

Health And Budget Reform As Handmaidens

Health reform is not one-time but continual, and it can succeed only if budget principles are recognized.

by **C. Eugene Steuerle and Randall R. Bovbjerg**

ABSTRACT: Meeting almost any new major federal budget priority—for children, the elderly, energy independence, budget balance, or even the uninsured—soon will be nearly impossible if health costs grow as projected. Budget-driven reforms in health policy, therefore, are almost inevitable for any president seeking to set new national priorities. Those health reforms must confront the fundamental budgetary flaw of health policy: creation of decision-making structures and incentives that look mainly to benefits while shifting costs freely to others. All players need more reliable mechanisms for making choices reasonably, albeit no longer for open-ended consumption of care or payment to providers. [*Health Affairs* 27, no. 3 (2008): 633–644; 10.1377/hlthaff.27.3.633]

MANY POLICYMAKERS AND INFORMED CITIZENS recognize that federal health spending grows much faster than the economy and that such growth is arithmetically unsustainable. Fewer appreciate the extraordinary extent to which health spending is already crowding out other public initiatives. Federal health entitlements claim the majority of federal revenue growth for the rest of this decade. Absent change, sometime between 2016 and 2020 existing federal revenues will cover only health entitlements, Social Security, debt service, and a smaller defense posture—nothing for the environment, education, or answering the phone at the White House.¹ Meanwhile, in the private sector, rising costs will lead to more uninsured people.

Public failure to take action against the causes of ever-rising and often inefficient health care spending is mainly political. Imperfect knowledge and competing visions of an overarching future system are excuses for policymakers to resist reforming a status quo that fails to decide competing claims on the basis of finite resources. Health costs are mainly driven by entitlements to traditional, open-ended health coverage, both public and private. Despite their loud complaints about past minor restrictions on growth, providers and patients still largely determine what care is needed without a budgetary framework to consider both bene-

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Eugene Steuerle (esteuerle@urban.org) is a senior fellow and Randall Bovbjerg (rbovbjerg@urban.org), a principal research associate, at the Urban Institute. Steuerle is a former deputy assistant secretary of the treasury; Bovbjerg, a former state insurance regulator.

fits and costs. This is the original sin of health policy, and no reform can be adequate without addressing it.

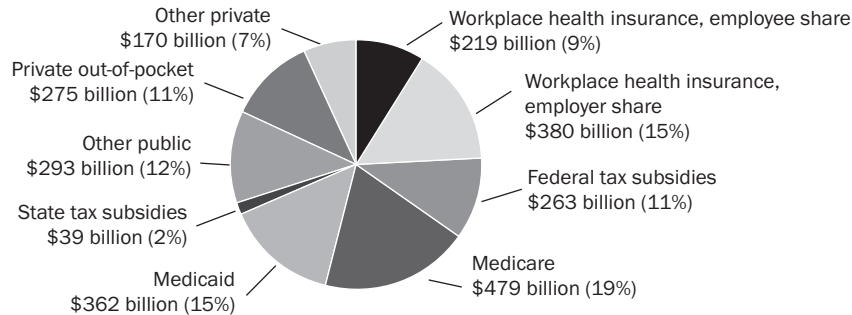
Consider, by contrast, public and private decision making for most nonhealth services. Responsible parties constantly trade off alternative claims for budgetary resources—education versus community development, foreign aid versus defense, automobile travel versus mass transit, and so on. Rising capabilities almost certainly justify higher future spending in many areas, including health—but not automatically.

Basing health reform on budget principles means promoting explicit attention to both benefits and costs throughout the medical coverage and care supply chain. It is not enough somehow to restrict the purchase of worthless or unproven health care. This “waste and abuse” strategy only deals with costs when benefits are zero or negative. No part of the system should be entirely exempt—not government programs and regulators; nor health plans, medical providers, and suppliers; nor health plan enrollees and patients. Sensible health decision making requires effective incentives to seek out or provide good value for money. Each decisionmaker, in turn, needs better-structured choices among reasonable alternatives along with better benefit-cost information about choices. At the same time, the most basic risk-spreading protections of workplace group insurance and public programs need to be preserved. Otherwise, the disadvantaged and unlucky will bear more responsibility for economizing than will their more fortunate and profligate fellow citizens.

The Budget Reality

Health care has greatly outgrown all other economic activity. From 1960 to 2007, health spending grew from 5.2 percent to 16 percent of the economy—to almost \$2.3 trillion, nearly \$22,000 per American household. The out-of-pocket share has shrunk to 11 percent, while the public share has risen nearly to 60 percent, counting tax subsidies as public (Exhibit 1). For public spending, voters and policymakers fail to agree on and adhere to any binding budgetary policy. Private spending faces budgets, but tax subsidy and insurance arrangements enable inefficient spending to occur and costs to be hidden.² New services and new spending often improve health or life expectancy.³ Yet many U.S. health indicators fall behind international norms, while spending exceeds them. And too many medical services are substandard or add relatively little value.⁴

Cutbacks in other public programs will no longer cover surging health costs, further stimulated by new drug benefits and impending baby-boomer retirement.⁵ Tax increases, although possible, would need to be so large as to be of questionable feasibility.⁶ More important, existing health programs should not automatically claim new revenues every year that might better be spent on education, work supports for the poor, expanded coverage for the uninsured, or environmental and public health.⁷

EXHIBIT 1**Estimated Sources Of Financing For U.S. Health Expenditures, In 2008 Dollars, Calendar Year 2008**

SOURCE: Authors' calculations based on data from the Centers for Medicare and Medicaid Services and the Budget of the U.S. Government, fiscal year 2009.

NOTES: Tax subsidies attributed to government sources, reducing the private share of health expenditures. Total spending is \$2.48 trillion; government sources, \$1.44 trillion.

No More Waiting For Godot

Large-scale federal economizing needs to come soon and cannot be held hostage to agreeing on full health system reforms such as putting everyone in the same financing mechanism for all time, whether Medicare for all or high-deductible health plans for all. No one can banish overnight forty years of ideological disagreement about the evolution of our national system.

A long history has generated today's hybrid of private and public actors and of regulatory and competitive incentives—even within Medicare and Medicaid. Hybrid approaches will likely persist. Even in a more nationalized system, some marketlike signals are required to avoid arbitrary choices on covered services, who should provide them, and how much each type of actor should pay. In a more market-oriented system, regulation will always be required, not just to enforce contracts but also to maintain risk spreading, subsidize the needy, and monitor public subsidies.

It is time to stop waiting for Godot and start basing all health policies on solid budget principles of matching costs and benefits. Consider some of the gains: First, an early start toward reducing growth rates even fractionally would soon compound into very large savings, restoring needed flexibility to federal budgeting.⁸ Second, deep divisions over ideal systems will bedevil near-term consensus building unless reasonable budget constraints can force agreement on less ideological grounds.⁹ Finally, whatever system or hybrid prevails in the future, its participants will benefit from the trial-and-error experience that budget-minded mechanisms tend to encourage.

Thinking In A Quasi-Constitutional Framework

Although many health policies were designed with little heed to budget principles, the real world of health care finance and delivery is already forcing decision-

makers to make some trade-offs. Some are consistent with one another, some mutually exclusive. Take the workplace. Some employers give workers incentives to choose among competing fully insured health plans, some emphasize wellness and prevention, and others emphasize cafeteria-style trade-offs at enrollment or high cost sharing at time of care. Or consider the states. Maryland perceives success from hospital budget regulation, while North Carolina promotes relatively generous payments to primary care providers. New York favors nonprofit insurers and hospitals, yet Tennessee prefers freewheeling competition. California relies heavily on well-established physician practice groups, while most of Ohio remains a bastion of solo practice. Many health spending decisions are drawing attention in many quarters—from new medical technology to end-of-life care. These diverse circumstances and approaches belie the notion that health policy cannot account better for costs until some clear, permanent consensus emerges among experts, politicians, and voters about who should make which allocation decisions, under what fiscal constraints, and using which clinical approaches.

What, then, is to be done? As in any other large economy, U.S. health care is complicated and ever-evolving. Today's decisionmakers can no more choose what health care to provide twenty years hence than they can prescribe for the entire (equivalent-size) economy of France. Instead, they should emulate the early U.S. leaders who remedied the young confederated nation's broken treasury, mounting state debts, and fractured commercial networks. Their mission was to decide on durable structures, not on the future winners and losers under those structures.

Analogously, it is helpful to address health fiscal reform in quasi-constitutional terms: deciding exactly what to do now is less important than creating a better budgetary framework for continual improvement—monitoring, revising, and reforming government programs and incentives over time. Ideally, these processes will allow maximum progress amid uncertainty, require minimum commitment to choices that might later seem inefficient or unfair, and facilitate an ebb and flow of shifting responsibilities.¹⁰ Like a sensible constitutional order, health care fiscal reform would empower decisionmakers with the right incentives to enhance the public good, while protecting individual rights and providing checks and balances. These quasi-constitutional steps could serve many different future health care scenarios.

Creating Better Incentives For Public Decisions

Federal policy making must first face its own budgetary trade-offs more squarely, instead of allowing entitlements to generate unquestioned increases and leaving “discretionary” programs to compete for leftovers. This is especially important for the three big-ticket health programs. Two are open-ended entitlements—federal Medicare benefits and the exclusion of workplace health benefits from taxation. The third is Medicaid, where the open-endedness of federal reimbursement of state program spending is at least somewhat offset by states' cost-

sharing obligations, need to make some trade-offs, and ability to alter program parameters. These three health programs already are scheduled to eat most new revenues made possible by economic growth—violating the budget principle that all public needs should compete equally or on a level playing field for limited budgetary resources (Exhibit 2).

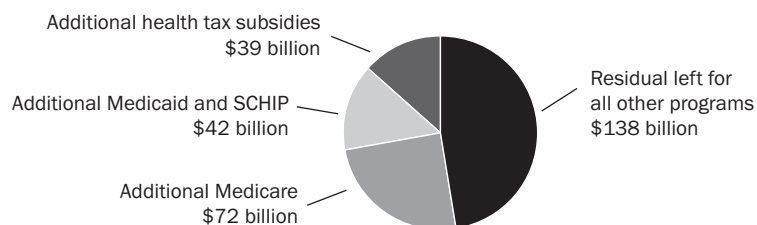
■ **Reinventing federal health budgeting, especially for Medicare.** Ideally, Congress should preserve its overall budgeting authority by periodically budgeting for health costs, actively voting for increases over time rather than passively accepting entitlement growth. Health cost increases should be openly “scored” and weighed against other options, many of which also improve safety, health, or longevity. Because zero-based budgeting to reconsider all spending every year is extraordinarily difficult, practical alternatives are needed.

Halfway between zero-based budgeting and entitlement nonbudgeting are budgetary targets or triggers. Hard triggers involve both forcing events and forced actions. They are tougher than soft triggers, which merely require new recommendations.¹¹ The forcing event for Medicare could be projected spending beyond some preset acceptable level, while the forced action could be devolution of responsibility to an improved Medicare Payment Advisory Commission (MedPAC)-like commission (or to program administrators) to put spending back on track, for example, by modifying conventional payment practices. If the empowered commission recommended insufficient cuts, the trigger could compel enough additional across-the-board price cuts to hit the target. A key for any such reform is to force Congress to vote for and score health cost increases when it overrides the decision-forcing mechanism. Triggers are not perfect. They simply create budget constraint absent congressional votes on spending or broader systems reform built on budget principles.

■ **More budget-mindedness for Medicaid.** Medicaid policy could also be made more budget-minded. President Bill Clinton proposed capitating support to states,

EXHIBIT 2

Health Entitlements' Claim On Future Increases In Revenues, 2010 Versus 2006 (In 2006 Dollars)



SOURCE: Authors' calculations based on data from the Congressional Budget Office, *Budget and Economic Outlook 2008–2018* and *Budget of the United States Government, Analytical Perspectives*, fiscal year 2009, Table 19.1.

NOTES: Current-law allocation of additional revenues of \$290 billion available in 2010: health uses, \$152 billion; all other uses, \$138 billion. Revenues include taxes that would be collected absent increases in tax subsidies. Revenues are overstated if relief is provided to the growing number of Alternative Minimum Tax (AMT) payers. SCHIP is State Children's Health Insurance Program.

effectively creating a per recipient budget. This type of marginal limit would help protect states when enrollment surges during economic downturns but would induce states at all times to focus more on obtaining high-value services for any additional dollars they contribute. Because spending varies widely by Medicaid enrollment category—and even more by health status—any set of capitation rates needs to be pegged to some measure of expected reasonable spending to avoid unfairness and risk-selection problems. This value-based approach makes budget costs more explicit for states, regardless of whether it saves money.

States may seek various innovations in response. New cost sharing on low-income enrollees is questionable, given their ability to pay and need for access to valuable primary care. New limits on capitated managed care may work better. Some states believe that they can make more cost-effective decisions through better use of primary care physicians and community-based care managers, or by managing dual Medicaid-Medicare enrollees.¹² Any method for financing state-level activities must allow alternative and experimental approaches, while continuing to rein in creative financing and budgetary gaming schemes that merely increase a state's allotment of federal spending.¹³

Crafting Better Incentives For Private Decisions

Restructuring incentives for individuals making decisions about health care spending involves examining current tax subsidies for employer-provided health insurance, the choices now given Medicare enrollees, health savings accounts, and other cost-sharing mechanisms.

■ **Reengineering subsidies for workplace health plans.** Budget-minded reform would address existing open-ended tax subsidies for workplace purchase of health coverage. These subsidies favor high-cost plans and taxpayers in higher tax brackets.¹⁴ One incremental reform is to cap the amount of tax excludability allowed. This approach has proved workable within many (formerly) traditional plans, where the employee share above a cap was paid out of after-tax wages. A simplified cap would allow for averaging across beneficiaries. Although an averaged cap would not perfectly measure value, it would still provide a more equal distribution of tax benefits than current law does. Most important, it would greatly improve incentives to seek higher-value insurance.

A stronger approach would be to convert the current tax exclusion at the employer-group level into a credit or voucher at the individual level. Individual vouchers offer large advantages relative to current law—fairer allocation of help for people with less income, strong incentives to weigh plans' marginal costs and benefits at time of enrollment, and opportunity for annual budgetary control over subsidy levels. An important caution: poorly designed vouchers could help further weaken traditional employer risk pooling. This unwanted outcome needs to be addressed by allowing voucherlike allowances only within approved insurance pools that include risk-segmentation countermeasures as discussed below. Pro-

posed in different ways by recent presidents and presidential candidates, tax-subsidy limits are made more saleable now by new fiscal exigencies, the ever-rising cost of the existing subsidy, and union concern over limited cash wage increases if workers' health costs keep exploding.¹⁵

■ **Reengineering support for Medicare enrollees.** Medicare has adopted a quasi-voucher approach by allowing beneficiaries to opt out of traditional Medicare into competing private plans, now known as Medicare Advantage (MA). Running Medicare through better premium credit or voucherlike mechanisms would create stronger incentives for enrollees to trade off value and cost. Any reformed system would need to deal better than the current system does with setting levels of support for health plans and with risk segmentation, as when high-risk people return to traditional Medicare either by free choice or because of strategic encouragement from their health plan.

Today's higher Part B Medicare premiums for higher-income beneficiaries (started in 2007) suggest that Congress is willing to let those with higher incomes face some costs. Unfortunately, the method adopted—raising premiums moderately for heavily subsidized insurance—mainly shifts costs without affecting decision making anywhere. An alternative is to involve higher-income people in cost sharing for some types of expenses.

■ **Enhancing individual incentives by promoting patient cost sharing.** Federal law has lately attempted to promote individual cost-benefit decisions at the time of care by giving new tax advantages to high-deductible plans with health savings accounts (HSAs). Higher deductibles provide incentives to economize, but not necessarily among low-benefit health services or at the high end of spending, where the bulk of resources are consumed.

HSA advocates asserted that they were leveling the playing field between out-of-pocket health spending and spending for health insurance. But HSA legislation additionally provided new tax subsidies for HSA savings that made HSAs the most preferred of all employee benefits. Tax advantages should be equal across all forms of health insurance.

Better-structured patient sharing in costs likely would improve trade-offs. Simple, low-end incentives such as flat deductibles lead to economizing, but the first dollars of spending may be the most valuable. Moreover, flat deductibles can be seen as unfair to the disadvantaged. Coinsurance or copayments provide more insurance protection while encouraging trade-offs throughout a longer spectrum of care. However, the need for insurance protection dictates an out-of-pocket limit on traditional cost sharing. More discriminating methods would build better incentives into coverage of high-marginal-cost items.

Other emerging methods of patient cost sharing need encouragement: enrollees' choice among health plans, as noted earlier, offers a good place to start.¹⁶ Enrollees can take up full coverage with fewer choices at the time of care or can pay more for more open-ended coverage. Sensible approaches also include carving

out approved preventive services from cost sharing and tiered cost sharing for pharmaceuticals and elective hospital use, so that enrollees share in the costs of choosing costly alternatives where basic ones suffice. Similarly, benefit or coverage decisions can create a kind of cost sharing—for example, by paying different prices for in- and out-of-network care. Plans might also limit payments for quasi-experimental therapies as opposed to fighting to maintain bright lines between full payment and no payment.¹⁷

Creating A Better Infrastructure For Decision Making

To respond effectively to better budgetary incentives, decisionmakers also need better decision support. Supportive infrastructure should help level the various playing fields among competing alternatives, facilitate benefit-cost trade-offs, and otherwise build in efficiencies.

Almost any reform must combat the normal tendency of health plans, medical providers, and purchasers of coverage to avoid high-risk people instead of helping them obtain care more efficiently. Current incentives at times reward efficiency but also reward segmenting risk rather than reducing it.¹⁸

Reducing the segmentation of risk across health plans requires some combination of adjusted community rating of premiums; better risk adjustment of premium support; monitoring of plan and agent behavior; and new pooling of higher risks through assigned risk pools, reinsurance, or premium withholds with subsequent distribution according to actual risks enrolled. These mechanisms need not be perfect, but they must undercut current rewards for segmenting risks.¹⁹

Reducing the segmentation of patient risk across providers requires improving today's risk adjusters for paying providers and perhaps also more monitoring of their profiles. Ideally, premiums for plans and payments for providers would be so well risk-adjusted that health plans and providers would compete to enroll diabetics and stroke survivors and better manage their care instead of avoiding them beforehand or discouraging them from staying once enrolled. Better management of at-risk or sicker enrollees is crucial because their care is so costly and potential quality improvements are large.

Facilitating benefit-cost trade-offs calls for more transparency for purchasers about differences across health plans, providers, and treatment alternatives. Comparisons are now obscured because insured people bear most costs only indirectly (see Exhibit 1). Various efforts to cap, capitate, and voucherize benefits will lead prospective enrollees and patients more directly to recognize and face costs above the subsidized amount. For those new incentives to be palatable, enrollees and patients must have decision-support systems, including enough standardization to allow them to make comparisons.

The administration of traditional Medicare must also be freed to make trade-offs and compete effectively with MA plans. It is hobbled by low budgets, inability to redistribute savings, and lack of support for payment-rule changes such as bid-

ding or declining payouts for maturing technologies. Medicare lacks authority to adopt improved strategies for value-based purchasing and to manage utilization or pay providers to do so, among other things.²⁰

MedPAC or any MedPAC-like commission might be given more than advisory authority. Commission members might be given responsibility for protecting Medicare revenues and promoting value for beneficiaries, and their recommendations might be made more binding. The base-closing commissions used for military right-sizing offer one model.

Whether administrators or commission members are considering budgetary changes, they should focus oversight less on the spending trend and more on value provided. Today's decisions on the size of annual price updates or increases build in a bias against decreases and insufficiently address utilization patterns. Deciding whether value is being delivered for money forces consideration of the types of price drops that are normal in other high-tech industries. Moreover, assessments should focus less on sectors such as hospitals or home health agencies, where industry lobbying is strong, and more on categories of patient care, regardless of site. There are already promising developments toward basing some payments on episodes of care and "bundling" together certain inpatient and outpatient services. Enhanced budgetary incentives for providers could further these efforts.

Some rethinking of health care regulation and liability is also called for. Traditional rules asymmetrically support higher and arguably better modes of care, typically without much regard for costs. Lower-cost alternatives have often been disfavored if not disallowed, not only under state licensure but also under payment rules, for example, that deny covered services through qualified alternatives to physicians. Such impediments go far to explain why health-sector prices fail to resemble prices in other growth sectors, which routinely fall more rapidly the more that new services are offered.²¹ Liability rules are only one piece of the puzzle, but courtrooms are particularly poor venues for taking account of general evidence on benefit-cost trade-offs. At the same time, better information and transparency are needed to avoid stinting on promised care and careless performance in delivery of care.²²

Producing Better Information

Better-informed trade-offs call for better information. The dearth of relevant knowledge currently allows low quality and high costs to coexist. Medical literature and the Internet offer a glut of data and opinion. Ideally, information would add value to decisions. Such information should be reliable, timely, accessible, and user-friendly. Useful data would compare competing claims on resources, include both benefits and costs, and would take into account such circumstances as patient characteristics or setting of care.

Again, this is a tall order, but one where a vital first step is possible now: to increase the share of the health budget spent on information relevant to cost-benefit

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decisions. For instance, support is warranted for an authoritative national source of information on comparative cost-effectiveness of competing modalities of care. It should be structured to minimize capture by affected interests. Britain’s National Institute for Health and Clinical Excellence (NICE) offers one model.²³ More generally, comparative performance needs to be traceable across many alternatives—health plans (including traditional Medicare versus MA plans), medical providers (hospitals, clinics, physicians), modes of diagnosis and treatment (including pharmaceuticals and devices), and categories of patients.²⁴

Stronger federal action seems appropriate not only because objective information is a classic public good, but also because Medicare provides the largest single source of data on real-world delivery of care. The unveiling by the Centers for Medicare and Medicaid Services (CMS) of the Hospital Compare Web site only begins to tap the rich possibilities.²⁵

The potential of health information technology (IT) to improve care is obvious, but only if reliable decision-making tools are in place will it more likely constrain costs efficiently, help practitioners perform better, and maintain quality when lower-cost procedures or caregivers are used.²⁶ As one example of how health IT could be advanced, Medicare and Medicaid could provide higher payments when prescriptions are computer-matched to lists of other prescriptions used by the individual, and lower payments when they are not. Other incentives could be provided for lab test results that are immediately portable and sharable, with patients’ permission. These topics go well beyond the scope of this paper. They merit high federal priority and are very inexpensive compared with uninformed and poorly structured health spending.²⁷

Concluding Remarks

This paper attacks several well-worn health reform positions. It demonstrates that addressing inefficient cost growth need not await some purer nationalized or individualized health reform, while reducing payment for waste or zero-benefit services is insufficient. Efficiency can be promoted through either market choices or votes, but both require adherence to basic budget principles: explicit recognition of trade-offs and a level playing field among choices.

History demonstrates an evolving array of mechanisms that adhere to these budget principles. Some have been developed by us, some reflected in newly evolving state initiatives, and many proposed by others. One at a time, they are likely inadequate; combined, they are powerful. Some readers may question why such approaches would be politically viable now. One need only perform some basic budget arithmetic. More than ever, federal health programs erode support for

other public needs unfruitfully and unfairly, while threatening large deficits or large tax increases that don't even solve problems within health care itself. Indeed, existing health programs grow so inefficiently that they often stifle improvements in quality and coverage.

The top goals are to end automatic year-to-year budget growth, push Congress to formally recognize when it chooses health cost increases over other priorities, and reintroduce private judgmental trade-offs based on actors' valuations of benefits and costs, especially at time of insurance purchase. Both to work well and to garner the support of affected individuals, these budget-related incentives require decision-support infrastructure, and information.

Budget mechanisms are means, not goals. They make possible a more natural, choice-based evolution of health policy, including long-sought coverage expansions, which would be made easier through lower costs relative to benefits. The examples here demonstrate that it is possible to promote efficiency and equity by attending more explicitly to checks, balances, and trade-offs both between health spending and other types of public spending, and among health programs themselves. Health and budget reform are natural handmaidens, not obstacles, to each other's development.

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Support from the Smith Richardson Foundation is gratefully acknowledged, along with input from many colleagues in health and budget policy who participated in a seminar convened by the Urban Institute and Health Affairs at the end of 2005. Space does not allow adequate recognition of the authors' debt to many seminal thinkers who consider health reform in budgetary terms; input from some can be seen in seminar materials at <http://www.urban.org/toolkit/conference-papers/hp-roundtable/index.cfm>. Such discussions also cannot be acknowledged adequately in a set of notes. Still, the authors remain solely responsible for the content of this paper.

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