A Performance-Based Approach to Universal Health Care

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Overview

For as long as health insurance rates have been measured systematically in the United States, there has been no progress in reducing the number of uninsured. Even after slight improvements in coverage rates at the tail end of arguably the strongest economy in the nation's history, coverage rates are still lower now than they were in 1987. Failure is all too common in health care policy and reform efforts.

Covering the uninsured requires a new approach to health policy. Current policies are based on propagating rules and manipulating behavior, rather than on achieving results. For example, Medicaid provides substantial federal funding in exchange for compliance with federal requirements. Yet, even where federal law requires coverage for certain categories, such as low-income, pregnant women and children, there is no automatic assessment of how effective state efforts are to enroll people. Not surprising, large gaps between eligibility and enrollment rates persist, especially in the case of children.

Rules and incentives are necessary and important tools, but they are more useful in helping to set the conditions for success than as ends in themselves. Health policy needs to include real-time assessment of performance and continuous recalibration of methods to achieve the desired outcome. *Describing success* so everyone can help to pursue it is more likely to inspire progress than merely *prescribing behavior* based on an incomplete theory or an inappropriate model.

Our vision of success is that nearly all U.S. residents have health care coverage, which they select for themselves and which provides them with a level of coverage that is appropriate to their health status and income level. Health care would be delivered safely without waste and with the best possible individual and population-based outcomes. People who remain uninsured for whatever reason would be assured access to community-based outpatient and preventive care services rather than having to rely on emergency room and hospital-based care only, often delivered too late in the course of illness to be effective.

In general, the government would ensure that everyone has the opportunity to get coverage, and individuals would be responsible for obtaining it and using resources wisely. We seek broad recognition that as a community, decisions about the use of health care resources affect our common health and our common wealth.

There can be no real progress or success without clearly defined accountability. Our framework for accountability is straightforward: The federal government provides a basic level of subsidy to everyone according to need and supports the research and encourages the information flow necessary for high-quality, cost-effective use of health care services. The states make sure that coverage is affordable and a choice of health plans is available to people in diverse circumstances. Employers act as conduits for enrolling and paying for coverage (even if they choose to make no contribution themselves), and individuals are responsible for securing coverage and paying their fair share.

Here, then, are the key ingredients of our proposal that are necessary for success:

Tax credits for employer-sponsored and individual health insurance to improve affordability. Our tax credits would apply to both employer-sponsored

coverage and individually purchased coverage. They would be available to the uninsured as well as people who are struggling to afford coverage they already have. The existing tax exclusion for employer-sponsored coverage would not be repealed. Therefore, the tax credits would not disrupt employer-sponsored coverage. In addition, the credits would be refundable, which means that low-income workers can use them even if they pay no income tax. They would also be advanceable so workers could use the credit at the time they purchase coverage.

Workplace focus to make coverage easy to get. People are accustomed to getting coverage at work, and our proposal would enable all uninsured workers to do so. However, it would not require employers to sponsor or contribute to coverage.

Voluntary purchasing groups or other options to make choices widely available. As a condition for receiving new federal grants, states would ensure that all employers and individuals could choose among competing group insurance plans through at least one, but preferably several, private purchasing groups. Alternatively, a state could issue a menu of options to make choosing coverage convenient. A modified version of the federal employees' system would be made available to individuals and small businesses as a backup if a state did not follow through.

Performance-based grants to assist states in improving coverage and health care for all their citizens, and to reward those that succeed. All states would receive a base amount to help them improve insurance options in the state, disseminate information about obtaining coverage, advertise the importance of coverage, protect people with high health care costs, and help assure basic care for those who lack coverage. To reward states that succeed, the federal government would give additional grants to states that could document increases in coverage rates. These new state grants would not require state spending to receive federal funding as current programs like Medicaid require. Moreover, these grants would not dictate the means for making improvements. Instead, the federal government would reward states that improve coverage rates so that coverage is equally available and affordable to the young and old, sick and healthy, poor and rich. A portion of the base grant would be set aside for states to participate in national collaborative efforts to develop and test measures of health care quality, access, outcomes, and public health. Those measures would become the basis for additional performance-based grants to states when the data become available.

Information networks to assess state performance, improve quality, and inform policy. In order to fully assess the performance of states, much more data about health care processes and outcomes will be needed. This very same kind of data is important to health professionals, hospitals, and patients in order to avoid costly medical mistakes and to improve quality generally. The same data is also important for research on "the benefit of benefits," which is the subject of controversies involving insurance coverage decisions in the private and public sectors. The federal government would catalyze the creation of information networks that can economically produce this data while keeping patients' medical records private.

Individual responsibility to obtain coverage. With State Children's Health Insurance Program (S-CHIP), Medicaid, tax credits, purchasing groups, and the new state grants, coverage for children would be universally available and affordable. A few years after enactment, parents would be denied the personal exemption—a small tax benefit—for any of their children who remained uninsured. As it becomes clear that coverage is more affordable and easy to obtain, adults remaining uninsured would lose their personal exemption as well.

Our plan is divided into two phases to encourage adjustments in federal policy based on a systematic, objective assessment of experience and to allow for an evolution in the political dynamic surrounding issues related to health care coverage.[1] The focus of Phase One is simply getting people coverage through tax credits and performance grants,

[1] For a similarly staged implementation of a tax credit, see Mark Pauly. "An Adaptive Credit Plan for Covering the Uninsured." In Jack A. Meyer and Elliot K. Wicks (eds.). *Covering America: Real Remedies for the Uninsured.* Washington: Economic and Social Research Institute, 2001, pp. 135–52.

because some coverage is better than no coverage. Phase One would set in place the accountability framework, rules, and incentives described above. Focusing on the relationship between work and coverage would help correct the misperception that the uninsured are non-workers (most are not). It also would help bind together the interests of the middle class with those who are trying to enter the middle class by making health care coverage more secure for everyone.

The focus of Phase Two is solving the problem of *under*insurance (inadequate benefits for a given health condition or income level) and enforcement of an individual mandate for coverage for all adults—explicitly shifting the burden of responsibility for having coverage to the individual. Five years after our proposed tax credits and other reforms went into effect, we propose a commission to study the impact of the credits and performance grants, to recommend changes if necessary, and, most important, to recommend whether to deny uninsured adults the personal exemption on their taxes. Because any coverage mandate must decide what level of coverage is sufficient, the commission would also need to examine the prevalence of underinsurance. Ultimately, the remaining uninsured must take responsibility for their own health coverage. But before we take that final step, we must make health insurance considerably more affordable and easier to acquire than it is today.

Assessing Performance: The Missing Link in Health Policy

A generation ago, health care financing only involved making sure people were reimbursed for their doctor and hospital bills. Indeed, the government appeared to be as capable as insurance companies of managing such a basic kind of transaction.

Today, health care is dramatically different. Scientific advances in screening and diagnostic tools, pharmaceuticals, and surgery techniques have dramatically increased our ability to detect and treat disease at its earliest stages. The possibilities for care are complex and seemingly endless. Knowledge is exploding, and no single doctor can be an expert about you, all the health problems you may face, and the many treatment options available. Health care increasingly requires patients to become active participants in their care, often involving multiple health professionals. Health care is moving from a focus on episodes of acute intervention to meeting the expanding need for care that is integrated and has continuity, especially for people with chronic conditions. In response to new knowledge and new challenges, policy makers need to let what we have termed the "new health care" flourish.[2]

The old policy levers are not working. Centralized, bureaucratic systems cannot keep track of an ever more complex care delivery system. The efforts by HMOs to control costs centrally produced a backlash, which prompted a general retreat from controls on physician and patient behavior. As an alternative, HMOs and other health plans have begun to deploy a wide variety of evolving tools that can empower physicians and patients: disease management, case management, pharmacy benefit management, self-care support, nurse hotlines, decision-support technology, provider and facility evaluations, and network contracts.

Given the growing importance of access to integrated care, especially for people with chronic conditions, health insurance, including federal and state health care programs, should consist of more than financial support for people who cannot afford health care. Such insurance must be a ticket to accessible, high-quality, cost-effective care that seeks to achieve the best possible outcome for everyone in every circumstance.

Managing an increasingly complex health care system requires a focus on performance. Performance is also a key ingredient in cost restraint because medical mistakes can be expensive, and waste cannot be identified without continuous and systematic assessment of medical effectiveness.

Both health care policy and coverage itself should be subject to ongoing performance assessment. Consider the relatively simple act of signing

[2] David Kendall, Jeff Lemieux, S. Robert Levine, and Kerry Tremain. "The New Health Care." *Blueprint: Ideas for a New Century 12* (September/October 2001): 58–59.

up people for free coverage. At a time when mortgage applications and other complex financial transactions commonly occur on the Internet, it has taken a partnership between a health care foundation and government officials in California to develop the nation's first online application, known as health-e-app, which permits community organizations and applicants themselves to check eligibility for Medicaid and S-CHIP.[3]

In areas other than health care, the federal government demands accountability from states for using federal funds. The recently enacted reauthorization of the Elementary and Secondary Education Act granted more flexibility to states and school districts in exchange for more rigorous performance measures. Formulas for performance rewards, however, need to be devised carefully. Some performance rewards in the 1996 welfare reform act have been criticized as wasteful. For example, the District of Columbia "won" a bonus for reducing teenage pregnancies for reasons that remain unclear even though it had made no efforts to do so. Performance-based grants in health care should be aimed at improvements that are not attributable to larger demographic or economic trends.

Any health care policy that runs on autopilot needs to be challenged, even when it is fairly successful. For example, health insurance tax policy—which consists mostly of excluding employer-paid insurance premiums from personal taxation—requires minimal government intervention. To be sure, the current tax exclusion for employment-based coverage has been extraordinarily successful in creating a fairly stable private health insurance system. It has created a joint public and private health care financing system that covers most Americans with virtually no public bureaucracy. But outside the occasional congressional hearing, there is no formal scrutiny of this public expenditure, which is the third most expensive federal health care program after Medicare and Medicaid. This tax policy has remained nearly the same for 55 years, despite being highly regressive, inflationary, and unfair to workers whose employers do not offer coverage; to workers between jobs; and to workers who might prefer coverage other than the health plan chosen by their employer. Tax credits can compensate for many of the weaknesses of the existing tax exclusion.

[3] See http://www.healtheapp.org/.

Expanding Coverage with Tax Credits

We propose fixed-dollar tax credits as a base subsidy to help low- to middle-income workers purchase health coverage. The maximum credits would be $1,500 for single coverage and $3,750 for a family plan for taxpayers who do not have an employer-sponsored plan, or $600 for individuals and $1,500 for families that do have employer-subsidized coverage. The higher tax credit for people without employer-sponsored coverage reflects the fact that people with employer-sponsored health coverage already get a substantial tax break under current law. In subsequent years, the tax credits would increase by the average annual increase in the premiums of plans. The credits would be refundable—that is, they would be fully available even to those who otherwise would not pay any income tax.

The tax credits would be available to people or families whose incomes fall below certain levels. For taxpayers using the tax credit to help purchase family coverage, the top income for the full credit would be $50,000 a year. The tax credit for families would phase down to zero at incomes of $75,000 and above. For people using the tax credit for single coverage, the top income for the full credit would be $25,000 a year; the credit would be available in smaller amounts for single coverage for taxpayers with incomes up to $37,500 a year. (Of course, people whose incomes are too high to qualify for the tax credit could still receive the tax breaks for health coverage already available under current law.)

The phase-out ranges for tax credits begin at levels above the point where the phase-out ranges of the Earned Income Tax Credit end. Therefore, the tax credits should not create troublesome disincentives for additional work or higher earnings. In fact, the employment focus of the proposed program is intended to strengthen the connection between working and health benefits.

Extending the tax credits to people who have coverage at work is essential for two reasons: stability and fairness. The current tax system favors employment-based coverage, especially for high-wage workers. Making substantial tax credits available only for coverage purchased in the individual market, however, would tilt the tax incentive toward individual coverage. That could destabilize the employment-based system by giving some employers—especially those with low-wage workers—an incentive to drop coverage. While individual choice of coverage is one of the goals of our proposed system, we believe it will work better in the context of group coverage.

Tax credits at the levels we propose would create a similarly sized tax benefit for coverage in either the individually purchased or employment-based market, at least for most people, which would reduce the potential for tax policy to distort decisions about where to get coverage. We believe our tax credit proposal would expand both employer-based and individual coverage.

These tax credits are designed to induce those not covered to purchase insurance and to reward those who already have coverage for making the sacrifice. Economists widely agree that employer-provided benefits are a substitute for wages or other forms of employee compensation. That is why we have proposed tax relief to people who already make sacrifices to get coverage at work, a policy known as horizontal equity. Denying tax credits to those who have worked hard and played by the rules would be unfair. Moreover, it would disrupt health care delivery as people sought to change insurance coverage in search of the highest possible subsidy.

A final design issue is whether the tax credit should be a flat dollar amount or a percentage of the insurance premium price. Each option has advantages and disadvantages, so whichever one is chosen, additional measures are needed to compensate for its weaknesses.[4] We have chosen a flat dollar tax credit primarily because it is easier for employers to administer than a percentage tax credit would be. A flat dollar credit would remain the same regardless of employee's choice of health plan, unlike under a percentage tax credit, which would require employers to calculate a separate tax credit for each employee. A flat tax credit, however, is not fair to older and sicker people because they often must pay significantly more for insurance. Our proposal for performance grants would require states to choose between requiring insurers to charge everyone the same insurance rate regardless of age or health status (a practice known as community rating) or providing supplemental subsidies for older, sicker people (or a combination of the two).

Using Tax Credits at Work

The next element of our proposal asks employers to handle enrollment in health plans and payroll deductions and adjustments for workers with health coverage—even if the employer does not pay a part of the cost.

We propose that all employees, on their first day on the job and each year thereafter, receive an enrollment form for health insurance. At the very least, the enrollment form would contain the coverage choices available under a state-arranged menu of options or purchasing group. Employees who do not select a plan and do not have coverage from another source would have to sign a form stating that their choice not to have insurance is deliberate; those forms would be forwarded to the state, which could target the worker for additional outreach efforts.

Employers that *do* sponsor coverage would deduct premiums from employees' paychecks, as they do now. In addition, they would add on to an employee's pay the tax credit for which the employee was eligible, up to the amount of the employee's share of the premium. In effect, companies would transfer tax credits to their employees right on those employees' paychecks, providing an automatic federal subsidy, and making private health insurance more affordable. The federal government would pay employers back contemporaneously, through bookkeeping adjustments in the amounts withheld and sent to the federal government for employees' tax payments. At the end of the year, the company

[4] See Stuart Butler and David B. Kendall. "Expanding Access and Choice for Health Care Consumers Through Tax Reform." *Health Affairs 18* (6) (November/December 1999): 45–57.

would show the amount added to workers' pay from the tax credit on their W-2 forms. Then workers would file for the tax credit on their tax returns, which would be the final determination of exactly how much they would receive. It is important to note that workers whose employers pay a large share of the premium are still eligible for the full amount of the tax credit for which they qualify. The credit advanced on their paychecks would be limited to the employee's share of the premium, but any remainder would be claimed through the tax filing process as described above.

Employers that *do not* sponsor coverage nevertheless would give their employees enrollment forms for at least one menu of health plans offered by a state-sanctioned purchasing group or another menu developed by the state insurance commissioner. (Those employers could provide options from other insurance companies or groups as long as they also supplied the insurance commissioner's menu.) Like firms that sponsor coverage, these employers would be required to handle payroll deduction of premiums and forward those payments to the purchasing group. They would also add back to employees' paychecks the tax credits for which employees were eligible. Again, the company would be reimbursed for the tax credits via its business tax arrangements. Health policy analyst Lynn Etheredge has shown that the cost of making such transactions is minimal, and the practice is common, given the widespread use of electronic payroll processing services for many payroll-withholding functions, ranging from taxes to pensions to charitable contributions.[5]

How would employers know whether an employee was eligible for a tax credit? The employer would not need to know precisely, because the final tax credit would be determined on each employee's individual tax return, but the employee's hourly wage could be used as a guideline. For wages below $12 an hour, employers would assume employees were eligible for the full credit for either individual or family coverage. For wages up to $18 an hour, employers could adjust employees' pay for the full tax credit for family coverage. The Internal Revenue Service could add a worksheet on the W-4 form so that employees with multiple jobs or a spouse who works could figure an appropriate amount to add to their pay. But in any case, employees taking the credit at work—as long as their wages were within the guidelines—would not be subject to interest or tax penalties on tax credits received in advance if it turned out at the end of the year that they did not qualify for the credit.

[5] Lynn Etheredge. "Health Insurance Tax Credits for Workers: An Efficient and Effective Administrative System." Washington: Health Insurance Research Project, George Washington University, 2001.

Pooling Insurance Risk and Grants to the States

Our plan would establish a federal grant program that would require the states to provide everyone who lacks employer-sponsored coverage with a menu of reasonably priced health plan choices. The menu of choices could be as formal as one offered by a purchasing group similar to the Federal Employees Health Benefits Program (FEHBP) plan or as informal as a list of insurance products compiled by the state insurance commissioner, as described above. "Reasonable" means that someone who is sick and has a low to moderate income would not have to pay more for insurance than someone who is healthy. Community rating laws would be one of several ways for the state to satisfy the requirement for reasonable prices. States could also create and subsidize local purchasing groups (similar to the federal employees plan), negotiate with local insurers for options available to everyone in the state, risk-adjust or reinsure health plans or groups with a high proportion of older or sicker enrollees, or directly subsidize high-risk residents.

The state grants would total $12 billion a year and would consist of two portions: (1) a base amount of about $2 billion, allocated to each state based on a state's population, to create and administer a menu of reasonably priced choices, and (2) a performance-based amount for the rest of the grant, which would be divided between improvements in the state's insurance coverage rates and improvements in health care quality, access, and outcomes; public health; and the adequacy of benefits

throughout the population. (The performance-based portion is described in the next section.) The state grants would not depend on matching funds from the states, as do Medicaid and S-CHIP.

Although the menu of choices is aimed primarily at people without job-based coverage, it could also benefit employers too small to offer workers a choice of health plans. States would ensure that all businesses, as well as individuals without employer-sponsored coverage, receive a menu of health plan options from at least one source each year. If, after two years, a state failed to ensure that at least one such menu was available to its residents, individuals and small employers would be able to sign up for a modified version of the federal employees' program directly. That state's grant money would go toward financing the costs of setting up and administering an FEHBP-like program.

These state grants are a critical addition to our proposal, because a tax credit by itself would not guarantee that everyone would be able to find affordable coverage in a stable marketplace. Premiums for individual coverage can be much higher than group rates offered to employers for a given set of benefits, and individual coverage may not be readily available to people with severe health problems. Furthermore, lower-income people need financial assistance at the time they purchase insurance, not after the fact, and tax credits for individual coverage cannot be provided easily in advance. (Advancing tax credits directly to individuals or their insurance companies could prompt some people to purchase nearly worthless or fraudulently marketed insurance, which would be difficult to regulate and audit. The market for employment-based coverage, by contrast, is more readily regulated and defined.)

Health insurance would become more portable with these new purchasing options. The combination of letting people switch between individually purchased policies and creation of a purchasing group that includes multiple employers would make it possible for a high proportion of individuals to keep their coverage for long periods even if they changed jobs or dropped out of job-based coverage. Another advantage of purchasing groups is that employers, especially small firms, would have an easier time offering employees a choice of competing health plans. By making good choices of coverage easy to arrange, and by boosting the tax advantage to employees, we hope a great many more employers will decide to sponsor and/or contribute to employee health insurance. Good choices of health insurance, we believe, will be a key to maintaining employee satisfaction.

Finally, unlike past proposals for purchasing groups that have met with strong opposition from some health insurers and their agents, our proposal permits alternatives that might be acceptable. For example, states could combine a menu of existing insurance products with subsidies to individuals targeted by health status, age, and income level. This approach would be more comprehensive than a standard high-risk pool, but it would not require a state to adopt community rating or to to create a purchasing group. Although we favor purchasing groups, we recognize that each state needs the flexibility to adapt federal policy to its local political culture, market conditions, and existing regulatory structure.

Health Care Improvements through Performance-Based Grants

The larger portion of the state grants would be performance-based. Of the $12 billion total, $10 billion would be divided between improvements in coverage and improvements in health care quality, access, and outcomes; public health; and the adequacy of benefits. States would have the flexibility to use the performance-based grants to expand public or private coverage or both. They would receive the funding, however, only after the uninsured rate for low- to moderate-income families and individuals has actually dropped. The funding would continue while the uninsured rate remained at that rate or decreased. The funding would be capped on a per person basis, although it could be adjusted for state-level insurance premium variations. States would not be required to match federal funding with their own funds, but they would need to file a plan with the Secretary of Health and Human Services that

describes how they intend to respond to the basic grant conditions.

The distribution of the grants would depend primarily on the degree of improvement in each state. There would be an adjustment for economic conditions so that during a recession, when some people might drop coverage, the state would continue to receive performance-based grants, despite having declining coverage rates. Such payments might only be partial, however, so that states have an incentive to keep coverage rates high even in times of economic distress.

States would be required to maintain current eligibility levels for Medicaid and S-CHIP. This requirement would prevent states from substituting the more generous funding from performance grants for current spending on Medicaid and S-CHIP, which require state matching funds.

The data required and the formulas for calculating the performance-based grants would be complex. Research is underway to develop prototypes for these formulas based on existing data, but better state-level data would be required for proper implementation.[6] The Department of Health and Human Services (HHS) would be charged with working collaboratively with an expert advisory panel to develop formulas and identify data needs. HHS and this panel would have to consider a wide range of issues, including the standards for performance that should be achieved to receive the grants, the causality of a state's action on a given outcome, the need for accountability even in the absence of clear-cut accountability, and adjustments, if any are needed, to make the measures of improvement fair across states without undermining the performance standard.

In addition, states would set aside a portion of their grants to participate in national collaborative efforts to develop and test measures of health care quality, access, outcomes, and public health. Those measures would become the basis for additional performance-based grants to states when the data become available.

One model for such a collaboration is the Child and Adolescent Health Measurement Initiative (CAHMI). CAHMI includes more than 50 state and federal agencies, consumer organizations, researchers, and health care professionals. Its work helped develop the quality measures that were mandated as part of S-CHIP.[7]

In general, performance grants would create a new bargain with the states. Instead of being financial partners with the federal government, which creates an incentive to limit access and coverage, states would focus on increasing coverage rates. Since the grants are based on success in reaching measurable objectives, not the methods used to reach those objectives, states would be free to choose whether to expand private insurance or public programs, or some combination of the two. Thus, the grants could flow into wherever coverage gaps existed in the state. Moreover, this flexibility would prevent federal policy from unintentionally destabilizing existing coverage by favoring one source of coverage over the other.

This framework of flexibility and accountability would create a wide variety of possible actions by states. They could build on the federal tax credit with a supplemental state tax credit or grant, so that low-income workers could choose mainstream private coverage at work or individually. The states could use S-CHIP funds to allow workers to buy job-based coverage for their children. Alternatively, workers could use the federal tax credit to buy into S-CHIP or Medicaid programs.

Improving the Safety Net through Performance Grants

A final condition for receiving grants is that states have a safety net that can provide coordinated outpatient and preventive care services for people who remain uninsured for whatever reason. States would specify how they intend to provide care for the remaining uninsured as part of their state plan. They would also measure and disclose the health care quality, outcomes, and health status of the

[6] The Progressive Policy Institute is researching prototype formulas for performance-based grants.

[7] "The Child and Adolecsent Health Measurement Initiative," www.facct.org/cahmi.html.

uninsured according to the same measures used to judge the performance of all health plans and providers. (The process for determining these measures is specified in the quality of care and cost restraint section below.)

Given the additional financing to cover the uninsured provided under this proposal, the current financial strain on the safety net should be dramatically reduced. That would free up resources for improving the safety net. If necessary, however, states could use a portion of the performance grants to help pay for such improvements.

An active safety net is important for three reasons. First, no matter how successful implementation of this proposal might be, there will still be a significant number of uninsured in the short term before mandated coverage takes effect, and a small number of uninsured in the long run made up of those who slip through the cracks for one reason or another (including being underinsured). Second, the existing entitlement to emergency room care creates a perverse incentive for the uninsured to seek non-emergency care in a very high-cost setting. Third, opportunities for health improvement are often greatest among those who do not have regular access to care.

One way for states to improve the safety net is to give the uninsured the same opportunities that are available to the insured. For example, the uninsured could be given access to a health care services discount card, and/or obtain low-interest health care credit cards. Otherwise, they will have to pay high retail prices because they do not have a health plan that negotiates wholesale prices on their behalf. Some areas of the country have created networks of doctors to function as a health plan for the uninsured. For example, in Asheville, North Carolina, low-income uninsured residents qualify for such a network.[8] Physicians donate their time, and hospitals cover the cost of prescription drugs, thus realizing savings from eliminating preventable hospitalization that has turned into bad debt.

States that maintain high-quality care for the uninsured through community health networks would be rewarded through performance-based grants. First, participants in such care systems may identify themselves in surveys of the uninsured as having coverage, thereby letting states qualify for a coverage bonus in the performance-based grants to the states. Improvements in health care quality for the uninsured would also be rewarded through the peformance-based grants.

The Critical Role of States

Why give the states such a significant role with such wide-ranging responsibilities? Successful political movements to increase coverage rates have occurred in only a handful of states. Still, states like Minnesota, Oregon, Massachusetts, Rhode Island, Wisconsin, and Tennessee have provided inspiration (and hard-won lessons) by demonstrating what is possible and what is problematic. Many states want to do more, and have done so with S-CHIP, which gives them more flexibility than Medicaid. But they are frustrated in general by the complexity of federal policies and their own lack of resources. Indeed, the success of high-performing states has been partly due to federal waivers from Medicaid regulations, and such states are likely to be enthusiastic about taking greater responsibility for achieving results.

States that have not yet responded aggressively to federal incentives to cover the uninsured through Medicaid and S-CHIP will likely be energized by a new relationship with the federal government. Performance grants would let state-elected officials take credit for covering the uninsured with little or no additional financial responsibility as long as the state maintains its current eligibility levels for Medicaid and S-CHIP.

A requirement for states to maintain eligibility may seem unfair to some states that already have gone well beyond minimal federal requirements for coverage in Medicaid. Presumably, however, these states have already realized the benefits of their past expenditures. And given that high-spending states will likely want to continue to be leaders, performance grants will give them a new opportunity for more progress and acclaim if they achieve near-uni-

[8] Fran Carlson. "What Works: Pooling Resources for the Poor." *Blueprint: Ideas for a New Century 6* (Spring 2000): 28.

versal coverage ahead of the national schedule anticipated by our proposal. Still, equitable sharing of federal funds will be an issue and should be debated, along with remedies for abuses of the disproportionate share program and other Medicaid loopholes.

Another reason to give states a key role is the issue of regulating insurance rates. Setting an adequate subsidy for insurance requires that the subsidy be related to the cost of insurance. Regulation of insurance rates ranges widely from state to state, from pure community rating in New York to full-risk rating in other states. That makes it difficult at best to set a fair federal subsidy. By aiming the tax credits toward job-based coverage, we have minimized, but not eliminated, some of the individual variation in pricing workers face. As long as states have the primary responsibility for regulating insurance rates, they also need to be responsible for ensuring that all residents can afford coverage.

Of course, the federal government could preempt state insurance regulation. We believe, however, that a political consensus on insurance regulation is far less likely, at least in the short run, than a consensus on financing coverage.

It is important to note that returning insurance regulation completely to the states is also unlikely. Large employers avoid state insurance regulations by self-insuring under the Employee Retirement Income Security Act (ERISA). At the same time, large employers have achieved near universal coverage for their workers and families. Indeed, many large employers require employees to show proof of other coverage before they are allowed to decline the company's health benefits.

Interaction with Medicaid and S-CHIP

The performance grants are designed to give states neutral choices in expanding coverage through government programs or tax credits. Some analysts would prefer to favor one or the other. We believe that it is critical to blend the advantages of both approaches in a framework of flexibility and accountability.

The biggest advantage of Medicaid and S-CHIP is that they deliver an appropriately rich set of benefits to individuals targeted by income. These programs avoid the problem of benefits that are too rich for the general population.

The biggest disadvantage of these programs is the lack of accountability for performance. States that comply with federal rules are eligible for funding, but there are few guarantees that beneficiaries will actually get coverage or access to care. For certain populations, such as pregnant women and children, states are mandated to offer coverage. But access to care is not guaranteed, because there is no common yardstick for measuring it. Many states pay health providers very little under Medicaid, which restricts access to and choice of providers. While some providers are willing to accept such low payments because they consider it part of their mission or professional duty, mainstream providers have a substantial incentive to shun or severely limit acceptance of Medicaid patients in low-payment states.

Another problem is that optional expansion of Medicaid and S-CHIP varies widely. Some states simply take greater advantage of federal funding than others, which is inequitable for people who live in the states that skimp.

A related problem is that the per capita spending levels vary widely by state, with results that range from inequitable to abusive. The most notorious example is the disproportionate share program, which is supposed to compensate states with high rates of uninsured, but, instead, is sometimes used by states to fund non-health care portions of the state budget.

If tax credits and S-CHIP were to evolve side by side, many new possibilities might emerge. People would have the chance to bundle funds that might be available from multiple government programs to help them buy one insurance policy. For example, families whose children qualify for S-CHIP coverage would have a choice: Parents could use S-CHIP to cover their children and then use the tax credits to help purchase employer-based or individual coverage for themselves. Or they could combine the money from the tax credit with additional funds from the S-CHIP program to purchase one health policy for the whole family. In the latter case, S-CHIP rules would apply to any purchases of private

insurance that were supported by S-CHIP funds. If necessary, the caps on federal outlays for S-CHIP could be raised to accommodate this new option.

Possible State Uses of State Grants and Tax Credits

By focusing on states' performance instead of on program design, the federal government can create a wide range of options for state action. Such flexibility is critical, given the variation in the states' political cultures and the difficulty of achieving consensus and coalitions that can drive change. As mentioned earlier, the performance grants set four key conditions for each state: (1) funding is directly linked to lowering the rate of uninsured, with adjustments made for adequacy of coverage levels by income, evenly distributed gains in coverage across age and health status groups, and economic and social factors that are beyond the control of the state's health care system; (2) additional performance-based grants are awarded for improvements in the population's health status and for the quality of care; (3) a menu of choices must be available to every person without employer-sponsored coverage at a reasonable cost; and (4) a safety net must be in place that guarantees access to primary care and coordinated specialty care for chronic illnesses. Some of the ways states might respond to these conditions follow.

Subsidized purchasing groups. Purchasing groups can offer community-rated insurance premiums without disrupting the existing insurance market. Some states may want to ensure broad access to coverage through community rating, but might not be able to enact community-rating regulations, as New York has done. The performance grants would give states funding to ensure the success of purchasing groups under that circumstance. The funding would be used to subsidize premiums in the purchasing group, whose lower community rate for older, sicker people would draw some of them away from the small-group or individual markets. States would have to watch carefully to ensure that insurance rates stabilized in *and* outside the purchasing groups after an initial adjustment period. If need be, a state could impose some restrictions on how often people could join the purchasing group, so that when they got sick, they could not immediately join the purchasing group to get lower rates and thereby drive up premiums, which could cause a spiral of ever-rising premiums due to adverse selection. In any case, community-rated insurance premiums would be the most direct way to ensure that the flat amount of the federal tax credit was as valuable to the sick and old as to the young and healthy.

High-risk pools. States that prefer to avoid community rating could use the performance grants to target subsidies at people with higher health risks. A high-risk pool is an example of targeting people who have been turned down for insurance and, therefore, are deemed to be uninsurable. A majority of states have high-risk pools, but many of them are underfunded. Performance grants offer a new source of financing high-risk pools, but high-risk pools by themselves would not be sufficient to ensure equitable access to coverage and care. States would need to offer subsidies targeted to older, sicker, and lower-income people who are nonetheless insurable. This could be done through supplemental tax credits or payments directly to insurers on behalf of workers or individuals who qualify for assistance.

Expanding public programs. Another general approach would be for states to use the performance grants to expand Medicaid and S-CHIP. The base level of funding of performance grants could be used to increase provider payment rates under Medicaid and S-CHIP to increase beneficiaries' access and choices. Such performance-based funding would allow program expansion without a state match. The challenge for such expansions would be to connect the uninsured who are mostly workers and their families to public programs. One way would be to work with employers to help with outreach and enrollment. States like Wisconsin and Massachusetts have already taken steps in that direction. States also could use public programs to supplement employer-based coverage, which would ensure adequate coverage for lower-income workers, which, in turn, would be rewarded as part of the performance payments. Such a policy direction

could lead to a seamless integration of state and private purchasing and coverage.

Civic ventures to boost coverage rates and improve public health. Having health insurance is a seldom-promoted public health message. As obstacles to coverage diminish under this proposal, a sense of personal responsibility will increase. Indeed, part of creating a dynamic approach to health policy is recognizing that the commitment to and importance of health insurance must be renewed continuously as a public mission. Just as with public health campaigns like the one against cigarette smoking, the nation's civic capacity should be tapped for this mission. For example, the AmeriCorps program could be a source of organizing support for small businesses and individuals to obtain health care coverage. Just like the many volunteer tax advisors at seniors' centers, AmeriCorps's "enrollment advisors" are needed to help people with complex health insurance issues. A similar kind of effort can work in other areas of public health as well. For example, Massachusetts uses AmeriCorps to promote health and prevention in low-income communities, where the need for reliable information and connections to personalized health resources is greater and less likely to be met.[9]

Financing and Budgeting

The cost of this proposal will be significant, as would any other major effort to reduce the number of uninsured. Much of the cost would be for tax credits, but a significant amount ($10 billion to $12 billion a year) would be appropriated for performance-based grants to the states.

Not all of the costs of our proposal should be considered new spending on health care, however; a significant portion amounts to tax relief for low- and moderate-income families who are already struggling to afford health insurance. Furthermore, the cost to the government does not include any potential savings from reductions in health premiums for people who already have coverage.

Although covering the uninsured through tax credits is expensive, it could reduce costs for those who already have insurance, because most of the uninsured are relatively young and healthy. Adding them to large insurance pools would reduce the average premium for the group. Furthermore, uninsured people usually get at least some treatment if they are ill or injured. The costs of that care are spread to government programs and to those with insurance, sometimes directly and sometimes in subtle ways. Therefore, reducing the number of uninsured would allow governments and insurers to reduce the portion of their payments that essentially subsidize hospitals and doctors for treating those who cannot pay.

There are a host of financing possibilities, many of which are not health-related and, therefore, difficult to prioritize. Health-related revenue raisers that are worth mentioning include alcohol and tobacco taxes and a tax cap on the tax exclusion for job-based coverage, which would also help to restrain costs by ending subsidies for expensive and inefficient health plans.

Mandatory Coverage

The new tax credits, combined with the current S-CHIP program and other initiatives, should eliminate any excuse for children going without health coverage. All but seven states have enacted eligibility for S-CHIP coverage for up to 200 percent of poverty.[10] The performance grants would ensure that all states have the necessary additional funds to make child coverage affordable for all families. Furthermore, families could also get tax credits to finance their children's health care coverage. Given that level of affordability, we recommend requiring that all children be covered within three years of enactment of our proposal.

Enforcement of this requirement would deny parents of uninsured children the personal exemption for those children they list on their tax forms. That would barely penalize parents in the lowest tax

[9] See "Health Services Corps." Washington: Democratic Leadership Council, July 7, 2001, http://www.ndol.org/.

[10] Kaiser Family Foundation State Health Facts Online, http://www.statehealthfacts.kff.org.

brackets—for whom the personal exemption matters little to their final tax bill—but it would have an important symbolic impact (and a real financial impact on middle- and upper-income families that chose not to cover their children). Public and private health plans would be required to make available to the IRS their lists of enrollees for verification purposes.

Even with tax credits and convenient group-purchasing options, some adults still may choose to remain uninsured. However, that choice places a burden on the rest of society, which must pick up the tab when uninsured people are hospitalized or need extensive medical care. For that reason, and to promote the public health, society has an interest in prodding all Americans to protect themselves with health care coverage.

Under Phase Two of our proposal, about five years after initial enactment, a commission would be established to study the impact of the credits, recommend changes if necessary, and, most important, recommend whether to deny adults who remain uninsured the personal exemption on their taxes.

Benefits

Phase Two of our proposal would also include an assessment of the problem of underinsurance. There are two reasons to believe that the problem would have been partially solved during Phase One, however. First, group insurance tends to produce a wide scope of coverage because it must satisfy a range of health care needs. Second, states would be rewarded through performance grants for ensuring that everyone has coverage, especially older people, poorer people, and people with chronic health conditions. Still, since subsidies for the non-poor require some sharing of premium costs, there is a chance that people may skimp on their benefits beyond a reasonable level of risk taking.

Furthermore, states might be tempted to allow the sale of insurance with substandard benefits as a way to increase coverage of the uninsured as cheaply as possible, and possibly draw down significantly more performance-based grant income than it cost the state to cover the uninsured. That is why the performance grants must be based on health care quality, outcomes, and access to care; public health; and adequacy of benefits in addition to coverage rates. States that allowed substandard benefits, or whose public programs effectively funneled enrollees to low-quality providers, would not show as much improvement in these other areas as states with better benefits and better-paid health providers.

The important point here is not to overanticipate problems, but rather to prepare a range of innovative solutions, test them, review their impact, and adjust them to sustain progress toward achieving a set of pre-determined goals. For that, the federal government, the states, and the public will need good information about benefits provided over time and across regions of the country. Therefore, we propose a new federal commission to study health benefits, including current benefit practices, the cost and clinical appropriateness of benefits, the extent and nature of benefit mandates (specific benefits that are required by law or regulation, either nationally or locally) and their cost and clinical effectiveness, and so on. Benefit controversies are certain to continue to drive the health care debate as new technologies and treatments confront concerns about affordability and access to health care. Solid data on what is happening across the nation, the actual measured health impact of certain benefits, and what the trade-offs are will be more essential than ever.

A Health Information Network

The real-time exchange of personal health information and medical records is critical to the delivery of safe, high-quality, cost-effective health care. The federal government needs to take a more active role in encouraging the formation and optimal use of a secure health information network, and in helping to build public confidence in such a network.

The benefits of systematic data collection, aggregate analysis, and health information exchange will be felt throughout the health care system. A health information network also may provide a platform for the creation of "personal health accounts" through which the uninsured (and insured) can learn about their eligibility for assistance with obtaining cover-

age, "bank" benefits from multiple sources, and use these various subsidies to purchase plans best suited to their needs. The network also can become the secure means through which patients can communicate with their providers and plans and the world's health knowledge base, helping them to gain access to best practices in care opportunities as well as providing a convenient means to resolve disputes.

By having a rich flow of information about health care and health outcomes, caregivers and researchers can develop greater understanding of what is effective. Additional benefits include better communication between doctors and patients, more customization of care based on patients' needs and preferences, fewer medical errors, low-cost assessment of provider performance, and a more finely honed sense of the value of health care and the need for coverage for that care.

Ongoing federal efforts have focused on setting standards for transmitting data, including privacy protections as part of the Health Insurance Portability and Accountability Act (HIPAA). The core problem in setting such standards is effectively linking together different sources of data on individual patients and populations, and providing this information to those who need to know, when they need to know it, and in a fashion that respects the interests and privacy expectations of individuals while contributing to the enhancement of individual and population health outcomes. The key problem is not technological; software solutions are widely available. The problem is how to create trust in a system that handles the most personal information about individuals.

Privacy protection requires more than the passive legal protections that are part of HIPAA. It requires a dynamic system that continuously assesses and customizes each person's preferences and privacy needs. For example, AIDS patients, who often understand the benefits of participating in clinical trials in exchange for timely reports on results, may be surprisingly willing to share personally identifiable data electronically if they know they can choose the security system themselves and control and audit who has access to their information. This example is not hypothetical, but is an actual research project at the New England Medical Center.[11]

The federal government should encourage and take part in cooperative health information network development ventures that seek to build public trust. The Patient Safety Institute (PSI) is one example.[12] PSI is designed to engender trust by giving patients control over their medical records, and by a board of directors that is controlled equally by representatives of patients, doctors, and hospitals. Such networks can provide patients the tools they need to gain the comfort and control necessary to benefit fully from sharing personal health information. Patients need that comfort and control to allow information about themselves from multiple, disparate sources (including information they themselves can contribute) to be linked. Performance-based grants would encourage states to adopt such networks that produced measurable improvements in health care quality.

Quality of Care and Cost Restraint

To improve quality *and* restrain costs, we propose a federal information clearinghouse—patterned after the Securities and Exchange Commission (SEC)—that would report on health quality and outcomes, not just in health plans, but also among individual health providers, including hospitals and physician groups. Comparative information would help consumers make good choices and allow consumer advocates to make sound recommendations. It also would create new incentives for quality improvements in the health industry.

As envisioned by the Jackson Hole Group, the role of an SEC-like organization would be to require disclosure of performance information about health plans.[13] The standards for measurement would apply to public and private health plans as well as to safety

[11] Brad Miskell. "If Silence = Death, Will Numbers = Answers? Information Activism on the Net." *Journal of the International Association of Physicians in AIDS Care* (December 1998).

[12] See Patient Safety Institute, http://www.ptsafety. org.

[13] Paul Ellwood, Alain Enthoven, and Lynn Etheredge. "The Jackson Hole Initiatives for a Twenty-First Century Health Care System." *Health Economics 1* (1992); see also Regina Herzlinger. "Protection of the Health Care Consumer." Washington: Progressive Policy Institute, March 1, 1999.

net providers who care for the uninsured. Unlike the ongoing evolution toward tougher corporate accounting standards, a health care SEC would be launched with tough standards from the start.

Some progress has already been made through the National Committee for Quality Assurance, and, more recently, provider-level performance information is becoming more common. For example, auto companies and unions have joined to provide workers with online ratings of local hospitals.[14] Another example is Medicare, which has contracted with the National Quality Forum, a broad-based membership organization, to develop extensive quality indicators for nursing homes. Basic information on the quality of nursing homes, health plans, and dialysis centers is currently available at www.Medicare.gov.

Assessment of health outcomes and health care safety are key parts of the performance-based state grants program. Not only would such measures focus state governments on collective actions for improving quality (for example, public investments in health information exchange), they would also spur states to require providers and facilities to report their performance so the states can devolve responsibility for quality where appropriate.

Working in conjunction with the National Quality Forum and other interested parties, the Department of Health and Human Services, which would oversee the performance grants, should envision an "ideal" of where quality measurement should be in five years; determine what can be accomplished first; and take steps to build the infrastructure, culture, and responsibility for moving toward the ideal.

Quality measurement is critical for cost restraint. Without systematic quality assessment, cost restraints risk being penny-wise and pound-foolish or a shell game of shifting costs from one part of health care to another.

Finally, by expanding choices, competition, and information for health care consumers, our proposal would create the framework for tougher measures to restrain costs, such as limits on open-ended subsidies for health care coverage through the tax code.

[14] "Hospital Profile Consumer Guide," www.hospitalprofiles.com.

Political Challenge

As health care costs rise, so does insecurity about coverage. People will lose part or all of their health benefits or they may hear about others who do. This insecurity gave rise to the health care debate in 1993 and 1994 as well as earlier debates.

While coverage for the uninsured is an appropriate response to this feeling of insecurity, it is neither a complete nor an all-encompassing response. While people may feel more insecure, they also realize that reform could make the situation worse. That is what caused the public to reject President Clinton's proposal, even in the face of wide support for universal coverage. The harsh truth is that Americans—most of whom had coverage—were not prepared to risk what they already had to achieve universal coverage for someone else.

That is why any expansion of coverage to the uninsured must minimize disruption to people with existing coverage. Our proposal, for example, would not undermine job-based coverage by eliminating the tax exclusion. Instead, it would expand the use of tax policy to help the uninsured through tax credits. It would not eliminate or fold Medicaid and S-CHIP into larger programs, but, rather, encourage states to make government programs work in concert with private-sector choices.

Finally, our proposal would facilitate broad political support by expanding public financing through each of the three key health care markets: individually purchased coverage (favored by conservatives), job-based coverage (favored by centrists), and state-based government programs (favored by liberals). A broad coalition is necessary, not so much to reach a consensus at the beginning of debate, but to ensure there will be enough common ground to bring people together at the end of debate.

Conclusion

The pursuit of universal coverage should be a national mission to unleash the energy needed to build support for legislation and to make sure the job gets done after enactment. A performance-based system plays to the strengths of each element of the

health care system. The federal government is best equipped to provide significant funding for the uninsured and to catalyze creation of the basic infrastructure for health care purchasing and health information exchange. The states are best at working with local health care markets and ensuring that no one falls through the gaps between public and private health care systems. Employers are best equipped to be the registrars and transfer agents for expanded health coverage because they already serve that role for taxes, pensions, and other types of insurance. Finally, all Americans must assume final responsibility for their own health care coverage and that of their family, once the opportunity to obtain coverage has greatly improved.

The political battles over health care are often waged as if a single act of Congress could solve the problem of health care coverage once and for all. Health care financing is too closely linked to health care delivery, however, to expect a single policy on coverage to be valid for very long. For example, Medicare has failed to develop a prescription drug benefit because action depends on Congress, while most private health plans have a prescription drug benefit to answer consumer demand. Still, it would be a mistake to expect minimalist government intervention to set the nation on a course toward universal coverage. Instead of pursuing the false promise of a one-time universal entitlement "solution," or acting on a false belief in the "invisible hand" of the market, health policy makers should embrace a dynamic process of systematic, ongoing assessment and revision of policies to achieve the desired outcome. Universal coverage is a mission that should succeed or fail based on its impact on the lives and health of everyone in the United States. ■

Kendall, Lemieux, and Levine

Key Elements

David B. Kendall, **Jeff Lemieux**, and **S. Robert Levine** have outlined a plan for a performance-based approach for achieving near-universal coverage. It establishes universal coverage as a national mission and has the following elements:

FEDERAL INCOME-RELATED, refundable, advanceable tax credits to individuals and families.

PERFORMANCE-BASED GRANTS to states linked to improvements in coverage rates, access to care, health care quality, outcomes, public health, and protection from financial hardship for their residents.

STATE-ESTABLISHED PURCHASING GROUPS (similar to the federal employees' plan) or other purchasing options that would allow every individual and business to choose from a variety of competing health plans.

EMPLOYER RESPONSIBILITY to permit workers to enroll in a health plan at the work site, pass along federal tax credits, and deduct the cost of coverage from employees' paychecks.

AFTER FIVE YEARS, AN INDIVIDUAL MANDATE enforced through disallowance of the personal exemption for federal income tax.

ESTABLISHMENT OF A HEALTH INFORMATION INFRASTRUCTURE to improve communication and enhance secure information exchange among stakeholders and enable continuous improvement of health care safety and quality and cost-effective use of health care resources.

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DAVID KENDALL is the Senior Fellow for Health Policy at the Progressive Policy Institute, a centrist think tank in Washington, D.C., and works from Missoula, Montana, as a telecommuter. Mr. Kendall has written book chapters, including one in *Building the Bridge: 10 Big Ideas to Transform America* (Will Marshall, ed.); articles in publications such as *Health Affairs* and *The Wall Street Journal;* and reports available at www.dlcppi.org. He has testified at congressional and state legislative hearings and spoken extensively about health care issues. Prior to joining PPI in 1995, Mr. Kendall served for seven years on the staff of Congressman Michael A. Andrews. In 1994, he worked extensively with the Jackson Hole Group and Congressman Jim Cooper on the Managed Competition Act. In 1993, he served on the President's Task Force on National Health Care Reform, and in 1986, Mr. Kendall was a legislative assistant to Congressman James R. Jones. He attended the University of Chicago as an undergraduate.

S. ROBERT LEVINE, MD, is a national leader in efforts to promote wider use of information technologies to empower consumers and improve health care access and quality. He is Chairman of the Board of Chancellors of the Juvenile Diabetes Research Foundation, the world's top non-profit funder of diabetes research, where he has helped develop its highly effective grassroots advocacy program as well as lead efforts to help its research funding program be more responsive and focused on its mission—a cure for diabetes and its complications. In 1998, he was a recipient of Research!America's Research Advocacy Award for his leadership in generating broad-based support for the doubling of federal biomedical research funding. As Chairman of the Progressive Policy Institute's Health Priorities Project, he has co-authored core papers on an Information Age health system, covering the uninsured, and Medicare reform. Dr. Levine also serves on the Boards of the Center for the Advancement of Health and the Foundation for Accountability. He is a graduate of Cornell University and the Loyola-Stritch School of Medicine. He completed his Internal Medicine and Cardiology training at the Mount Sinai Medical Center, New York, where he later joined the full-time faculty as the founding Director of its Cardiac Health and Rehabilitation Program.

JEFF LEMIEUX is the Senior Economist for the Progressive Policy Institute (PPI). A health economist, he is responsible for studies of overall economic and federal budget, tax, and entitlement issues, as well as health care. Mr. Lemieux was an author and issues editor for the Spring 2000 *Blueprint* magazine published by the Democratic Leadership Council (DLC): *Health Care, Igniting a Consumer Revolution.* Some of his recent publications on health care are "A Progressive Path Toward Universal Health Coverage" (PPI, December 2000), "A New Medicare for the New Economy" (DLC, February 2001), "Transitional Health Coverage: A Tax Credit for COBRA" (PPI, August 2001), and "The New Health Care" (DLC, September 2001). Prior to joining the PPI, Mr. Lemieux was the Staff Economist for the National Bipartisan Commission on the Future of Medicare. He was responsible for the long-term baselines for Medicare spending used by the Commission and the budgetary estimates of the Commission's proposals. From 1992 through 1998, Mr. Lemieux was with the Congressional Budget Office (CBO), where he estimated the cost of national health reform plans and, later, the impact of Medicare reforms enacted in the Balanced Budget Act of 1997 and other laws. He formed CBO's projections of national health expenditures in 1992. Those projections were updated in a series of CBO publications between 1992 and 1998. Between 1990 and 1992, he was with the Office of the Actuary at the Health Care Financing Administration (HCFA), and prior to HCFA, worked for DRI/McGraw-Hill, an economic forecasting firm.