



Budgetary Approaches to Health Policy

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Summary Materials For Roundtable Discussion Only

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Decision-making by Consumers

As health-coverage purchasers/enrollees

Incentives and Interventions

- Reduce counterproductive state insurance regulations, including most benefit mandates and premium restrictions. In addition, permit insurance sales across state lines, with either enhanced federal oversight or harmonizing state regulatory regimes. (Antos)
- Limit tax deductions and exclusions:
 - The most important intervention would be to limit the employer tax deduction and employee tax exclusion to the premium of the most efficient financing and delivery plan in each region. (Enthoven)
 - At the plan level, capping of the exclusion from income for employer provided health care is an essential change. (Hungate)
 - Health insurance tax deduction should definitely be capped. (Penner)
 - The government could limit the tax deductibility (better yet a credit) (Reischauer)
 - A fixed (but unindexed) cap on the value of employer provided insurance that can be excluded from taxation enforced through some liberal or simplified “safe harbor” rules for calculating whether the cap has been exceeded. (Steuerle)
- I favor approaches that face employees with marginal cost of more expensive plans, provided that the benchmark plan provides needed financial protection and access to quality care. Substantial standardization of health plans is needed in a multiple choice situation with beneficiaries bearing the marginal cost. (Gray)
- Relate cost-sharing to income or earnings in some rough and ready way. (Van de Water)
- How much exposing consumers to more of costs will be cost constraining versus cost shifting needs discussion. While there may be a one-time effect, the skewed distribution of health spending with relatively few accounting for the bulk of spending may limit the over-time cost savings potential. (Scanlon)
- Indirect mandate on individuals: if they do not obtain health coverage, they would be denied the benefit of some subset of federal tax preferences such as the child credit, personal exemption, higher education subsidy, or itemizing deductions. While this is normally thought of as an issue of expanding coverage (& could be combined with an expanded subsidy for buying health insurance), it is also a way of reducing the costs of Medicaid by encourage more people to insure before drastic circumstances force them into Medicaid. (Steuerle)

Choices for Enrollees

- Achieving good long-term health suggests a long-term relationship with a plan. That would mean moving gradually away from employment-based coverage and it requires tax or other subsidy systems that are not tied to employment. (Butler)
- In the emerging market, beneficiaries are being offered increasing incentives to shift compensation out of pre-paid health benefits into other forms of compensation. In this environment, expanding information about the consequences of choices isn't optional. (Moran)

- Employers should cap their reimbursement of employee insurance at a dollar level, so that employees have an incentive to choose cost-effective plans. Furthermore, insurers should take care that co-payments and deductibles not deter preventive care. (Minarik)
- Providers need to be aware of and subject to budget constraints, so that they understand the need to consider them in clinical decision-making. Too much choice creates problems for getting this message to providers – lots of plans mean providers will simply adopt one type of care for everyone. (Russell)
- Larger role for non-employer groups:
 - Trusted intermediaries that organize health care for a person and act on their behalf are a key feature of a health market. Today employers or the government play that role. But other groups could and should do so, including unions, AARP, and churches. Regulatory and tax changes are needed to make that happen. (Butler)
 - Permit insurance purchase through non-traditional organizations (such as churches), which may reach populations that would otherwise not purchase coverage. (Antos)
- Different modes of delivery:
 - The “natural health market” for consumers is not fee-for-service choices but choosing between “packages” from “assemblers”, much as people typically buy automobile packages rather than designing their own car. That in turn means managed care. (Butler)
 - More sophisticated payment systems are required to facilitate consumer markets, including Enthoven-style insurance exchanges and refined payment systems such as those developed by the company BENU. Such refined payment systems would help address adverse selection and also encourage the specialization of health services that is held back by today’s payment systems. (Butler)
 - Interventions are needed to give enrollees effective multiple choices among competing delivery systems, not just plan designs from the same carrier, which is not competition. Government should create incentives for employers to participate (e.g. conditioning the tax exclusion on offering choices). Perhaps startup grants—like the HMO Act—should be made to accelerate the growth of choice models like BENU and Keenan’s CAPEP¹. Multiple employer exchanges (with risk-adjusted employer contributions and risk adjusted premium payments—RACS/RAPPS) could yield significant economies of scale in administration provided that employers would be willing to agree to standardized contracts. (Enthoven)
 - Consumers should be given choices of plans which include different modes of delivery, with an incentive at the margin to choose cost-effective plans and providers. (Minarik)
- Amount and management of choice:
 - It may be necessary to limit the number of choices so as to avoid totally confusing the consumer. (Penner)
 - Too much choice is worse than too little, leads to suboptimal decisions. Standardization, minimum requirements would help. (Russell)

¹ California Public Employees’ Plan, a private sector competitor to CalPERS.

- Choice needs to be managed. Medigap policies were standardized years ago. Now behavioral economics is confirming that too much choice can be a bad thing. (Van de Water)
- It is *not* useful to require employers to provide more information on the cost of insurance on the pay stub (which few ever read, and the information does not lead to changed behavior since the employee cannot change plans during the year). (Antos)
- Competition among plans needs to be managed. Benefits contracts need to be standardized to facilitate switching by lowering the switching cost, to facilitate price elastic demand, and to inhibit risk selection by plan design. This does not mean all exactly the same. (Enthoven)
- Health care is a highly complex, multidimensional product and only a fool who was also a genius would spend the time needed to understand even half of the conditions inherent in any health plan. Plans will not answer questions about what is meant/offered by this or that provision and take the position of “send the bill to us and we will let you know.” Some standardization would probably be helpful if the individual was faced with grreater choice. (Reischauer)
- Simplifying plans reduces cognitive overload, removes obstacles facing employees, reduces employer incentives to avoid certain workers and standardizes health insurance costs of employers. (Russell)

Decision-making by Consumers

As patients/purchasers of health services

HSA Related Comments

- Maintain a level playing field among types of coverage. Do *not* bias subsidies in favor of high-deductible coverage. Reduce the bias that currently exists in the tax system against out-of-pocket payments. (Antos)
- HSA modifications:
 - The tax provisions in HSAs are bad tax policy and should be repealed, as they constitute a massive tax avoidance opportunity. Health economists, for the most part, are entirely unaware of this problem. (Aaron)
 - HSA restrictions should be modified to reflect the involuntary nature of some medical services. In-patient hospital admissions are involuntary and should be subject to a lower deductible (or leave that decision up to the insurance market). (Antos)
 - Incentives created by HSAs and high deductible coverage are not appropriate. They are likely to deter and under-fund primary care and prevention. Patients should be in a more or less continuous contact with their delivery system so that the delivery system can educate and motivate healthy behavior. (Enthoven)
 - Allow employers to make differential contributions to employees' HSAs, based on risk factors (age, chronic illness) (Hall)
 - The price transparency problem: Could health plans negotiate fee schedules that apply specifically (and perhaps only) to enrollees' out-of-pocket or out-of-HSA payments? (Havighurst)
 - Consider how HSAs may relegitimize predetermination of benefits by making funds available to pay for things the plan contract doesn't cover. (Thus, the plan can more easily be seen as rationing only financing, not care itself.) (Havighurst)
 - CDHPs are a method of shifting costs on to the sick. HSAs when offered as part of a choice of plans will not be sustainable unless employers risk adjust their contribution to the HSA and catastrophic plan. Most health spending is by the very sick and those with chronic diseases so the potential for HSAs and CDHPs to generate significant savings or a major shift in behavior. (Reischauer)

Quality and Price Information

- The necessity of better information:
 - Patients need access to better information about the likely value of the service (in terms of improving health status and the possible negative side effects of treatment), the likely quality of care offered by the provider, and the cost to the patient *prior* to the delivery of the service—along with similar information for treatment alternatives. (I don't see a mandate here.) (Antos)
 - Information on price per visit or procedure is poorly correlated with cost per episode. Cost per episode, (as measured by ETGs²), are poorly correlated with

² Episode Treatment Groups

per capita costs, which are the variables of greatest interest. Consumers should have clear information on the annual cost (premium and out of pocket) of the health plans/delivery systems from which they select. (Enthoven)

- Improving information for consumers to make informed choices is a given. Attention should be paid to the comprehensiveness and validity of the information as well as the mechanisms for dissemination. (Scanlon)
- Skepticism concerning the use of information:
 - It is unrealistic to assume they [consumers] will use such information. People won't "shop around" for care—for big ticket items it is an unrealistic expectation when the information is so complex. The transaction costs (monetary and psychological) of shifting from one provider to another are just too high. (Reischauer)
 - Consumers cannot be expected to make sensible decisions based on quality and price. At the Brookings health policy forum on October 20, there seemed to be a consensus that the information necessary to make health care decisions based on quality and value generally does not now exist. (Van de Water)

Non-fee-for-service Modes of Pricing

- Partial capitation is a method that health plans may use to pay providers, but there is no obvious consumer use of partial capitation rates. The consumer is interested in what he or she pays, not what someone else pays. (Antos)
- New modes of pricing provider services is very important and does not belong under the category of patients paying at the point of service (how does a patient pay for an actuarially estimated episode of care at the point of service?) Plans need to administer needed payment innovations. (Berenson)
- If a competing health plan wants to use ETGs (Episode Treatment Groups), that should be its prerogative. But Plans are likely to find that ETG costs are not a good predictor of total costs per capita because they do not reward efforts to prevent episodes or to deliver only appropriate treatments. (Enthoven)
- Acute episodes and major discretionary interventions must be episode priced and risk-adjusted outcome accountable. Only in this way can the providing institutions be driven to effective comparison of their results with others and effective trade-off decision making. Patient co-payment should be based on a prospectively determined price. (Hungate)
- It is hard to see how we could ever get the incentives right if we don't move to capitation over the long run but it presupposes that providers organize themselves in different ways from the prevailing lone ranger fragmentation we have now. Payments for episodes is devilishly difficult to implement. (Reischauer)

Comparing and Choosing Providers in Advance of Care

- Comparative performance data on providers, and possibly patient satisfaction information, would be useful for those consumers who seek such information. That is a small minority of consumers currently. (Antos)

- Consumers need and should have informed responsible choice of network or delivery system. Market forces should drive the formation of ever more cohesive networks and ever more efficient delivery systems. (Enthoven)
- It would be nice if consumers could choose among networks of providers, but multiple networks do not exist in most places. (Gray)
- If providers are able to effectively compare to each other, which procedure pricing and outcome measurement would force the best balance of utilization will evolve. If reliance is placed only on the specific provider it will only be effective if the patient knows what they will need. Then they will want the best. (Hungate)
- Consumers deserve information, but should have a choice about how much they want to handle. Detailed information should be optional -- available but not required, e.g., information on therapy for particular conditions. (Russell)

Other Comments (For comments on risk selection, see “Decision-making by Government”)

- Co-payments should be designed to make consumers and physicians cost conscious over a wide range of expenditures. Patient costs can be constrained by having lower deductibles. (Penner)
- Incentives to economize through deductibles and co-payments work only on small expenditures, which are a small share of total health spending. (Minarik)
- Conditions to support competition do not exist in most markets, and things are getting worse. Providers are all consolidating and gaining market power -- need to fundamentally ask how to promote competing providers and also the growing concentration of insurers - - this does not bode well for managed competition even if Enthovian requirements were put into place. (Berenson)
- Competition between plans does not address utilization, the real cost determinant. (Hungate)

Decision-making by Government

As managers of public programs (Medicare, Medicaid)

Medicare Advantage/Medicare+Choice

- If one believes in competition, then one should favor an end to the excessive subsidization of Medicare Advantage. (Aaron)
- Medicare Advantage is a large distraction from what needs to be done -- and the payment to plans needs to be overhauled. How does one save money by spending 15% more than FFS program spending on the same beneficiaries? (Berenson)
- In the absence of some explicit defined contribution theory, there is no “right” amount to pay Medicare Advantage plans under current policy. (Moran)
- Reduce micromanagement by Congress and CMS, which results in constantly shifting requirements and inhibits innovation—FEHBP is a model that maintains a reasonable balance of federal oversight and plan management of their own operations. (Antos)
- All Medicare should be transitioned to a system of risk adjusted defined contributions by government. (Enthoven)
- There should be a cost-effectiveness based co-payment structure. (Hungate)
- The structure is pretty good now if we begin using pay for performance and reduce the overpayments for the benchmarks. (Reischauer)
- Means-tested programs are particularly intrusive, hard to administer well, and prone to error. When means-testing is used, steps should be taken to make it as easy as possible. For example, use simplified rules (as with SSA’s implementation of the low-income drug subsidy), the income tax mechanism, or lifetime earnings (Medicare taxable earnings). (Van de Water)

Provider and Beneficiary Rules in Fee-for-service Medicare

- Medicare should be in full competition with MA (Medicare Advantage). On a less-grand scale, more could be done to reduce the “stove pipe” effect: pay on a more complete episode basis for major interventions (such as hospitalization, but including more pre- and post-admission services related to the particular condition being treated). (Antos)
- For FFS Medicare, for as long as it exists, there should be incentives for doctors to be PCPs (primary care physicians) and for patients to choose and stick to PCPs who coordinate care. (Enthoven)
- Medicare should begin to move payment from DRG and RBRVS toward “evidence-based protocols” to foster competition based on advancing medical science, quality and costs. (Etheredge)
- If MA plans can deliver the Medicare package of services at an acceptable quality cheaper than FFS can, premiums for FFS should be raised—there should be a level playing field. (Reischauer)
- The purchasing power of these programs should be exerted to require sufficient oversight, medical data, cost information and policy development. (Scanlon)

Controls on the New Drug Benefit

- The drug benefit should be repealed and replaced with a budgeted subsidy to lower-income individuals lacking adequate drug coverage. (Butler)
- Limit outlays for the drug benefit: Retract the requirement that all drugs be covered in 6 disease categories, which has chilled enthusiasm for cost containment. Adjust bidding process so that beneficiaries receive all of the savings from selecting a low-cost drug plan, rather than half. Convert Part D to a capitated subsidy rather than an unlimited entitlement. (Antos)
- Tiered benefits in the Medicare drug program makes sense. (Gray)
- Allow/encourage DHHS to at least set reference pricing for drug plans, as it has done for physician services under RB-RVS (Hall)
- Policymakers have posed the issue as optimizing the supply of available plan alternatives – but this logic has been hijacked by various interests (e.g., rural states). It will be interesting to see whether this same policy calculus leaks into Part D in terms of depth of subsidies – and potential steering of subsidies if rural plan availability falters. (Moran)
- The increases in the subsidy should be pegged to the increases in a cost effective formulary. (Reischauer)

Risk Selection and Competition

- Risk selection: Before leaping to the conclusion that risk selection is rampant, get data on actual enrollment during 2006 when the drug benefit is in place. Risk selection may be down considerably if MA plan enrollment increases significantly. Better risk adjusters are needed, but there is a limit to the accuracy of such adjusters. (Antos)
- Better risk adjusters and more sophisticated payment arrangements are essential in Medicare, as they are in the private sector. (Butler)
- Risk adjustment does not undercut competition. It makes competition possible without untoward consequences. The real question is whether risk adjustment can be made good enough to prevent insurers from competing on risk selection. (Aaron)
- Risk adjustment can be made to be good enough. (For example, carriers are accepting it as a basis for payment in CA.) (Enthoven)
- Premiums absolutely need to be adjusted for the risk of each individual. There more waste to be saved on the most expensive enrollees than on the cheapest. Failing to pay more for that management is a serious failing for any wish to make markets work. (Hungate)

Medicaid

- Medicaid: Capitated payments using good risk adjusters would hold states harmless from some exogenous risks but not all. The “swap”—giving full responsibility for non-Medicare participants in Medicaid to the states, giving full responsibility for Medicare participants in Medicaid to the feds—eliminates the destructive overlap in financing and responsibility. States should not simply be relieved of the cost, however—some reasonable “clawback” is needed. (Antos)

- There is no reason to think that block granting will improve state level resource allocation under Medicaid and many reasons to believe that block granting will damage state level resource allocation. (Aaron)
- Block granting Medicaid is a terrible idea for two reasons. First, unresponsive to changes in need resulting from macro economic trends (e.g., recession). Second, likely to result in increases in numbers of people who lack coverage. (Gray)
- While it is politically impossible to do, eliminating the scams—upper payment limits, DSH abuses, etc should be considered first, next we should narrow the definition of permissible expense some of which have been sources of abuse, next states should be required to impose greater oversight and monitoring of expenditures. Only after all of these have failed to moderate spending to acceptable levels would I consider any kinds of caps. (Reischauer)

Decision-making by Government *As regulators/facilitators*

Oversight of Pharmaceuticals and New Technology

- If greater encouragement is to be given to individual insurance, regulation should require standardized health insurance products and govern sale. (Aaron)
- FDA regulatory process could be streamlined to allow faster decisions on new drugs and to allow more modern manufacturing processes. (Antos)
- Create/promote information clearinghouses to facilitate the provision of comparative information on plan choices to individuals. Such clearinghouses could also allow consumers to enroll in the plan of their choice. (Antos)
- In order to make rational decisions about how to allocate personal spending, consumers should have access to quantitative information on the magnitudes of health benefits, risks, and personal costs (immediate and future) associated with alternative medical interventions. It is not clear that this information can be presented to consumers in a comprehensible way, or that availability of such information would affect consumer choices. (Weinstein)
- Technology assessment is among the most important areas for government initiatives, including real-time learning from EHR-based patient experience, including genomic information. (Etheredge)
- Mechanisms need to be developed to assist Medicaid programs with coverage decisions—both to do assessments of technologies and to share the results across states. Such work done by Medicare should also be shared with Medicaid programs. (Gray)
- With respect to government's own programs, administrators should use their market leadership to require standards of electronic records, and should use those records to enable careful outcomes research. Government should use that research to steer treatments towards those with the best results. (Minarik)
- Working through NIH and other institutions, government should use appropriations and grants to encourage cost-saving technological innovations. (Penner)
- New standards should be set for drug approvals and a major effort should be undertaken to examine post market data on effectiveness of drugs and devices especially for off label use. (Reischauer)
- Technology assessment should be a routine matter given the access to more comprehensive information flowing from electronic medical records and the enhanced administrative resources at CMS. (Scanlon)
- Medicare and Medicaid should pay a slightly higher fee to those who use e-prescribing, maintain electronic health records, and submit filings electronically (this can be done by raising fees for some, lowering them for others, or a combination). (Steuerle)
- The government should play a greater role in identifying best healthcare practices and discouraging the development of costly technologies that are of little marginal benefit. (Van de Water)

Federal Dissemination of Clinical Practices – A New Agency?

- Top-down imposition of professional standards, even based on evidence, will not guarantee compliance. Moreover, the evidence will likely change, but a regulatory approach will be slow to react. (Antos)
- Hierarchical management, someone to decide, breaks down seriously with great complexity. It is interesting the many British physicians are impressed by complexity science but always fall back to the “right authority” as the critical decision to be made! (Hungate)
- Information about clinical tradeoffs would be helpful, but history suggests that any institution that tries to provide such information must be independent. (Russell)
- We should have a NICE and it should be able to make findings re. Value for money that health plans can incorporate in contracts by reference (“we follow NICE guidelines.”) Strong political insulation (like the Fed.) and freedom from conflict of interest are crucial. (Enthoven)
- A model analogous to NICE should be considered. This activity might involve a collaboration among government agencies, the Institute of Medicine, academic research institutions, and industry. The information produced should be transparent, subject to formal peer review and public comment, and ultimately endorsed by a credible independent entity. (Weinstein)

Federal Dissemination on Prices and other Healthcare Topics

- Government should generate and disseminate information on prices and other consumer information. Such a service should allow consumers to view commentaries and other information from plans or professional groups. (Butler)
- Government may be uniquely situated to collect data on medical practice, including indicators of value, quality of care, and price. Difficulty interpreting these data, however, means that others (including directly interested parties) should be able to provide their own interpretations. Data and useful information are often two different concepts. (Antos)
- Consumer information is a public good, under produced by the private sector. Government should subsidize the production and dissemination of objective information. Again, there need to be assurances of objectivity and independence from political and financial interest. (Enthoven)
- The government could develop alternative platforms (print or electronic) for presenting such information, and conduct research on the effects of alternative media for doing so on consumer choices. This research could involve hypothetical choice experiments in the presence of different types of information on quantitative benefits, risks, and costs, or it could involve real-world experiments in which consumers are given discretionary accounts. (Weinstein)

Decision-making by Providers or Other Intermediaries

Regulation for Insurers and Health Plans

- Aggressive anti-trust is essential to promote effective competition. (Antos)
- Getting the basic incentives right should reduce the need for command and control regulation. (Enthoven)
- It's hard to see a moral justification for "budgeting" anyone as long as since egregious waste is the norm. (Etheredge)
- Either apply anti-trust to health insurance (which is exempt), or replace with FEHBP type systems, which operate at 1/3 or less the admin costs and provide competitive choices (Etheredge)
- The change from "necessary and appropriate" to cost-effective, an essential change both for equity within the system and for balance to other economic systems, is unlikely to occur without an external boost, most likely from regulation. (Hungate)
- In comparison to 1998, no clear evidence of a problem at the intermediary level. Question is whether consumer will be "over-empowered" – not whether consumer will be disenfranchised. (Moran)
- Presumably a lot could be done through the use of the tax preferences for health. (Reischauer)

Public Policy Incentives for Providers and Intermediaries

- A minimum disclosure statement that can be understood by the non-expert would help consumer decision-making, but firms should be able to go beyond the minimum in marketing. (Antos)
- Medicare/caid could require certain actions (such as compliance with a disease management mechanism) as conditions of payment, but we should not provide incentives or mandate the use of such things on private insurers. (If the interventions work, they will be adopted.) (Antos)
- Public policy should tilt in favor of true integrated delivery systems, and both private plans and public programs need to design policies, especially payment policies, that promote the development of these organizations, with more traditional FFS payments a default mechanism for those not able or willing to join systems. (Berenson)
- The more important point is that the action is with the providers, not the plans. In many cases, the plan intermediary merely is a cost center that provides little value. Direct contracting needs to be discussed, at least in public programs which have the ability to perform insurance functions, with others contracted as administrators, not as risk bearers. (Berenson)
- It could be a good thing if regional exchanges were to factor out care for very high cost diagnoses, such as organ transplants, and buy their treatments competitively from regional or national centers of excellence. (Enthoven)
- Require modified community rating, so that only specified demographic factors can be used to varying premiums, and not individual health status. (Hall)

- Nature of patent protection provided for drugs should be scrutinized and firewalls should be constructed, so that physicians have no economic interest in testing labs and fees for using expensive machinery. (Penner)
- Government should expend more resources scrutinizing hospital and physician bills searching for both fraud and gross inefficiencies. (Penner)
- Eligibility for tax preferences could be conditioned on making quality, cost and effectiveness data available to the new institution. (Reischauer)
- A requirement that employers show on the wage statement the value of health insurance in a transparent way that reflected total compensation and its health component. (Steuerle)
- A requirement that employers at least offer health plans that employees could buy, and that the purchase cost of such plans be deducted from wages to the extent that costs are paid directly by employees. This may require the offering of community pooled plans, at least for smaller employers. The likely expansion of coverage would reduce some Medicaid health costs. (Steuerle)
- Benefit-based pricing of health services, as an alternative to cost-based pricing, should be considered. Can price be related to the expected number of quality-adjusted life years provided? (Weinstein)

Traditional Service Units and Alternatives

- More bundling of payments under FFS would reduce some inefficiencies, but that can be a difficult technical task. Episode payments would be sensible if feasible. (Antos)
- Expect continued innovation around existing FFS payment systems, moving in the direction of further balkanization by provider type. (Moran)
- Capitation with quality monitoring could serve as an alternative. (Reischauer)
- Under current fee-for-service or DRG-based reimbursement mechanisms, providers have incentives not to be cost-effective. Example: Reluctance to adopt new technologies that prevent the utilization of expensive yet profit-generating services. Capitation payment to provider organizations may promote cost-effective allocations, but it won't work as long as some services are excluded from the purview of the provider organization. It also won't work as long as patients can switch from one provider organization to another. (Weinstein)

Separation of Information and Fiscal Intermediaries

- Information intermediaries (II's) may be a good idea. They would have different skills than fiscal intermediaries (FI's)—II's have to structure information to be understandable to consumers and maybe providers, for example, while FI's rarely produce understandable information. (Antos)
- Information intermediaries should be encouraged. There would be a need for quality and independence assurance. (Enthoven)
- Yes, they will be an essential part of a knowledge based, learning medical care system of the future. But just as the financial reporting system has rules and law behind it, so will these emerging entities. (Hungate)

Other Strategies and Observations

Overall Budget Limit

- We should move toward fixed budgets for Medicare and Medicaid as in Britain and Canada. If resultant rationing was by explicit or implicit regulation, it could be informed by cost-benefit analyses done by independent body established for that purpose. (Penner)
- A permanent “benefits commission” should propose alternative modifications of the Medicare benefits package to meet the budget while modernizing benefits. These should be subject to up-or-down votes in Congress without amendment. If no alternative wins package, there should be across-the-board cuts in payments. (Butler)
- For Medicare, the rule enacted in the prescription drug bill should be allowed to operate for two years supplemented by an additional rule. If the first rule fails to slow Medicare cost growth to something approximating the growth of potential GDP, the program's cost growth would be capped either highly restrictively (e.g., equal to potential GDP growth in the past five years) or less restrictively (e.g., 1 percent above potential GDP growth). See Rudolph Penner & Eugene Steuerle, “A Radical Proposal for Escaping the Budget Vise.” (Steuerle)

Budget Treatment

- Dropping the entitlement treatment in the budget is important. Health programs will remain difficult to meddle with by politicians even without that protection. The presumption of unlimited spending creates an imposing inappropriate incentive. (Antos)
- A measure of the present value of future Medicare and Medicaid obligations should be included in the annual budget. (Butler)
- To balance Medicare expenditure goals against other national expenditure goals, the current entitlement should be converted into a “defined contribution” budgeted over several decades which can be adjusted as economic circumstances change. (Butler)
- All federal payments for health care ought to be defined contributions or budgeted (as in the case of VAH). (Enthoven)
- We need to have budget strategies that allocate public funds by need for assistance. (Etheredge)
- If we seriously wish to deal with budgetary issues in our information rich society we will have to move consumers to a “skin in the game” posture before budgetary control in other parts of the system can work. (Hungate)

Commissions

- My instinct is that the ideological and special interest pandering differences among Democrats and Republicans are so profound at this point that a very visible commission given authority to do something meaningful would implode. Better to start in places where public and private insurance programs have common interests, e.g., developing new payment methods and introducing evidence-based, and cost conscious coverage policy decision-making. (Berenson)

- Commissions deliberate, but rarely cause difficult actions to be taken by Congress. A base-closing commission analogy might be promising for some applications, but closing facilities is not the answer to the health cost problem. (Antos)
- Payment commissions will make tougher decisions if there is a market for them and political protection against retaliation from politicians whose constituents do not like the tough decisions. If Congress says they want it and will respect it, tougher decisions can be made. “Tax expenditures” should be turned into expenditures. The employer/employee tax break should be abolished and replaced with fixed dollar contributions set at the Low Priced Plan. (Enthoven)

Data and Reporting

- Health IT: Medicare could take the lead on *minimal* electronic standards. Federal subsidies for health IT will do little to accelerate adoption, which requires behavioral change among providers. (Antos)
- Medicare and Medicaid should demand that all participating providers use state of the art electronic health records, and help cover the startup costs. They should reward providers who have it. (Enthoven)
- A national tracking/analysis system is needed for national health spending that documents annual changes and trends, not just by pieces, but by changes in clinical care provided to patients with different diagnoses. (Etheredge)
- Outpatient IT:
 - IT will help people do better whatever it is that they do. Achieving social benefits depends on having them do the right things. As a new technology, IT inevitably has unanticipated consequences as well. (Miller)
 - IT’s potential to improve quality is great (eg, reminders and recommended care protocols at the point of care, potential to monitor course of care between visits, and to automate follow up). However, in outpatient care, IT is not now being much used in this way, so advantages remain hypothetical. Big, capitated groups with electronic health records (EHRs) doing much better than small practices with EHRs, but even big groups can do much more. Better incentives are needed to promote quality (and good value for money). (Miller)
 - Encouraging EHR adoption and use requires not just meeting physicians’ expected costs but also offering a risk premium -- because of the possibility of losing data, uncertainty about how soon financial benefits will ultimately be achieved, extra provider time costs for months during/after implementation, and so on. Encouragement is better done by pay for performance than by subsidy. Subsidy is wasted on those who would adopt anyway and on those who implement E HR but do not use it effectively (Miller)
 - IT’s effect on improving quality can increase or decrease spending. It is uncertain how much QI will occur and what the balance will be between improvements that reduce spending “downstream” (eg, less hospital use) and those that increase outpatient and downstream spending (eg, more chronic care visits, conditions diagnosed and treated). (Miller)
 - Outpatient IT achieves modest in-office efficiency savings (mostly in non-clinical personnel, eg. medical record keeping, transcription (IT typically reduces lower-

- skilled personnel)), and can increase efficiency savings for capitated providers. But who will get the savings? In short run, providers. In longer run, will payers and patients benefit from efficiency gains? (Miller)
- Outpatient IT can increase visit coding levels and payments from payers, for little QI in return, given current fee-for-service payment system. Automation allows physicians to easily conduct more thorough visits and also to document services provided much better, using traditional “evaluation and management” forms that capture components of service delivered. In practice this tends to raise the level of coding. One EHR software program even had a real-time calculator that tells a doctor how many points a visit is accumulating. As now used, these changes probably now marginally improve quality, but they certainly leads to on-going increased spending by payers, without assuring better output. (Miller)
 - Regional health information organizations will increase quality benefits some, due to increased data sharing. Benefits will take time. Unknown: effects on net financial costs/benefits. (Miller)