'RESPONSIBLE CHOICES':
THE JACKSON HOLE
GROUP PLAN FOR
HEALTH REFORM

by Paul M. Ellwood and Alain C. Enthoven

Prologue: More than two decades have passed since an informal panel of distinguished health professionals, government officials, business leaders, academics, and other experts began convening in the Teton Village, Wyoming, living room of Paul Ellwood. Ellwood founded and led InterStudy, an organization formed in 1973 for the purpose of researching and promulgating the concepts of competition in health care delivery. The Jackson Hole Group, which incorporated separately from InterStudy in July 1992, provides a forum under the leadership of Ellwood and longtime collaborator Alain Enthoven for rich discussion and debate. The group’s 1991 publication, The 21st Century American Health System, contained the concept of “managed competition” that formed the basis of several health care reform proposals, including that of President Bill Clinton. The Jackson Hole Group continues to host national health care forums two to four times a year, attracting a wide cross-section of participants from the health care industry, academia, federal and state governments, and business. In this paper Ellwood and Enthoven outline “Responsible Choices,” the Jackson Hole Group’s latest proposal for nationwide health system reform. In this version, the authors state, “[t]he Jackson Hole Group has not bucked away from its commitment to adequate health protection for everyone.” Rather, they continue, once some of the serious problems of the marketplace are addressed, “we can better identify and deal with those still left out of the system.”

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Abstract: “Responsible Choices” identifies the actions that the private sector and government should take to improve the U.S. health care system and accelerate and expand the health care revolution that is already under way. Policy proposals are made for Medicare; Medicaid; reforming the tax treatment of health insurance; insurance reforms and expanding group purchasing opportunities; and improving the availability of comparative information on health benefit offerings, quality accountability, and cost and coverage data. The recommendations refocus the Jackson Hole Group’s original managed competition proposals contained in The 21st Century American Health System (1991).

The United States has been rapidly transforming health care by implementing a market-driven system that works—a unique approach that has reduced rate increases for private purchasers and consumers of medical services. The market works in health care because multiple purchasers, not just the government, can introduce bold new methods of buying health care and because providers and insurers can respond with new approaches to organizing and paying for care.

This evolution, turned revolution, which has been under way for at least twenty-five years, is being driven by corporate purchasers and cost-conscious consumers. It has created an extraordinary array of health plans aggressively competing with one another on price and quality. This is evidenced by the fact that health maintenance organization (HMO) enrollment has grown by 30 percent since the Jackson Hole Group wrote its original managed competition proposal in 1991. However, some consumers—such as most Medicare beneficiaries, persons with preexisting illnesses, and the employees of small firms—are not fully benefiting from this health care revolution. Despite being the largest single purchaser of health care, the federal government has been particularly slow in bringing public programs in line with those in the private sector.

“Responsible Choices,” the Jackson Hole Group’s latest proposal, has five objectives: (1) to align Medicare and Medicaid costs with revenues, while offering public beneficiaries the same cost-conscious choices now available to private consumers through employers or purchasing groups; (2) to make the tax benefits of health insurance coverage equitable, while increasing consumers’ awareness of cost and quality through a value-based tax credit for health coverage; (3) to give individuals and employees of small firms, regardless of their health status, the same opportunity to purchase reasonably priced health insurance that large-group purchasers have; (4) to ensure that consumers know what the various health plans offer in terms of benefits, consumer satisfaction, access, and health outcomes; and (5) to set timely, realistic targets and measure results as reform proceeds.

“Responsible Choices” does not promise health insurance for everyone, since that is an impossible goal without raising taxes, creating unfunded mandates, or prolonging the deficit. The Jackson Hole Group has not backed away from its commitment to adequate health protection for every-
one but proposes that once the size of the problem is decreased and understood, we can better identify and deal with those still left out of the system.

These recommendations are not based on untested economic and social theory but are taken directly from actual clinical and operational experience gained in providing health care and health insurance to more than 100 million Americans. The various pieces of the plan can be implemented as stand-alone proposals. However, they will most effectively generate progress and improvement in the health care system if implemented in this comprehensive, incremental manner.

**Twenty-First-Century Medicare**

Medicare expenditures were $160 billion, or 2.4 percent of gross domestic product (GDP), in 1994 and are projected to grow to $460 billion, or 4 percent of GDP, by 2005. Meanwhile, private-sector HMO premiums, driven down by employer purchasers, are projected to decline, on average, 1.2 percent in 1995. From experience in Medicare and the private sector, we know that further raising of deductibles and coinsurance is unlikely to decrease program costs significantly and surely will lead to beneficiary dissatisfaction. Relying on congressionally mandated changes or perhaps giving the Health Care Financing Administration (HCFA) more discretion in modifying payments and incentives to physicians and hospitals may lead to a modest, though unpredictable, reduction in cost. The Jackson Hole proposal focuses on moving away from traditional Medicare as soon as possible without threatening seniors’ health or scope of coverage. It assumes that, like employers, Congress will expand health plan options and will encourage seniors to choose more economical sources of care.

**The new Medicare approach.** The proposed new Medicare structure is based on two principles: First, the Medicare program should be patterned on the private business sector’s successful experience in making the transition from traditional indemnity insurance (analogous to traditional Medicare) to cost-conscious consumer choice among health plans that compete on price, quality, and customer satisfaction. Second, real cost savings can be achieved while increasing benefits and seniors’ satisfaction. Reducing Medicare’s exponential rate of cost growth would be gradual at first but would become significant following a major shift to new Medicare in the year 2000.

The first four years of the new program should be used to install the necessary health plan choices and quality assurance system, to get health plans competing with each other, and to help seniors make the transition from traditional Medicare to a new Medicare system based on choices among competing plans. We estimate that this new Medicare approach can
produce potential savings of $272 billion by 2002 and $671 billion by 2005.

**Step one: Separate health plan payments from traditional Medicare program costs.** Medicare health plan premiums are now linked to traditional Medicare indemnity costs, so savings accrue only to the extent that cost growth in the traditional program is reduced. Exhibit 1 shows the Congressional Budget Office (CBO) baseline, estimated to increase approximately 9 percent per capita per year in the absence of program reforms, as a reference.

Medicare should change to a new payment method for health plans. During the transition, payments to health plans would be disconnected from traditional Medicare payment levels. Traditional Medicare would then continue to follow the CBO baseline, unless congressionally mandated changes or HCFA management can do better. Medicare payments to health plans would be permitted to grow 5 percent per year, beginning in the first year with a payment level at 95 percent of what the government pays traditional Medicare. This should not hinder managed care growth in areas with low average annual per capita costs. In fact, based on our analysis of Medicare health plan market penetration, health plans do succeed in enrolling beneficiaries in areas where Medicare capitation rates are lower.4

The new Medicare baseline curve in Exhibit 1 shows the combined effect of this transitional policy. The projections do not assume any other modifi-

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**Exhibit 1**
Separating HMO Payments From Fee-For-Service

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare outlays (billions of dollars)</th>
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<tbody>
<tr>
<td>1994</td>
<td>140</td>
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<td>1995</td>
<td>190</td>
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<td>1999</td>
<td>390</td>
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<td>2000</td>
<td>440</td>
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Notes: New Medicare annual savings in 2002 are $93 billion ($272 billion cumulative); in 2005, $156 billion ($671 billion cumulative). Extra annual savings with competitive bidding in 2005 are $28 billion ($77 billion cumulative). Assumes health maintenance organization (HMO) payment growth of 5 percent and a fee-for-service cap in 2000.
cations to traditional Medicare, because experience has shown that there is little long-term savings from making the changes that were typical of past years. However, actual health plan premiums would be based on market rates, so beneficiaries choosing a plan that costs more than the government contribution would have to pay any additional amount, while beneficiaries choosing a less costly plan would be refunded the difference.

**Step two: Encourage Medicare health plan enrollment.** To encourage Medicare beneficiaries to join a health plan, plans should offer a more comprehensive benefit package. The benefits should be similar to the HMO benefit package, including prescription drugs and reduced deductibles and coinsurance, which should eliminate the need for additional Medigap coverage and the confusion over who should pay doctor and hospital bills.

The HCFA management team may face a conflict of objectives in both promoting health plan options (thereby decreasing the number of beneficiaries in the traditional program) and continuing to manage traditional Medicare. Therefore, it may be necessary to separate the management of new Medicare from that of traditional Medicare by creating a new office within the Department of Health and Human Services.

**Step three: Ensure competition.** An annual open enrollment period should be established to ensure that each beneficiary has a choice among all participating plans, including traditional Medicare. Seniors should be given information on health plan quality measures, including beneficiary satisfaction data, to facilitate informed decision making. The private sector is increasingly focused on quality and outcomes of care, so the same quality assurance systems that are employed by the private sector can be used by government.

**Step four: Invest in beneficiary education.** Any restructuring of Medicare will fail unless the public, and especially seniors, are convinced of the benefits of a more rational, efficient, high-quality health care system structured around competitive health plan choice. The federal government therefore must educate seniors on the new Medicare choices available. Private-sector groups, especially organizations that traditionally have served seniors, should be allowed to function as benefit managers to strengthen leverage for Medicare recipients, to provide comparative information on health plan choices, and to educate beneficiaries.

**Step five: Move to a per capita government contribution based on competitive market rates.** Under this proposal, we estimate that new Medicare health plan per capita costs to the government in 1999 would be, on average, $1,290 less than the cost per traditional Medicare beneficiary. Since health plan market penetration should then be sufficiently high that plans will be familiar to and acceptable to most seniors, traditional Medi-
care payments from the year 2000 should be based on the new Medicare health plan rates. It is anticipated that by 2000 competition will be such that health plan market rates will be below the administratively set government contribution, which should then become based on market rates through a bidding process. The effect of this policy change is shown in Exhibit 1. If desired, a market-based government contribution could be adopted earlier in high-cost Medicare areas with high managed care penetration. Conversely, it may be appropriate to delay the introduction of a market-based government contribution in areas where Medicare rates are low.

Seniors would continue to have the option of traditional Medicare but would be responsible for paying any amount in excess of the government's contribution. Similarly, if some private plans found it necessary to charge more to deliver the more generous HMO benefit package, they would be free to do so, but the beneficiary would again pay any difference in premium cost. Conversely, any health plan able to provide the covered benefits for less than the government payment could rebate the difference to the beneficiary. Our analysis shows that by increasing choice of private health plan options and by initially controlling the rate of growth in Medicare health plan payments but ultimately moving the whole program-traditional and new Medicare-to a government contribution in 2000 based on health plan premiums, Medicare can save approximately $272 billion by 2002 and $671 billion by 2005, without going through the political trauma of trying to drastically change the course of traditional Medicare. The annual savings under new Medicare over time will exceed those of a program designed to lower the rate of per capita Medicare cost growth from 9 percent to 6 percent immediately, as shown in the 6 percent program cap reference curve in Exhibit 1. With the addition of market-determined premium contributions in 2000, we estimate potential savings of $285 billion by 2002 and $748 billion by 2005.

Encouraging State Solutions For Acute Medicaid

While Medicaid is further along than Medicare in bringing managed care options to beneficiaries and promoting effective price competition, states' progress with the acute care portion of Medicaid has been impeded by the federal waiver process and the lack of health plan availability. The nation spent $82 billion, or 1.2 percent of GDP, on Medicaid in 1994, and spending is projected to increase to $234 billion, or 2 percent of GDP, in 2005. To accelerate the use of competitive managed care for the acute care portion of Medicaid, Congress should grant states the authority to make the transition to managed care for Medicaid without obtaining waivers.
The federal government should give states per capita grants (a fixed amount per eligible beneficiary) for the acute Medicaid program. To facilitate state management of the program, the federal government should specify in advance the rate of growth in the federal share of the capitation rate. If the current GDP growth rate and inflation remain the same, this could be set at 6.5 percent per year in 1996, 6 percent in 1997, and 5 percent in 1998. These ground rules should be reconsidered if managed care premiums begin to decline to the same extent that they are now declining in the private sector or if there is a drastic change in the number of people eligible for Medicaid. States should face a maintenance-of-effort requirement in determining their contribution based on fiscal capacity. In addition, disproportionate-share payments to states should be phased down from the current level of 14 percent to about 4 percent over a period of five to seven years.7

Medicaid eligibility requirements should be federally determined, but scope of benefits should be set by the states. States could adopt the proposed benchmark benefit package that is described below. In addition, states could require standardized quality accountability by participating health plans and thereby ensure the availability of comparable information, which is essential to consumer choice.

Reforming The Tax Treatment Of Health Insurance

The unlimited exclusion of employer-paid health care and insurance from the taxable incomes of employees makes the additional cost of more costly coverage lower to employees, inducing them to choose more costly coverage than they would if they were using their own money.

**Tax cap.** The natural solution is to cap the exclusion: Set limits for individual, couple, and family coverage and legislate that employer contributions above the limit must be included in taxable income. At the same time, repeal Section 125 of the tax code, which allows employees to shelter funds spent on health care, so that the total tax-sheltered premium—not just the employer’s part—is limited by the cap. This would motivate consumers to be responsive to the full differences in premiums.

Numerous issues, such as the perpetuation of “job lock,” arise in connection with such a tax cap. However, job lock helps to perpetuate a desirable pooling of “good risks” (with low expected medical costs) with “bad risks” (with high expected costs). A tax cap also would give more incentive to become insured to people in higher tax brackets, who need the incentive less, and less incentive to lower-bracket people, who need it more.

**Tax credit.** These shortcomings have led people to propose replacing the exclusion with a refundable tax credit, available only to those who buy
coverage that meets certain criteria. Again, Section 125 would have to be repealed. Taxpayers would be allowed to reduce their tax bill by a fixed amount (or by an amount determined by a formula) if they met certain conditions. Individuals would get cash refunds if the credit exceeded the rest of their tax bill.

The tax credit approach offers some distinct advantages over the tax cap: (1) It would end job lock by providing portability of the tax subsidy. The credit would be available to the self-employed, the nonemployed, and those whose employer does not provide health insurance. (2) Both low- and high-income persons would receive the same credit, and it could be designed so that the poor could receive more. (3) The existence of a tax credit for the nonpoor would ease the work disincentive associated with the reduction of benefits as subsidies for low-income people are phased out. (4) It could be characterized as giving people something in exchange for the abolished exclusion, as opposed to a tax cap, which some perceive as taking something away.

**Tax credit structure.** Under one version of the tax credit, Congress would pick a dollar amount that reflects the price of an efficient, comprehensive health plan meeting federal standards in most parts of the country, say, $4,000 per family. Next it would pick a percentage for the credit that would make the whole program a budget-neutral trade for the exclusion, say, 25 percent. A family buying coverage of up to $4,000 could take a tax credit equal to 25 percent of the premium. This would give everyone an incentive to buy coverage up to the $4,000 amount. Above that amount, people would be required to use their own money, so they would be cost-conscious. In another version, Congress would set a fixed-dollar credit amount for individuals, couples, and so forth, which would be a budget-neutral replacement for the exclusion, say, $750 per family per year. The whole credit would be available to anyone buying coverage that meets federal standards.

**Potential problems.** Converting to a tax credit direct to individuals could weaken the “glue” that holds insurance purchasing groups together and threaten the employment-based group purchasing system, because good risks might demand their employer contributions in cash and seek better rates elsewhere. Pooling of health risks within groups might be destroyed, although some employers might resist this, preferring to keep their risk pool together and their average costs per employee down by refusing to turn employer contributions into cash. Persons not covered through employment groups (including those who successfully took their cash out of the group) might face an insurance market beset by the pathologies that we observe in today’s individual and small-group markets.

**Tax credit linked to group purchasing.** The tax credit should be
structured so as not to dismantle the group purchasing system. If an employer offers coverage, the credit should be available only if the employee purchases insurance through that employer. Employers might be mandated to offer, but not necessarily pay for, several coverage options and could do so by contracting with a voluntary certified purchasing group. The self-employed, nonemployed, or those whose employer does not offer health care coverage should be able to use the credit independently in the individual market or through a voluntary certified purchasing group.

Catastrophic Coverage And Medical Savings Accounts

There has recently been some enthusiasm for the combination of insurance coverage with high annual deductibles (for example, $3,000), known as “catastrophic coverage,” and tax-favored medical savings accounts (MSAs) to encourage people to set aside the money needed to pay for care below the deductible. The idea is that if consumers were using their own money to pay their own bills, they would be more cost-conscious in their use of care. If they could have tax-favored MSAs, they would be more likely to accept high-deductible policies.

Catastrophic coverage would do little to moderate cost growth in the long run. Most spending is concentrated on very few sick people, beyond the cost-reducing incentives of the deductible. In 1993, 80 percent of total health care spending was spent on the 15 percent of people who incurred the highest costs, with expenses exceeding $3,050.10 As soon as someone is diagnosed with a condition he or she knows will cost more than $3,000 to treat, the additional cost of more care for the whole family is zero, so the incentive to economize on care is gone.

Catastrophic coverage also would increase costs that result from lack of preventive services and early detection and treatment. For example, a recent study of acute appendicitis patients in California found that patients covered under indemnity insurance were 20 percent more likely than those in prepaid (first-dollar) plans to develop ruptured appendices.” The important opportunity for savings is not in deterring primary care, but in motivating doctors to provide high-cost care only when it is appropriate.

The $3,000 deductible policy would be especially attractive to the healthy and wealthy. The bad risks would increasingly bear the burden of the additional costs associated with their care. In a spiral of increasing costs and higher risks, first-dollar coverage would be driven from the market. Do we want people with costly chronic conditions to have to pay $3,000 more per year out of pocket than those who have the good fortune to be healthy?

Tax-favored MSAs raise a number of additional problems. A dollar increase in deductible does not translate into a dollar decrease in premium.
The additional money to fund an MSA would increase tax losses to the federal government. Consumers’ out-of-pocket health expenditures in 1993 were $158 billion, much—though not all—of which would be eligible for tax shelter. After-tax MSAs. The Jackson Hole Group tended to object to the approach advocated by proponents of the tax-favored MSA theory because it favors one form of health insurance—catastrophic coverage—and because it would encourage good risks to leave the risk pool. But, recently, Mark Pauly and John Goodman (one of the architects of the MSA idea) proposed a new version that is much more neutral and less likely to split the risk pool. Therefore, this might be an approach worth trying.

Under the Pauly/Goodman approach, Congress would set a fixed-dollar tax credit amount (presumably one for individuals, one for couples, and so forth). The whole credit would be available to anyone buying coverage meeting standards that would include a deductible no higher than, say, $3,000 and a requirement that anybody choosing a plan with a deductible (possibly above another threshold, such as $200) would have to fund the deductible up front with after-tax dollars in an MSA. Because the $3,000 deductible would continue to be attractive to the healthy and wealthy, risk selection should be monitored and an appropriate remedy employed if a problem occurs.

Insurance Reforms And Group Purchasing

Purchasing groups offer a proven, powerful tool for structuring a competitive, well-functioning market, including the creation of a market with choices among competing health plans, side-by-side comparisons, comparative information about cost and quality, standard coverage contracts, equal rating rules, and economies of scale that result in significantly reduced administrative and marketing costs. While large employers now enjoy these benefits, the small-group and individual market has largely been unable to realize the advantages of group purchasing.

National standards. A prerequisite to effective group purchasing is a set of uniform market rules or standards, for the following reasons. First, health care markets do not adhere to state boundaries. Second, the preponderance of large multistate employers reinforces the need for a federal framework. Moreover, state regulations designed to monitor traditional insurance carriers are outdated. Enforcing uniform federal standards, however, would be a logical extension of the state’s traditional role as insurance regulator. Finally, and perhaps most importantly, national standards are needed to uniformly shift the basis of competition from risk avoidance to the delivery of cost-effective, high-quality care.
Insurance reforms. National standards should begin with enacting those insurance reforms at the federal level that have already been implemented in most states—for example, guaranteed issue, renewal, and portability of all insurance products; limitations of preexisting condition exclusions; and limited rating restrictions (not community rating). Portability and continuity-of-coverage provisions are particularly important because they reward those already in the system by improving access to coverage while fostering a more competitive market by allowing people to change plans more easily. Federally defined insurance reforms should serve as minimum standards and should not preempt state-level reforms that go further.

ERISA. These reforms should apply to all health plans regardless of risk-bearing arrangements, including self-funded plans under the Employee Retirement Income Security Act (ERISA). Guaranteed issue, for example, would not mean that a self-insured plan would have to take anyone who wanted to join. Self-insured plans would, however, not be able to deny coverage to a sick employee or family member based on health status. ERISA plans should have to abide by marketplace rules relating to portability and should be subject to solvency standards that ensure an appropriate level of capital reserves. Although they should be required to adhere to the basic uniform standards that are applied across the state-regulated market, states should be prohibited from taxing ERISA plans to finance efforts to expand coverage, since doing so would penalize those employers already providing coverage for their employees. Employee family members should have the option of purchasing coverage through the plan. However, employers should in no way be required to pay for such coverage.

In addition to insurance reforms, all health plans, including ERISA plans, should adhere to uniform quality reporting standards adopted by the health industry.

Certifying voluntary purchasing groups and enforcing standards. States should have the responsibility of enforcing national standards through the accreditation of voluntary certified purchasing groups (CPGs). Many existing purchasing groups already comply with similar standards and could easily receive state accreditation as a voluntary CPG. If multi-employer arrangements are afforded ERISA protection, as some policymakers have proposed, the federal government should enforce compliance with uniform standards. Eligibility criteria would be left to the purchasing group, as long as it accepted all who met its defined eligibility criteria and precluded any discrimination on the basis of health status.

Purchasing groups should be encouraged to take individuals—the tax credit would give healthy persons an incentive to purchase coverage, and administrative savings and economies of scale associated with group pur-
chasing should enable the groups to offset the additional costs of adverse selection—but should not be mandated to do so. Requiring the acceptance of individuals would shift the excess burden of adverse selection in the individual market to small employers. Rather, carriers serving the individual market should be required to community rate and not be permitted to select on the basis of risk. This may, however, lead to excessive premiums for individuals. If that becomes the case, it may be necessary to implement a broad-based tax or make adjustments among market segments to spread the costs of adverse selection more fairly.

To maintain risk pools, group purchasers should be prohibited from selecting members on the basis of health status or past claims experience, and receipt of the proposed tax credit should be linked to purchasing through a group for employees of firms of two or more workers.

Benchmark Benefits

While national uniform standards and group purchasing will greatly increase the availability of reasonably priced health coverage, the comparative information necessary for decision making still will be absent. Health plan comparability, coverage and treatment decisions, and inclusion or exclusion of specific benefits and technologies are just a few of the problems associated with the current lack of information related to benefit plan offerings. For this reason, a benchmark benefit package—a voluntary, real, and valid offering of all health plans—is needed. It need not and should not be the only offering. Plans should be able to offer packages both richer and leaner to respond to the needs of purchasers. Since many plans have had lengthy experience with the federal HMO benefit package, it should serve as the initial benchmark package until the process for revising and improving it is in place. A specific benefit package should be developed as quickly as possible to deal with the ambiguity in this benefit package.

The process of defining and maintaining the benchmark benefit package should be open, fair, understandable, and for information purposes only. The criteria for additions and deletions should be available and the process should be clear, so that coverage decisions by the health plan would be protected from unreasonable challenge. For the purposes of avoiding antitrust lawsuits, health plans may need to be excluded from the process and should not collude to ensure inclusion or exclusion of benefits. In the absence of a voluntary benchmark, plans will vary benefits to satisfy the demands of various customers, and comparability will remain elusive.

Maintenance of the benchmark benefit package. Maintaining a benchmark benefit package that most effectively protects the nation’s health will require ongoing evaluation, revision, and updating. Technology
Assessment and cost-effectiveness analysis will be necessary to achieve this objective in a rational way. Since technology assessment is now done by several different organizations, expertise from the private market would be available and should be used. This would mean purchasing technology assessment expertise from organizations such as the Emergency Care Research Institute or the Blue Cross/Blue Shield Technology Evaluation Committee, networking current expertise.

Additionally, health plans’ individual coverage decisions often require independent evaluation and recommendation. Such evaluations should be carried out by experts in the appropriate field of medicine and thus would be free of vested interests. Independent expert reviews would remove coverage decisions from the legal system, in which judges and jurors often rule in favor of coverage if there is uncertainty or urgency.

A new, independent organization, the Benchmark Benefits Group (BBG), should be formed to address these needs in the health system. The proposed functions of the BBG are defining, updating, and maintaining the benchmark benefit package; recommending the inclusion or exclusion of new technology in the benchmark benefit package based upon technology evaluation done by recognized groups; recommending continuation, limitation, or exclusion of existing technology; providing cost-effectiveness information and recommendations; and making decisions about disputed coverage in defined situations.

A critical element to the success of the BBG is its independence and autonomy. This would reassure doctors that an appropriate process exists with adequate clinical input; it would reassure patients that their interests are being dealt with fairly; and it would reassure new technology providers that a fair process exists to facilitate fair competition for all. Thus, the processes and criteria of the BBG should be open, published, and available for revision as the health care industry develops and matures.

**A Health Accountability System**

To evaluate the nation’s health, it is necessary to measure the results of interactions between individuals and health plans to hold health plans accountable. Today’s health care quality measurement industry uses various definitions of quality and differing methodologies to measure quality. Consequently, comparable, reliable, and valid quality accountability data are not available to consumers. Although these initiatives are admirable and more extensive than any previously undertaken, there is pressure from the purchasing community to move forward at a more rapid pace.

The Jackson Hole Group proposes a new health accountability system that would not rely on traditional systems of quality assurance, which fail to
disclose health outcomes to consumers or provide them with comparable information about the quality of care they will be provided by a given plan. This system would include collaborative efforts between the private and public sectors to address two areas: (1) the selection and endorsement of uniform data disclosure requirements; and (2) the research, design, and evaluation of health accountability measures.

The first set of responsibilities would be carried out by the Health Accountability Foundation (HAF), an independent, collaborative body between the public and private sectors. Funding of HAF should preserve its independent status; it should not be dominated by health plans.

HAF would have a permanent staff of scientists, who would systematically consult with outside experts. They would present recommendations to the foundation’s board, whose majority would be represented by purchasers and consumers from the private and public sectors. Health plans, providers, researchers, the pharmaceutical and technology industry, and the health care quality organizations would have input. It is important to link health plans into the system, to ensure that the data requirements specified by the board inform quality improvement and the furthering of medical knowledge and are fair and feasible. The closest existing model for HAF is the Financial Accounting Standards Board (FASB). The recommendations endorsed by HAF should be scientifically justified and subject to scrutiny at public hearings.

The second set of responsibilities would be carried out by an Accountability Measures Clearinghouse. The clearinghouse would be a private/public partnership, perhaps in collaboration with an existing organization such as the Agency for Health Care Policy and Research (AHCPR) or a consortium of government and private research institutions. Funding could come from foundation grants, government agencies, and per capita contributions from the health care industry.

The final piece of the new health accountability system would be the many well-established mechanisms already in place. Existing organizations that have considerable experience in accrediting plans and providers and quality improvement could play a major role in auditing the process and facilitating quality improvement activities. Continuing education of physicians and other health plan staff is important to each stage of the process. There would be considerable overlap between components, and continuous feedback to the clearinghouse and HAF functions would be necessary.

The benchmark benefits and health accountability system could work synergistically under a private umbrella organization sponsored by a broad range of participants and involved parties. The organization would be a not-for-profit entity that could be funded by user fees. The BBG would be private, although government collaboration would be possible in key areas,
such as clinical trials, Medicare, and Medicaid. Representatives could come from purchasers, consumers, managed care organizations, self-funded employers, academic medical centers, physicians, and government.

**Health System Information**

Attempts at federal health care reform last year showed that the health system data available were not sufficiently timely or accurate. The CBO was hampered in its efforts to estimate the cost of various proposals by its inability to evaluate the effects of undocumented improvements that were under way and differences in inflation rates from community to community.

For policymakers to address the problems of attaining broader coverage while containing the cost of health care, health system data will be required in four basic areas: (1) Cost—what is the per capita cost of health care to third-party payers and to the individual?; (2) coverage—who is and is not covered by the health insurance system?; (3) vital health statistics (morbidity, mortality, and reportable diseases); and (4) quality—what are the measures of quality of services provided? While cost, coverage, and vital statistical data require federal intervention, quality information can be collected through private-sector initiatives, as recommended above.

Data collection should be guided by some basic principles. (1) Confidentiality of records and privacy rights of individuals must be preserved, such as through the use of a unique, encrypted identifier. (2) Data must be exchanged electronically, either directly or indirectly. (3) Data collection must be timely and must represent the minimum required to serve the basic needs of the health care system. (4) The information needs of the health care system will change as the payment system changes. (5) The aim of the uniform data system should be to reduce administrative costs in the health care system. (6) Determination of which data elements are collected should be driven by a clear mission—to improve the health of the population. (7) Data should be collected at the state level and then aggregated nationally.

The ability to collect uniform, timely, and accurate data on health system costs and coverage is a goal that justifies a federal presence. Private industry collaboration alone will be neither comprehensive nor sufficiently rapid. However, it is in the interest of the health care industry to encourage federal financing of this endeavor. This function could be performed by an existing agency, such as HCFA’s Office of National Health Statistics or AHCPR, or by interagency collaboration. It should be separate from all purchasers, including Medicare. Federal legislation will be required to ensure reporting of the chosen data elements by all parts of the health care delivery system, as well as by states.
Conclusion

The health care market is moving rapidly toward reform, even in the absence of legislative action. There now exist, however, certain barriers to a better-functioning marketplace that if removed could greatly accelerate the progress that is under way. The Jackson Hole Group proposal depends on the willingness of government and the private sector to work together. The elements of this proposal can be put in place rapidly and will accelerate the reforms already taking place in the market.

The Jackson Hole Group gratefully acknowledges the research and contribution to these proposals by the following persons: Nancy Ashbach, Jay Carmathers, Robyn Lunsford, Sarah Pundy, Graham Rich, Sara Singer, and Ellen Wilson.

NOTES

3. The per capita rate of annual growth equals the total program growth, as reported by the CBO in The Economic and Budget Outlook: Fiscal Years 1996-2000, divided by enrollment growth projections from the Health Care Financing Administration, Office of the Actuary (March 1995).
4. HCFA Office of Managed Care, Operations and Oversight Team, “Medicare Managed Care Program Update” (1995).
5. U.S. Department of Health and Human Services, “Medicare and Managed Care” (Presentation at the Jackson Hole Group meeting, Jackson, Wyoming, 17-20 February 1995); and GHAA, 1994 HMO Performance Report.
9. This credit would be slightly less than in the first example because people buying coverage for less than $4,000 would forgo some of the tax credit.
10. A. Monheit, unpublished data from the Agency for Health Care Policy and Research, based on 1987 National Medical Expenditure Survey data.