Proposed Health Care System Reforms

Health care system reform covers a disparate and controversial array of issues, a characteristic apparent in the related literature. The literature on proposed system reforms appears to be strongly driven by the actual public policy environment in Washington. Many articles discussing tax credits and reform proposals constructed using tax credits were published during the time when the Bush Administration and Congress were constructing legislation that led to the 2001 tax rebate. Notably, little has been published on health care system reform after the terrorist attacks on September 11, 2001, when national attention became focused on a single issue. There is little hope that this inattention will be remedied soon. We can only speculate as to why this focal change also appeared in the health industry research literature—perhaps there are articles in the publication pipeline that were delayed by editors for coverage of more timely issues, perhaps researchers' focus has changed, perhaps some other reason or simply coincidence.

Common discussion and study areas found in the reform proposal literature included:

- Medicare reform;
- Individual-market reform;
- Tax credits and subsidies for health insurance purchase;
- Pre-Medicare retiree population; and
- Medicaid or other public program expansion to provide coverage for the uninsured.

Although listed separately above, these common themes often overlapped; for example, expansion programs often used subsidies in their proposals (ie, Mitchell and Osber [2002]) and individual-market reform was often included with the use of tax credits (ie, American Medical Association [2001]. Some articles critiqued specific proposals (ie, Burman [2001]); others explored system overhauls (ie, Ballard [1999]; Etheredge [1999]). Rarely, articles returned to core values in evaluating appropriate health care systems (ie, Bolnick [2002]). A few articles question the economic assumptions that underlie our policy approach toward health care in general (Reichert and Cebula [1999]; Pauly [2000]) or specific reform proposals such as tax credits.

Medicare Reform

Medicare reform discussions approach the "problem" of Medicare from many directions. Outside of the concern for Medicare's future financial viability, Medicare's "problem" remains ill defined and the literature reflects this.

Finance-focused discussions include those seeking historical perspective (Patashnik and Zelizer [2001]), vouchers or rebates (Feldman et al [2001]), public private financing mixes (Pauly [2000]), the impact of health care inflation (Reichert and Cebula [1999]), and how geographic differences in health care spending impact Medicare (Wennberg et al [2002]).

Some authors sought to address broader problems rooted in the disparate public policies that inadequately address difficulties faced by the aged (see Etheredge [1999]

and Reichert and Cebula [1999]). These proposals focused on integration of policies for financial stability (ie, social security), medical care (Medicare), and long-term care.

Pre-Medicare Retiree Population

Similar to those seeking to address the more general issues of aging, some authors investigate the difficulties faced by pre-Medicare retirees (see Short et al [2001]). Such proposals often seek public program expansion or individual market reform to aid this high-risk population in obtaining and maintaining health insurance coverage.

Individual Market Reform

Pauly and Percy (2000) provide a comparison of individual and group insurance market performance. They also predict how recent public policy changes, in particular the Health Insurance Portability and Accessibility Act of 1996, will affect the individual market.

One of the most common individual market reforms proposed intends to create favorable conditions for purchasing individual health insurance coverage. Kirk (2000) provides an overview of three states' efforts toward reforming their individual insurance markets. Several conclusions are made from this review: 1) there is an unmet consumer demand; 2) reform is a high-profile and difficult process; 3) most commercial insurers leave reformed markets; 4) tightly defined regulations have tradeoffs (eg, standard product offerings); and 5) both full implementation and repeal of such legislation do occur.

Most individual market reform proposals seek alternative purchasing pools that would function as organizations within the market similar to the manner that employers do currently (American Medical Association [2001]). However, Curtis et al (2001) concludes that such entities are unlikely to arise on their own and need specific policies to stimulate their creation.

No recent literature was identified that addressed high-risk pools. David Sky, in a 1998 article, describes New Hampshire's efforts to use risk subsidization to compensate for the affordability once individual market reforms prohibiting selection and classification practices.

Tax Credits and Subsidies

As mentioned, tax credits and subsidies were the most common reform proposed. They took two general forms. The first in which tax credits or subsidies were provided to individuals for the purchase of health insurance; the second in which tax credits and subsidies were provided to employers.

Single Payer System

For the present, it appears that discussion of a single-payer system has disappeared from the literature. Although some reform discussions may mention such finance reforms or propose altered systems (see Ballard and Goddeeris [1999] and Weil [2001]), such discussions are rare. Since the failure of the Clinton reforms the window of opportunity for systemic change appears to have closed. The literature reflects this closure with its focus on incremental reform plans.

Medical Malpractice and Health Care Reform

Two articles on medical malpractice are included in this review. Medical malpractice is rarely discussed in the mainstream literature in ways that advance our understanding of existing health policy or health care reform. Matthews (1999) discusses the possibilities and likely outcomes of adopting practice guidelines as technical procedures on which to base tort reform. The author concludes that although there are benefits to promoting practice guidelines (eg, cost effectiveness), linking them to tort reform in order to establish culpability in court may be unsuccessful. This argument is based on the fact that cases look at facts specific to the situation and generally not at abstract decision procedures. Mello and Brennan (2002) investigate the deterrence effect of medical malpractice litigation. They conclude that there is a limited deterrence effect but that it is weak and the evidence does not overwhelmingly support its effect.

Reform and Preventive Care Costs

Little research has been published on the costs and benefits of prevention services and almost none of that related to our interests in health care system reform. It appears that such investigations are likely in-agency analyses that are specific to decisions under consideration and that remain unpublished. Those that were published were almost exclusively focused on prevention services in health maintenance organizations (Dorfman and Smith [2002]; Miceli and Heffley [2002]; Patrick et al [1999]; and Solanki et al [2000]) and produced mixed findings. Dorfman and Smith (2002) sought to identify cost effective behavioral health interventions and found that 6 out of 54 studies were both effective and at least cost neutral. Solanki et al (2000) studied the effects of cost-sharing on prevention service use and found significant, negative direct effects of cost-sharing on use of Pap smear, preventive counseling and mammography. They conclude that cost sharing may need to be eliminated if we want to encourage the use of these screening services.

One of the most interesting articles identified in this area, by Miceli and Heffley (2002), theoretically investigated the relationship (or market) between prepaid managed care organizations and consumers. They conclude that a pure prepaid plan will result in either over- or under-consumption of prevention services and that the overall costs of such a plan will be *higher* than those of a pure fee-for-service plan or a plan that includes a copay and a fee-for-service component.

Medicaid or Other Public Program Expansions

Incremental reform often takes the form of current program expansions. Several authors discuss existing examples such as Massachusetts, Tennessee or Oregon (see Gauthier et al [2002], Haber et al [2000], Jacobs et al [1999], Leichter [1999], Mitchell and Bentley [2000], Mitchell and Osber [2002], and Weil [2001]). Others are more general in nature, suggesting expansion of State Children's Health Insurance Programs or Medicaid (see Rosenbaum et al [2001]) and Medicare (see Etheredge [1999] and Short et al [2001]) as the best means to increase coverage rates for the uninsured.

Ten years ago, one of the most-discussed health care reforms was the Oregon Health Plan (OHP) (see Jacobs et al [1999] and Leichter [1999] for a thorough

background discussion on the development of the OHP; see Gauthier et al [2002], Haber et al [2000], Mitchell and Bentley [2000] for discussions of specific aspects of the OHP). This Section 1115 waiver program was considered one of the most innovative and controversial reforms implemented. The OHP, while no longer the only innovative expansion program, is still under close scrutiny as an experiment in health care service rationing and the politicization of funding specific health care services.

When systemic reform efforts failed at the national level, the country looked to the states to provide needed changes and they responded with these expansion programs and other incremental efforts to increase access to health care. These efforts are now in real danger. The economic downturn has seriously hurt states' financial situations, to the point where funding "superfluous" programs is impossible and states are forced to reconsider their generosity. The OHP's prescription plan has been discontinued (Egan T. A prescription plan hailed as a model is a budget casualty. *The New York Times*. March 5, 2003. www.nytimes.com). TennCare, the Tennessee expansion program, has cut prescription benefits, changed eligibility criteria, and is considering limiting coverage of other medical services (de la Cruz B. Bredesen explains TennCare cutbacks. *Tennessean*. March 14, 2003. www.tennessean.com). Such changes are common and point out that an advantage of state-based policy reform—flexibility—also serves as a disadvantage by its impact on policy stability. It is unlikely that states will continue to carry the same proportion of the health care burden in the current economic environment. Health care is treated variably as a right or a privilege in the United States—most often it is considered a right, but we usually behave as if it is a privilege.

Summaries—

American Medical Association. *Expanding Health Insurance: The AMA Proposal for Reform*. Chicago, Ill: American Medical Association. 2001. http://www.ama-assn.org/ama/upload/mm/363/expandinghi.pdf (October 13, 2002).

Keywords: Health insurance tax credits and subsidies, Individual market, Risk pools
Purpose: Describe the American Medical Association proposal for reforming private health insurance in the United States; a proposal whose purpose is to attain access for all to health insurance
Data and Methods: Commentary, not applicable
Results: The AMA's proposed reforms are intended to transform the US health care system "from a system that is primarily responsive to employers to one that is primarily responsive to patients." It intends to: 1) insure the uninsured; 2) give consumers more choice in and control over their insurance; 3) alter the tax code to a more progressive tax treatment of health care expenditures; 4) create a market that offers affordable choices to consumers. The proposal uses the following mechanisms to attain these goals: 1) refundable tax credits for the purchase of health insurance for low-income individuals; and 2) create opportunities for alternative insurance markets for non-employer groups such as risk pools. Example scenarios are provided that show the predicted effect of the tax credit, given the assumption of no change in current market-related behavior. Estimated health insurance coverage rate under this plan is given as 93 percent. Government agency review is proposed as a means verification method in some situations.
Uses: Any reform proposal of this scope from a stakeholder group of this importance has relevance to the policy process. Such a detailed proposal informs other parties involved of what the AMA perceives as a preferred and acceptable reform.
Limitations: The primary caution is that this proposal comes from one of the core health care stakeholders and should be approached as such. Additionally, there appears to be no accounting for either the administrative costs that the proposed system would entail, or the impact on social efficiency involved in the move to a market driven more by individual purchasers.

Ballard CL, Goddeeris JH. Financing universal health care in the United States: a general equilibrium analysis of efficiency and distributional effects. *National Tax Journal*. 1999; 52(1): 31-51.

Keywords: Health insurance tax credits and subsidies, Mandated coverage, Single-payer health system
Purpose: Determine the effects of financing universal health insurance coverage
Data: Current Population Survey (March, 1992)
Methods: Probit analysis
Results: This study estimated that the aggregate efficiency loss from financing universal health insurance would be between 0.2% and 1% of net national output. It predicted that overall efficiency losses would be smaller for a reform plan that used mandated health insurance coverage with a tax credit for low-income individuals than it would be for a plan that used taxes to finance the full program; distribution of costs and benefits also varied by plan form. All plans redistributed resources in favor of the poor. The elderly were worse off in all tested plans because they gain nothing from universal coverage but do bear some portion of the cost. The highest income group was best off under the mandated coverage with tax credit plan; the lower-middle class fared worse under this scenario. Economic utility outcomes varied dramatically for most groups based on the plan's finance and structure.
Uses: This study simulates possible outcomes of policy choices; in this case, various finance structures of universal health insurance coverage in the United States. If the modelers fully understand their model's limitations, such analyses can be valuable policy tools. The economic impact to the US economy of universal health-care coverage is of interest to all who are concerned with health care access and is an important starting point for policy discussions.

Limitations: These sophisticated simulations are based on many factors, but do not, and in reality cannot, include all factors involved in what the outcome of universal coverage would be. These are predictions and need to be understood as such.

Bolnick HJ. Designing a World-Class Health Care Financing System. Presentation at the International Congress of Actuaries. Cancun, Mexico. 2002.

Keywords: Preventive care costs, Single-payer health system

Purpose: Evaluate existing health care systems and develop a framework that includes the necessary components for an ideal health care system

Data and Methods: Information for this comparative analysis comes from *The World Health Report 2000*

Results: This discussion merges public health values applied to a national health care system, as embodied in the values of the World Health Organization (WHO), with the extant values of the US market-based health care system. This is done through contrasting health care systems in the United States, the United Kingdom, and the European Union and draws extensively from the WHO's publication *The World Health Report 2000*. A "world-class" health care system is defined here as one that has a disability adjusted life expectancy of 70 years or greater. The author uses the WHO model of health care systems to make these comparisons and makes the following conclusions about effective health care systems: 1) government involvement in public health is necessary; they are mixed, public-private structures; 3) a minimum of $1000 (US) annual per capita spending on health (public health and medical care) is necessary; 4) spending more than the minimum does not result in corresponding improvements in health outcomes but it does tend to improve system responsiveness; 5) the provision of basic medical care reduces disease (eg, infectious disease and childbirth complications for mother and infant) and injuries; and 6) all systems have problems meeting public expectations because of the high value placed on optimal health. Detailed comparison of the US and UK systems focused on measures of health, responsiveness and financial fairness. Economic theory of the various financing arrangements is discussed and compared.

Uses: This framework provides an interesting approach to adding values to the policy development process.

Limitations: The framework does not include political behavior and thus is an ideal rather than a pragmatic approach.

Burman LE, Gruber A. First, do no harm: designing tax incentives for health insurance. *National Tax Journal*. 2001; 54(3): 473-493.

Keywords: Health insurance tax credits and subsidies

Purpose: Discuss the economic arguments for health insurance subsidies and describe a model illustrating the impact of different subsidy schemes

Data and Methods: Current Population Survey data underlies the discussion and commentary

Results: This discussion examines the Bush Administration’s 2001 proposal for a health insurance tax credit and its possible ramifications. The authors determine that the proposal was equivalent to a general insurance tax credit with a tax on employer-sponsored insurance and that such a proposal risks injuring the existing employer-based system. They propose that a tax credit applied to insurance that is portable and renewable, with fair rates in both the individual and employer market would be more likely to correct for current problems in the health insurance market without damaging the existing system than the Administration’s proposal.

Uses: Provides an overview of tax credits, their economic rationale and their impacts to the marketplace. Tax credits have been popular policy tools in recent administrations and a better understanding of their operations is important for decision makers.

Limitations: This discussion seems to assume that change to the existing system of employer-based coverage is bad and uses that assumption to frame the recommendation.

Cassel CK, Besdine RW, Siegel LC. Restructuring Medicare for the next century: what will beneficiaries really need? *Health Affairs*. 1999; 18(1): 118-131.

Keywords: Medicare reform
Purpose: Examine Medicare's role in the broad continuum of medical care and its social context
Data and Methods: Commentary, not applicable
Results: The authors propose Medicare reform at several foci. They suggest a shift from episodic care toward concern with more general health outcomes. Emphasis is to be placed on functional status, care management, integration of care types (eg, acute, long-term, mental health). They place these suggestions in the context of Medicare's current structure and discuss the incentives and barriers that structure creates in geriatric care delivery.
Uses: Geriatric health care is a growing area of concern and our increased understanding of the needs of our elders highlights the importance of reexamining the existing policies that protect and care for them. Although this proposal is incomplete, because of its focus on the medical care delivery, it is important to remember that care for individuals is delivered in the population-based policies we develop. This is important because it is with the individual cases that become personal nightmares, not the population-level successes, where the political difficulties often begin.
Limitations: Takes a medical care focus without consideration of finance structure for the program

Curtis RE, Neuschler E, Forland R. Private purchasing pools to harness individual tax credits for consumers. *Inquiry*. 2001; 38(2): 159-176.

Keywords: Health insurance tax credits and subsidies, Individual market, Risk pools
Purpose: Describe a reform proposal to use private purchasing pools for tax-credit recipients
Data and Methods: Commentary, not applicable
Results: Even with the assistance of health insurance tax credits, some individuals will find purchasing health insurance coverage too great a financial burden. The authors propose the creation of private purchasing pools for tax credit recipients. These purchasing pools would allow recipients to enjoy the same advantages experienced by employees who participate in large employer-sponsored plans by lowering administrative costs, removing the potential barrier of health ratings, and providing a formal organization to serve as an advocate for enrollees. The authors, concerned that purchasing pools will not arise on their own, believe that public policy efforts are needed to stimulate their creation. Through these policy incentives, they intend to strengthen the stability and gain the numbers needed to create pools that can credibly negotiate with plans. Specific policy structure recommendations are made.
Uses: Purchasing pools provide one mechanism under which the private market can increase coverage rates and are included in many reform proposals. This analysis investigates what specific elements are needed to create stable pools that can serve as credible market forces.
Limitations: None as presented

Dorfman SL, Smith SA. Preventive mental health and substance abuse programs and services in managed care. *Journal of Behavioral Health Services and Research*. 2002; 29(3): 233-258.

Keywords: Preventive care costs
Purpose: Summarize the published literature on effective mental health and substance abuse prevention interventions with likely positive or neutral benefit/cost ratios
Data and Methods: Literature review
Results: Fifty-four studies were identified that met the purposes of this study. The authors conclude that there are preventive behavioral health interventions based in managed care settings that have proven effective and cost neutral or cost effective. They recommend six such interventions for implementation in managed care settings based on this literature review: 1) prenatal and infancy home visits; 2) targeted cessation education and counseling for smokers, especially pregnant smokers; 3) targeted short-term mental health therapy; 4) self-care education for adults; 5) pre-

surgical education intervention with adults; and 6) brief counseling and advice to reduce alcohol use.

Uses: Clinicians, administrators, health plans and other organizations involved with managed care could find this analysis useful in determining what services to offer or how to structure their services. This information could also be informative to decisions by policymakers

Limitations: Not all published studies reported cost information

Etheredge L. Three streams, one river: a coordinated approach to financing retirement. *Health Affairs*. 1999; 18(1): 80-91.

Keywords: Catastrophic illness, Medicaid/public program expansion, Medicare reform, Pre-Medicare retiree population

Purpose: Discuss options for a policy approach that coordinates Medicare, Social Security and pension policies to address problems caused by the disjointed approach currently used

Data and Methods: Commentary, not applicable

Results: The author proposes an integrated approach to retirement policy that includes Social Security, private pension, and Medicare reform. The coordinated policy reform should include: 1) work incentives for older persons (eg, lump-sum bonuses for delayed retirement); 2) the option for workers without workplace pensions to use the existing federal Social Security payroll deduction system to contribute to personal pension accounts; 3) allow pension-plan assets to be used for paying long-term care insurance premiums; and 4) focus on financing basic Social Security and Medicare benefits to sustain these valuable programs.

Uses: This commentary urges a cross-policy coordination of the retirement life-stage programs—something few others have done. The ideas presented remind policymakers that an incremental approach can create an inefficient and, more importantly, an inadequate system

Limitations: None as presented

Feldman R, Dowd BE, Coulam R, Nichols L, Mutti A. Premium rebates and the quiet consensus on market reform for Medicare. *Health Care Financing Review*. 2001; 23(2): 19-33.

Keywords: Health insurance tax credits and subsidies, Medicare reform

Purpose: Describe the issues behind and rationale for premium rebates

Data and Methods: Commentary, not applicable

Results: This article discusses the debate concerning the use of premium rebates in the Medicare program. Premium rebates give cash rebates to enrollees who choose more efficient coverage options instead of extra benefits; an untested cost-control incentive. Rebates were introduced to provide market-type pricing in the Medicare program. Equity questions are raised by this approach, because such approaches can produce variation in a national entitlement program. Medicare+Choice plans will be allowed to offer rebates beginning in 2003. The authors discuss several implementation issues that need consideration and how rebates affect Medicare reform proposals under consideration by the 107th Congress.

Uses: Adopted policies that await implementation need consideration when evaluating current policy proposals.

Limitations: None, as presented

Gauthier AK, Gates VS, Helms WD. State coverage expansions: learning from research and practice. *Health Services Research*. 2002; 37(1): 33-42.

Keywords: Medicaid/public program expansion, Oregon Health Plan

Purpose: Provide a context with which to interpret the findings of a study on the impact of the Oregon Health Plan on access and satisfaction of low-income adult enrollees and related broader lessons from state coverage expansion efforts

Data and Methods: Commentary, not applicable

Results: The authors review the development of state health care reform efforts since the early 1990s. They conclude that states responded to welfare reform, and correspondingly structure their health care policies, based on their political values and that these vary greatly among states. They note that states who saw Medicaid as an important means to support low-income working families took advantage of the separation of welfare and Medicaid and the opportunities provided by the State Children's Health Insurance programs. Barriers to coverage expansion are identified: 1) progress depends on public/private partnerships; 2) concerns about crowding out of private insurance through public programs; 3) economic constraints; 4) political priorities.

Uses: Provides a national context to the Oregon experience and useful commentary to help interested readers understand the dynamics affecting this policy issue in Oregon and elsewhere

Limitations: None as presented

Haber SG, Khatutsky G, Mitchell JB. Covering uninsured adults through Medicaid: lessons from the Oregon Health Plan. *Health Care Financing Review*. 2000; 22(2): 119-135.

Keywords: Medicaid/public program expansion, Oregon Health Plan

Purpose: Describe the eligibility expansion experience in Oregon and characterize the expansion population and its service use, and evaluate the continuity of coverage provided by the program

Data and Methods: Case study; telephone survey of Oregon Health Plan (OHP) expansion beneficiaries

Results: The OHP eligibility expansion did successfully increase coverage rates among the previously uninsured and the working poor. However, most beneficiaries are enrolled for brief periods. This group was more likely to enroll when they needed services; there was no waiting period between sign-up and service use. There was no evidence of crowd-out. The expansion population was relatively sick and had high service use rates.

Uses: Provides information on the characteristics of an expansion population that could inform policymakers in other states

Limitations: None as presented

Hall MA, Wicks EK, Lawlor JS. HealthMarts, HIPCs, MEWAs, and AHPs: a guide for the perplexed. *Health Affairs*. 2001; 20(1): 142-153.

Keywords: Risk pools

Purpose: Determine how current reform proposals would function within the existing health care market and predict the consequences of these reforms

Data and Methods: Commentary, not applicable

Results: This study examines how various forms of health insurance group purchasing arrangements will function in the existing health care market. The authors predict that these proposals may erode the contributions of previous reforms because they may undo existing risk pools and force higher risk groups to drop current coverage. Concern is that it will occur by low-risk individuals leaving existing pools to form large, low-risk groups to lower their own costs at the expense of elders and those with chronic illnesses. However, the new reforms address problems that have hurt purchasing cooperative performance in the past and clarify governments' role in oversight of these organizations. The authors are unwilling to condemn these proposals, but instead recommend careful consideration of their contributions. However, they predict that these reforms will not significantly reduce premiums or the uninsured rate.

Uses: Many reform proposals include purchasing pools in some form. Consideration of how they would function in the existing marketplace is important in determining the value of such reforms.

Limitations: None as presented

Jacobs L, Marmor T, Oberlander J. The Oregon Health Plan and the Political paradox of rationing: what advocates and critics have claimed and what Oregon did. *Journal of Health Politics, Policy and Law*. 1999; 24(1): 161-180.

Keywords: Medicaid/public program expansion, Oregon Health Plan

Purpose: Provide a review and interpretation of the Oregon Health Plan (OHP) policy adoption and creation process

Data and Methods: Case study

Results: These authors provide a historical overview of the policy adoption and implementation process for the OHP. They note that the reform process was strategically managed by reformers to build support, was intensely political, that the reformers never controlled the process, and that the outcome of the process was unforeseen. Reformers used technocratic justifications for the OHP and promoted the "rational, scientific instrument—the list." The authors do not believe that there is real rationing with the OHP, because of the subsequent political adjustments and the lack of adequate outcomes and effectiveness data on which to base the list. They conclude that Oregon's innovation is a political one, not a technical one.

Uses: Provides insight into the policy process that brought the OHP about, which can inform others about the dynamics of significant state policy reform

Limitations: Only that the perceived success or failure of an implementation is dependent upon one's perspective and the desired goals (also see Peterson [1999] and Leichter [1999] for comments and counterpoints)

Kirk AM. Riding the bull: experience with individual market reform in Washington, Kentucky, and Massachusetts. *Journal of Health Politics, Policy and Law*. 2000; 25(1): 133-173.

Keywords: Individual market

Purpose: Describe and draw lessons from the policy processes and the context before, during and after significant individual market reforms occurred in three states (Kentucky, Massachusetts, and Washington)

Data: Interviews, written sources, market source data from the Alpha Center's health insurance database, and financial data on insurers from state documents

Methods: Case Studies

Results: The author draws the following conclusions from the case studies: 1) consumers respond to guaranteed issue of policies; 2) rate regulation will be a conflict-ridden and high-profile issue; 3) insurers are concerned about maternity benefits and adverse selection and will work toward developing their plan offerings with this in mind; 4) there are trade-offs to requiring the offering of standard products; 5) once a market is reformed, it will resegment if allowed; 6) most commercial insurers will leave a reformed market; 7) once reform is passed, full implementation and possible repeal do occur.

Uses: Provides insight into the policy process and specifically into the dynamics that occurred when individual insurance markets were targeted for reform. This is useful information for policymakers and others interested in attaining (and maintaining) reform.

Limitations: The study describes three cases. Case studies, although valuable in their own right, have an inherent limitation to the generalizability of the information obtained because of the specific nature of study findings.

Laws KE, Gabriel RM, McFarland BH. Integration and its discontents: substance abuse treatment in the Oregon Health Plan. *Health Affairs*. 2002; 21(4): 284-289.

Keywords: Medicaid/public program expansion, Oregon Health Plan (OHP)

Purpose: Investigate managed care practices relating to substance abuse treatment of health plans serving OHP enrollees

Data and Methods: Case study; interviews and surveys of stakeholders (1999)

Results: Service integration was an intended result of the OPH. Authors found several factors that hindered such integration: 1) how plans incorporated managed behavioral health into their operations (ie, direct involvement vs. contracting); 2) mental health carve outs, which separated behavioral health care from physical health care and other organizational problems; 3) health plans' financial status; 4: physicians tended to not make referrals for substance abuse treatment. This study concludes that health plans do not make integrated health care a priority.

Uses: Discussions often focus on physical rather than behavioral health services. This highlights issues important to consider when attempting to increase efficiency and integration of services.

Limitations: None as presented

Lee DR, Warren RS Jr. Mandated health insurance and the low-wage labor market. *Journal of Labor Research*. 1999; 20(4): 505-515.

Keywords: Mandated coverage

Purpose: Detail the argument that the imposition of health insurance mandates on employers harms the individuals they intend to help

Data and Methods: Commentary, not applicable

Results: This discussion argues that the imposition of health insurance mandates on employers would inadvertently harm the employees' welfare. It analyzes variations in compensation patterns and concludes that that these variations are based in employer/employee preference diversity and technology. They argue that groups of firms that are less likely to provide health insurance do so because it is beneficial to both firms and employees. They base their argument against health insurance mandates on this variation and the efficiency it should be providing to participants—that it is the optimal arrangement for this market and that forced uniformity could make those involved in that market worse off.

Uses: The authors approach this issue from a labor analyst/economist perspective and outline the base theory that underlies strict economic-based approaches to the health insurance market. Such a perspective is important for policymakers to understand.

Limitations: Although this provides a thorough explanation of the economic justification the damage mandates may inflict, economic-based values are not the only values on which public policy is based

Leichter HM. Oregon's bold experiment: whatever happened to rationing? *Journal of Health Politics, Policy and Law*. 1999; 24(1): 148-160.

Keywords: Medicaid/public program expansion, Oregon Health Plan

Purpose: Provide a review and interpretation of the Oregon Health Plan (OHP) policy adoption and creation process

Data and Methods: Case study

Results: Leichter provides a historical overview of the policy adoption and implementation process for the OHP. He provides the perspective of a long-time observer of state policy processes and an Oregon resident. The author deems the OHP to be a success in that it has provided health coverage to an additional 100,000 individuals and decreased the percent uninsured, reduced uncompensated care costs and emergency department visits for hospitals, and reduced cost shifting within the health care financing system. Conclusions are drawn that provide guidance to other states interested in similar programs: 1) money has been saved by creating a priority list with a cut-off; 2) OHP shifted concern from which uninsured populations to cover to what benefits to offer; 3) policy changes are more likely to be politically successful if they are incremental in nature.

Uses: Provides insight into the policy process that brought the OHP about, which can inform others about the dynamics of significant state policy reform

Limitations: Only that the perceived success or failure of an implementation is dependent upon one's perspective and the desired goals (also see Peterson [1999] and Jacobs et al [1999])

Long SH, Marquis MS. Low-wage workers and health insurance coverage: can policymakers target them through their employers. *Inquiry*. 2001; 38(3): 331-337.

Keywords: Health insurance tax credits and subsidies, mandated coverage
Purpose: Relate employer health insurance survey data to the difficulties inherent in creating policies to increase access to health insurance for uninsured workers
Data: Robert Wood Johnson Foundation Employer Health Insurance Survey (1997)
Methods: Statistical comparison
Results: This study compares low-wage employers against other employers in practices relating to health insurance benefits. They found that low-wage employees are less likely to work for an employer that offers insurance. If the employer does offer insurance, low-wage employees are less likely to qualify and less likely to enroll if eligible. Low-wage employers contribute lower percentages toward premiums and the policies they offer are less generous than other employers. The authors caution against viewing subsidies toward these employers as certain strategies to increase coverage among the uninsured. Such employers are difficult to target and identify as a group because characteristics, such as firm size, that have been proposed to identify low-wage employers are poor indicators where low-wage workers are concentrated in the workforce.
Uses: This study provides a critique of employee subsidies for health insurance, a common reform proposal to increase the insured rate among the working poor.
Limitations: None as presented

Matthews JR. Practice guidelines and tort reform: the legal system confronts the technocratic wish. *Journal of Health Politics, Policy and Law*. 1999; 24(2): 275-304.

Keywords: Medical malpractice
Purpose: Discuss the impact of linking practice guidelines to tort reform
Data and Methods: Theoretical discussion, not applicable
Results: The author concludes that although there may be other benefits to promoting practice guidelines (eg, cost effectiveness), linking them to tort reform in order to establish culpability in court may be unsuccessful. This argument is based on the fact that cases look at facts specific to the situation and generally not at abstract decision procedures. Discussion includes background on a proposed technocratic approach to medicine and how it is desired that practice guidelines create that approach.
Uses: Practice guidelines are an often-discussed issue among clinicians, health care plans and policymakers. This article provides a bridge for policymakers, who approach problems at the population level, to understand the potential affects of policy change in the outcome of individual cases
Limitations: None as presented

Mello MM, Brennan TA. Deterrence of medical errors: theory and evidence for malpractice reform. *Texas Law Review*. 2002; 108(5): 1595-1637.

Keywords: Medical malpractice
Purpose: Investigate the role of deterrence in health policy and what is known about the deterrence effect of malpractice litigation
Data and Methods: Literature review with commentary
Results: The authors do find limited evidence of a deterrence effect due to tort and malpractice litigation. However, they state that the evidence is not plentiful or conclusive. Reforms are proposed that change the deterrence effect to better impact quality improvement incentives. They examine the quest to identify a "business case for quality" and focus reform recommendations toward building this case. Suggested reforms included: 1) rather than focusing on individuals, group individuals

("channel") into organizations (eg, hospitals or health systems) that serve as both a unit of liability and deterrence; 2) experience rating; and 3) no-fault compensation.

Uses: The authors discuss and identify some interesting incentives and possible alterations to those incentives of interest to most policymakers, health care organizations, clinicians, health plans and others. Quality, financial, and liability issues are central to this discussion and those concerned with such health care areas would find this useful.

Limitations: None as presented. The authors discuss some difficulties with their reform suggestions in the text

Merlis M. Public subsidies for employees' contributions to employer-sponsored insurance. *Inquiry*. 2001; 38(2): 121-132.

Keywords: Health insurance tax credits and subsidies, Individual market

Purpose: Discuss a proposal for a tax credit for the employee contribution to employer-sponsored health insurance premiums

Data and Methods: Commentary, not applicable

Results: This article proposes a tax credit for the employee share of employer-sponsored health insurance as part of a broader program of income-based health insurance tax credits. The author theorizes that assisting uninsured workers to cover the cost of available employer-sponsored plans would be more cost-effective than assisting them in the nongroup market. The proposal also makes the tax credit available to insured workers for equity reasons and to reduce the incentives for employers to drop coverage or for workers to shift to subsidized individual plans. Other structural issues and incentives and counter-incentives are discussed. Other design questions considered by the article include whether workers should be able to choose between employer-sponsored health insurance and nongroup coverage, whether minimum benefit standards should apply for employer plans, and how to achieve a fair balance in subsidies for group and nongroup coverage.

Uses: Tax credits have been popular policy tools in recent administrations and a better understanding of their operations is important for decision makers.

Limitations: None as presented

Meyer JA, Wicks EK. A federal tax credit to encourage employers to offer health coverage. *Inquiry*. 2001; 38(2): 202-213.

Keywords: Health insurance tax credits and subsidies

Purpose: Describe a reform proposal based on a tax credit to employers for the provision of health plans to low-income workers

Data and Methods: Commentary, not applicable

Results: This article discusses a reform proposal to increase the health insurance coverage rates of low-wage employees that is based on a tax credit to employers. It would take the form of a permanent, fixed-dollar, refundable credit and would be available to all low-wage employers. The credit would be graduated depending on the average wage at the firm and would vary by family size. Both part-time and temporary workers would be covered and participating employers would be required to cover at least 50% of the premium. The Internal Revenue Service would administer the program.

Uses: This tax credit proposal provides a different approach to decreasing the uninsured rate from the other proposals presented here. Such alternative proposals serve to stimulate more creative policy reform discussions.

Limitations: As a reform proposal it is incremental in approach and would not achieve 100 percent insured rates. Small employers can be difficult to educate about such initiatives and may be reluctant or incapable of offering coverage to their employees even after the rebate. Some employees may decline coverage, if offered, because even subsidized premiums may be too great a financial burden.

Miceli TJ, Heffley D. Do HMOs encourage prevention? an analysis of alternative health care plans. *Contemporary Economic Policy*. 2002; 20(4): 429-439.

Keywords: Preventive care costs
Purpose: Develop an analytical framework for evaluating the consumption of prevention services by consumers under alternative health care plans
Data and Methods: Theoretical; economic theory analysis
Results: The authors conclude that consumers will choose the Pareto-optimal quantity of prevention services and that providers will choose to offer optimal capacity under both a pure fee-for-service plan and under a plan that includes both an up-front fee for the consumer and a fee-for-service component. They predict that consumers will either under- or over-consume prevention services under a pure prepaid plan and that capacity restrictions under such a plan such as long office waits could be seen as a response to overconsumption. Interestingly, they find that the dollar costs of health care are higher under a prepaid plan, which is contrary to some of the common justifications for adopting a managed care/health maintenance organization approach.
Uses: This analysis provides a theoretical base with which to examine the true benefits of managed care and forces us to reexamine our assumptions of these organizations' motivations and how they function within the health care market—with specific regard to prevention services.
Limitations: None, as presented

Mitchell JB, Bentley F. Impact of Oregon's priority list on Medicaid beneficiaries. *Medical Care Research and Review*. 2000; 57(2): 216-234.

Keywords: Medicaid/public program expansion, Oregon Health Plan (OHP)
Purpose: Assess the impact of the OHP's priority list on OHP enrollees
Data and Methods: Case study; OHP enrollee survey
Results: The authors found that one third of OHP enrollees had needed an uncovered service since their enrollment with OHP. Thirty-eight percent of these uncovered services were identified as services falling below the priority list's cutoff line. Below-line services that were most often mentioned included hernia repair, chiropractic treatment, dental splints, and newborn circumcision. Approximately half of these below-line services were received anyway, and the enrollee commonly paid for the service. Overall, there was no evidence that the priority list has adversely impacted enrollees, but the authors recommend that OHP enrollees' access to care needs to be monitored.
Uses: The priority list is one of the most controversial elements of the OHP. This study provides information on the enrollees' perceived impact of the list to their health status.
Limitations: Information rooted in personal perceptions of health status is important, but it would be nice to have medical measures of health status to substantiate the perceptions.

Mitchell JB, Osber DS. Using Medicaid/SCHIP to insure working families: the Massachusetts experience. *Health Care Financing Review*. 2002; 23(3): 35-45.

Keywords: Health insurance tax credits and subsidies, Medicaid/public program expansion
Purpose: Describe the Massachusetts program designed to subsidize health insurance for small employers and their employees through Medicaid or State Children's Health Insurance Program (SCHIP) funding
Data: Interview and administrative data
Methods: Case study
Results: Using a 1115 Medicaid waiver, Massachusetts has implemented a program to increase access to health insurance that uses Medicaid and SCHIP funding to subsidize small employers and their employees. They find that the use of SCHIP funds for this purpose experienced barriers due to federal requirements for use of such funds. The program did increase the health insurance coverage rate and most enrollees were previously uninsured. The development and

implementation of this program is discussed and recommendations made for other states wishing to pursue similar expansion programs.

Uses: Provides insight into the policy process and how an expansion program was implemented and subsequently functions. This is useful information for policymakers and others interested in using expansion programs to cover the uninsured.

Limitations: None as presented

Patashnik E, Zelizer J. Paying for Medicare: benefits, budgets, and Wilbur Mill's policy legacy. *Journal of Health Politics, Policy and Law*. 2001; 26(1): 7-36.

Keywords: Medicare reform

Purpose: Inform readers of the historical background of the Medicare funding structure and place that origin in the current context of medical care delivery and reform proposals

Data and Methods: Commentary and historical report, not applicable

Results: This discussion focuses on the historical development of Medicare's financing structure. The authors describe House Ways and Means Committee chair Wilbur Mills' role in developing this structure. They conclude that fiscal conservatism and budgetary restraint were important to the Medicare legislation design. They place the historical account and their conclusions into the current Medicare context, with acknowledgement that restructuring the funding design may be necessary given changes in the health care system since 1965. They then briefly evaluate several proposed Medicare finance reforms.

Uses: Inform those interested in social policy and health care reform of the unique structure and origins of the Medicare funding structure so that its origin may be considered in the reform process.

Limitations: None as presented

Patrick DL, Grembowski D, Durham M, Beresford SAA, Diehr P, Ehreth J, Hecht J, Picciano J, Beery W. Cost and outcomes of Medicare reimbursement for HMO preventive services. *Health Care Financing Review*. 1999; 20(4): 25-43.

Keywords: Medicare reform, Preventive care costs

Purpose: Test the cost-effectiveness of a senior health promotion program in a staff-model health maintenance organization

Data and Methods: Case study; surveys

Results: The treatment group completed more advance directives, participated in more exercise and consumed less dietary fat than the control group. They reported higher satisfaction with health, less decline in self-rated health status, and fewer depressive symptoms than the control group. This program did not yield lower cost per quality-adjusted life year.

Uses: It is useful to see how one health maintenance organization structured its seniors' health prevention program and what the outcomes were.

Limitations: The health maintenance organization involved in this case study has a history of focusing on prevention, which may confound the findings. Health prevention efforts rarely see results after two years, which is the timeframe for this study.

Pauly MV. The Medicare mix: efficient and inefficient combinations of social and private health insurance for US elderly. *Journal of Health Care Finance*. 2000; 26(3): 26-37.

Keywords: Medicare reform

Purpose: Determine why the US health finance system for the elderly combines both public and private insurance

Data and Methods: Commentary, not applicable

Results: This study investigates two possible explanations for the combined public-private insurance system for financing health care for the elderly. The first explanation is that the combined system

is an efficient method for financing a public good. The second explanation is that it is actually a private good, but is provided through a public system to ensure optimal distribution of the good. The author finds more support for the theory that the combined system is an efficient method for financing a public good, but determines that it is a suboptimal configuration. Problems with the combined system include the lack of coordination between Medicare and Medigap insurers and the relatively generous coverage obtained by the wealthy. Some reform proposals are assessed against these deficiencies.

Uses: Some reform proposals support expanding coverage; an understanding of how the two coverage components interact can help future policy development.

Limitations: None as presented

Pauly MV, Percy AM. Cost and performance: a comparison of the individual and group health insurance markets. *Journal of Health Politics, Policy and Law*. 2000; 25(1): 9-26.

Keywords: Individual market

Purpose: Describe trends in the individual health insurance market, compare its performance to that of the group insurance market, and make recommendations for policy efforts based on these observations

Data: Current Population Survey

Methods: Longitudinal trend comparison

Results: There is increasing dissatisfaction with the current employer-based health financing system for multiple reasons. The authors believe that the basic policy issue relating to the form of financing and policy reform involves balancing choice, portability, and coverage stability with administrative cost and risk distribution. The authors discuss the effects of recent health care reforms (eg, the Health Insurance Portability and Accessibility Act of 1996) on the individual market. They conclude that two characteristics of the individual market are problematic: 1) individual insurance is expensive; and 2) insurers in the individual market try to match risk with premiums and range of coverage offered. They then describe reform tools proposed to address these problems.

Uses: This article provides background information on the individual market for health insurance.

Limitations: None as presented

Pauly M, Herring B. Expanding coverage via tax credits: trade-offs and outcomes. *Health Affairs*. 2001; 20(1): 9-26.

Keywords: Health insurance tax credits and subsidies

Purpose: Discuss link between tax credit programs and reforms, and discuss possible reforms

Data and Methods: Medical Expenditure Panel Survey (1996) is used to estimate changes in medical costs through simulations

Results: There are two effects of tax credit programs of concern to policymakers: 1) how it impacts the health care system (ie, the change in the number and mix of the uninsured that results from the tax program); and 2) how it impacts the economy (ie, how the tax credit affects disposable income). The effect of tax credits depends on the size and form the tax credit takes, and there is little previous experience with subsidizing private insurance for low-income individuals to help us predict outcomes. Based on simulation experiments, the authors predict that small credits will not significantly change the uninsured rate, but that credits subsidizing approximately 50 percent of the premium might significantly change the uninsured rate. Such effects would be more likely if the tax credit has a fixed dollar structure and can purchase health care coverage with few restrictions.

Uses: Simulations are useful tools to predict possible outcomes of policy change. The results of these simulations aid in the understanding of how tax credits may function to change health care coverage rates and their economic impact, thus informing policymakers of possible results of their actions.

Limitations: None as presented

Peterson MA. Editor's note. *Journal of Health Politics, Policy and Law*. 1999; 24(1): 146.

Keywords: Medicaid/public program expansion, Oregon Health Plan
Purpose: Provide an introduction and context to the Jacobs et al (1999) and Leichter (1999) articles in the same issue
Data and Methods: Not applicable
Results: Peterson provides a brief context to the perspectives from which the Jacobs et al and Leichter articles arise. Jacobs et al are outsiders to the Oregon policy process but are experienced students of health policy. Leichter is an Oregonian and an expert on state health policy who watched the process closely.
Uses: Provides readers a context to the above-mentioned articles
Limitations: None as presented

Reichert UN, Cebula RJ. A note on health care inflation. *Journal of Economics and Finance*. 1999; 23(3): 193-198.

Keywords: Health care costs, Malpractice litigation, Medicare reform
Purpose: Examine the determinants of the inflation rate of the consumer price index for health care services
Data: Economic Report of the President (1995) and the American Medical Association data from 1960 to 1994
Methods: Econometric analysis
Results: This study found significant relationships between the following determinants and the inflation rate of the Consumer Price Index for health care services (CPI-HC): 1) the percentage of population over age 65 years has a positive impact on the CPI-HC; 2) the number of physicians per 100,000 population has a negative relationship on the CPI-HC; 3) the average malpractice premium has a positive impact on the CPI-HC; 4) Medicare coverage has a positive impact on the CPI-HC; 5) technological change has a positive impact on the CPI-HC; and 6) the Consumer Price Index inflation rate has a positive impact on the CPI-HC.
Uses: This study provides insight into the factors that impact health care cost inflation over an extended period. Identification of these factors allows policymakers to better understand the possible outcomes of decisions related to efforts to control the health care inflation rate and to identify possible targets for intervention that might affect that rate.
Limitations: None as presented

Rosenbaum S, Borzi PC, Smith V. Allowing small businesses and the self-employed to buy health care coverage through public programs. *Inquiry*. 2001; 38(2): 193-201.

Keywords: Health insurance tax credits and subsidies, Medicaid/public program expansion
Purpose: Propose a reform that expands the State Children's Health Insurance Program (SCHIP) to allow states to use the program to assist small businesses and the self-employed to purchase health insurance
Data and Methods: Commentary, not applicable
Results: This proposal suggests the development of publicly organized and subsidized group health insurance program for small firms with low-wage workers. The authors recommend that it be an extension of the SCHIP and that it involve federal financing. States would administer the program's framework and provide subsidies to both employers and employees. However, employers would be responsible for worker enrollment, insurer selection, premium payments and eligibility monitoring. Crowd-out concerns are addressed with required waiting periods for employer eligibility under certain criteria. Take-up estimates are discussed

Uses: Employer/employee subsidies are often suggested as policy options to increase the insured rate among the working poor; this discussion offers one such proposal.

Limitations: This proposal assumes federal funds for these state programs. Although there may have been a time when such funding was conceivable, there is little political interest in channeling funds to the states for this purpose at this time. Because this is a general proposal, there is no mention of how such a program would be funded and how the costs of this program weigh against the benefits; particularly in comparison to other options.

Short PF, Shea DG, Powell MP. A workable solution for the pre-Medicare population. *Inquiry*. 2001; 38(2): 214-224.

Keywords: Medicaid/public program expansion, Medicare reform, Pre-Medicare retiree population

Purpose: Describe a proposal to expand Medicare coverage to elders currently ineligible for coverage

Data and Methods: Commentary, not applicable

Results: This proposal calls for Medicare buy-in, pre-Medicare savings accounts and vouchers to offset premium costs for the uninsured pre-Medicare population. It proposes expanding access to Medicare to allow buy-in at age 62 years. The program would use community-rated premiums and would provide vouchers for low-income individuals. To address the rise in premiums as age increases, tax-preferred savings accounts would be used to help offset the increased cost burden. Although Medicare would be a buy-in option, the subsidies could be used to purchase coverage from other sources.

Uses: As the Baby Boomers approach retirement, the concerns of the near-retirement population become more pressing social concerns. Policy options that address these years are important concerns for health care reform.

Limitations: None, as presented. However, the authors describe the drawbacks of their proposed reform, which include the impact on the private insurance market and program administration costs.

Sky D. High risk pool alternatives: a case study of New Hampshire's individual health market insurance market reforms. *Journal of Insurance Regulation*. 1998; 16(4): 399-423.

Keywords: Risk pools

Purpose: Report on the risk subsidization mechanism used by New Hampshire to compensate for a smaller risk pool for the individual market

Data and Methods: Case study, not applicable; process discussed used risk adjustment methods

Results: Concern about the inherent disincentives present in high-risk pools for some groups of uninsured, prompted the New Hampshire Insurance Commissioner to request implementation of a risk subsidization mechanism. This mechanism determines appropriate subsidy levels used to compensate writers of individual health insurance policies for those who cover high-risk individuals. It also provides the means of financing these subsidies. This mechanism is reported to encourage a wider array of product offerings than would otherwise be offered and incorporates incentives for proper claims management and adjudication.

Uses: Informative as an alternative to classic high-risk pools as potential mechanisms to provide coverage for those unable to obtain coverage in the individual market.

Limitations: Because this is a case study, the results cannot be directly generalized.

Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34(6): 1331-1350.

Keywords: Preventive care costs

Purpose: Develop a model to estimate the direct and indirect effects of cost sharing on use of prevention services

Data and Methods: Pacific Business Group on Health survey (1994)

Results: Both copayments and coinsurance/deductibles had significant, negative indirect effects on preventive counseling in health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Only copayments had a significant, negative direct effect on preventive counseling and Pap smears in HMOs and PPOs; for mammography, only in PPOs. Cost sharing produced inconclusive effects on blood pressure screening. For those services with negative direct effects (Pap smears and mammography), it may be important to decrease or eliminate cost sharing in order to increase service use.

Uses: This analysis illustrates the dynamics underlying the use or non-use of prevention services. This is particularly relevant for us to consider as health plans and health plan purchasers increase copayments and deductibles in order to keep premium costs down.

Limitations: None as presented. However, this study, by focusing on econometric methods, glosses over the psychosocial determinants of health behavior that underlie their measured behaviors and that could provide additional understanding in the quest to predict and promote health prevention services

Swartz K, Garnick DW. Adverse selection and price sensitivity when low-income people have subsidies to purchase health insurance in the private market. *Inquiry*. 2000; 37: 45-60.

Keywords: Health insurance tax credits and subsidies

Purpose: Describe and investigate adverse selection and price sensitivity in a premium subsidy program, Health Access New Jersey

Data and Methods: Administrative data and enrollee surveys

Results: This study examines Health Access New Jersey, a short-lived premium subsidy program that subsidized purchase of health insurance in the state's individual health insurance market. Families with incomes below 250 percent of the poverty level who had no other available insurance options (eg, employer-sponsored or Medicaid/Medicare eligibility) were eligible for the program. The authors found no evidence of adverse selection as evidenced by comparison of health status. They did find that potential enrollees were price sensitive. Enrollment rates were lower among individuals at the higher eligible income levels—those who would receive lower subsidies.

Uses: Little information is available on the effects of subsidy programs. This study provides some indications of how recipients may behave when offered subsidies and can be useful in setting guidelines for future subsidy programs.

Limitations: None as presented

Weil A. Increments toward what? *Health Affairs*. 2001; 20(21): 68-82.

Keywords: Health insurance tax credits and subsidies, Medicaid/public program expansion

Purpose: Discuss how incremental approaches to health policy change function and examine the long-term impact of such approaches

Data and Methods: Commentary, not applicable

Results: Incremental policy change affects future policy options by impacting markets (both positive and negative effects) and by building institutions and expectations. This discussion focuses on five elements of incremental health policy reform: 1) who determines coverage options; 2) what risk pool the newly insured will enter; 3) governmental financial contribution toward coverage; 4) what barriers are created when efficiency becomes the goal; and 5) division of responsibility between government levels (federalism issues). It compares how tax credits and the State Children's Health Insurance Program expansion developed through an incremental approach to policy change and how these two policies might impact future possibilities for policy change.

Uses: This discussion warns us to consider the future ramifications of incremental policy change. Because systemic change failed, we are dependent upon incremental change for improving the US health care system. Weil cautions policymakers and others interested in the policy process to

consider carefully the choices made, or "settled for," because they may close off future policy options.

Limitations: None as presented

Wennberg JE, Fisher ES, Skinner JS. Geography and the debate over Medicare reform. *Health Affairs*. 2002; Web Exclusive: W96-W114.

Keywords: Medicare reform

Purpose: To explain and correct the geographic differences in Medicare spending

Data and Methods: Commentary, not applicable

Results: Medicare spending varies by geographic region, even after correcting for differences in health status. This study investigates several questions relating to the geographic differences in Medicare spending. The first question is whether the differences lie in illness differences among geographic area. Findings suggest that there are geographic differences for certain conditions and illnesses (but not for others) and that these differences could be used to adjust regional capitation payments to health plans and providers. The study also asked if medical practice patterns are different across regions and if the high-use areas provide higher quality care. The authors conclude that there are variations across regions but that high-use areas do not necessarily deliver higher quality care, nor does it ensure better health outcomes. Suggestions for reform included: increasing the use of effective care, improving medical decision making quality, and reducing supply sensitive care. The mechanism for addressing these goals was the creation of Comprehensive Centers for Medical Excellence.

Uses: Provides one approach to address geographic inequities in Medicare services.

Limitations: While the goals of this proposal are laudable, the resource costs of such a program would seem to be large and yet are not addressed by the discussion.