

**HAMILTON PROJECT Economic Policy Innovation Prize
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**Medicare & Medicaid Reform
Ensuring Long-Term Solvency**

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Abstract

Maintaining the long-term solvency of entitlement programs represents the greatest intergenerational challenge for the United States in the 21st century. Fundamental reforms are necessary to address the underlying cause of Medicare and Medicaid insolvency: excess cost growth in health care. Current budgetary decisions must be made against the backdrop of the unfunded liabilities of entitlement programs. Budget rules should be more comprehensive by including projections of future budgets and forcing Congress to vote on them; such maneuvers can create a political mindset for spending restraints, revenue increases, and other reforms.

A multifaceted policy regime can ameliorate the situation of fast-growing mandatory spending. The Centers for Medicare & Medicaid Services (CMS) could develop a premium support model in health care to control medical costs. Tax incentives should be given so low-income workers can save for their post-retirement health care expenses. In addition, the government’s legislative and executive branches should empower CMS to implement controversial reforms like the certification of cost-effective medical interventions and incentives for evidence-based medicine. Since such actions can be politically sensitive, CMS should be permitted to operate free of excessive political influence. A measure of autonomy would also facilitate improvements in the health agency’s administrative decision-making.

Introduction

Health care in the United States annually consumes over \$2 trillion, 16 percent of the nation’s gross domestic product (Poisal 2007). Medical spending is growing faster than the economy. These ballooning expenditures are compounded even further by a demographic wave as 78 million baby-boomers age, retire, and become eligible for Medicare. Medicare’s liabilities will exceed revenues by \$36 trillion over the next 75 years (Gregg 2008). In fact, spending on Medicare and Medicaid is expected to account for 13 percent of national income by 2040 (CBO 2007).

Tax increases alone will be unable to close the liabilities of Medicare and Medicaid. To sustain the increase in Medicare outlays expected by 2030, the federal government would need an across-the-board income tax hike of 36 percent (Capretta 2008). The resulting tax rates would reduce incentives to work and invest, dampen purchasing power, and affect the nation’s economic growth rate and standard of living. Consequently, the pursuit of health and its financial implications have become a critical priority for policymakers.

Moreover, the expenditures associated with Medicare and Medicaid do not necessarily achieve better health outcomes, demonstrating a lack of cost-effectiveness in America’s health care system. Every year, approximately 100,000 Americans die due to medical errors (Corrigan, Donaldson, and Kohn 2000). Despite the higher quality and efficiency associated with electronic medical records, fewer than 25 percent of providers have incorporated the use of health information technology (Wachter and Shojanian 2004). In 30 clinical categories which account for half of the reasons people seek care, only 55 percent of proven-effective therapies are administered to patients who need them (see Figure 1). Health care providers did not perform the other procedures and failed to meet the rest of the evidence-based medical benchmarks.

Medicare insures the recommended treatments, yet adherence to these quality indicators did not significantly vary between Medicare and non-Medicare patients (McGlynn et al. 2003). As the largest purchasers of health services in the United States, Medicare and Medicaid have the singular opportunity to use their substantial market clout and develop new cost and quality measures to leverage improvements in the entire medical delivery system.

Figure 1: Lack of Adherence to Recommended Care

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				
Preventive	38	6711	55,268	54.9 (54.2–55.6)
Acute	153	2318	19,815	53.5 (52.0–55.0)
Chronic	248	3387	23,566	56.1 (55.0–57.3)
Function				
Screening	41	6711	39,486	52.2 (51.3–53.2)
Diagnosis	178	6217	29,679	55.7 (54.5–56.8)
Treatment	173	6707	23,019	57.5 (56.5–58.4)
Follow-up	47	2413	6,465	58.5 (56.6–60.4)

* CI denotes confidence interval.

Source: Elizabeth McGlynn et al., “The Quality of Health Care Delivered to Adults in the United States,” *The New England Journal of Medicine* (2003)

Problem: Poor Value of American Health Care Spending

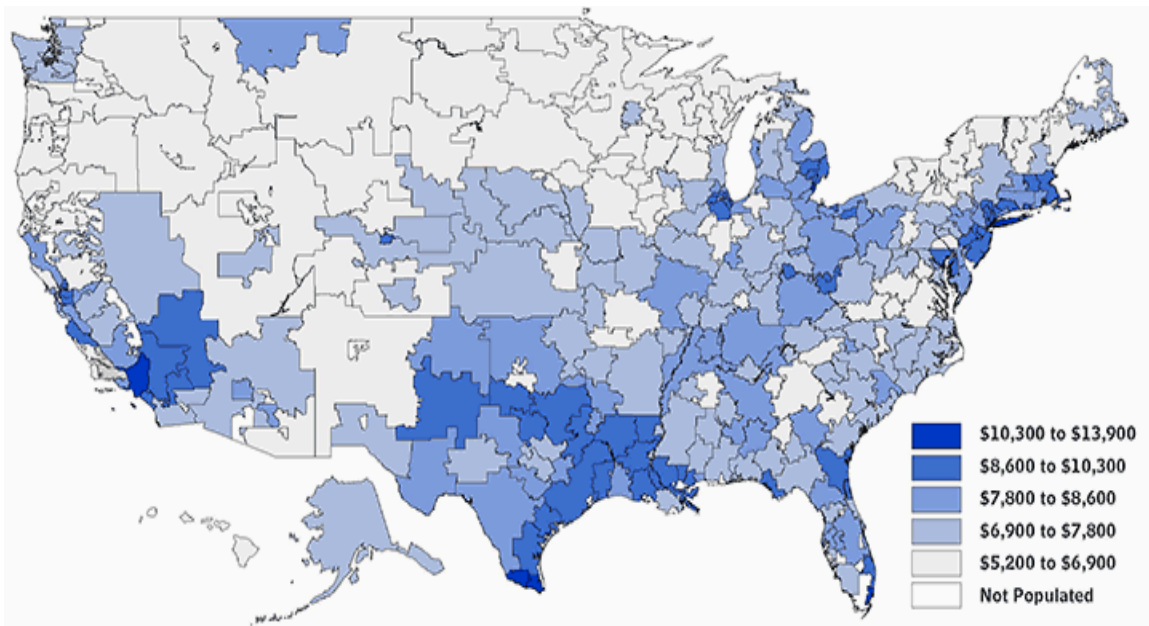
U.S. health expenditures per person are on an unsustainable path, growing at about twice the growth rate in per capita GDP (CBO 2007). Half of this excess cost growth is due to the rapid diffusion of new medical technologies (CBO 2008). In most industries, innovations unleash productivity and reduce costs as new technology displaces older equipment. In medicine, however, newer technologies like MRI machines are typically used along with today’s devices such as X-ray systems. Medical advances often expand the set of treatment possibilities, adding to overall spending (Greenspan 2007).

The new technologies may not be used on patients who would benefit the most, or they may be used on patients who would benefit equally from less expensive treatments. For example, the drug Avastin, which can cost \$100,000 per year for each patient, is currently proven to be effective for only breast, colon, and lung cancers, yet the therapy is frequently used by oncologists to treat all types of cancer (Kolata & Pollack 2008). System-wide reform is required to give innovators a compelling incentive to produce cost-effective medicines and procedures.

In addition to cost-increasing technology, health care expenditures may be spiraling upwards due to deteriorating productivity of medical service delivery. In most sectors of the economy, price markups are restrained by productivity gains. However, productivity in the provision of health care is greatly diminished when each provider is reimbursed “on the basis of services it produces rather than on what is done by all providers to address a patient’s medical condition” (Ginsberg 2008). Medicare’s fee-for-service system encourages providers to increase their incomes by maximizing the tally of procedures performed on each patient. Providers are incentivized to be efficient in the delivery of each service but are unconcerned with the number of services or the cost of other providers’ services involved in that patient’s care.

Across the United States, inefficiency in medical service delivery is underscored by the enormous geographic variation of per beneficiary Medicare spending (see Figure 2). For example, Medicare spending on chronically ill patients – those suffering from diseases like cancer, heart disease, and diabetes – in the last two years of life ranges from an average of \$93,842 at U.C.L.A. Medical Center to \$53,432 at the Mayo Clinic’s Minnesota hospital. Most of the discrepancies in regional expenditures can be explained not by the price of the services but by the number of health care services consumed. Medical utilization and expenditures in a particular region soar as capacity (local supply of hospital beds, imaging machines, physician specialists, etc.) expands. Furthermore, the increases in hospitalizations, doctor’s visits, and other “supply-sensitive” medical procedures in high-spending areas did not result in enhanced health outcomes. Since all of the surveyed beneficiaries suffered from the same outcome, it is highly implausible that illness intensity could explain such drastic variations in Medicare spending (Wennberg et al 2008). Many experts believe that without impairing health outcomes Medicare could save 30 percent if medical providers in high- and medium-spending areas were as efficient as those in low-cost regions (Wennberg et al 2002).

Figure 2: Medicare Spending per Beneficiary in the United States, by Hospital Referral Region, 2005



Source: Congressional Budget Office based on data from the Centers for Medicare and Medicaid Services.

It should be noted that some research disagrees with the traditional view that the higher number of services (or higher price of services) fails to produce improved outcomes. Another explanation for the regional divergence is that the variation reflects productivity spillovers in health care; some regions specialize for patients who need intensive care while other regions cater to low-cost patients. Advocates of this view argue that changing medical practices to mirror those of lower-cost regions would make patients who benefit from more expensive treatments worse off, while patients who would do better with less expensive treatments would gain (Chandra & Staiger 2007).

Even if the traditional view does not completely account for deviations in geographic health care expenditures, Medicare and Medicaid are nonetheless ripe for reform. The twin programs lack a payer process for preventive care. They also reward “the adoption of new medical technologies that while offering great hope to some patients also offer tremendous scope for overuse in others” (Chandra 2008). The public insurers create incentives for the potential overutilization of certain treatments while the proven-effective interventions are underused. This culminates in expensive, unnecessary complications and poorer health conditions. It is abundantly clear that the cost-effectiveness of Medicare and Medicaid could be greatly improved.

Confronting the Problem

Greater transparency in fiscal decision-making can encourage Congress to address the long-term deficits and debt posed by entitlement programs. Since much of the mandatory spending occurs in later decades, political bodies have an incentive to postpone action until a later date. Therefore, budget reforms are critical to foster an impetus for fixing Social Security, Medicare, and Medicaid.

Congress should enact an explicit thirty-year budget, which would be subject to review every six years, for the three entitlements (Antos et al 2008). A trigger provision would be included; whenever entitlement spending surpasses the allocated amount, the budget mechanism will automatically cut benefits, raise taxes and premiums, and/or cut reimbursement rates to providers. The legislative branch would decide which of the three options will occur and to what degree they will happen. If Congress chooses, it could adopt a formula for determining how the adjustments will be made. A Congressional vote and presidential signature of approval would be required to suspend the trigger. Such a device that demands an explicit vote will dramatize the need to modernize these entitlement programs to reflect budgetary realities.

A mandated Congressional vote would serve as a brake to slow down entitlement spending growth or at least weigh its benefits and costs relative to other policy priorities. As a result, lawmaking bodies will find it more difficult to escape from fiscal concerns. Comprehensive budgeting aims at creating a political environment conducive to curtailing discretionary spending, raising taxes, and reforming entitlement programs. Spending on Social Security, Medicare, and Medicaid would no longer be on autopilot and would be subject to overt political debate.

Reforming Medicare & Medicaid through Premium Support

Medicare and Medicaid should no longer remain an open-ended, fee-for-service program that entitles beneficiaries to health care services. This proposal incorporates a premium support model into Medicare and Medicaid; the government programs would no longer pay providers but instead make capped per person (capitation) payments to health plans (Aaron & Lambrew 2008). The two programs would be restructured into a public-private entity that provides eligible persons with health insurance. CMS will solicit bids from private health plans to insure beneficiaries. Insurance companies would offer a menu of approved health plans to eligible people, and individuals could then select an appropriate policy. These plans will compete with one another for consumers in different regional markets; this will restrain health care costs and promote quality in the sector. The government would make risk- and income-adjusted subsidy payments to plans that insure beneficiaries.

Under the status quo, private insurers have limited incentives to encourage preventive medicine and healthy behaviors in their enrollees because they will lose beneficiaries to Medicare once customers turn 65. Consumers also delay treatment until they are covered by Medicare. This exacerbates the intensity of chronic illnesses and contributes to higher long-term health costs for the public sector (Hammergren & Harkins 2008).

For example, osteoporosis tends to develop in persons in their 50s, but the symptoms (broken bones after minor falls) typically manifest after the age of 65. As a result, many insurers do not promote the use of biphosphonate therapies and other anti-bone degeneration drugs. For similar reasons, numerous health plans fail to cover screenings for type II diabetes, “a disease whose major expense comes from cardiovascular complications. These costs increase with age, and most of the expense is post-65” (Snyder 2008).

This proposal invites the private market into Medicare and Medicaid so health plans have a long-term stake in their clients. Since customers could stay with the same insurer after age 65, insurance companies would then have a renewed incentive to provide enhanced health management techniques to maintain their consumers’ wellbeing beyond the age of 65. Enrollment periods would be set up to prevent Medicare and Medicaid beneficiaries from switching to different insurance carriers too frequently. This way insurers reap the benefits of disease prevention, care management, and other investments which they make in their beneficiaries, without losing those potential cost savings to their competitors.

Determining the Basic Benefit

To submit a bid, insurers would have to meet certain guidelines. CMS would define the benefits that must be included in any basic insurance plan. The agency would also set the values for the deductible, the coinsurance rates, and the catastrophic limit on a beneficiary’s out-of-pocket health care spending. Private companies would be permitted to set their own cost-sharing rates provided that the alternative coverage structure is actuarially equivalent to the basic benefit. Medicare and Medicaid will adjust the mandatory covered services in the basic package to match fiscal realities and advancements in technology. Similarly, the agency will periodically update deductibles, coinsurance rates, catastrophic thresholds, and other charges to reflect growth in

health care spending and federal budget priorities. Any plans that offer additional benefits beyond the standard arrangement would be deemed as supplemental coverage. CMS would not subsidize the supplemental parts of plans (MedPac 2007).

By distinguishing between basic and supplemental benefits, a control variable is introduced for the rationing of medical resources. This distinction allows the government to exogenously allocate “part of the expenditure budget, leaving it to the public to set the rest” (Diamond 1994). To raise the level of cost-effectiveness in public health care expenditures, the government can classify cost-inefficient benefits (expensive medical interventions that achieve marginal health outcomes) under the supplemental category. This division would also refocus research and development into the creation of efficient medical alternatives because such technologies would be more likely to be covered for everyone in the basic plan.

Furthermore, a distinction between supplemental and basic benefits could also serve as a benchmark for comparing plans. All basic plans will be actuarially equivalent, so consumers have a guaranteed level of benefits. They could use that benefit level as a measurement for assessing the value of supplemental health plans, which they may or may not purchase. Consumers will be better able to discern supplemental health plans by evaluating those additional services (wider choice of doctors and hospitals, more complementary medical procedures, etc.) relative to the benefits they have under the basic package. A basic plan could potentially enable patients to make more informed decisions about their health and be smarter shoppers of medical insurance.

Every year, private plans would submit bids to CMS. These bids would reveal the plan’s expected benefit outlays and administrative expenses after subtracting for the estimated CMS reinsurance payments. Plans would project the expenses incurred for insuring a beneficiary of average health and then use that projection to make bids. The agency uses the bid amount to make modified payments based on the actual health status of each participant.

CMS would receive bid amounts from each basic plan and portions of plans attributable to basic coverage. After aggregating the bids, the agency ascertains a nationwide average. A standard premium will be established as some percentage of the average bid. Participants will pay the calculated standard premium plus or minus any differential between their plan’s bid and the national mean. Low-income participants would receive subsidies to pay for plan premiums and other charges.

Since consumers pay the differential between the plan’s bid and the national average, plans that submit bids below the nationwide mean can offer lower premiums and woo more beneficiaries. This would enable beneficiaries to keep more of the savings when they use a less costly plan that fulfills their medical needs (McClellan 2008). As cheaper plans gain market share, the weight of their bids will increase, restraining overall growth in the nationwide average bid (Norwalk 2005). The bidding process is engineered to place perpetual downward pressure on health care expenditures, reducing CMS’ payments to health plans.

This plan’s proposed form of managed competition and premium support can control health care costs and improve quality as demonstrated by the Medicare prescription drug benefit.

Under the Part D program, private plans compete with one another to insure the pharmaceutical needs of Medicare-covered customers. The cost of the benefit has turned out to be less than projected. The 2004 Social Security trustees report predicted that the Part D entitlement would cost \$85 billion in 2006 and \$93 billion in 2007. Instead, during each of those years, the actual price tag was around \$50 billion (Shultz & Shoven 2008). In fact, insurance companies submitted bids that were 10 percent lower in 2007 than the year before (Foster 2007).

Reimbursing Health Plans

For each enrollee, CMS would reimburse the health plan to cover a certain percentage of the basic benefit. This reimbursement would be manifested in the form of capitation subsidies, individual reinsurance, and risk corridor payments.

Capitation Subsidy:

In a capitation subsidy, the agency compensates health plans for each of their enrollees by making fixed, prospective payments that are risk-adjusted for the beneficiary’s age, sex, and health history. A plan’s bid would be modified according to the enrollee’s actual health status, and after subtracting for the beneficiary’s premium, the capitation subsidy is calculated (see Figure 3). On balance, health plans would be reimbursed more if they provided coverage to sicker, elderly participants and less for younger, healthier ones (Lueck & Zhang 2006). Medicare Advantage special needs programs already practice risk adjustment. Medicare pays private insurers \$4,075 for a healthy woman, but this figure rises to \$12,182 if she has circulatory problems caused by diabetes. With risk-adjusted payments, adverse selection problems are mitigated, and health plans have less incentive to evade the sick (Phelps 2003).

Instead, organizations would push the chronically ill to visit physicians frequently and take medications and other steps to prevent costly hospitalizations and emergency room visits. Plans that failed to reduce hospitalizations would face higher costs, and consumers would switch to more cost-effective plans. A capitation payment encourages a payer process for preventive care, giving health plans a financial incentive to keep enrollees well. If health plans are successful at reducing health care costs through better prevention and disease management, they retain the savings, which can in turn be used to lower premiums or offer more benefits to attract beneficiaries. Insurers would also encounter pressure to eschew expensive technologies that confer marginal health benefits and eliminate duplications and errors in medical procedures (Emanuel & Fuchs 2007). By forcing insurers to develop innovations in care management and healthy living, capitation payments will yield productivity gains in health care.

Supplanting the fee-for-service system of Medicare and Medicaid with a fixed, capitated reimbursement to health plans would also improve the efficiency of health care delivery coordination. This end is likely to be achieved by integrating the actions of all providers in addressing a patient’s medical condition. Under a capped payment scheme, health plans would be encouraged to “steer patients away from high-resource/high-volume providers” toward more efficient networks of hospitals and physicians (Wennberg et al 2005). This will limit the “overuse of supply-sensitive care” and could result in gains in health care quality and system efficiency (Wennberg et al 2005).

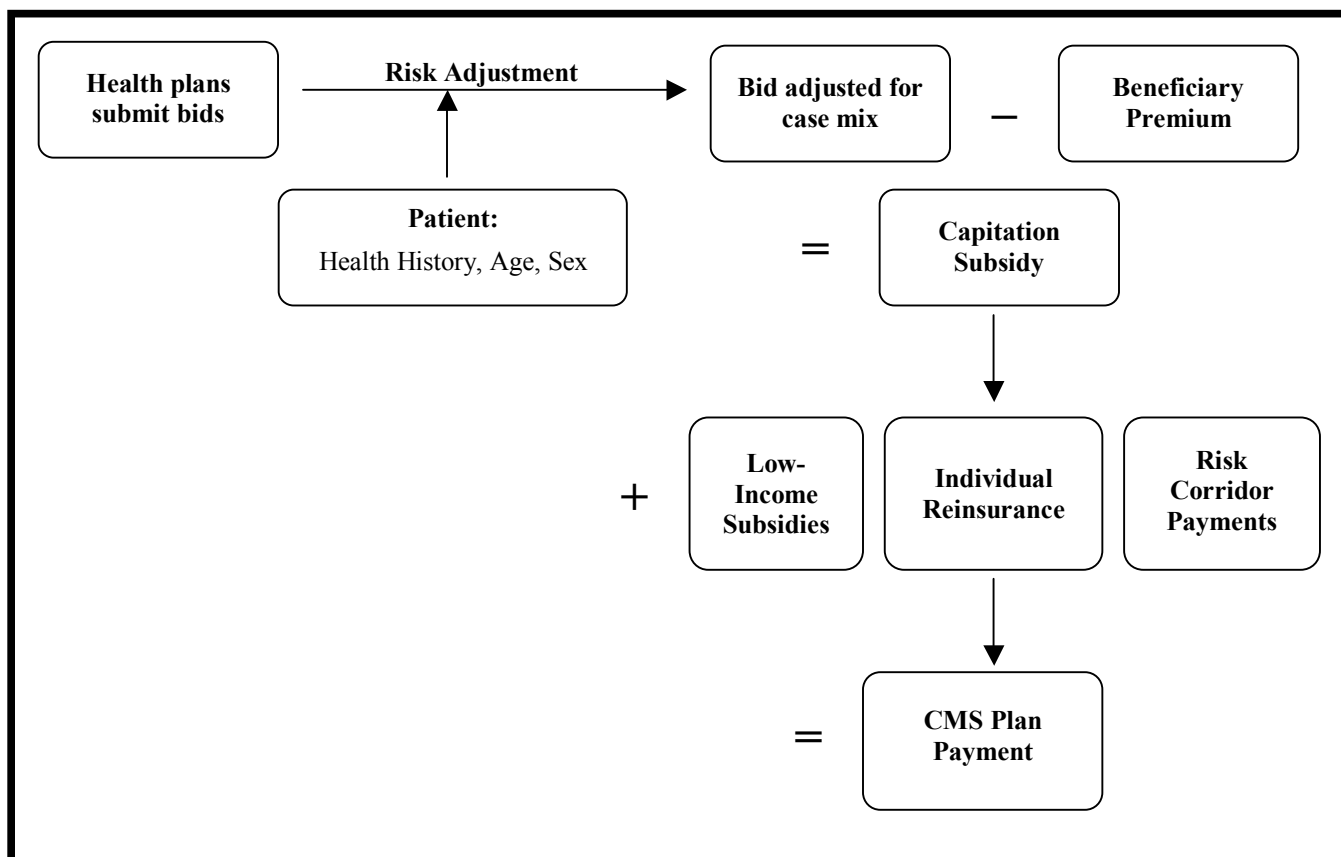
Individual Reinsurance:

With individual reinsurance, CMS provides an additional, retrospective payment by subsidizing the vast majority of spending above the catastrophic limit, giving insurers a stronger incentive to enroll high-cost patients (Piper 2006).

Risk Corridors:

When health plans insure high-risk populations like the elderly and the poor, they may face higher-than-usual costs like the unexpected cost and utilization of medical interventions as well as other uncertainties. A third payment scheme – risk corridors – could be introduced to mitigate these concerns. Risk corridors would cap the losses or gains of each plan. Analogous risk corridors were initiated when Chile privatized its pension system; the Chilean government regulates the losses of private pension funds so each fund achieves at least a target rate of return (Diamond 1996). If a plan’s claimed benefits exceed its bid, CMS would subsidize a portion of the losses. Conversely, if a plan’s expenditures are below the bid amount, the agency reserves the right to limit the plan’s profits. Proposed risk corridors could be broadened over time to make health plans gradually bear more of the risk.

Figure 3: Plan Payment Scheme



Limiting the Administrative Costs of Plans

Competition between plans can lead to elevated administrative costs, which includes sales promotion efforts, eligibility determination, enrollment, and premium-collection (Diamond 1992). Under this proposal, such expenditures will be reduced by having plans deal with the marketing while the government manages eligibility issues, enrollment, and premium-collection activities. A standardized process will reap economies of scale by utilizing Medicare and Medicaid’s existing infrastructure for verifying eligibility, registering individuals, and collecting premiums (CBO 2002).

Preserving the Safety Net

Cost-sharing charges and supplemental insurance are significant out-of-pocket costs for beneficiaries, especially for low-income, elderly, and chronically ill populations. Tax incentives should be devised to encourage low-income earners (those with incomes up to 300 percent of the poverty line) to save for their post-retirement medical costs. Since many low-income workers pay no income tax, a matching tax credit should be created for every dollar they put into savings. Such a subsidy scheme could attract participation rates of 20 to 40 percent of low-income workers (Fishman et al 2008).

Any reforms of Medicare and Medicaid should not put an undue burden on lower-income groups. Medicaid participants who earn incomes up to 100 percent of the poverty threshold would face no deductibles or coverage gaps. Medicare recipients who pass an asset test and have incomes below 150 percent of the poverty line would be eligible for full or partial assistance with premiums, coverage gaps, and other cost-sharing (Summer et al 2008). However, it must be acknowledged that income and asset eligibility requirements can expose all but the poorest individuals to considerable out-of-pocket expenses, thus limiting the resources available for non-care consumption (Brown & Finkelstein 2008).

Comparative Effectiveness

CMS should embrace the concept of comparative effectiveness to check the use of costly medical technologies, curb excess cost growth, and improve the cost-effectiveness of dollars spent on health care. Such studies determine which treatments work best for which patients, helping to avoid unnecessary or more costly care. Comparative effectiveness research can also help inform whether the added benefit of more effective, but more expensive, treatments is adequate to justify the higher costs. Rigorous cost-benefit analyses could rein in health care costs without adversely affecting health outcomes (*The New York Times* 2008).

Medicare, Medicaid, and their partners in the private sector should not have to insure costly medical interventions that only marginally improve health outcomes. Until recently Medicare reimbursed surgeons for osteoarthritis procedures. However, comparative effectiveness studies showed that surgery for osteoarthritis is no better than placebo (*Time* 2008). Research also indicates that older and cheaper anti-psychotic treatments are generally as effective as the latest, expensive pills (Lieberman et al 2005).

Another analysis overturned long-standing medical wisdom. Patients with stable coronary-artery disease were subjected to two rival treatments: the conventional approach of angioplasty and drugs, or the drugs alone. The medicines by themselves achieved the same health outcomes, measured by heart attacks and survival rates, as the more invasive, costly action (Boden et al 2007).

CMS should evaluate the cost-effectiveness of drugs, devices, diagnostic tests, and other procedures in the treatment of a particular condition. The agency should also sponsor research into how those technologies should be deployed in clinical settings. The federal government must devote a significant, constant funding stream to the Center for such studies. Any medical intervention that is covered under the basic benefits package should have to meet parameters of clinical effectiveness, appropriateness, and cost-effectiveness. CMS would issue certifications for medical technologies to indicate for which situations they are proven to be effective, as well as their cost-efficiency relative to other treatment options. This would convey invaluable information to health care consumers, insurers, and providers.

In addition, Congress should legislate a fiscal ceiling for a quality-adjusted life-year (QALY), which is an additional year of life discounted for disability, pain, side effects, and other handicaps. A medical service with a price per QALY that exceeds the limit would not be included in the basic plan, sending a signal to drug and medical device companies to shift their research and development priorities toward cost-effective interventions (Emanuel & Fuchs 2007). Such absoluteness and predictability for future coverage decisions would also reduce the uncertainty that innovators endure over which interventions will be insured when their products reach the marketplace. This will lessen their need to recover costs as quickly as possible through high prices. The promotion of efficient medical practices would over time moderate technology's cost-increasing impact on health care spending.

Comparative effectiveness research should also lead to the promulgation of evidence-based standards for the medical community (both in procedures and equipment). These best practice guidelines could slash health care spending by 30 percent, roughly \$700 billion annually (Orszag 2008). CMS should create incentives for the adoption of standards by reducing payments to health plans that do not adhere to optimal clinical practices. This will ensure value-based purchasing in America's health care system.

Granting Autonomy to CMS

Congress should grant CMS a level of autonomy on par with what the Federal Reserve presently enjoys. A policy of political insulation will enable improvements in the decision-making of the twin insurers. Currently, Congress has to periodically set payments for oxygen tanks and a host of other medical supplies and procedures. As a result of its slow-paced and deliberative nature, political bodies may not be as responsive to the needs of providers and patients. An independent agency could commission studies and establish coverage decisions and reimbursement rates accordingly.

Rather than just responding to changes in the health care industry, an independent CMS could harness its massive buying power to drive reforms of the entire medical sector. CMS

would perform research into improving risk adjustment techniques when making payments to health plans. CMS could actively collaborate with professional health care providers to establish evidence-based, best practice guidelines in medicine. CMS could then experiment with alternative ways to reimburse health plans based on how well they accord with optimal medical practices. CMS would also have the flexibility to engineer waivers for a multitude of demonstration projects on a local, state, or national basis to see which health care policies work and which ones do not work.

Autonomy would facilitate CMS’ ability to serve a crucial oversight role in health care. The federal bureaucracy would collect data about health outcomes, cost, and other quality indicators from health care plans and providers. The agency would guarantee the accuracy of the information and make it accessible to the public. This would create a common platform allowing lawmakers, consumers, providers, and insurers to assess cost-effectiveness across health care groups. If CMS were to specialize in technical decisions, Congress would be free to refocus its efforts on the establishment of overall health care policy.

In addition, a self-directed health care agency could better implement the findings of comparative effectiveness studies. All too frequently, CMS is unable to carry out controversial administrative decisions because of undue influence from political bodies. Contentious decisions made by the Center are often subjected to intense scrutiny by Congress and the executive branch. These groups may even overturn agency decisions in order to placate vested interests. For example, in 2007, Medicare demanded evidence of clinical benefits before reimbursing any more CT heart scans. This directive resulted in fierce lobbying by cardiologists until Medicare relented and revoked its original decision (Berenson & Abelson 2008).

Britain’s National Institute for Health and Clinical Excellence (NICE) is instructive. NICE uses comparative effectiveness studies in deciding whether to insure for drugs and medical devices. Recently, NICE refused to approve the use of four cost-ineffective kidney cancer drugs, provoking a vociferous uproar from patients and medical provider constituencies (*The Economist* 2008). Since the British health agency is sufficiently detached from the political system, it was able to put into practice the results of its comparative studies and adjust payments to providers according to cost-effectiveness data.

For comparative effectiveness to thrive in the United States, Congress should grant CMS a similar level of autonomy. This would increase the likelihood that trials are insulated from political interference, while encouraging the introduction of value-based purchasing policies in health care. Sufficient independence from political bodies will allow the health care agency to enhance its organizational decisions as well.

Conclusion

This comprehensive policy regime encompasses many strategies to improve medical quality, curtail excess cost growth in health care, and promote the long-term solvency of Medicare and Medicaid. Budget rules are reformed to engender fiscal transparency in entitlement programs. A competitive bidding process and a premium support model are established to contain health care costs. Tax incentives are introduced to augment the post-retirement medical

savings of low-income workers. Furthermore, institutional reforms are initiated so an autonomous CMS can improve its decision-making and implement controversial decisions like the certification of cost-effective health interventions and incentives for evidence-based medicine.

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