTRACT

NEW AMERICA FOUNDATION

A SUSTAINABLE HEALTH SYSTEM FOR ALL AMERICANS

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EXECUTIVE SUMMARY

America's health care system fails to meet the standards set by its peers around the world. It delivers substandard patient care far too often, leaves tens of millions uninsured, and its rising cost growth threatens the foundations of our economy and society. Unless we move toward comprehensive, system-wide reform, we will continue to waste billions of dollars and thousands of lives every year in a health care system that is riddled with inefficiencies. A health care system for the Next Social Contract should correct these deficiencies by expanding coverage, creating better incentives for quality and efficiency, and linking health insurance to individuals, rather than to their place of employment. It should be guided by the principles of personal responsibility for one's own health and shared responsibility to ensure the health and welfare of all our citizens, including our most vulnerable ones.

This paper outlines what a health system under the Next Social Contract ought to look like. It would shift the responsibility for providing health insurance from the employer to the individual, freeing American companies to concentrate on growth and competitiveness without having to

worry about rising health care costs. It would make health insurance mandatory for all U.S. citizens, but it would also offer generous subsidies and large risk pools to help defray the cost of premiums. It would be guided by a refocused approach to health care delivery that emphasizes prevention, early diagnosis, and evidence-based treatments rather than expensive and often known-to-be ineffective diagnostic and treatment techniques. And it would encourage the widespread adoption of information technology to reduce administrative costs and help all clinicians and patients share best-practice information in real time.

The stakes are high. A failure to act to stem rising health care costs will jeopardize our public's health and undercut our international competitiveness. And the failure to make affordable health care available to the 45 million Americans who are currently uninsured is morally indefensible. But the current crisis of our health care system is also an opportunity to rethink its basic tenets and improve its overall performance. If we use this opportunity wisely, we will fashion a health care system suited to the needs of citizens in a 21st century society.

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Our health care system is broken. It is a drag on our economy, it undermines our international competitiveness, and it is a source of insecurity for families up and down the income scale. Relentless cost growth has made health insurance increasingly expensive, straining household resources and leading to an increasing number of Americans without coverage. Almost 45 million Americans live without health insurance. This has profound consequences for our society, as the uninsured are more likely to suffer prolonged illness and even premature death.¹

In 1987, a family health insurance policy claimed 8 percent of median family income; today it takes 20 percent, and it will require even more tomorrow.² If we do not make health insurance more affordable, a majority of working Americans will be uninsured by 2020. At the same time, our high spending does not buy a commensurate amount of health. Poor average quality harms hundreds of thousands of patients, and inappropriate care adds billions of dollars in unnecessary costs.³ The interconnected problems of cost, access, and quality contribute to a system whose performance is mediocre at best and notable for its stunning lack of transparency and accountability to health care consumers.

Moreover, employers, burdened by the costs of providing health insurance to their employees, are finding it difficult to remain competitive in the globalized economy. The wages of workers are being siphoned off to pay for the increased cost of coverage, which has led to a prolonged period of wage stagnation for working-class Americans. The status quo is unacceptable, and the system is unsustainable.

Washington policymakers have allowed this crisis to develop unabated. However, a consensus is emerging about

possible solutions, a consensus articulated with increasing clarity by state governors, members of Congress, and presidential aspirants. Recent proposals by Republican governors in Massachusetts and California, by Senators Ron Wyden (D-OR) and Robert Bennett (R-UT), and by presidential candidates like John Edwards form the basis of a promising new approach.⁴ What their proposals have in common is an emphasis on personal and shared responsibility. The objective of this paper is to present the first complete, integrated statement of these emerging themes and to show how they can serve as the foundation for a health care system suited to the 21st century.

The old arrangements of our existing social contract no longer make sense in an economy characterized by global labor markets, shortened job tenure, heightened capital mobility, rapid technological change, and increased pressure for short-term profits. In such an economy, it makes little sense to link health care to employment status. Rather, we need to ensure that benefits are portable and tied to the individual, rather than to his or her place of employment. This will not only expand employment options for all

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Americans over the course of their work lives but also allow them to focus on maximizing their productivity rather than worry about losing their benefits.

It is worth noting at the outset that any social contract presupposes a community to which all citizens belong. The very idea of a contract, or covenant, that specifies personal and social responsibility is to be found in the oldest descriptions of community we have. The Hebrew Torah, revealed to and written by Moses 3,400 years ago, admonishes landowners to leave a portion of their harvest in the field for the widow, the orphan, and the stranger.⁵ Without such “gleaning” rights, these vulnerable populations would have starved, and it was impermissible to tolerate preventable starvation, even for those of different faiths or ethnicity. Every human being was believed to have been made in the image of God and thereby possessed a right to participate in the life of the community. Communities could set rules, but they were supposed to keep the door open to all those willing to join, and to feed those who could not feed themselves for whatever reason.

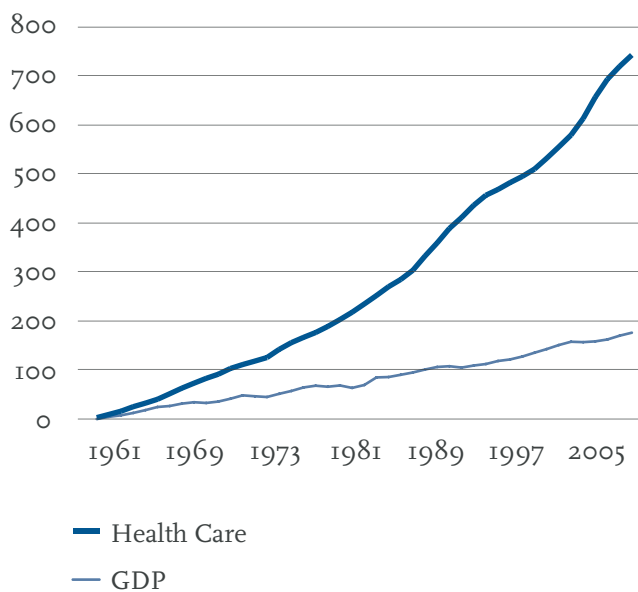
Jesus clarified the universality of “the stranger,” and Mohammed accepted and rearticulated these principles, which are shared by the monotheistic faiths (and by many people who adhere to no formal faith tradition).⁶ Jesus and Mohammed, and the prophets who preceded them, also

made clear that full membership in the community meant more than being entitled to a minimal level of subsistence.⁷ In some ways, the definition of any social contract is about specifying requirements for “full participation” in a society.

At the time the Abrahamic Scriptures were written, food was the only commodity one human could give another to support life, and the laws to guide and strengthen communities were largely designed to lessen the precariousness of life. It was clearly immoral to do nothing in the face of preventable starvation: the admonition to “feed the hungry” is repeated throughout the Scriptures in a hundred different ways. The analogy to our current health care crisis is also clear. Five years ago, the Institute of Medicine concluded that 18,000 Americans die every year due to lack of health insurance, which prevents them from getting timely access to effective care.⁸ We cannot claim to be a moral society and ignore or accept this reality.

Even so, it is well to keep in mind that in ancient times, no community was admonished to give equal amounts of food to each person, nor was any community required to give all of its food to one person; stewardship of the community’s scarce resources was presumed to be an important function of leadership. It is also worth noting that even where gleaning rights are spelled out—in Leviticus and elsewhere—the landowner was not admonished to cook for the hungry, but rather to leave some food in the field for those in need to gather for themselves. That is to say, our oldest written obligations to one another were mutual—personal responsibility and shared responsibility were linked.

Growth in Health Care Spending Exceeds GDP 1960-2005



Source: David M. Walker, “DOD’s 21st Century Spending Challenges,” General Accounting Office, Presentation for the Task Force on the Future of Military Health Care, April 18, 2007, p. 8.

AMERICA’S HEALTH CARE SYSTEM IS FAILING

Our health care system is failing. Excessive cost, mediocre quality, and inequitable access to care add up to a debilitating trifecta. Not only have our political leaders failed to address these issues, until recently they have shown little indication that they understand how they are linked, or what impact they have on the economy in general.

Unsustainable Cost Growth

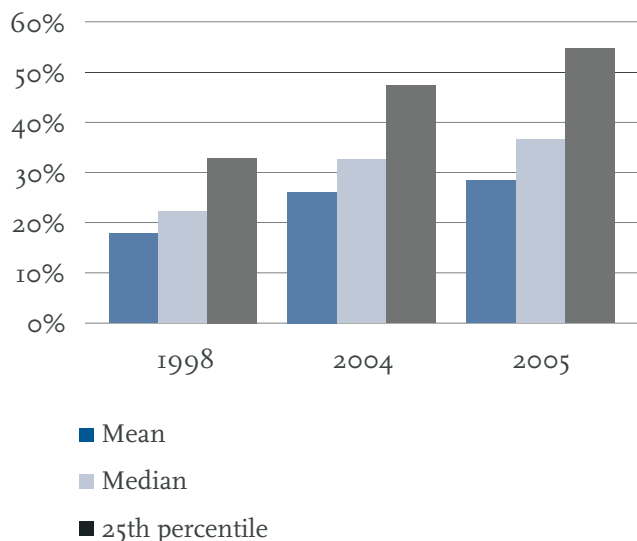
Since 1960, real per capita health care cost growth has exceeded national GDP growth by 2.6 percent a year.⁹ Families and employers alike are finding health insurance increasingly unaffordable. This is the main reason that the number of individuals with health insurance coverage, either through their employers or purchased individually,

is dropping so precipitously.¹⁰ Moreover, health insurance costs represent a growing fraction of employee compensation costs. When employers pay for a portion of these rising costs, the total costs of employment increase even though worker's wages do not rise.

Employer-paid health costs also represent a growing share of wages. This exacerbates labor-management friction since most workers (as well as many employers) believe that employer contributions come out of profits, not out of wages. Economic theory argues that over time wage and non-wage compensation alike must be financed by labor's productivity, or employment at a given compensation level will not be sustained. This is why economists argue that employer contributions for health insurance (as well as for pensions, sick leave, etc.) are implicitly taken out of what would be higher wages. In the short run, when employers make tactical changes in compensation packages subject to the constraints of competitive labor markets, the actual burden, or "incidence," of employer-paid health costs is likely shared between employers and workers, or between capital and labor. Evidence supporting this theory of "partial incidence" includes recent reductions in the employer share of the cost of insurance premiums.¹¹ Given federal income and payroll tax exclusions, it is mutually beneficial for employees to voluntarily trade wages for employer premium payments and for employers to pay 100 percent of the premium so that health insurance may be bought with pre-tax dollars. If workers and employers believed the economists, this would be the norm every year, regardless of health care cost growth. But the percentage of firms paying 100 percent of insurance premiums has declined steadily since the mid-1970s to near zero, and many companies have significantly reduced their share of the costs in recent years.¹² Thus employers are behaving as if they believe that they cannot shift all health care costs to wages.

Whether employer-paid health insurance is shifted fully or only partially to wages in the short run, when the costs of health care grow faster than the rise in productivity employers are constrained from sharing productivity gains with workers. This further exacerbates labor-management tensions over health costs. In the mid-20th century, U.S. companies engaged in international trade had more market power than they do now and could pass cost increases on to consumers relatively easily by raising the price of their products. In the intervening years, the competitiveness of international markets has increased considerably, and the market power of U.S. exporters has declined.¹³ This has eliminated a safety valve employers could formerly count

Health Care Premiums as a Percentage of Total Wages Have Risen



Source: "Employer Health Benefits: Annual Survey," Kaiser Family Foundation, various years; Bureau of Labor Statistics, "National Compensation Survey: Occupational Wages in the United States," Supplemental Tables, various years.

on to relieve pressure from excess health care cost growth. Today, many employers are engaged in a focused search to reduce health care costs and their exposure to future cost increases.¹⁴

Most of us intuitively understand that there are opportunity costs to rising health care expenses. That is, we know that when we pay more for insurance we have less left over to pay for other goods and services we might otherwise wish to purchase. The opportunity costs imposed by the uninsured are less obvious, but no less real. They include the "hidden tax" that the insured pay—in higher insurance premiums and medical fees—to help subsidize care the uninsured receive but cannot pay for.¹⁵ They also include longer waits in the emergency room for the insured, since the uninsured often have nowhere else to go.¹⁶ And they include less access to medical care in general in areas where the uninsured are concentrated because providers are not inclined to locate where patients cannot pay the full cost of their services.¹⁷ But by far the largest opportunity cost imposed by the uninsured is the lost economic output due to unnecessarily prolonged illnesses, lost days of work, and even premature death that result from late diagnosis and treatment. The Institute of Medicine has estimated that the total social cost of the uninsured is roughly equal to the public cost of subsidies that could cover all Americans.¹⁸ Thus, aside from the immorality of tolerating preventable illness and death, there is a compelling economic case that univer-

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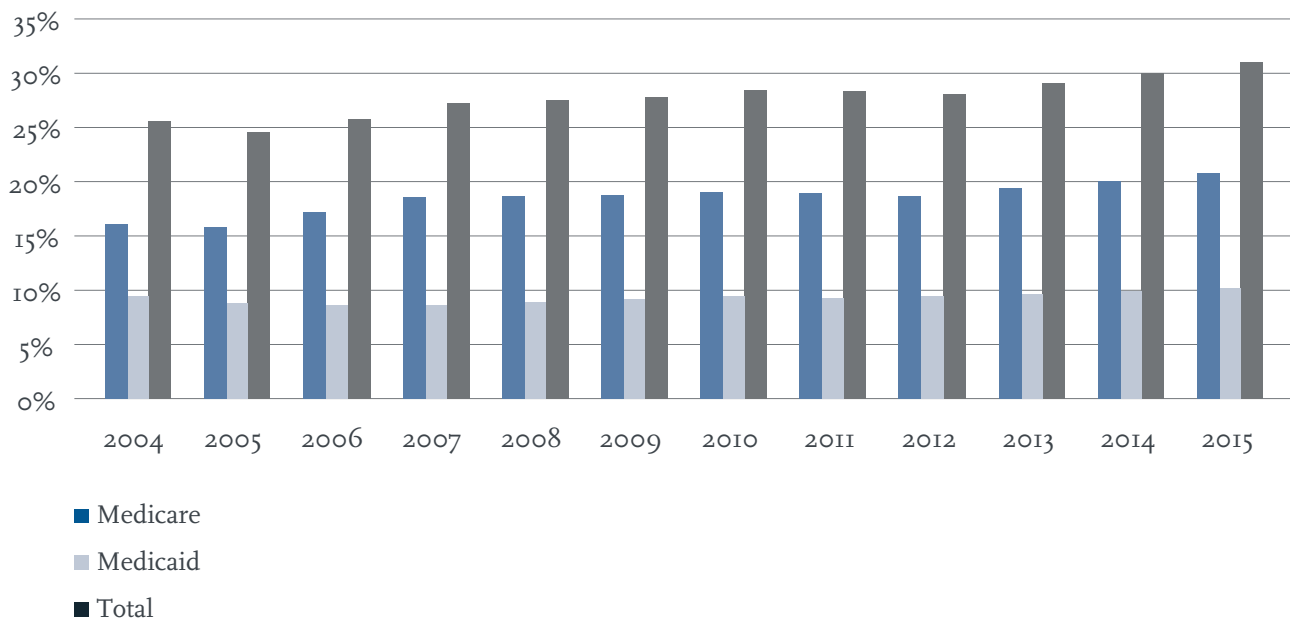
The unsustainability of our current health system is also evident in the growing pressure on federal, state, and local budgets. Under current law and cost growth trends, spending on the two largest public health insurance programs, Medicare (for the elderly) and Medicaid (for the poor), is projected to grow from 25 percent to 30 percent of the total federal budget in the next 10 years.¹⁹ Medicaid is already the largest government expenditure in most states, and it is the fastest growing in almost every state.²⁰ Local governments are increasingly footing the residual bills for the uninsured that have nowhere else to turn. The ballooning opportunity

costs of health expenditures are forcing government officials at every level to focus on long-run cost growth containment.

Declining Coverage

According to the U.S. Census Bureau, 45 million, or 15 percent, of Americans were uninsured in 2005—up from 38 million and 13 percent in 2000. Virtually the entire net decline in coverage has been in employment-related insurance. Seventy-five percent of those who lost coverage during this period did so because their employers stopped offering insurance altogether, reduced eligibility, or scaled back dependent coverage. About a quarter of the decline in coverage stemmed from lower employee take-up rates of employers' offers of insurance.²¹ The primary reason for the decline in coverage is the increase in health costs relative to economy-wide productivity and individual income. If Medicaid, created to cover those with incomes below poverty, had not grown by almost 9 million participants in this period, 20 percent of Americans might now be uninsured. The resulting growth in the cost of Medicaid has strained the federal and state budgets to the point that the program is unlikely to be able to play a residual safety-net role for the unraveling employer system much longer.

Growth and Projected Growth in Medicare and Medicaid Spending as a Percentage of the Federal Budget



Source: Barry Bloom, Mark Booth, Ann Futrell, and Christina Hawley Sadoti, *The Budget and Economic Outlook: An Update*, Congressional Budget Office, August 2005, p. 6.

The challenges presented by the 21st-century economy demand flexibility on the part of both employers and workers. Workers now in their twenties are expected to change jobs 12 times in their working lifetimes, compared to workers now in their late fifties who have changed jobs six times on average.²² But changing jobs under an employer-centered health insurance system often requires changing health plans and clinicians, which can disrupt long-term doctor-patient relationships and impair health maintenance and the quality of clinical care.²³ This would be reason enough for to reform the way we provide health coverage. However, there is another compelling reason. The rising importance of entrepreneurship and small business formation in the 21st-century economy, coupled with the fact that the high cost of purchasing health insurance for small numbers of workers is among the greatest obstacles to small business creation and growth, make severing the tie between health insurance and employment essential to future growth. A system of portable health insurance would aid the economy and benefit workers and employers alike.

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Mediocre Quality at a High Price

While the United States has some of the best clinicians and health facilities in the world, and better short-term survival rates with respect to certain acute conditions than other developed countries, we spend at least 50 percent more per capita on medical care and yet achieve far worse average health outcomes, as reflected in such measures as life expectancy and infant mortality. According to the World Health Organization, the United States ranks thirty-seventh in overall health system performance, nestled between Slovenia and Costa Rica, countries with significantly lower per capita income than the United States.²⁴ Americans get appropriate care in their doctors' offices only 55 percent of the time.²⁵ High-income Americans receive only marginally better care.²⁶ That is the American health care system in a nutshell: we pay a lot for relatively little.²⁷ Geographic variation in the quality of care is particularly stunning: a person with cancer living in Utah has a one-third greater chance of surviving a year than a can-

cer patient in North Carolina.²⁸ We also suffer over 150,000 unnecessary deaths each year from avoidable medical errors and substandard care.²⁹ The Institute of Medicine's clarion call for quality improvement has gotten the attention of policymakers and health system leaders alike, but progress, while encouraging, has been slow.³⁰ Americans have the right to a health care system that works well for everyone.

A HEALTH CARE SYSTEM FOR THE 21ST CENTURY

The two essential pillars for creating an affordable health care system for all Americans are *personal responsibility* and *shared responsibility*. Policy reforms that build upon these pillars will help us create a health care system consistent with the principles of the Next Social Contract. Demands will be made both of the individual and the collective. Mandates to buy insurance and subsidies to help people afford to do so will be balanced with the creation of an insurance marketplace that is affordable and a delivery system that works in terms of both cost and quality.

The concept of personal responsibility means that individuals must be full participants in maintaining their own health and that of their children. They must follow accepted guidelines for maintaining good health, seek appropriate medical care in a timely fashion when necessary, and purchase insurance coverage. Shared responsibility refers to the collective task of ensuring that there is a functioning insurance marketplace capable of meeting the needs of the society as a whole, providing assistance to those that need help to purchase insurance, and ensuring that the delivery system for providing quality care is as efficient and cost-effective as possible.

Our vision of a new health care system begins with personal responsibility and builds outward. The Institute of Medicine takes the position that the best health care is "patient-centered."³¹ This means that the ideal system is one that focuses in the first instance on individual patient well-being, rather than on the convenience of providers or institutions. Individual responsibility for decision-making with respect to behavior that affects health and compliance with professional advice and counsel is also essential to patient-centeredness.

Shared responsibility extends over three dimensions of our proposed new health care system, all of which reflect the need for collective stewardship of common resources. The first is to create and maintain an insurance marketplace

that works for all and is fair and efficient. The second is to finance and implement a subsidy schedule that makes basic insurance coverage affordable for all. The third is to remake the delivery of health care far more efficient and sustainable than it is today.

Personal Responsibility for Maintaining Good Health

Maintaining good health is not a spectator sport. In order for our health care system to be more effective, each individual must be willing to follow nutritional guidelines, get appropriate amounts of exercise, seek preventive care, and comply with treatment regimens. We aim to create a culture or set of norms around individual responsibility for both encouraging healthy personal behavior and securing access to appropriate professional care through the purchase or enrollment in a qualified health insurance plan. Centering responsibility on individuals reflects the reality that behavior is a major determinant of health status and of health improvement, within contexts and limits defined by family, community, and social environments.³²

Personal responsibility requirements are not meant to punish those who become ill, but rather to clarify that everyone is expected to behave responsibly to prevent illness when possible and to mitigate the effects of chronic diseases by making good choices once afflicted. Thus, financial incentives to meet agreed upon health or adherence targets will become increasingly important components of the health benefit packages of the future.

Personal Responsibility for Obtaining Coverage

Given the well-documented importance of medical insurance for facilitating access to timely and effective care,³³ our personal responsibility concept includes a requirement that everyone purchase coverage. It is essential to establish a legal mandate requiring every individual to purchase insurance. Purchase requirements are necessary to boost the efficiency of insurance markets because mandates greatly reduce insurers' legitimate fears that they may otherwise be forced to provide coverage for disproportionate numbers of individuals with high health costs. Getting everybody into the insurance pool will lead to significant reductions in administrative and marketing costs that can be passed on to consumers and payers.³⁴

Under our plan, all U.S. citizens and legal aliens aged 19 and older would be required to purchase coverage for themselves and their dependents. Imposing such a requirement under our current system is unrealistic because the cost of premiums offered to many is prohibitive; we will need to

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construct a new marketplace to facilitate affordable coverage for all. Key elements of this marketplace—such as the rules of competition, basic and supplemental benefit packages, subsidy schedules—will be described in the following section. Since our overall proposal hinges on the development of a prevailing culture of coverage, government must help create a fair, accessible, and affordable insurance market.

Imposing an individual purchase mandate will necessitate enforcement mechanisms since free riding will remain an attractive option for some. Financial sanctions must be put into place and enrollment in a basic plan defaulted, so that no citizen (or legal alien) is ever actually without coverage. Those who fail to buy coverage will be assigned to a basic health coverage plan with low premiums. Employers, schools, health care providers, automobile insurers, and tax authorities will be required to ask for documented proof of health insurance coverage and to notify the insurance market administrator of individuals without coverage. Some states have already begun to experiment with information sharing in enforcing automobile insurance mandates.³⁵ The state of Massachusetts and the governor of California have made the individual purchase mandate central to their health insurance reform proposals.

Individuals who fail to comply with the mandate will be required to pay back premiums plus a penalty based on the length of time they have been unenrolled. Health care providers will not be denied payment for treating patients who lack coverage, however, since an individual's assigned default plan will be responsible for covered services. The market administrator will be authorized to employ collection agencies against those who attempt to free ride, as health provid-

ers and state agencies do today. In extreme cases, wages can be garnished to ensure collection of unpaid premiums and penalties. Since most people want health insurance coverage, enforcement problems are likely to be limited to a fairly predictable few once the norm of personal responsibility for coverage has been established, as shown by the experience of Switzerland and the Netherlands, where individual insurance purchase mandates are in effect and highly successful.³⁶

A New Insurance Marketplace

Our 21st-century health care system will rely on private markets to the degree possible, as well as transparent and accountable regulatory institutions. Private markets are better able to serve the diverse preferences and circumstances of Americans than a one-size-fits-all scheme for universal coverage. Choice—stimulated by competition—is desirable because it will reassure those worried about quality that they can seek out the providers they prefer. At the same time, health markets need rules to operate fairly and efficiently. The regulatory institutions required to make and enforce these rules will themselves need to commit to an evidence-based decision-making process and be open to public scrutiny.

The bedrock of our proposal is an insurance market that preserves and improves upon the advantages of employer group purchasing and marketing, with its inbuilt administrative economies of scale and broad risk pooling. Ensuring that the new insurance marketplace is efficient, fair, and transparent can best be accomplished by establishing an

Insurance Purchasing Exchange, designed to govern the health insurance marketplace. The exchange could be managed by a public entity, as is the Federal Employees Health Benefits Program, which is run by the Office of Personnel Management. Or it could be managed by a nonprofit entity like the Pacific Business Group on Health, which administers coverage for large employers in California. It might also make sense initially to have multiple exchanges operating throughout the country. These exchanges could also be organized along state lines, or on a regional basis, with smaller states joining forces to form a single marketplace. Large states like California and New York might consider establishing several separate exchanges to serve their local health markets more efficiently.

All health insurance would be sold within the exchange (or exchanges), and the exchange would specify and enforce the rules of competition that in turn would guarantee transparency in the content of products as well as fairness in access and pricing. To participate in the marketplace, insurers would be required to offer a standard product, or Basic Plan, as well as a cost-sharing complementary package that would help to defray the cost of deductibles and co-payments. Insurers would be allowed to offer auxiliary packages to cover services excluded from the Basic Plan, so long as auxiliary benefits were priced separately. In this way, price competition with respect to Basic Plan coverage would not be confused with risk selection and benefit variation effects on quoted premiums for the extra packages. And because

A Health Care System for the 21st Century: Personal Responsibility

Personal Health:

Responsibility and Incentives:

Individuals are expected to take responsibility for their own health, including diet, exercise, prevention, seeking professional care when appropriate, and following treatment recommendations. Insurers may adjust premiums based on key behavioral targets, such as smoking and weight-loss goals.

Individual Mandate:

Insurance Purchase Requirement:

Health insurance is necessary to secure access to appropriate health care. All adults age 19 and older are required to purchase insurance for themselves and their dependents. Subsidies will be available for the low income population. Enforcement will be facilitated through information sharing among health providers, schools, employers, tax authorities, and the Insurance Exchange. Failure to pay one's fair share will lead to financial penalties.

every insurance company would have to sell a Basic Plan to qualify for membership in the exchange, price competition would help keep the Basic Plan affordable for those who were not subsidized.

The Insurance Purchasing Exchange would be governed by certain basic rules: individuals would be permitted to buy any product from any insurer (guaranteed issue), insurers would be prohibited from summarily dropping any individual (guaranteed renewal), and there would be limits on how much premiums could vary across individuals (modified community rating). Consistent with our principle of personal responsibility, insurers would be allowed to adjust their premiums based on select criteria, such as the age of the insured, location (to reflect health input cost variation), and key behavioral targets linked to good health. These targets might include completing a health risk assessment questionnaire, not smoking or participating in smoking cessation classes, or signing up with a primary care team, sometimes referred to as a “medical home,” to help manage chronic diseases like diabetes or congestive heart failure.

The exchange would collect premium dollars from employers (on behalf of workers) and households, and facilitate the delivery of subsidies for low-income individuals and families from the federal government. It would also coordinate the Web-based enrollment of individuals and marketing by and payments to health plans, adjusting premium revenue to reflect extreme differences in average health status across insurers (risk adjustment). Since different exchanges would likely operate along state lines—at least initially—state governments would be expected to remain involved in making policy decisions in conjunction with

federal health officials. States would continue to regulate and license insurance providers, and state exchanges would likely hire most state insurance regulatory staff to enforce the new insurance market rules. On other matters, the secretary of the Department of Health and Human Services would have approval authority over any state exchange plan.

The Basic Plan and its mandated benefits package would be determined and modified periodically by a Benefits Board, whose members would be appointed by the U.S. comptroller general. This board would be charged with balancing the natural tension between expanding coverage of clinically valuable services and minimizing the increase in taxpayer-financed subsidies. It would also evaluate medical research to identify effective treatments and procedures. This knowledge would inform decisions about which services to cover as well as how to set cost-sharing with respect to services covered in the Basic Plan. This will enable cost-sharing, or demand-side incentives, to be used to guide patients toward effective treatments and away from treatments that have not been proven effective. A similar approach, pioneered at the University of Michigan and used as an employee-benefit negotiation tool, has been successful in getting diverse citizens to see the need to balance benefit package limits with concerns about access to appropriate care.³⁷

The Benefits Board would also be responsible for developing the complementary cost-sharing subsidy package that low-income individuals will receive along with the Basic Plan at no cost or at reduced cost. The existence of this cost-sharing complement would allow the board to recommend more parsimonious coverage under the Basic Plan’s mandated benefit package, e.g., a \$2,000 deductible for

A Health Care System for the 21st Century: Shared Responsibility

New Marketplace:

Insurance Purchasing Exchange:

Serves as a general marketplace where all health insurance is sold. Regulates and enforces the rules of competition. The Exchange will ensure that all insurance providers offer coverage and renewals to those seeking insurance. The Exchange will be responsible for collecting and distributing premium payments. Small states might choose to share a single exchange; large states might have several exchanges.

Basic Plan:

All insurers will offer a Basic Plan, which will entail the legally-required minimum of health insurance. More expensive supplemental policies will also be available to those who want to buy them.

singles, and a \$4,000 deductible for families. Finally, the board would specify the patient cost-sharing and provider payment incentives to be included in the Basic Plan. For example, lower premiums might be offered to nonsmokers or to individuals who sign up with a medical home to help them manage and coordinate care throughout the delivery system. Or higher payments might be offered to clinicians for maintaining superior health outcomes in patients with chronic diseases.

The Benefits Board would be an independent entity, but since Congress would fund the board, the Insurance Purchasing Exchange, and subsidies, it would be expected to work closely with Congress, more or less like the Federal Reserve chairman does .

Subsidies for Purchasing Coverage

Any humane and politically sustainable health care system must subsidize the access of low-income individuals and families to health insurance and health care. Historically, the burden of paying for health care for those of modest means has fallen on low-income households themselves, employers, governments, and providers (through the provision of free or below-cost care to the medically indigent). We describe below how and why it makes sense to relieve employers of this responsibility in order to build a health care system more compatible with 21st-century economic realities. But that means the social commitment to subsidizing low-income Americans must be firm and unwavering, for without generous and substantial financial assistance, tens of millions of Americans would be unable to afford health insurance.

Under our proposal, all individuals will be expected to enroll in an insurance plan of their choosing to cover themselves and their dependents from among those offered within the Insurance Purchasing Exchange. And everyone will be required pay at least a nominal amount toward the cost of coverage. The minimum payment might be \$5 a month for an individual policy, or \$10 a month for a family policy. Individuals or families with incomes under 67 percent of national median income would receive a subsidy sufficient to buy the Basic Plan (less that minimum personal contribution). Those with incomes between 67 percent (\$31,038 in 2005) and 180 percent of the national median income (\$83,387 in 2005) would also receive a subsidy.³⁸ Those with incomes above 180 percent of national median income would be expected to pay for insurance on their own. Because the Basic Plan—under which everyone would be covered—would likely have relatively high deduct-

...the social commitment to subsidizing low-income Americans must be firm and unwavering.

ibles and large co-payments in order to keep costs down, a complementary cost-sharing package would be made available to low-income individuals on a sliding scale. It would be free for those with those with the lowest incomes. This would help minimize the price of the Basic Plan for those who did not qualify for a subsidy but are still required to purchase insurance. Still, in keeping with our principle of personal responsibility, even the poorest Americans would have to pay providers a nominal fee at the point of service, although the fee could be waived at the discretion of providers in hardship cases. Individuals could always choose not to purchase the complementary cost-sharing coverage, regardless of what subsidy level they qualified for.

This integration of the Basic Plan and cost-sharing subsidies for those at the lowest income level will obviate the need for Medicaid and the State Children's Health Insurance Program (SCHIP), except for those beneficiaries who are disabled (and uninsurable in the traditional sense) or elderly and also eligible for Medicare. Current SCHIP and non-disabled, non-elderly Medicaid recipients will be required to obtain Basic Plan coverage and will receive a subsidy to do so, so the Medicaid program will be reduced considerably. Medicare, on the other hand, will remain as it is today.

An Efficient and Sustainable Delivery System

The fundamental dynamic driving health care reform is cost growth that exceeds productivity and income growth. Thus, if we simply require all citizens to buy medical insurance and do nothing about efficiency and cost growth, the economic stresses on our health care system will become even more acute, and our ability to sustain redistributive taxes to subsidize low-income individuals and families will likely collapse. Analysts estimate that up to 50 percent of the care provided under our current system fails to improve health outcomes.³⁹ Thus, changing how we deliver care is imperative if we are to build a sustainable system.

Given our failed reform efforts over the past 60 years, many observers are skeptical that high and rising costs can

A Health Care System for the 21st Century: Shared Responsibility

New Subsidy Structure:

Basic Plan Subsidy:

The purchase of insurance is subsidized on a sliding scale. Those earning up to 67% of national median income pay only a nominal fee; those earning up to 180% of the national median income pay a reduced fee.

Cost-Sharing Complementary Subsidy:

The complementary cost-sharing subsidy will be made available free to households earning less than 67% of the median income, and at a reduced cost to households earning between 67% and 180% of the median income. Purchase of the complementary subsidy is optional. The size of the subsidy will decrease as a household's earnings rise. The purpose of the complementary subsidy is to ensure that lower income individuals are not denied appropriate access to care because of cost.

One-Time Wage Adjustment:

In the first year employers will inform employees exactly how much they are paying in health care premiums on their behalf. In the second year, every employee who currently receives health care through their workplace will receive a raise at least as large as the amount the employer formerly paid in premiums. Starting in year two employees will be expected to purchase their own insurance on the Exchange. Employers who fail to pay the raise will be subject to a tax equal to 200% of the health care premium paid in year one for each employee.

Tax Treatment of Health Insurance Premiums:

The current tax exemption for employer-paid or for employee-paid health insurance will be ended. Revenues saved from this tax expenditure and generated by the one-time wage adjustment will be used to partially offset the subsidy costs for the program.

be controlled, especially since powerful stakeholder interests, including many physicians, hospitals, academic medical centers, and insurers, do quite well under the status quo. At the same time, our ability to ensure that all Americans have access to essential health care is threatened unless we restrain the rate of cost growth. Formulaic cost-growth reduction strategies, such as global budgets—which set limits on how much can be spent in a given year—or provider price controls, are political nonstarters in the U.S. context because they require arbitrary enforcement rules that appear to limit individual choice about health care decisions. A more promising strategy would depend on a combination of market forces and government programs (e.g., to promote the dissemination of research evidence and best-practices information) to educate insurers, providers, and the public

as to how their interests would be served by a more efficient health care system. This could earn their acceptance of the broader use of incentives in order to align patient, provider, and payer interests more effectively than they are today.

This “mixed” strategy includes three major elements: (1) an electronic information system; (2) better incentives; and (3) buying technology smarter.

The development of a nationwide *Electronic Information System* would give any clinician anywhere instant access to a patient's medical history, plus diagnosis and treatment options. The system would include Web-based electronic health records, as well as medical decision support tools so that best practices could be applied to every clinician-patient encounter. Today, a Las Vegas casino can determine the precise details of an individual's creditworthiness in real

time, but no emergency room doctor in that city (or anywhere else in the United States) can find out what medications an unconscious person is on. A notable exception is the health care delivery system pioneered by the Veterans Administration, which has successfully incorporated an electronic records system that facilitates information sharing.⁴⁰ An electronic information system would help us monitor care, protect patients, and improve the overall quality of health care in the United States. Information about the best therapeutic practices and diagnostic techniques would be shared in an electronic database accessible to health care providers and consumers across the country. This would require public funding of the dissemination of best-practice information in order to eliminate the ability of providers to profit by keeping such information private. Clinicians would be motivated to employ best-practice care, since consumers would be able to evaluate the quality of the care they receive.

Turbo-Charged Incentives for Quality and Efficiency. The stunningly low value of health care received per dollar spent in the United States is the direct result of poor provider and patient incentives. Basically, we pay providers to perform procedures regardless of their clinical value, and we shield most insured patients from awareness about the marginal cost of various diagnostic and treatment options. We need to shift from a system that pays after the fact for services rendered to the sick to a system that pays providers to keep patients healthy and makes them accountable for that outcome. We could turbo-charge these incentives if we also structured patient cost-sharing with incentives to choose high-value options and avoid services or products that are unlikely to improve outcomes when compared with cheaper alternatives. Doing both of these things would require us to expand the current evidence-based research base by an order of magnitude, but this investment should have a very large payoff over time as it enables us to both standardize best practices—to do what we know works and stop doing what we know does not work—and educate consumers to the fact that more care is not always better care. Moreover, Americans are likely to become smarter consumers of medical care if they find themselves paying for ineffective treatment out of their own pockets.

Encouraging the use of medical homes is also a good idea, since this will likely lead to better overall care. Today, primary care is far less remunerative than specialty care, with procedure-oriented specialists earning far higher incomes than evaluation and medical management generalists. At the same time, navigating our health care system

can be daunting even for the most sophisticated patients.⁴¹ Typically, patients with complex health problems find themselves under the care of multiple specialists, each of whom is focused on a specific body part or medical condition, with no one keeping track of all prescribed medications or treatments being administered, which in combination could put the patient at risk. Here lies the value in the medical home concept.⁴² Putting such a system into practice would mean paying the primary care provider—chosen by the patient—to manage the care of the patient in the delivery system as a whole. This would enable physicians and other health care professionals to make a living seeing fewer patients and devoting more attention to each. The ideal payment structure would include performance-based bonuses for well-managed care, for keeping patients with chronic conditions within approved guidelines (for blood pressure, blood sugar levels, lung capacity, etc.) and out of the hospital. Incentives could also be provided to encourage patients to comply with clinician-determined targets vis-à-vis medication, weight-loss targets, exercise, and the like. The fundamental idea is to link payments to providers with health outcomes without putting primary care physicians at full financial risk for whatever medical care and services patients might need under extreme circumstances.

Malpractice reform must be a part of realigned incentives, since fear of malpractice claims drives the practice of “defensive medicine” which leads to unnecessary diagnostic testing and interventions, and perhaps worse, perpetuates a fear of sharing information and experiences that could improve patient safety and outcomes. Admittedly, our current malpractice system adds at most only 5 percent to the overall cost of medical care; nonetheless, the system ought to be reformed to encourage physicians to carry out fewer unnecessary procedures and to encourage the exchange of information about ineffective treatments and interventions.⁴³

Our malpractice reform program would include a combination of protections against legal action if evidence-based medical practices were adhered to (thus providing physicians with “evidence-based safe harbors”), no-fault compensation rules for adverse events, and special malpractice pre-trial proceedings to weed out spurious claims without unfairly delaying legitimate ones. This reform package is subtler and provides better incentives than the traditional damage caps that limit exposure and malpractice premiums but do nothing to encourage higher quality and safer care. The reforms we propose would foster a culture of learning from inevitable mistakes and result in better overall patient care.

A Health Care System for the 21st Century: Shared Responsibility

Reformed Delivery System:

<i>Benefits Board:</i>	Charged with determining the benefit components of the Basic Plan, based on assessment of medical research that is linked to health outcomes. The Board will report to Congress in a manner similar to the Federal Reserve.
<i>Electronic Information Infrastructure:</i>	Electronic records that give all relevant clinicians access to a patient’s medical history, symptoms and treatments in real time. In addition, decision support tools will be available to inform important clinician–patient encounters with evidence-based best practice syntheses.
<i>Incentives for Medical Homes:</i>	Paying the primary care provider of the patient’s choice a fee to manage the patient’s navigation and the care of the patient in the delivery system as a whole.
<i>Incentives for Performance:</i>	Performance-based bonuses to clinicians and hospitals for following best-practices guidelines for diagnosis and treatment.
<i>Malpractice Reform:</i>	Evidence-based “safe harbors” from litigation, no-fault compensation rules, and pre-trial proceedings that weed spurious claims out of the system.
<i>Comparative Effectiveness Agency:</i>	Funds the research efforts of universities and hospitals in order to determine best practices for specific types of conditions and patients. The Board of the CEA would be taken from leaders in academic medicine. Its decisions would not be binding on the Benefits Board, but would be widely publicized.

Buying Technology Smarter. Advances in medical technology have saved lives and improved the quality of life for many, and future advancements are likely to be nothing short of breathtaking in their possibilities. However, the overuse of new technology has been a primary factor in driving up costs. Future advancements are likely to drive costs up even further, to the point of their being potentially catastrophic for the health of the U.S. economy. We need to establish processes for assessing the clinical value-added of new technologies compared to existing diagnostic or treatment options prior to their widespread adoption and use. The Federal Drug Administration’s drug approval process is a case in point. Today, to get a drug approved for a specific use, a manufacturer must simply prove that the proposed

new drug did not manifest serious side effects and is more effective than a placebo. We should require a higher standard for approval: new and more expensive drugs should be shown to be better than the best existing treatment for any given patient subpopulation. To compensate for the longer and more expensive trials this would require, we would probably need to lengthen the life of drug patents. We should apply the same logic to medical devices and new diagnostic or surgical techniques. As a result, we would become far smarter purchasers of costly new technologies.

To further the cause of efficiency, we should create a Comparative Effectiveness Agency (CEA), a public organization that would fund and direct a series of efficiency studies on new medical devices and surgical procedures.

The research itself would be conducted by universities and private research entities using rigorous scientific methods. The CEA would not have the power to force the Benefits Board to follow its recommendations, but it would have the power and capacity to disseminate its findings to the health care providers, health plans and to the media, so that with proper pay for performance incentives in place, the use of inferior products or techniques would become far more rare and persist for a shorter time than is the case today. The CEA could be constituted as quasi-public agency, because although it would need federal funding it could and should be governed by a combination of political appointees and the leadership of the major learned medical societies and of academic medicine.⁴⁴ By this means, we would obtain a “buy in” from research leaders to improve the efficiency of health care delivery services. This is the best way to make a 21st-century health system continue to function well for all Americans.

THE TRANSITION FROM AN EMPLOYER-BASED SYSTEM

Remaking our health care system into one designed around the pillars of personal responsibility and shared responsibility will require a major reform effort to overcome the

status quo. Our current employer-based system, which has developed over time, has become the means by which many Americans receive their health insurance. This system has been reinforced by decades of federal policy as well as large administrative, marketing, and risk-pooling economies of scale.

Today, 60 percent of Americans get their health insurance through employment, and employers actually pay for over a quarter of all health spending in the United States.⁴⁵ Employers’ share of health spending has risen from 15 percent in 1970 to over 26 percent today; real per capita health care costs grew 2.5 percent a year faster on average than economy-wide productivity during that period. Since health care now claims 16 percent of GDP, employers in effect pay 4 percent of GDP for health insurance for their workers. Private employer-financed health care costs now account for almost 8 percent of average employee compensation, up from around 1 percent in 1960.⁴⁶ This percentage figure is an average and includes firms that do not offer any fringe benefits, with considerable variance among those that do. Thus, the real cost of insuring an employee today ranges from 8 percent to 20 percent of total compensation costs.

As competition becomes increasingly global, the burden this places on U.S. companies, which is higher than that borne by most foreign competitors, is seen by management and workers alike as a threat to U.S. competitiveness and middle-class jobs.⁴⁷ It is therefore not surprising that we see

THE HISTORICAL RISE OF THE EMPLOYER-BASED HEALTH CARE SYSTEM

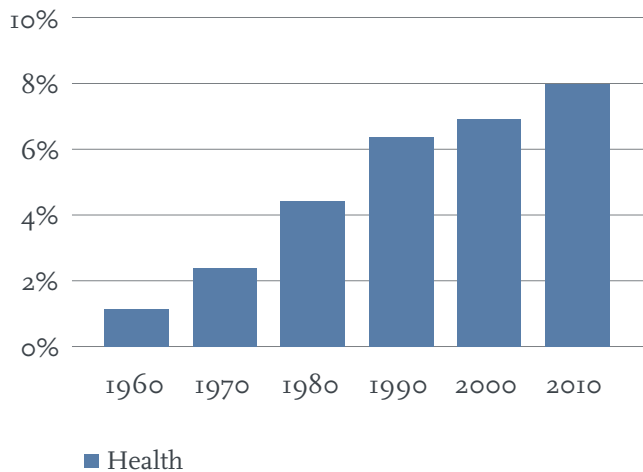
For nearly 70 years, federal tax law, administrative economies of scale, and insurer aversion to excess risk have made employers the primary source of health insurance for the vast majority of Americans. During WWII, employers’ premium contributions were exempted from federal income and payroll taxation as firms competed for scarce workers under wage controls (implemented to limit wartime inflation). By 1954, the employees’ contributions could also be exempt from federal income tax liability.

Other factors contributed to the employer-based system we have today. Marketing and administrative costs for insurers and employers are largely fixed and are thus much lower per enrollee the larger the group buying insurance. In

addition, in voluntary insurance markets, insurers naturally fear adverse selection, the tendency of those with the greatest health risks to seek the financial protection and access to care that insurance affords, while the healthiest individuals forgo insurance and take their (low-risk) chances. Employer groups, since they are organized for production, not to purchase health insurance, offer insurers a naturally representative and relatively healthy set of risks all wrapped up in a convenient point of sale. Insurers discovered all this long before federal tax law changed, and were offering employment-based groups much lower premiums per person (for the same level of benefits) than could be obtained in the individual or non-group market, even as early as the 1930s.ⁱ

ⁱRobert Cunningham, “Professionalism Reconsidered: Physician Payment in a Small-Practice Environment,” *Health Affairs* 23 (November/December 2004): 36–47.

Health Benefits as a Percentage of Total Compensation



Source: Employee Benefits Research Institute, “Finances of Employee Benefits, 1960-2003,” Facts from EBRI, January 2005, p. 3.

forward-thinking labor leaders like Andy Stern of the Service Employees International Union saying publicly and repeatedly, “The employer-based health insurance system in this country is dead. We have to find an alternative.”⁴⁸ Still, while many would agree on the need to move toward a new kind of health financing system that is more compatible with our 21st-century economy, no one to our knowledge has worked out the analytic details of how to actually make the transition work in practice.⁴⁹ While there are a variety of potential pathways to pursue, we believe three essential steps must be taken to move our current system toward a sustainable health care system that works for all Americans.

The essential first step is to create an insurance marketplace that is fair, efficient, transparent, and open to all. Building such a marketplace is indispensable because it will extend to everyone the advantages of group purchasing: marketing and administrative economies of scale combined with broad risk pooling. No individual shall be excluded due to low income or poor health status. Organized competition in this marketplace will also put a premium on insurers’ adding value by coordinating information flows and care among disparate members of a patient’s entire care team.⁵⁰ All providers and insurers will be rewarded for producing better health outcomes at lower total cost, rather than for performing unnecessary services, avoiding patients with complex health problems, or by denying care for high-value services.

The second step is to convert employer premium payments into wages. This will preserve existing compensa-

tion levels and reassure workers while relieving employers of their long-run vulnerability to health care cost growth, which they cannot control. Under the counsel of University of Chicago economists, Chile in the 1980s required employers to take this step as the country moved from an employer-based to an individual-based pension system.⁵¹ In general, the idea is to speed up and guarantee with rules what the market would accomplish on its own in the long run.

Economists generally teach that employers consider wage and non-wage benefits to be fungible, meaning that benefits can substitute for wages in the overall scheme of worker compensation. Thus rising health care premiums will result in lower wages, at least on average in the long run. Therefore, the argument goes, removing the health care burden from employers will lead to higher wages. But not all workers and employers trust or should be expected to follow economic theory, so a requirement to make a one-time wage adjustment in the form of a raise equal to the employer’s health insurance contribution on behalf of the worker or the worker’s family in the previous year will likely be politically reassuring.

The transition from an employer-based system will be facilitated by eliminating the current tax preference for employer-paid premiums. Currently, this tax preference costs the Treasury over \$147 billion a year in forgone income tax revenue, and represents the federal government’s largest tax expenditure by far.⁵² As we move away from an employer-based health care system, the employer’s premium payment should no longer be exempt from an employee’s taxable income. Ending the current exclusion will remove the incentive to the employer to provide health insurance rather than cash wages. If we then no longer permit employers to deduct premium payments from their profits for tax-reporting purposes, or tax firms on any lingering premium payments unless they convert such payments to wages, employers will be unlikely to continue to make premium contribution payments.

The final step in the transition will be to provide subsidies to make insurance affordable for all, enabling low-income Americans to buy mandated coverage. This subsidy will serve to reassure workers and their families that they will not be forced to shoulder an excessive financial burden during the transition. There are many ways to structure and deliver such a subsidy. Currently, most subsidies available to families are delivered through the tax code. For example, the federal exemption for dependents lowers a family’s income tax liability, and the Earned Income Tax Credit generates tax refunds if the value of the credit exceeds a family’s

tax liability. It would appear to make most sense to link the delivery of the subsidy to tax filing since this is the process that will be used to assess household income and thus the ability to pay. Creating a new refundable tax credit may be necessary to ensure that households can receive their subsidy even if they have low income tax liabilities.

Once employers are out of the financing picture, what a family or individual will be required to pay will depend upon family or individual income, the subsidy schedule, and our ability to rein in cost growth over time. Once a subsidy pro-

gram is in place, non-elderly Medicaid recipients, as well as the self-employed and workers in firms that do not offer insurance coverage, can be added to the system. Clearly, the level at which this subsidy is set is important because it will not only affect the overall cost of the proposal but also represent the clearest statement of our social willingness to enable all Americans to participate in the program.

Earlier in this paper, we summarized the proposed subsidy level, but since the subsidy level can be adjusted over time, it is important to bear in mind that the efficiency

MANAGING THE TRANSITION

Imagine a firm paying a typical 75 percent of premium costs for a workforce representative of American workers, with an average annual wage of \$40,000. Sixty percent of workers purchase family coverage policies, which cost \$12,000 a year, and 40 percent buy single policies, which cost approximately \$5,000 a year. The firm spends \$6,300 per employee on health insurance, which, putting aside inflation, pensions, and social security for simplicity's sake, brings the total employee compensation to \$46,300 for each employee, 13.6 percent of which is used to pay for health insurance premiums.

Every firm that currently offers insurance coverage to its employees would buy coverage for its workers through the new Insurance Purchasing Exchange in year one, paying the same wages it would have paid and making the same health insurance contribution it would have made in the absence of any policy change. Our proposal would require employers to inform employees of exactly how much they are contributing to health insurance on their behalf, preferably through an attachment to the employee's W-2 year-end tax form. This would clarify the true costs of health insurance for workers and let them know what to expect in year two. This would also put most working families in the exchange's risk pool, enabling efficient and fair insurance markets to be built with those who are covered as the base.

In year two, firms would be required to "cash out" or convert the previous year's premium contribution to wages on a one-time basis. This will look and feel like a raise, but would really be just transforming one kind of compensation into another. From this higher income base, all non-elderly adults will simultaneously be required and expected to purchase health insurance for themselves and their dependents. To reassure workers skeptical of economic theory and

employer intentions, employers would be taxed an amount equal to twice their previous year's premium contribution unless they raised wages by at least that much. This transition would keep the "right" amount of money flowing to health insurance in year two; thereafter the oversight of cost growth and premium affordability will be in the hands of the public sector and the health care industry, with the employer out of the picture altogether.

Premium inflation, meaning a higher premium cost, would complicate the computation of the cash-out, but the basic logic of the transition would remain the same. Since new subsidies would be in place, they would protect low-wage workers. It would be prudent to require only that firms increase the wage base by at least as much as they contributed to the previous year's premium for each worker. Employers would be free to raise wages even further in accordance with the requirements of labor market competition, of course, but the required "raise" will keep employer money in the health system while minimizing the business cycle risk of a one-time cash-out requirement. Tying the wage increase to each worker's own prior health insurance arrangement (single, family, or none), rather than any kind of average across-the-board payout will preserve the inter-worker equity that prevailed before the cash-out. A worker who accepts his employer's offer of a premium contribution today gets more compensation than a similarly paid worker who is covered on his spouse's policy from a different employer. The first worker will get more compensation after the transition as well, but now the compensation bundle will have more cash in than before. This arrangement is likely to withstand worker scrutiny better than any significant redistribution from married to single workers, as almost every "across-the-board average" wage adjustment would entail.

and fairness of our future health care system will depend upon the collective exercise of stewardship over resources. This means that we have to buy smarter and create incentives to turn consumers into allies for the cost-growth and value-enhancement components of a reformed 21st-century health care system. Because employers are among the most sophisticated buyers in the current system, they should participate in selecting members of the Benefits Board so that buying expertise and experience is not lost in the transition to a new financing system. But the key role of employers during the transition will be to ensure that the amount in total compensation that they currently pay for insurance premiums get passed along to their employees.

The proposed transition to a citizen-based health care system will have a number of positive effects. The income of workers will rise, generating added tax receipts for the U.S. Treasury. Employers will be relieved of the burden of covering health care costs, freeing them to concentrate on productivity and competitive creativity. Employers will be expected to collect premium payments for transfer to the Insurance Purchasing Exchange on behalf of their employees, irrespective of whether they offered health insurance in the past. But since this function will be similar to the current withholding of taxes for state and federal governments, it is unlikely to be onerous. The proposed new system is more likely to unite employers and employees, especially as they join together to assume partial responsibility for cost containment over the long run.

FINANCING AND SHARED RESPONSIBILITIES

Creating a new health care system that breaks from the employer-based model will require a substantial social commitment. This commitment will need to be expressed through the allocation of budget resources—which are the ultimate statement of shared responsibility. Many factors will influence costs through the transition and into the future. Rather than present an analysis of these factors, it may be more constructive to describe the broad components of our proposed financing system and present estimates of their orders of magnitude.

At its core, this proposal is a call for market reform and policy measures that require action by individuals, insurers, and health care providers. Yet to make it work and ensure participation requires financing. There are two primary costs for implementing the policy that must be covered. The

We have to buy smarter and create incentives to turn consumers into allies for the cost-growth and value-enhancement components of a reformed 21st-century health care system.

first is the cost of the Basic Plan subsidy and the second is cost of the complementary cost-sharing subsidy for low-income populations.

The Basic Plan subsidy, which will flow to all households earning less than 180 percent of the national median income, will cost an estimated \$200 billion a year.⁵³ Households earning up to 67 percent of the national median will receive a subsidy that will cover the total cost of the Basic Plan; households earning between 67 percent and 180 percent of the national median will receive partial subsidies. Obviously, adjustments to these cutoffs would lower or raise overall costs.

The complementary cost-sharing subsidy will be made available free to households earning less than 67 percent of the national median, and at a reduced cost to households earning between 67 percent and 180 percent of the median. The size of the subsidy will decrease as a household's earnings rise. The purchase of the complementary cost-sharing subsidy will be optional, which makes it difficult to estimate with certainty how much it will cost; our best estimate is \$40 billion a year.⁵⁴

The \$240 billion in annual budget resources needed to implement our proposal will be covered by four primary sources. The first source of revenue will be higher tax revenue generated by increased wages. The cash-out provision will serve to recalibrate incomes so that the contributions employers currently make on behalf of their employees to purchase insurance will be passed on directly to employees. We estimate that an additional \$100 billion a year will be collected by the Treasury as a result of this cash-out.⁵⁵

Furthermore, the elimination of Medicaid and SCHIP, except for the disabled and the elderly who are already eligible for Medicare, would generate a substantial windfall for states equal to roughly 30 percent of current Medicaid

spending, or approximately \$40 billion a year,⁵⁶ and would otherwise save the Federal government another \$50 billion. States would be expected to contribute these savings to fund the health care system through a “maintenance of effort” requirement. A natural shift in responsibility would be to require the states to finance the complementary cost-sharing subsidies for citizens in their states. However, this would penalize poor states, and therefore a simpler and more formulaic maintenance of spending effort requirement might be both wiser and more politically feasible.

Local governments would also receive a windfall from the achievement of near-universal coverage, since their need to subsidize local safety-net providers would be vastly reduced. Some localities, however, would still have substantial financial responsibility due to large illegal immigrant populations. Decisions about maintenance of effort requirements on local governments should devolve to the states because they can best take into account remaining burdens and the most efficient division of labor between the state and local governments.

Today, nonprofit hospitals and clinics, along with private philanthropic entities, provide and help finance most of the care that is delivered to the uninsured. Both providers and charities have historical missions to help those without the ability to pay obtain essential services. In a 21st-century health system designed to cover all citizens and legal immigrants, those who will need such help will largely be illegal immigrants. It is conceivable that some nonprofit philanthropic organizations will turn their focus in this direction as the desperate need for health care services for illegal immigrants becomes apparent. It is unclear, however, whether philanthropies will be able to fill this void. It is likely that some health providers will maintain open doors for uninsured children and adults to the extent feasible legally and financially, but there is no easy answer to this problem. The issue of access to urgent health care for illegal immigrants will have to be addressed by the larger society.

The revenue sources we have outline above will likely need to be supplemented. We conservatively estimate that another \$50 billion will be needed annually at the outset of our proposal’s implementation. This could be generated from a new or existing revenue source, or it could come from general funds or from a new dedicated tax. Over time, if we are able to implement our proposed delivery system reforms, the net new revenue required should decline as a percentage of total subsidy costs.

Funding Our 21st-Century Health System

Subsidy Financing for One Year, Fully Phased-In

Sources

Income Tax Revenue from Higher Wages:	\$100 billion
Medicaid Maintenance of Effort by States:	\$40 billion
Federal Medicaid Spending Reduction:	\$50 billion
New Revenue Requirement:	\$50 billion
Total:	\$240 billion

Uses

Basic Plan Subsidy:	\$200 billion
Cost-sharing subsidy:	\$40 billion
Total:	\$240 billion

CONCLUSION

While there is a growing awareness among stakeholders, legislators, and public policy analysts that health care will be a key domestic issue in the next few election cycles, some still lack a sense of urgency about addressing health system reform.⁵⁷ This is lamentable since it is clear that in the absence of serious reform our present trajectory will lead us toward economic and moral decline. The rising opportunity cost of unabated health care cost growth is undeniable: an unreformed health system will increasingly preclude needed investment in infrastructure, education, and nonmedical research and development, even as it serves a smaller fraction of our population each year. Employers will react to declines in competitiveness by accelerating the pace of off-shoring middle-class jobs. And as the cost of health care rises, so does the cost of current government-provided safety-net services such as Medicare, Medicaid, and SCHIP. Unless cost growth can be tamed, the price tag on Medicare and Medicaid alone will rise to 10 percent of GDP, which would necessitate both much higher taxes and dramatic reductions in other vital government programs.

There is an ethical dimension to our looming health care crisis as well. As economists Paul Krugman and Robin Wells put it, “Our health care system often makes irrational choices, and rising costs exacerbate those irrationalities. Specifically, American health care tends to divide the population into insiders and outsiders. Insiders, who have good insurance, receive everything modern medicine can provide, no matter how expensive. Outsiders, who have poor insurance or none at all, receive very little.”⁵⁸ The more expensive our health care system becomes, the greater this chasm between the haves and the have-nots will grow, and the more America will come to resemble a two-tiered society where the fortunate will have access to state-of-the-art drugs and medical procedures, while those at the bottom and in the middle will have to rely on inferior treatment at free clinics and in emergency rooms, and die prematurely from preventable diseases. As noted above, the Institute of Medicine has estimated that the total social cost of the uninsured—including the economic losses from excess days lost from work and school, and from premature death—is already equal to the net public cost of covering the uninsured. That social cost will rise as the proportion of uninsured rises in the absence of reform. One compelling analysis predicts that by 2013 the ranks of the uninsured will have swelled to 56 million, or to more than a quarter of the population.⁵⁹ We can only speculate what effect this growing underclass will

have on the fabric of our democracy. Abraham Lincoln once feared that our government could not endure half slave and half free; a nation that is half insured and half uninsured may prove similarly unstable.

But we need not wait for a crisis—civil unrest, economic depression, or a public health pandemic—to precipitate change. There is a growing recognition among leaders in government and business that our employer-based health care system is not sustainable, and that an acceptable alternative must be found. The comprehensive reform outlined above is our best chance to achieve universal coverage (through an individual mandate), higher quality (through electronic health records, preventive medicine, and best-practices guidelines), and lower costs (through reduced paperwork, better incentives, and a smarter use of new technology).

Abraham Lincoln once feared that our government could not endure half slave and half free; a nation that is half insured and half uninsured may prove similarly unstable.

Health care is widely recognized as an integral part of the social contract, and yet the voluntary, employer-based system, along with the inefficient delivery system it has been financing, is failing more of us every day. This system is simply incompatible with the demands of a global economy and the values of a just society. But we should not be daunted by the task before us. The barriers to reform are high but not insurmountable, and many are already acknowledging the necessity of fundamental reform. By drawing on the best ideas of those already focused on reform—policy analysts and clinicians, as well as leaders in business, labor, and government—and by emphasizing personal responsibility and mutual responsibility in equal measure, we can fashion an affordable and sustainable health care system that can help America meet the challenges of the 21st century.

ENDNOTES

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- ² Author’s calculations from Gary Claxton, Isadora Gill, Benjamin Finder, Bianca DiJulio, Samantha Hawkins, Jeremy Pickreign, Heidi Whitmore, and Jon Gilmore, *Employer Health Benefits: 2006 Annual Survey* (Chicago: Henry J. Kaiser Family Foundation, 2006), 60–75; U.S. Census Bureau, <http://www.census.gov/prod/www/abs/income.html>, accessed on May 23, 2007; Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#, accessed on May 23, 2007.
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- ⁵ Leviticus 23:22, New Revised Standard Version. “And when you reap the harvest of your land, you shall not reap your field to its very border, nor shall you gather the gleanings after your harvest; you shall leave them for the poor and for the stranger: I am the LORD your God.”
- ⁶ More detail on the later traditions is available in Len M. Nichols, “The Moral Case for Covering Children,” *Health Affairs* (March/April 2007): 405–07.
- ⁷ M. Douglas Meeks, *God the Economist: The Doctrine of God and Political Economy* (Minneapolis: Augsburg Fortress Press, 1989).
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A HEALTH CARE SYSTEM FOR THE 21ST CENTURY

Personal Responsibility

Personal Health: **Responsibility and Incentives:** Individuals are expected to take responsibility for their own health, including diet, exercise, prevention, seeking professional care when appropriate, and following treatment recommendations. Insurers may adjust premiums based on key behavioral targets, such as smoking and weight-loss goals.

Individual Mandate: **Insurance Purchase Requirement:** Health insurance is necessary to secure access to appropriate health care. All adults age 19 and older are required to purchase insurance for themselves and their dependents. Subsidies will be available for the low income population. Enforcement will be facilitated through information sharing among health providers, schools, employers, tax authorities, and the Insurance Exchange. Failure to pay one's fair share will lead to financial penalties.

Shared Responsibility

New Marketplace: **Insurance Purchasing Exchange:** Serves as a general marketplace where all health insurance is sold. Regulates and enforces the rules of competition. The Exchange will ensure that all insurance providers offer coverage and renewals to those seeking insurance. The Exchange will be responsible for collecting and distributing premium payments. Small states might choose to share a single exchange; large states might have several exchanges.

Basic Plan: All insurers will offer a Basic Plan, which will entail the legally-required minimum of health insurance. More expensive supplemental policies will also be available to those who want to buy them.

New Subsidy Structure: **Basic Plan Subsidy:** The purchase of insurance is subsidized on a sliding scale. Those earning up to 67% of national median income pay only a nominal fee; those earning up to 180% of the national median income pay a reduced fee.

Cost-Sharing Complementary Subsidy: The complementary cost-sharing subsidy will be made available free to households earning less than 67% of the median income, and at a reduced cost to households earning between 67% and 180% of the median income. Purchase of the complementary subsidy is optional. The size of the subsidy will decrease as a household's earnings rise. The purpose of the complementary subsidy is to ensure that lower income individuals are not denied appropriate access to care because of cost.

Continued

Shared Responsibility *Continued*

New Subsidy Structure:

One-Time Wage Adjustment: In the first year employers will inform employees exactly how much they are paying in health care premiums on their behalf. In the second year, every employee who currently receives health care through their workplace will receive a raise at least as large as the amount the employer formerly paid in premiums. Starting in year two employees will be expected to purchase their own insurance on the Exchange. Employers who fail to pay the raise will be subject to a tax equal to 200% of the health care premium paid in year one for each employee.

Tax Treatment of Health Insurance Premiums: The current tax exemption for employer-paid or for employee-paid health insurance will be ended. Revenues saved from this tax expenditure and generated by the one-time wage adjustment will be used to partially offset the subsidy costs for the program.

Reformed Delivery System:

Benefits Board: Charged with determining the benefit components of the Basic Plan, based on assessment of medical research that is linked to health outcomes. The Board will report to Congress in a manner similar to the Federal Reserve.

Electronic Information Infrastructure: Electronic records that give all relevant clinicians access to a patient's medical history, symptoms and treatments in real time. In addition, decision support tools will be available to inform important clinician-patient encounters with evidence-based best practice syntheses.

Incentives for Medical Homes: Paying the primary care provider of the patient's choice a fee to manage the patient's navigation and the care of the patient in the delivery system as a whole.

Incentives for Performance: Performance-based bonuses to clinicians and hospitals for following best-practices guidelines for diagnosis and treatment.

Malpractice Reform: Evidence-based "safe harbors" from litigation, no-fault compensation rules, and pre-trial proceedings that weed spurious claims out of the system.

Comparative Effectiveness Agency: Funds the research efforts of universities and hospitals in order to determine best practices for specific types of conditions and patients. The Board of the CEA would be taken from leaders in academic medicine. Its decisions would not be binding on the Benefits Board, but would be widely publicized.

THE NEXT SOCIAL CONTRACT INITIATIVE aims to reinvent American social policy for the twenty-first century. Through a program of research and public education, the initiative will explore the origins of our modern social contract, articulate the guiding principles for constructing a new contract, and advance a set of promising policy reforms.

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