



**HEALTH CARE REFORM:
TAMING THE PAC-MAN OF GOVERNMENT**

By

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Consider the plight of Governor X. Elected in 2006, he promised during his campaign to increase spending on public education, transportation, and local aid, while expanding the number of citizens who had health insurance. Within a month of his election, the outgoing budget director informed him of a harsh truth: there would be little new money to accomplish these worthy goals. The rising cost of health care would devour most new revenue.

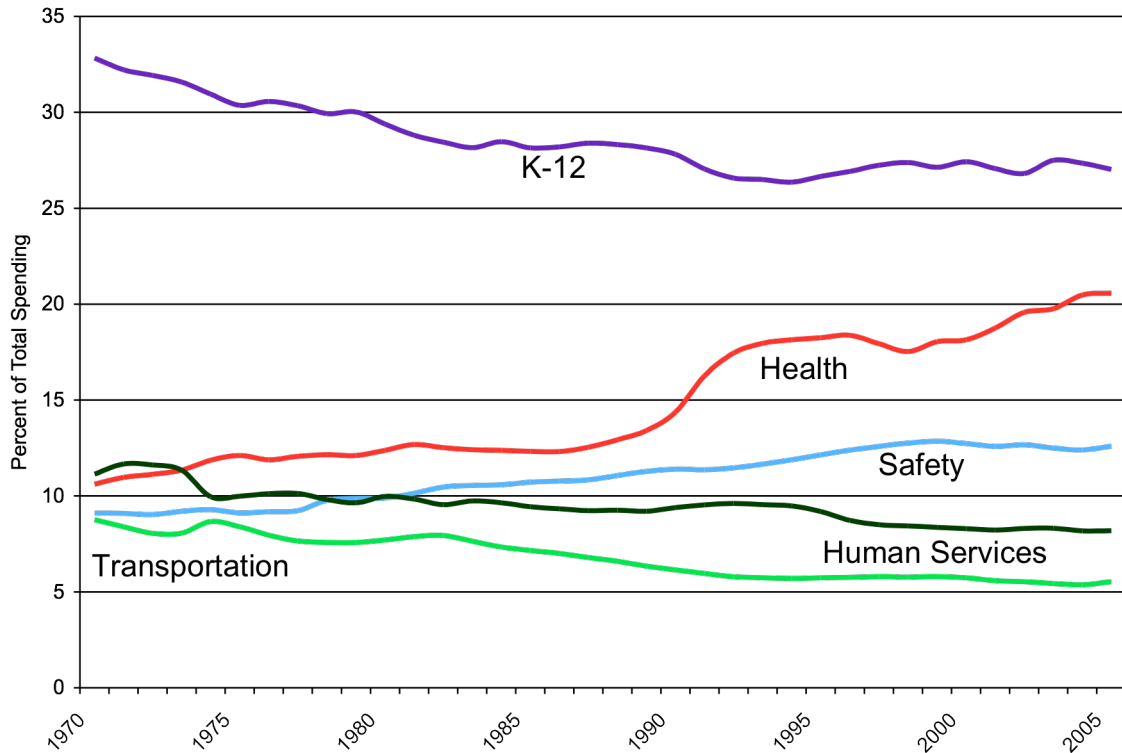
Virtually every governor and many mayors and city and county managers find themselves in some version of this situation, particularly now that the Governmental Accounting Standards Board requires them to report their health insurance obligations to retirees.

Health care is bankrupting America. Since 1960, costs have accelerated 10 percent a year—doubling every 7.5 years.¹ We spend 16 percent of our gross domestic product on health care, almost double the European average,² yet the World Health Organization ranks the U.S. 37th in the world for the overall quality of its health care system.³ Large American firms are at a competitive disadvantage because they spend so much more on health care than their foreign competitors.

But the fiscal squeeze is particularly debilitating in the public sector. By 2005 state and local governments spent 21 percent of their money on health, almost double the figure

from 1972. Where did the money come from? Education, down from 39 to 32 percent; human services, down from 11 to 8 percent; and transportation, down from 8.7 to 5.5 percent.⁴ (See Figure 1.)

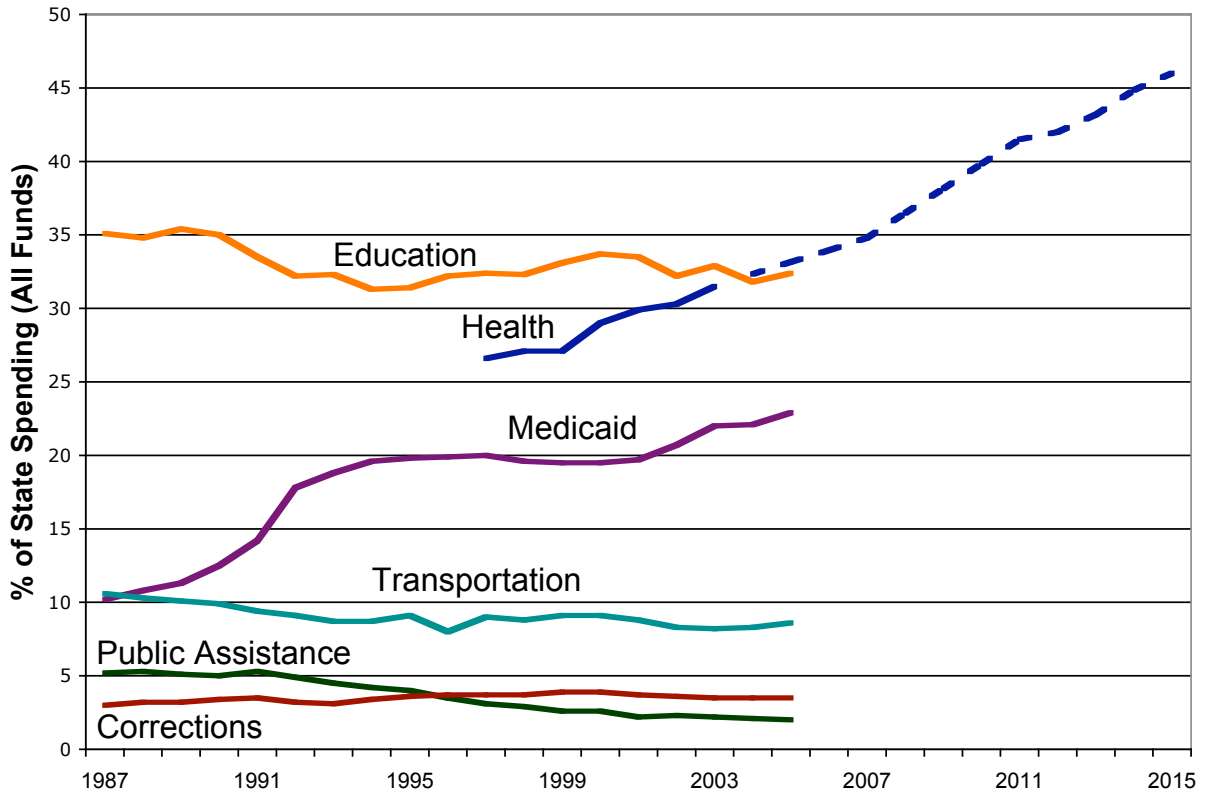
Figure 1: Distribution of State and Local Spending 1970-2005



Source: Bureau of Economic Analysis, National Income and Product Accounts (NIPA) Table 3.16.

At the state level, health care consumed *a third* of all state spending by 2005.⁵ If current trends continue, it will devour *half* of all state spending within 10 years.⁶ Every time it gobbles up another percentage point—*every 1.2 years*—we lose the equivalent of 150,000 teachers.⁷ (See Figure 2)

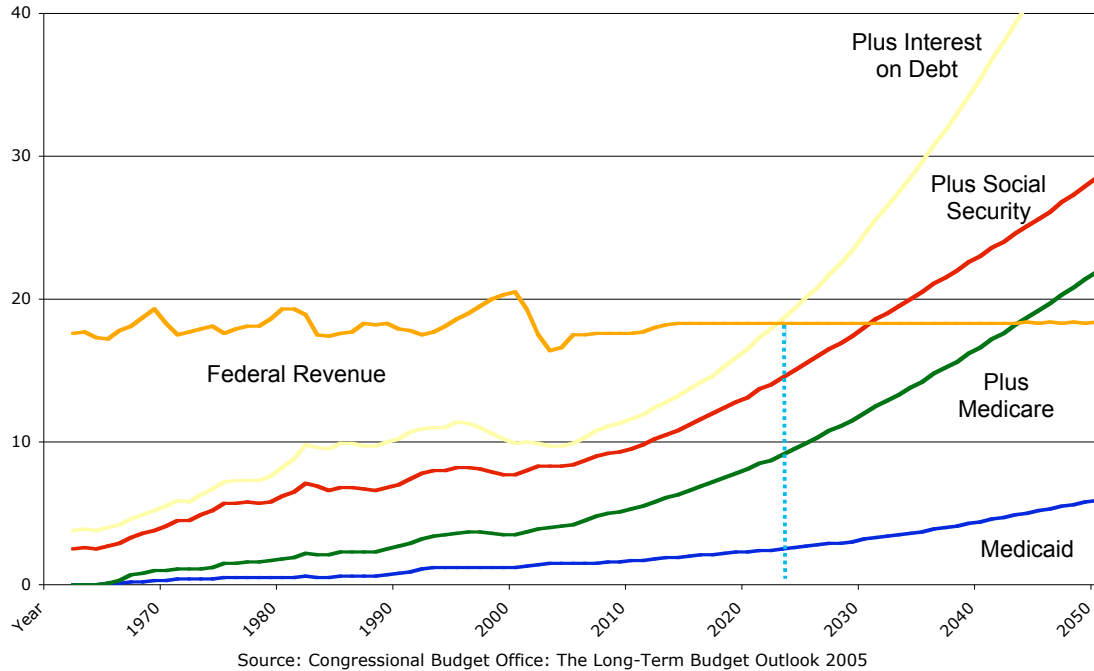
Figure 2: Distribution of State Spending 1987-2015



Source: for 1987-2005 data, National Association of State Budget Officers; projections of health care spending (dotted line) calculated by author.

The federal numbers are even worse. In 1972, the federal government spent 5.6 percent of its budget on Medicare and Medicaid. By 2006, the figure was 20.9 percent.⁸ In 15 years, under current policy, Medicaid and Medicare will consume half of all federal revenues (Social Security and interest on the debt will consume the other half).⁹ (See Figure 3.)

Figure 3: Medicaid, Medicare, Social Security and Interest as a Percentage of GDP



All the money we spend does not necessarily buy us quality health care, however. According to the Rand Corporation, patients receive the right care only about half the time.¹⁰ Between 48,000 and 98,000 patients die annually because of medical errors in hospitals.¹¹

Meanwhile, both private employers and governments are cutting back wherever possible, and the number of uninsured Americans has risen to 47 million.¹² The Institute of Medicine reports that 18,000 people without insurance die prematurely every year because they can't get the non-emergency care available to those with insurance,¹³ and many more suffer poor health because they lack care.¹⁴

Our health care system is in slow-motion collapse. No one is happy with it: not doctors, not nurses, not hospital administrators, and surely not patients. Tinkering around the edges of the system will not fix it.

Many governors and legislators are struggling to create universal health insurance. But solving the *insurance* problem without solving the quality and cost problems is a mirage. Pennsylvania Governor Ed Rendell had it exactly right when he told the *New York Times*, "If we're ever going to have accessible health insurance for all Americans, we have to begin by containing costs. If costs continue to spiral out of control, there is no way the government can afford to pay for it."¹⁵

We believe states can cut this Gordian knot, once again functioning as America's laboratories of democracy. This paper lays out an approach that will cut costs by 25 percent while improving quality.

The Diagnosis

To develop a workable solution, it helps to understand the basic problems our system faces.

First, we focus most of our energy and money on responding to illness, rather than sustaining health.

Second, most medical institutions are designed to provide episodic care for acute illnesses, but the real burden has shifted to chronic problems that need continuing and coordinated care: diabetes, asthma, cancer, AIDS, etc. "In fact," report health care experts Alain Enthoven and Laura Tollen, "about 45 percent of noninstitutionalized Americans have chronic illnesses, and they account for 75 percent of personal health care spending."¹⁶ More than 40 percent of them have more than one chronic condition.¹⁷ Unfortunately, our health care institutions were not designed to provide coordinated care for chronic conditions.

Third, our system is so fragmented between myriad medical practices, hospitals, and insurance companies that it produces enormous waste. Complex administrative processes, such as billing, absorb absurd amounts of time; indeed, studies estimate that administrative costs consume 25-30 percent of all health care dollars.¹⁸ Because multiple specialists dealing with the same patient rarely coordinate their care, patients fall through the cracks. And according to a 2004 report by the President's Information Technology Advisory Committee, one out of five lab tests must be repeated because previous records are not available, and one of seven hospital admissions occurs for the same reason.¹⁹

Fourth, our fee-for-service payment system creates perverse and expensive incentives. Providers make more money by performing more services. Indeed, if a doctor or hospital makes a mistake or omits something important and the patient has to be treated again, the doctor or hospital makes more money!

Fee-for-service payment leads to more care but worse outcomes. It actually creates disincentives to improve quality or make care more cost-effective, since practitioners who find ways to cut back on procedures make less money.

Drs. John Wennberg and Elliott Fisher at Dartmouth University have studied Medicare data for decades. Their research shows that in regions with more doctors, rates of hospitalization and procedures are far higher—often twice the level of regions with fewer doctors. Yet this higher spending, induced by a higher supply of physicians reimbursed based on the number of procedures they perform, does not yield better outcomes or more satisfied patients—it yields just the opposite.²⁰ Other studies show the same pattern with

Blue Cross Blue Shield insurance.²¹ Dr. Christine Cassell, president of the American Board of Internal Medicine, sums it up succinctly: “There is a stark correlation between reduced utilization and better outcomes.”²²

Dr. Wennberg believes that up to one-third of the \$2.1 trillion we spend on health care each year is wasted on unnecessary tests, treatments, and hospitalizations, overpriced drugs, and end of life care that yields nothing. “The Medicare system could reduce spending by at least 30 percent while improving the medical care of the most severely ill Americans,” he argues.²³

Reformers have put forth three general models to fix this ailing system. Some liberals propose a single-payer, single-administrator system, to cut administrative costs. They cite the fact that Medicare spends only four percent on administration, and their ideal model often looks like Medicare for all.

Unfortunately, this model would leave fee-for-service payment in place—insuring continued rapid cost inflation. Nor does it address the fragmentation of medical practices that creates so much waste. And on a practical level, it would require us to put the health insurance industry out of business, a daunting political task.

Conservatives typically prefer to intensify the market dynamics in the system by making consumers more sensitive to the price of medical services. They propose to do so by maintaining insurance for catastrophic costs, but with high deductibles before it kicks in and with health savings accounts (HSAs), which give individuals money they can use to purchase medical services. Experience suggests that this would change consumer behavior, in both good ways (more efficient use of health care) and bad (less purchase of needed drugs and therapies by the chronically ill, leading to greater hospitalization and higher costs). Nor does this “consumer-directed” strategy address the real cost drivers in the system, since it leaves fee-for-service medicine in place and provides insurance for those who consume a great deal of health care. By most estimates, 90 percent of health care costs are incurred by only 30 percent of the population.²⁴ These people will quickly exceed the deductible, at which point 100 percent of their medical bills will be covered and any incentive to shop for cheaper care will disappear.

The truth is, market dynamics in health care are unlike those in other industries, and more of them will not solve the problem. Third party payment is inevitable if we want people to get health care when they become seriously or chronically ill, and third party payment destroys a consumer’s incentive to shop for the best deal. In addition, many consumers are incapable of shopping effectively. Health care is extraordinarily complex, and most patients with cancer or other diseases that are not yet well understood find it difficult to make informed choices between treatments and doctors. Finally, while technological advances drive costs down in most markets, they drive costs up in health care. When we buy a car or a computer, we use it for a time and then dispose of it and buy another, which is better and cheaper because technology has advanced. But when technology succeeds in health care, it keeps people alive. We don’t dispose of them; instead, they

live to a ripe old age. Then, as their systems fail in their eighties or nineties, they become extremely expensive.

We suggest a third way, which goes beyond the ideologies of left and right. It is built on these simple principles:

- *Prevention is better and cheaper than care.*
- *Personal behavior determines health outcomes—and it must change.*
- *Incentives should reward better, cheaper care, not more care.*
- *Health care is a team sport: integrated, managed care is most cost-effective.*
- *Information technology can improve quality and lower costs.*
- *Our approach to end-of-life care is misguided and expensive.*

We have boiled these principles down into five initiatives a state government can undertake. We will also discuss several smaller pieces of the solution, but the keys to dramatic savings, quality improvements, and expansion of coverage lie in these five proposals:

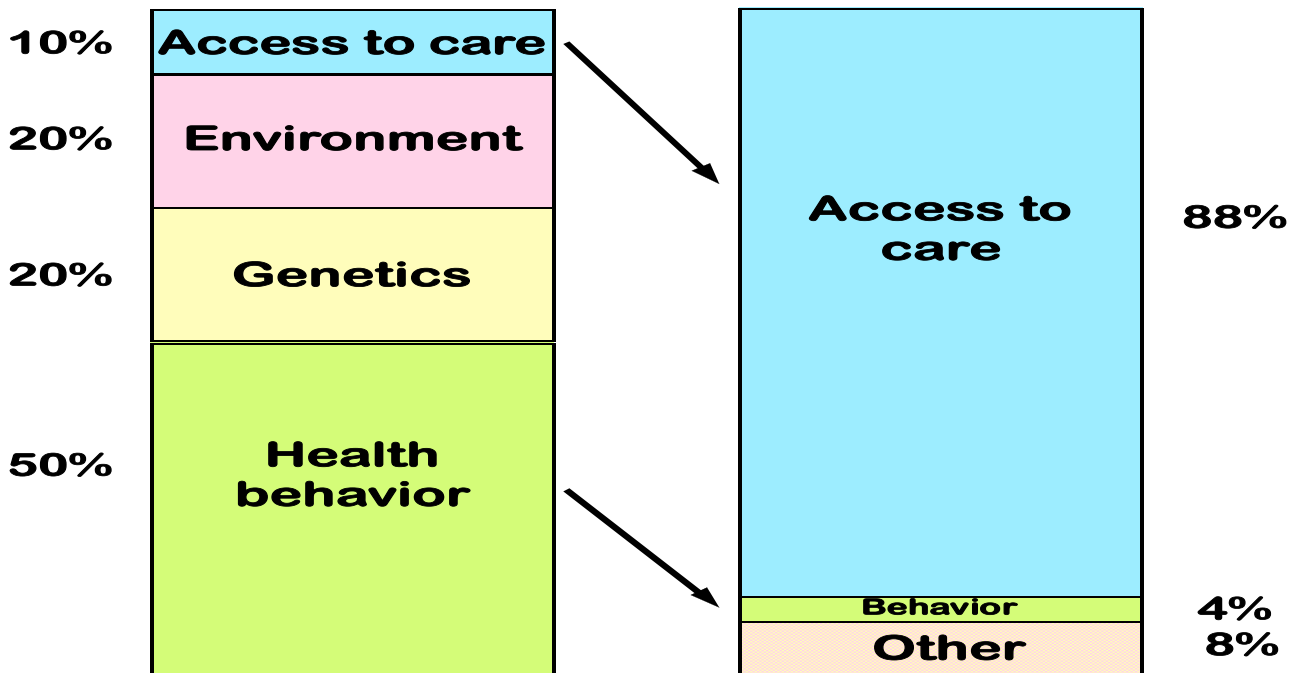
- 1. A massive effort to maintain *health* by encouraging healthy behavior.**
- 2. Replacing fee-for-service payment with managed competition between health plans that charge annual per-patient fees and pay integrated delivery systems for cycles of care.**
- 3. Statewide, interoperable electronic health records systems.**
- 4. New policies to encourage rational end-of-life care.**
- 5. A new system of health courts to contain medical malpractice costs.**

1. INVEST IN HEALTH

One way of describing America's health care problem is that we experience too much care and not enough health. Our most important goal, after all, is not *health care*, but *health*. And the biggest obstacle to good health for many Americans is not a lack of care; it is their own behavior.

According to the U.S. Centers for Disease Control and Prevention, four big factors influence our health: personal behavior, the environment (elements in our air, water, homes, communities, workplaces and food that cause disease), access to health care, and our genetic makeup. Of these four, personal behavior accounts for 50 percent of the variance in our health, the environment and genetics about 20 percent each, and health care only 10 percent.²⁵ Nevertheless, we spend 88 percent of our health resources on treatment, but only 4 percent on changing personal behavior.²⁶ (See Figure 4.)

Figure 4: Health Impact vs. Spending (Centers for Disease Control and Institute for the Future)



If we want better health, we must invest in changing behavior and cleaning up the environment. We all know that smoking causes cancer, heart disease, and other health problems, and for 40 years our governments have been working to reduce smoking rates, with substantial success. But obesity has become an even greater problem. According to the Centers for Disease Control, by 2006 one in four Americans were obese and 36.5 percent were overweight.²⁷ Obesity leads to diabetes, heart disease, and many other health problems. Medical research proves that consistent exercise lowers the risk of obesity, diabetes, heart disease, cancer, osteoporosis, depression, and high blood pressure,²⁸ yet fewer than half of American adults get the minimum necessary to enjoy these rewards, 30 minutes of aerobic activity most days of the week.²⁹

State leaders should pick the top five behaviors that undermine health in their states—such as poor diet, inadequate exercise, smoking, drinking, drug use, and teen pregnancy—and lead massive public campaigns to change them. Imagine what a governor could accomplish by leading public campaigns to boost exercise and move our diets away from their heavily reliance on carbohydrates. Altering some behaviors, such as unprotected teen sex, will require more targeted efforts, such as contraceptive health services and prevention programs focused on families that have already experienced one teenage pregnancy. Others will require legislation: for example, laws to require helmets on motorcycle drivers and cars that cannot be started if the front seatbelts are not in use. Still others, such as neighborhood designs that encourage walking, running, and biking, will require more complex initiatives.

We must also change the incentives that affect personal behavior. For instance, a state might create a Healthy Lives Trust with the power to define the 25 food and beverage products that create the most harm and levy taxes on them based on the amount of health spending they cause. The Trust could then be empowered to use that money to create financial incentives for people to exercise, stop smoking, and the like. We could require health plans to include similar incentives—such as discounts for people who regularly use an exercise facility, don’t smoke, and have healthy weights—and extra charges for those who smoke, are overweight, or drink to excess. (United Healthcare, the nation’s largest health insurer, recently unveiled just such a plan, based on successful experience with this approach by some employers.³⁰) We could also give employers financial incentives to create effective “wellness programs” for their employees, with the same goals.

Schools, both public and private, can play a role. In the 20 states that fall below the national health objective of 95 percent of kindergarteners having received seven recommended vaccinations, public health departments could organize vaccinations for all school children.³¹ All states could provide annual dental checkups in school, since only half of children aged 2 to 17 get them.³² In middle and high schools they could organize health clinics to deal with problems such as teen pregnancy. (To be clear, schools would provide the space for all these activities but have no other responsibilities except to get students there; the state would provide the funds and contract with providers to offer the services.) Finally, why not ask schools to require participation in physical education or sports every day, as we did a generation ago? If the school day must be lengthened to accomplish this, so be it. Creating healthy habits at a young age will pay dividends for a lifetime.

Another necessary element of a *health promotion* agenda is “secondary prevention:” once a condition occurs, we must ensure that it is managed well, to minimize its effects. Once people have diabetes, for instance, we should make sure they change their diets and receive proper care. Many diabetics find their illness difficult to control, and some develop expensive complications: between 1988 and 1994, diabetes accounted for nearly nine percent of adult hospitalizations, 12 percent of nursing home admissions, and 10 percent of adult deaths.³³ Programs such as the Stanford Chronic Disease Management Program (in California), Enhance Wellness (in Seattle), Active for Life (in Austin), and a Matter of Balance (in Boston) educate patients and their families and help them manage such chronic conditions. Canada, the United Kingdom and Australia have adopted this approach as national strategies.³⁴ States could do likewise, contracting with proven disease management programs to implement statewide efforts. They could also create incentives to encourage health providers to focus on secondary prevention.

2. REPLACE FEE-FOR-SERVICE WITH MANAGED COMPETITION BETWEEN HEALTH PLANS THAT CHARGE ANNUAL PER-PATIENT FEES AND PAY INTEGRATED DELIVERY SYSTEMS FOR CYCLES OF CARE

In an experiment run by the Rand Corporation, group medical practices that cared for patients for a set, prepaid fee cost 25-30 percent less than those paid on a fee-for-service basis.³⁵ The fundamental reason was that they had clear financial incentives to become more cost-effective, as Enthoven and Tollen explain:

Prepayment rewards doctors for keeping patients healthy, for solving their problems in economical ways, and for avoiding errors. It encourages superior ambulatory care for patients with chronic conditions, thereby reducing their need for hospitalization. In contrast, the fee-for-service payment system gives doctors powerful financial incentives to do more (and more costly) procedures, which may not be in patients' best interests, financially or clinically.

Prepaid *delivery systems*, such as health maintenance organizations (HMOs), have similar incentives and even more weapons to improve quality:

...a system prepaid for total costs can examine the full spectrum of care to find opportunities for cost reduction, not just shifting costs to other parts of the system. For example, a prepaid delivery system can evaluate new technologies for their cost-effectiveness and impact on quality and can deploy them as needed....

Prepaid (and partially prepaid) integrated delivery systems are far ahead of small groups and individual doctors in the use of quality-enhancing decision support tools, disease registries, guidelines, automated reminders, performance feedback, patient self-management, linkages to community resources, and electronic medical records.³⁶

To capture these benefits, states should switch to prepayment for all health programs: Medicaid, the State Children's Health Insurance Program (SCHIP), state employees' and retirees' plans, and all others. Wisconsin's insurance program for state employees offers a good example of how to use prepayment to stimulate price competition: it defines a basic benefit package, asks health plans to submit bids specifying the annual dollar amount they would charge for this package, per individual and family, and ranks those bids. The program uses price and quality measures to define three tiers. Plans in tier one, which are low in price and high in quality, cost the least for state employees. If they prefer a more expensive plan in tier two or three—because their family physician is not part of a tier one plan, for instance—they are free to choose it and pay the monthly difference. But the majority of members choose tier one plans, and this fact creates a powerful incentive for health plans to lower their prices. (Members can switch plans once a year.)

Wisconsin put this approach into effect in 2003. In Dane County, which includes the state capitol, the state employee plan covers 30 percent of the market. Competition between health plans has reshaped the market in Dane County, while driving costs for individual and family plans 14 percent below the statewide average and 30 percent below the most expensive regions.³⁷

The Basic Benefit Package:

If a state created such a purchasing pool for all its programs, all health plans in the system would provide the same basic benefit package, though individuals and employers would be free to purchase additional coverage. The state would define the benefits package based on hard evidence about which services were most cost-effective, as Oregon did a decade ago in the Oregon Health Plan. To control drug costs it would include a preferred drug list. Generic drugs would require the lowest co-payments; non-generics on the preferred list would be slightly more expensive; and those not on the preferred list would be most expensive. (These co-payments might be in the range of \$5, \$15, and \$40, for instance.) The state would use the size of its pool to negotiate steep discounts for drugs on the preferred list. By creating joint purchasing consortia with other states, it could increase its bargaining power.

The benefits package could have a deductible and require co-payments, to discourage wasteful use of medical care. But preventive care and chronic care would be covered without deductibles or co-payments, because such charges discourage the purchase of needed drugs and care. (A recent study of three managed care plans with co-payments of more than \$10 for drugs showed a 20 percent reduction in the use of diabetes medications.³⁸) This leads to more emergency room visits, more hospitalizations and more nursing home care. As the *New England Journal of Medicine* explained in an editorial:

Attempts to save money through the redesign of insurance plans—involving caps on benefits and increases in out-of-pocket spending for prescription drugs—results in the delivery of poor care to chronically ill patients.... We should be reducing the barriers to treatment and encouraging patients to take appropriate medications for the recommended duration, rather than increasing these barriers by limiting benefits.³⁹

Health savings accounts (HSAs) could also be useful elements of the benefit package. By creating a \$1200 annual deductible and offering an \$800 annual health savings account, for example, a state could give residents an incentive to shop carefully for health services, as well as expanded choices, since they could use the HSA to buy services not covered by the benefits package. To make this more effective, states would need to help consumers understand the price of different medical services, perhaps by requiring that providers post their prices on a state sponsored web site.

To protect against “adverse selection,” in which unlucky health plans attract older or sicker people who drive up their costs, each individual covered by the state purchasing pool would be “risk-adjusted”—meaning that the price the state paid to health plans would reflect the individual’s degree of risk upon entry. In addition, a state would be wise to offer reinsurance to health plans, to cover the cost of catastrophic cases. Without risk adjustment and reinsurance, health plans would bid higher to limit their risks.

Encouraging Health Plans to Purchase Prepaid Cycles of Care for Medical Conditions

In their book, *Redefining Health Care*, Michael Porter and Elizabeth Olmsted Teisberg argue that we will not get better, cheaper care unless medical providers have to compete

based on the price and quality of full cycles of care for particular medical conditions, such as pregnancy, diabetes, particular types of heart disease or stroke, and hip or knee replacements. If medical groups had to compete based on price *and* the results they produce over a full cycle of care (which could be multiple years), they would have powerful incentives to use prevention, disease management, best practices, and innovative treatment methods to improve outcomes and drive costs down. As Porter and Teisberg point out, care that produces better outcomes is often cheaper, because preserving health is cheaper than managing disease.

To make this possible, states need to do two things: systematically measure and report risk-adjusted medical outcomes for each condition and provider; and push health plans to pay providers for cycles of care for medical conditions. Currently many “integrated” health plans still pay physicians and hospitals on a fee-for-service basis. States should work to move them into prepayment for cycles of care: nine months of obstetrical care and delivery, for instance; or a knee replacement, which would include all post-surgical therapy and complications; or two years of care for diabetes.

Until robust outcome measures are available, states could give plans points in their rating system if they shifted the majority of their purchases from fee-for-service to prepayment, and could pay higher bonuses the fewer services a plan reimbursed on a fee-for-service basis. Once states have developed mature outcome measurement systems, they could *require* prepayment for cycles of care. To enable this, they could create electronic exchanges: web sites on which physicians and hospitals would list their best prices and outcomes for each cycle of care and health plans (and individuals) could purchase the most cost-effective options. (Still a work in progress in many areas of medicine, outcome measurements would need auditing to ensure that they were honest and accurate).

Once they were required to provide cycles of care for prepaid prices, doctors and hospitals would face very different incentives. They would be rewarded not just for doing procedures but for driving down their costs by eliminating errors, managing chronic patients more effectively, providing care in doctor’s offices rather than hospitals, helping their patients take the proper medications and make healthy lifestyle choices, using electronic health records, and the like.

States might even encourage plans to offer their members an option in which the insurance buys them a set amount of money for each condition, rather than services. If a woman became pregnant, for example, she might be given a voucher for \$5,800, which she could use to purchase nine months of care and delivery. If she could find it for \$5300, she could pocket the savings; if her preferred doctor charged \$6500, she would have to pay the extra. In this way health plans could enlist members who wanted to make active choices as allies in the effort to make providers compete based on price.

The one danger of prepayment is that health plans and providers can make money by simply withholding care from members: refusing certain procedures, making it difficult to schedule appointments, and the like. Plans that did this would quickly lose most of their subscribers, of course. One way to prevent such behavior in the first place is to

include points for quality in the formula used to rank the health plans that bid each year; another is to make information on quality available to the public. There are many methods to measure quality already in widespread use: customer satisfaction surveys; measurement of error rates; indication of whether plans and providers have systems in place that require doctors and others to use best practices; and the most important method, measurement of outcomes.

Encouraging Integrated, Managed Delivery Systems

The approach we have described would reward integrated, managed health systems and provider groups, as it has in Dane County, Wisconsin, because they are more efficient. (Examples of such systems include HMOs like Kaiser Permanente and Minnesota's HealthPartners, medical groups like the Mayo Clinic, the Cleveland Clinic, and Geisinger Health System, and emerging networks such as North Carolina's Community Care, which serves 745,000 Medicaid patients. Some of these systems employ physicians as staff members, while others pay independent practitioners to care for their members. Some, like Kaiser, are fully integrated, even owning their own hospitals. Others, like Community Care, are virtual networks that knit together many private practitioners and hospitals to act as one coherent system.)

According to Wennberg and Fisher's research, regions dominated by integrated, managed systems have costs one-third lower than other areas.⁴⁰ One reason is that they have the financial resources to create Electronic Health Record (EHR) systems, which dramatically lower both waste and error rates (a subject we will return to in a moment). Another is that they have a built-in incentive to prevent disease, since prevention lowers their overall costs. A third is that they have both the resources and incentives to use best practices: "evidence-based standards of care," in industry lingo. Finally, they can use a more cost-effective mix of personnel: fewer doctors, more nurse practitioners, midwives, medical assistants, nutritionists, and the like.

Several of these factors help such systems deliver higher quality as well. Their integrated nature also helps: patients fall through the cracks less often. In the fragmented world of most private practices, when a physician refers a patient to a specialist, there is often no coordination. For patients with complex conditions, this can lead to problems. For instance, a specialist might prescribe a medication that interacts badly with medications the patient is already on, because he is unaware of the patient's medications and the patient has forgotten to tell him. As many experts have pointed out, medicine today is more a team sport than an individual one.

Integrated, managed systems typically require that every member have a medical "home"—a physician who acts as his or her primary caregiver and is responsible for coordinating his or her care. (States could require that every person in the state purchasing pool have such a medical home.)

Some systems even provide "case management" for patients who consume a great deal of health care. (One percent of the population uses 27 percent of all health care dollars, and

five percent consumes more than half.⁴¹) These are typically people with chronic conditions that require a great deal of care, often by multiple doctors. Sometimes the doctors don't coordinate, as noted above. Sometimes patients don't comply with their physicians' instructions—because they are elderly, or do not speak English, or are alcoholics, or have memory or other mental problems. They don't take the medications prescribed; they don't return for follow-up visits; they don't follow the doctor's behavioral recommendations.

Community Care in North Carolina has begun to use case managers to work with these patients and their physicians to ensure better compliance, better coordination between multiple physicians, and thus better health. It has had great success with this model.⁴² Similarly, the Monroe Plan, a managed care organization in Rochester, New York, has dramatically reduced admissions of babies to neonatal intensive care units by using case managers to reach out to pregnant women on Medicaid and help them get prenatal care and avoid risky behaviors. Every dollar invested in the program has saved \$2.⁴³

States could push the adoption of all these practices faster with incentives, such as extra points in the ranking system for degrees of integration and management. They could even reward integrated systems that demonstrate efficiency and quality with “charter health plan” status. As with charter schools, charter health plans could be given greater flexibility under state (and federal, if possible) regulations, in return for greater accountability for outcomes.

Managed Long-Term Care

Including nursing homes and other forms of long-term care in the state purchasing pool is critical. Medicaid spends 68 percent of its money on long term care for the aged, blind and disabled, who make up only 27 percent of its enrollees.⁴⁴ It pays for nearly half of all long-term care.⁴⁵

Most long-term care is provided on a fee-for-service basis, with little coordination. Managed care for fixed prices—in which members can choose their plan and switch annually if they are not happy—provides incentives for health plans to find the most cost-effective setting for each person, whether in their home, a nursing home, a rehabilitation hospital, a chronic long-term care hospital, or a day program. Oregon, Arizona, Florida, Texas, and Wisconsin have already proven that such programs improve quality and cost-effectiveness.⁴⁶ Oregon's case management approach has reduced claims by roughly 50 percent.⁴⁷ “Cash and Counseling” programs in several states, which give patients some Medicaid money each month to purchase their own goods and services, also show promise by helping people make choices that keep them out of nursing homes and hospitals.⁴⁸

The next step would be to integrate managed care for those who are eligible for both Medicaid and Medicare—among the most challenging populations because they are both poor and elderly. Medicare and Medicaid policies do not always mesh well, and when both are paying for services overall costs tend to be higher.⁴⁹ A few states have earned

waivers to combine the two programs, however. Minnesota's Senior Health Options Program, which integrates the two in one managed care program, has significantly reduced the number of preventable hospital and emergency room admissions for those living both in nursing homes and in the community.⁵⁰ Massachusetts also has a small integrated program, called Senior Care Options. The Commonwealth Care Alliance, which manages care for 2,000 people under this program, has reduced costs significantly in two years while registering impressive customer satisfaction and very low levels of disenrollment.⁵¹

After integrating care for the “dual eligibles,” a state could ask Medicare for a waiver to integrate all Medicare into its managed care system.

Is This Just Managed Care All Over Again?

Some may say this model is simply “managed care,” which has been tried and rejected. Indeed, managed care by integrated health maintenance organizations was on the rise throughout the 1970s and 1980s, but was derailed by a backlash from consumers and doctors in the 1990s. It did succeed in lowering health care inflation; in Minnesota, for example, it drove utilization rates from the national average to 17 percent below average, as physicians and hospitals learned how to manage resources more wisely. But the use of managed care was flawed in three ways. Most employers did not give consumers choices of plans—they chose one managed care plan and offered it to all employees, who were unhappy if their doctor was not in the chosen plan.⁵² Few employers encouraged maximum price competition, because they chose one plan and paid virtually the entire premium for employees. And managed care did not penetrate enough of the market in most regions to drive prices down significantly.⁵³

A few large employers got the incentives right, however. Stanford University, the University of California, Hewlett-Packard, Well Fargo Bank, the Federal Employee Health Benefits Program, the Wisconsin employee health plan and the California Public Employees Retirement System (CalPERS) all asked various plans to bid, then paid a fixed price for plans and let their members choose any plan—but pay extra for more expensive ones. This created a powerful incentive for plans to lower costs. According to Enthoven and Tollen, “When employers pay a fixed-dollar amount and each employee can keep the full savings, experience shows that high percentages of employees choose economic care. For example, 70-80 percent of active employees and dependents covered by the University of California, CalPERS, and Wells Fargo in California choose HMOs.”⁵⁴

Wisconsin's experience in Dane County indicates that both patients and doctors can be quite happy in such a system, as long as they have choices. It also demonstrates that a government can dramatically reshape the health care marketplace—spurring the emergence of integrated delivery systems such as HMOs—by including just 30 percent of the market in its managed competition arrangement. This is true because most health plans compete for state employees, and when they make changes to become more efficient and effective to capture that market, those changes affect the rest of their

business. Hence leverage over 30 percent of the market gives the state power to reshape virtually all of it.

Two Paths to Implementation

There are two basic paths available to states that want to use the model we have described to lower costs while expanding access to health care. The first would be to include everyone (other than Medicare recipients) in the purchasing pool, replacing employer-provided insurance with coverage paid for through new taxes. This would create a single, statewide purchasing pool, but it would maintain competing health plans and private providers, to ensure competition on price and quality. It would be simpler to administer than today's system, cutting billing costs. And because it would include all residents, there would be no requirement to check people's incomes to see if they were poor enough to participate, nor any need to search for those who were cheating. Finally, the pool would be so big that adverse selection problems would be minimized.

There are many good reasons to separate health insurance from employment. Under our current approach, employers who provide health insurance are at a severe disadvantage in the marketplace, a fact that is driving more and more of them to drop this benefit. Employees are reluctant to change jobs, for fear of losing their health insurance. And people with pre-existing health conditions can face obstacles in getting jobs because of the cost of their insurance. Those with jobs live in fear of losing them, because they could never get insurance on their own.

The political hurdles in shifting from employer-based insurance to a tax-financed system would be daunting, however. Insurance companies would face a huge loss of market. Hospitals and doctors would see their power to charge higher prices severely limited by the competitive dynamics of the new marketplace. And state leaders would have to convince businesses and individuals to pay higher taxes, to fund the system. An analysis by the Lewin Group of one such proposal in Wisconsin indicated that employers' health care costs would decline more than their taxes would go up, in part because firms that didn't provide insurance would now have to pay their share.⁵⁵ Still, any proposal for a significant tax increase faces tough sledding.

The alternative is to build a pool that captures at least 30 percent of the market and use it to reshape the system, as Wisconsin has in Dane County. A state would begin with state employees and retirees, Medicaid, the State Children's Health Insurance Program (SCHIP), and other state health plans, then add local government and education employees to the pool. In the typical state, these groups total more than 21 percent of the market.⁵⁶ (This would require a federal waiver for Medicaid, but several states already have similar waivers, so it should be possible. In states that have low reimbursement rates for Medicaid it might require an increase in spending, to create the same benefit package and price for Medicaid recipients as for state and local employees.)

If the state adopted a mandate that residents have health insurance, it would also add the uninsured to the pool—another 16 percent in the average state.⁵⁷ If the total did not add

up to 30 percent of the market, it could require contractors who did most of their work for government, such as road builders, and firms that receive large state tax breaks, to join the pool. The state could also seek a waiver to integrate Medicare into the pool (something it should do in the long run in any case).

Once the system had demonstrated the power to restrain health care inflation, some employers would be tempted to join, to save money. Since more participants would increase the system's power to control costs, the state could offer businesses guaranteed prices for several years, to induce them to join. All entrants to the pool would have to be risk-adjusted upon entry; the state would charge more for higher risk groups and less for lower risk groups, to avoid driving younger, healthier groups out of the pool in search of cheaper rates.

If the model could hold annual price increases to 3.5 percent—and if the 10 percent average increase we have seen since 1960 continued in the rest of the country—the managed competition model would cut health costs by 26 percent in just five years. As this happened, more and more employers would join, and once half the state was in the pool the politics of moving to one tax-financed system that covered all residents would get easier.

3. CREATE A STATEWIDE, INTEROPERABLE ELECTRONIC HEALTH RECORDS SYSTEM

As we noted above, one of every five medical tests must be repeated and one in seven hospitalizations is ordered because records are missing or information is unavailable. The cost is enormous: the one in seven hospital admissions cost \$30 billion a year.⁵⁸

Many integrated delivery systems now have electronic health record systems, but the majority of American physicians and hospitals do not yet use them, and most private systems can't talk to one another. Perhaps the best system has come from surprising quarters: the Veterans Health Administration. Between 1995 and 2005, while the rest of the country suffered through doubling health care costs, the VHA's cost per patient remained level. With 10,000 fewer staff, the VHA more than doubled the number of patients it served.⁵⁹

The VHA's EHR system is the most advanced in the world. Leaders from Britain, Germany, and other countries seeking to create EHR systems visit to learn about it, and the government of Mexico is installing it in its largest health care provider system. In 2006 it won a prestigious Innovation in American Government Award.

How does it work? Every VHA physician is linked by computer to the system. He or she has access to every patient's entire medical record, including all x-rays, CT-scans, and test results. The doctor enters all notes and prescribes all medications electronically.

The VHA has mined the data the system has accumulated—and other sources of medical knowledge—to develop best practice guidelines, which the system provides physicians

through timely reminders. For instance, it might remind a doctor that a patient with diabetes is due for a retinal exam, or that an older patient should be immunized against pneumonia. If a doctor is prescribing a medication that will interact with another drug the patient takes—or to which the patient is allergic—the computer will flag it.

The system costs the VHA \$78 per patient per year: less than the cost of repeating a single lab test. It has saved billions of dollars while dramatically improving quality. Errors on prescriptions, which are bar coded, not handwritten, have fallen from the national average of five percent to a fraction of one percent. Study after study has concluded that the VHA's quality of care is superior to private sector care. Not surprisingly, customer satisfaction has soared: on surveys done using the American Customer Satisfaction Index, the VHA now outscores private sector health care providers.

EHR is not the only reform responsible for these improvements, but it has had a huge impact. And believe it or not, the VHA's software is available to anyone who wants it, free of charge.

Governors should use their bully pulpits to gather the leadership of every major health care provider and insurance company in the state into a consortium devoted to creating a statewide, interoperable system as good as the VHA's within five years. (Some might simply choose to adopt the VHA software.) Financing could be shared between the state and those who would benefit the most: insurance companies and integrated delivery systems. To encourage widespread adoption, the governor could announce that at the end of five years, the state would cease reimbursing—through Medicaid, SCHIP, state employee's health care, etc.—any provider not using the system.

The potential for improvement is enormous. In addition to the kind of savings and quality improvements experienced by the VHA, EHR systems could give individuals access to their own records, test results, and the like on a web portal. (To protect their privacy, individuals could determine who was allowed access to their records.) To extend the system's reach, we could put a patient's entire medical record on a smart card that could be read by any computer. If they showed up at an emergency room or doctor's office out of state, their record would still be available, in their wallet.

The next step would be a billing component, so different insurers could begin using the same forms and codes. Someday we may even be able to pay for our health services instantaneously, with a swipe of our smart cards.

Finally, states could use the EHR system to gather data on quality and outcomes and make this information available to patients on the web portal.

4. CREATE POLICIES TO ENCOURAGE RATIONAL END-OF-LIFE CARE

No one knows how many of our health care dollars go to elderly people in their last year of life, but 25 percent is a good guess. This is one reason American health care is so

expensive: we succeed in keeping many people alive into their eighties, then spend an enormous amount in their last few months as their systems collapse. In many cases this serves no rational purpose and pleases no one. But doctors and nurses are taught to do everything they can to help patients, and in the absence of specific policies that tell them otherwise, that's what they do.

Should a state pay for a knee replacement for an 82-year-old who is expected to die of lung cancer within a year? Should it pay for radiation or chemotherapy to treat breast cancer if an 84-year-old is expected to die of brain tumors? Governors should engage the public in a wide and deep consultation process to begin to answer such questions.

In addition, they should:

- require that all members of the state purchasing pool have a living will or “death plan,” describing what efforts they do not want made to extend their lives;
- define a default living will for anyone in the state pool who has not created one;
- encourage and perhaps incent health plans that cover people not in the state pool to take similar steps; and
- create a process to educate doctors and other hospital staff about the new state policy and default living will.

5. CREATE A SYSTEM OF HEALTH COURTS TO CONTAIN MEDICAL MALPRACTICE COSTS

Finally, we need to rethink the way we handle medical malpractice. Our current approach drives physicians to practice “defensive medicine,” doing more tests and procedures than necessary so they can prove they covered all the bases if sued. And because only two percent of those injured by negligent hospital care file malpractice claims—and only a third of them yield a payment to the injured party—more than 99 percent of those who suffer medical negligence are never compensated.⁶⁰ Meanwhile, physicians get no clear signals about standards of care.⁶¹

This is a dysfunctional system. The Progressive Policy Institute (PPI) has come up with a brilliant solution: Create a system of health courts, similar to the system that handles workers' compensation claims, to make it easier and cheaper for patients to seek compensation. David Kendall of PPI explains:

Under workers' compensation systems, workers injured on the job simply submit a claim form through their employer to an administrative law judge or board. If the judge or board determines that the injury occurred on the job, a worker receives compensation according to a schedule of benefits that takes into account the severity of the injury, the degree of disability, and the worker's age and pay.

A health court system would be similar to the workers' compensation system in two ways. First, there would be a schedule of benefits to compensate patients for medical injuries. Second, a health court system would be designed to provide quick, consistently fair damage awards. ... An injured patient would submit a simple claim form, available

through her health care provider, to a local health court review board. These boards would investigate claims and determine if they are clear, uncontestable cases of malpractice. In such cases, they would simply order the injured patient's health care provider to pay damages according to a schedule of benefits.

After a health court review board has ruled whether or not a case is cut-and-dry, appeals of that decision, along with cases that are not clear-cut, would go to trial before a health court judge. . . . Lawyers would represent both parties. But unlike malpractice cases in civil trials, health courts would render decisions that would help shape clear legal standards for medical practice. In addition, the health court judges, not the plaintiffs or defendants, would hire expert witnesses to settle questions about medical standards. When health court judges find incidents of malpractice, they would determine awards using the same schedule of benefits applied by the review board.⁶²

Kendall predicts that health courts would be less expensive than today's system, since more than 50 percent of court awards go to legal costs and lawyers fees. Medical malpractice premiums should fall, he reasons, as compensation becomes more predictable and the new system clarifies standards of practice.

OTHER STEPS

These five ideas do not encompass everything a state can do to get better health and lower-cost, higher-quality health care—just the most important steps. States also need to change the way doctors are educated and trained. Medical students and residents need to learn to how to promote health, not just attack disease. They need to learn evidence-based medicine, working in teams that include multiple specialties and nonphysicians (nurse practitioners, midwives, case managers, etc.). State leaders should seek to bring these changes about in all medical schools and teaching hospitals, not just the public ones. After all, they provide some of the funding for private medical training by paying for many of the patients, and they license physicians.

Many states also need to change the ratio of general practitioners to specialists. (The former include family practitioners, general internists, general pediatricians, and general obstetricians and gynecologists.) Many states already experience shortages of general practitioners. And as Wennberg and Fisher have documented, the more specialists a region has, the more procedures they will perform, the more people they will admit to the hospital, and the more health care will cost.

One way to change the ratio is to subsidize generalists' education. A state could forgive all medical school loans for those who practice as generalists and in underserved areas for at least five years, for example.

State regulation of health care should also be reexamined. If we are to create a more cost-effective system, we need to eliminate anticompetitive tactics by developing a form of medical antitrust policy. As we begin to use measurement of quality and outcomes to drive prepayment formulas and patient and doctor choices, we need to ensure that the measurement is honest and accurate. We also need to modernize our regulatory rules and

apparatus, so they do not stand in the way of positive innovations and the development of new fields of health care. And we need to ban the pharmaceutical company practice of using gifts to physicians—luncheons, trips, tickets to events, and other favors—to entice them to prescribe certain drugs. According to Health Care for All, an advocacy group in Massachusetts, pharmaceutical companies spent \$12 billion marketing to doctors in 2005—an average of \$13,000 per physician.⁶³ Minnesota has already enacted a \$50 limit on marketing to prescribers.⁶⁴

CONCLUSION

The most effective path to reform will vary from state to state, depending upon local political realities. But it is hard to imagine strategies as fundamental as these being embraced without leadership from the governor and/or a state's legislative leaders. State leaders would have significant leverage with health care providers and insurers, if they chose to exercise it. Governments insure 21 percent of the market in the average state, as we noted above. With the support of the consortium, state leaders could commit to a deadline for cooperation with key reforms. They could pass legislation mandating that the state stop doing business with any health care provider that did not join the electronic health record system or adopt default end-of-life policies for their members within, say, five years, for example. After the deadline, those providers would receive no reimbursement from any of the programs the states and local governments controlled: Medicaid, SCHIP, employee health insurance, retiree health insurance, etc.

Almost every idea in this paper is already working somewhere in the country, with the exception of end-of-life policies and health courts. They are all doable. But the most powerful argument for this approach is the cost of not taking it. Today health care consumes more than one-third of total state budgets. In 10 years, if current trends continue, it will consume 50 percent.

Where will we find the money? If the future is like the past, we will narrow eligibility for Medicaid and increase deductibles and co-payments for state employees. We will lay off teachers and eliminate extracurricular programs in our schools. We will cut aid to local governments, who will lay off police. We will defer maintenance on our infrastructure, even as more people clog the roads and rails. And we will raise both state and local taxes.

Meanwhile, 50 million Americans will be without health insurance.

This is a future none of us want. The time to act is now.

Endnotes:

¹ “Table 1: National Health Expenditures Aggregate and per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1980-2002,” U.S. Centers for Medicare & Medicaid Services (formerly the Health Care Financing Administration), <http://www.cms.hhs.gov/statistics/nhe/historical/t1.asp>, January 2004. The exact average annual increase in total spending on health care from 1960-2002 was 10.19 percent.

² *World Health Statistics 2007* (Geneva: World Health Organization, 2007), www.who.int/whosis/whostat2007/en/index.html. In 2004, the last year for which the WHO has data, the U.S. spent 15.8 percent of GDP on health care and the European Region average was 8.6 percent.

³ *The World Health Report 2000 – Health Systems: Improving Performance* (Geneva: World Health Organization, 2000), Annex Table 1: “Health system attainment and performance in all Member States, ranked by eight measures, estimates for 1997,” 152, http://www.who.int/whr/2000/en/whr00_en.pdf.

⁴ Bureau of Economic Analysis, National Income and Product Accounts (NIPA) Table 3.16, “Government Current Expenditures by Function,” September 2006, <http://bea.gov/national/nipaweb/TableView.asp?SelectedTable=315&FirstYear=2004&LastYear=20>.

⁵ Data for everything but the “health” line is from *State Expenditure Report Fiscal Year 19965* (Washington, D.C.: National Association of State Budget Officers, 1996) and *State Expenditure Report Fiscal Year 2005* (Washington, D.C.: National Association of State Budget Officers, 2006). The National Association of State Budget Officers (NASBO) only measured total state health spending from 1997 through 2003, and there is no other reliable source of this data. In 2003 NASBO’s figure was 31.5 percent: *2002-2003 State Health Expenditure Report* (Washington, D.C.: Milbank Memorial Fund, National Association of State Budget Officers, and Reforming States Group, June 2005). NASBO’s data shows health care’s percentage of total state spending rising .8 percentage points a year, on average, between 1997 and 2003. If the rise continued at that rate, the 2005 figure was 33.1 percent.

⁶ Current trends are a 10 percent annual increase in the cost of health care (see endnote 1) and a 6.5 percent increase in state spending over the past 30 years (personal communication from the National Association of State Budget Officers staff, July 6, 2007).

⁷ According to the U.S. Bureau of Labor Statistics, average teacher earnings, including salary and benefits, are \$49.72 per hour. (BLS does not track annual earnings for teachers.) If teachers work a 40 hour week for 39 weeks, this totals \$77,563.20. According to the National Association of State Budget Officers, total state expenditures in 2005 were more than \$1.2 trillion. One percent of this amount is \$12 billion. Dividing by \$77,563.20 yields 154,713.

NASBO measured the full cost of state health care for only six years, 1997 through 2003. In that time it increased from 26.6 percent to 31.5 percent of all state spending, an increase of 4.9 percentage points—a rate that equals a one percentage point increase every 1.2 years.

⁸ Congressional Budget Office, “Historical Budget Data,” www.cbo.gov/budget/historical.shtml.

⁹ Congressional Budget Office, *The Long-Term Budget Outlook* (Washington, D.C.: Congress of the United States, December 2005).

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¹¹ Kohn, Linda, *et. al.*, eds., Institute of Medicine, *To Err is Human: Building a Safer Health Care System* (Washington, D.C: National Academy Press, 2000), www.nap.edu/openbook/0309068371/html/.

¹² Penelope Lemov, “A System in Collapse,” *Governing*, July 2007, 66.

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- ¹⁹ President's Information Technology Advisory Committee, *Revolutionizing Health Care Through Information Technology* (Arlington, Va.: National Coordination Office for Information Technology Research and Development, 2004), www.nitrd.gov/pitac/reports/20040721_hit_report.pdf.
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- ²² *Ibid.*
- ²³ *Ibid.*
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⁵⁶ From *2002–2003 State Health Expenditure Report*: In fiscal year 2003, states reported a total population of 290.5 million, a total Medicaid caseload of 40 million, and 4.2 million SCHIP beneficiaries (see Table 49). According to the *Statistical Abstract of the United States*, in 1999 there were about 17.5 million state and local employees. These numbers, which do not include retirees or other state health programs, sum to roughly 62 million out of 290.5 million, or 21.4 percent.

⁵⁷ Today there are roughly 47 million Americans without health insurance today (see endnote 12) out of a total population of 300 million; this equals 15.67 percent.

⁵⁸ Kendall, *Fixing America's Health Care System*, 5.

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⁶¹ David B. Kendall, *Fixing America's Health Care System: A Progressive Plan to Cover Everyone and Restrain Costs* (Washington, D.C.: Progressive Policy Institute, September 2005), 10.

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