

How We Can Pay for Health Care Reform Summary

Timely Analysis of Immediate Health Policy Issues

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Introduction

How to pay for health reform is one of the greatest challenges facing the Obama administration and the Congress in the current debate. There are many options being discussed but each solution faces strong opposition from some quarter. In this paper, we argue that a number of strategies could be adopted, including savings that could be generated from within current government health programs, savings from creating a public health insurance plan to compete with private plans in a newly structured health insurance exchange, and new revenue sources. Further, the nation could be well served by adopting many approaches so the financing burden is spread broadly and no one subpopulation bears too much of the burden.

Financing reform will require policymakers to make explicit trade-offs between savings options and revenue options. For example, if policymakers are unwilling to undertake major health system reforms or if the Congressional Budget Office (CBO) will not “score” them, a public plan’s ability to lower subsidy costs will become even more important to the financing of reform. But if the public plan is politically unacceptable, policymakers will need to rely even more heavily on new revenues

and other program savings. While opposition will exist for each savings and revenue option, health care reform will only be viable if policymakers are willing to accept some of their less-favored strategies as part of an overall financing package.

Table 1 summarizes our estimate of the cost of a hypothetical health care reform plan. To calculate program costs and the magnitude of savings from specific policy options, we assume a health reform consistent with the broad outlines Congress and the Obama administration are considering. It includes a Medicaid expansion, health insurance exchanges, income-related subsidies, and an individual mandate. We estimate the cost of a Medicaid expansion for all nonelderly individuals with incomes up to 100 percent of the federal poverty level (FPL) to be \$550 billion over the 2010–2019 period. The government’s payments for income-related subsidies for those with incomes above 100 percent of the FPL are estimated to be \$1.26 trillion over the 10-year period. The total estimated cost for this health reform plan would be \$1.81 trillion over 10 years. This is a 10-year cost estimate and assumes full implementation in year 1; it assumes universal coverage with the exception of undocumented immigrants and a benefit package just slightly below

the average for employer-sponsored insurance today. Costs will be lower if coverage is phased in over a period of years, if the mandate is not fully effective, if some people are exempt from it, or if subsidies or benefits are less generous than we assumed.

Health System Reforms

We first examine savings options from various health reform initiatives. These are summarized in table 2. The first set includes reductions in Medicare and Medicaid provider payments. The second set includes delivery system reforms. There is considerable dispute about the magnitude of potential savings from delivery system reforms; consequently, we have tried to be conservative in these estimates. However, we find that the research evidence supports the expectation of some savings from several measures and that, taken together, these reforms could make an important contribution toward financing health care reform.

Medicare and Medicaid Provider Payment Reforms

Reducing Payments for Medicare Advantage Plans. It has long been argued that Medicare Advantage plans are paid well in excess of what traditional Medicare would spend to care for the same individuals.¹ MedPAC has argued that Medicare should pay the same amount for the same benefits across all options. Based on CBO estimates which we adopt for this paper, doing so would decrease federal spending by \$133.0 billion over the 2010–2019 period.²

Table 1. Paying for Health Reform (billions of dollars)

The Cost of Health Reform	2010-2019
Medicaid Expansion (Net)	550.4
Subsidies, No Public Plan	1,256.6
Total Reform Spending	1,807.1



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Table 2. Health System Reforms (billions of dollars)

	2010-2019	
	Government Savings	Total Savings ^a
Reductions in Payments to Medicare and Medicaid		
Establish Competitive Bidding for Medicare Advantage Program ^b	133.0	133.0
Savings from Reduction in Prices for Overpriced Services	80.0	80.0
Reductions in Other Medicare Payments		
Reduce Update Factor for Hospitals' Inpatient Operating Payments ^c	92.9	92.9
Reduce Update Factor for Payments to Post-Acute Care Providers ^c	54.2	54.2
Reallocation of Safety Net Funds	264.1	264.1
Total	624.2	624.2
Delivery System Reforms^d		
Savings from Chronic Disease Management for Dual Eligibles	200.5	200.5
Savings from Reducing Hospital Readmissions in Medicare and Medicaid	14.8	14.8
Savings from Improvements to End of Life Care for Medicare Beneficiaries	90.8	90.8
Savings from Increased Use of HIT to Medicare and Medicaid, or Subsidy Cost	48.5	97.0
Savings from Prevention to Medicare and Medicaid, or Subsidy Cost	142.9	191.0
Savings from Malpractice Reform to Medicare and Medicaid, or Subsidy Cost	129.2	258.5
Increased Health System Reliance on Primary Care/Medical Homes	0.0	0.0
Comparative Effectiveness/Public and Private Payer Coverage of New Technology	0.0	0.0
Total	626.8	852.6

* Additional savings to the privately insured were not estimated in all cases.

^a Total savings include savings to the government, as well as those that accrue to individuals with private health insurance coverage.

^b Ten year estimate from Congressional Budget Office. Information on the Options for the Medicare Advantage Program's Benchmarks for Federal Payments. Letter to the Honorable Mike Crapo. 2009 May 18. Individual Year estimates were derived using the predicted growth rate of Medicare, assuming a three year phase-in period.

^c The Congressional Budget Office, "Budget Options Volume 1: Health Care," December 2008, Chapter 7, p. 108-109. Annual estimates come directly from CBO for years 2010 to 2014 and for 2010-2019 total. Other years are estimated to reach total based on previous years and trends (estimates assume a constant third derivative of annual savings).

^d Research evidence and assumptions for these estimates are described in the text.

Reducing Payments for Overpriced Physician Services. There is considerable evidence that fees for certain physician services are too high. There has been rapid growth in minor procedures, imaging, and nonimaging tests.³ The evidence suggests that the profitability of the fastest growing services is relatively high.⁴ Reducing prices for these services could yield considerable savings. We assume that the Medicare sustainable growth rate (SGR) policy will be altered to yield a more predictable rate of growth in physician fees. Relative to this revised baseline, we estimate that reducing the fees for overpriced imaging, tests, and minor procedures could save \$80 billion in Medicare over 10 years. If other payers followed Medicare's lead to

correct physician fee schedule pricing distortions, additional private savings would be achieved, but they are not included here.

Reducing Medicare Provider Payment Rates for Inpatient and Post Acute Care. Recently the Obama administration has proposed reducing provider payment rates, suggesting a 1 percentage point reduction in the update factor for hospital inpatient payments under Medicare. The annual update factor, the administration argues, overcompensates hospitals because it ignores productivity gains that occur in part because of the Medicare payment system. CBO estimates that this would save \$92.9 billion between 2010 and 2019.⁵ CBO has also made estimates of

the savings from a 1 percentage point reduction in payments to providers of post-acute care services. The Medicare Payment Advisory Commission (MedPAC) concluded that Medicare payments for post-acute care services were too high relative to provider costs and recommended that payments be reduced.⁶ CBO estimated that reducing the update factor for nursing facilities, home health agencies, long-term care hospitals, and rehabilitation facilities by 1 percentage point would save \$54.2 billion between 2010 and 2019.⁷

Reallocating a Share of Safety Net Funds. Hadley and colleagues have estimated that the uninsured received approximately \$56 billion in uncompensated care while uninsured

in 2008, and about 75 percent of this (\$42 billion) was financed through government programs.⁸ By largely eliminating the uninsured population, it is hard to justify using these funds for the same purposes. Although there would still be a need to serve undocumented immigrants and others who fall through the cracks of the reforms, we assume that most of these dollars could be reallocated to support insurance subsidies. Eliminating Medicaid and Medicare disproportionate share hospital payments, some payments for graduate medical education and some payments made to community providers would permit reallocation of \$264.1 billion over 10 years to help finance subsidies. This would leave all state and local funds currently devoted to uncompensated care and a significant amount of federal funds now supporting community based providers to help finance the remaining safety net.

Delivery System Reforms

Chronic Care Management and Coordination. We focus on the cost of Medicare-Medicaid dual eligibles because they are a large share of both programs' spending, and hence the source of potential government savings. There have recently been a number of research studies that suggest approaches that offer the promise of significant cost savings.⁹ We describe these alternative approaches and the recent evidence on effectiveness. We conclude that if these interventions were adopted on a broad scale and if there were a strong commitment by Medicare and state Medicaid programs, the cost of dual eligibles could be reduced by 5 percent per year. This would generate \$200.5 billion in savings over the 10-year period. We make no assumption about savings from extending these approaches to others outside these government programs.

Reducing Payments to Hospitals for Readmissions within 15 Days. Rates of Medicare readmissions vary significantly across hospitals, suggesting that greater attention to the quality

of discharge instructions, improved communication at discharge to patients' usual source of care, and direct follow-up by transition nurses can reliably reduce readmission rates and their associated high expenses. This policy would reduce payments to hospitals for 15-day readmissions for particular conditions. For two years, any savings from the reduced payments would be put back into the base rates for these conditions, keeping the hospitals "whole" in aggregate and generating no government savings. After that period, savings would be split 40/60 percent between hospitals and the federal government. This approach would provide \$14.8 billion in government savings over the 2010–2019 period.

Health Spending at the End of Life. Consistently, 25 to 30 percent of Medicare spending in a given year supports the 5 percent of beneficiaries who die during that year.¹⁰ We suggest a number of approaches to reducing spending at the end of life in ways that could also improve the quality of end-of-life care. These focus on hospital palliative care teams, encouraging increased use of hospice services, and greater patient and family participation in decision making near the end of life. A 5 percent reduction in end-of-life costs would save Medicare \$90.8 billion over 10 years.

Increased Use of Health Information Technology (HIT). There have been numerous claims that HIT can save huge sums of money. The CBO and others have criticized these estimates¹¹ – we generally agree with the criticisms. However, we believe it is also incorrect to assume no savings from HIT.¹² The benefits from enhanced ability to monitor patient outcomes, to adhere to best practice standards, to provide clinical decision support, and to allow electronic ordering and drug dispensing and a variety of other measures should create significant cost savings. We recognize that the fee-for-service environment, which rewards the provision of redundant, unneeded services, can mitigate against cost

savings. While it is difficult to carefully estimate savings net of the cost of adoption, we estimate that in the last six years of the ten year period HIT could generate modest savings in national health expenditures of 0.5 percent per year. This yields estimated government savings of \$48.5 billion. Additional savings would accrue to the private sector.

Prevention of Diabetes and Hypertension. In 2009, the nation is estimated to incur \$129 billion in medical expenditures on diabetes and hypertension, rising to \$430 billion when the related costs of stroke, heart disease, and renal disease are added. The CBO has argued that many prevention efforts are expensive, not well targeted, and unlikely to be cost effective.¹³ But the CBO has also suggested that well-targeted approaches could yield cost savings.¹⁴ We describe such an approach and, even assuming a relatively low take-up of 20 percent, we find that government savings net of program costs would be \$142.9 billion over 10 years. Additional savings would accrue to the private sector.

Malpractice Reform. Malpractice reform can achieve savings because (1) tort reforms can directly lower malpractice premiums, (2) the cost of defensive medicine would fall, and (3) it can help other reforms be more effective. Based on research on the impact of caps on malpractice awards, or on their nonmonetary component (e.g., pain and suffering), the CBO has estimated that savings from lower malpractice premiums would amount to 0.3 to 0.4 percent of national health spending.¹⁵ Research on the effect of malpractice reform on defensive medicine suggests perhaps another 0.5 percent of total health spending could be saved.¹⁶ Combined with other related measures to reduce defensive medicine, malpractice reform could save 0.9 percent of health care spending. This would amount to \$129.2 billion in government savings over the 2010–2019 period. Additional savings from

malpractice reform would accrue to the private sector.

Medical Homes/Comparative Effectiveness. Increased use of medical homes and expansion of primary care offers considerable promise for future cost savings. However, the lack of evidence on medical homes and the long lead time required to expand primary care weighs against the assumption of near-term cost savings. Comparative effectiveness analysis also offers the promise of savings if reimbursement levels are tied to their findings. However, due to current uncertainty about the possible savings and whether there will be a sufficient commitment to modify reform payment methodologies to reflect comparative effectiveness we do not include resulting savings here.

Savings from a Public Plan

We examine the possible savings from a public plan option that competes with private insurance plans within the health insurance exchange.¹⁷ The public plan would be available across the nation through the new health insurance exchange and would pay providers based on local prices, just as the traditional Medicare program does. The public program would abide by all insurance market reforms and offer a limited set of insurance packages consistent with new federal standard benefit guidelines, just as the private plans in the exchange would. These plans would likely look similar to typical employer-based insurance packages. The public plan would have the same type of administrative structure as the traditional Medicare program does today and would use the Medicare payment systems, although the rates would be set between Medicare and average private payment levels. The public plan would be financially self-sustaining, using premium payments made by and on behalf of enrollees, just as is the case with private plans.¹⁸

We believe that considerable savings are possible from a public plan option due to somewhat lower administrative costs

and the lower provider payment rates that such a plan would use. Significant savings are possible even if the public plan sets rates between current Medicare and private plan rates. Currently, provider payment rates by commercial insurers are about 30 percent above Medicare rates on average. The exchange would provide coverage to small employer groups and nongroup purchasers, and exchange-based coverage (private or public) would be the only coverage for which income-related subsidies from the government could be applied. As a consequence of these design choices, most of those who now have small-group and nongroup coverage as well as those who are uninsured but above Medicaid eligibility levels will choose to obtain coverage through the exchange. A much smaller share of those who currently have coverage through a large employer will seek coverage through the exchange to obtain income-related subsidies, bringing their employers' health insurance contributions with them. Within the exchange, those with low incomes will disproportionately choose the public plan simply because it is likely to be one of the lower-cost options.

We estimate that 45 million people will choose coverage through the public plan; about half of those who purchase coverage through the exchange will choose to enroll in competing private plans. All who continue to obtain coverage outside the exchange will be in private plans; thus, the number of

people with private coverage will only fall from 177 million to 161 million.

We estimate that the government savings from the public plan would range from \$224.1 billion to \$399.8 billion depending on how aggressive the public plan is setting provider payment rates (see table 3). We estimate the effects of setting public plan rates at Medicare plus 20 percent and Medicare plus 10 percent, and assume public plan administrative costs to be 5 percent lower than private plan costs. We assume private plans in the exchange would respond to competition from the private plan by lowering their rates relative to today. Savings from the public plan are surprisingly large because of the structure of low-income subsidies. Because individual premium contributions are capped at a percentage of family income, a change in premium does not translate into a change in individual payments for those eligible for subsidies—the individual or family continues to pay the appropriate fixed percentage of their income. Consequently, as the public plan lowers premiums for the population covered through the exchange, the resulting savings among the subsidized population accrue almost entirely to the government. The public plan also generates additional private savings to unsubsidized individuals and employers who purchase coverage through the

Table 3. Public Plan Savings^a (billions of dollars)

	2010-2019	
	Government Savings	Total Savings ^b
Subsidies, No Public Plan	1,256.6	1,256.6
Savings From Public Plan		
Medicare Payment Rates + 20% ^c	224.1	412.0
Medicare Payment Rates + 10% ^d	399.8	788.0

^a Methods for estimating savings are described in John Holahan, and Linda Blumberg. 2009. "Is the Public Plan Option a Necessary Part of Health Reform?" Washington, DC: The Urban Institute.

^b Total savings include savings to the government, as well as those that accrue to individuals with private health insurance coverage.

^c Results in 15% savings on public plan, including administrative costs.

^d Results in 25% savings on public plan, including administrative costs.

exchange due to the availability of lower-cost plans.

Increasing Revenues

We then looked at a number of revenue raising options which are summarized in table 4.

Capping the Exclusion of Employer Contributions to Health Insurance

from Taxation. Many have suggested eliminating the current tax exclusion as a way to raise revenue to help finance reform and to improve tax equity.

The tax exclusion is highly regressive, contributes to high and rising health care costs, and costs the federal government a substantial amount in forgone revenue. However, eliminating the tax exclusion could severely disrupt

the employer health insurance market. Capping the exclusion would have a less significant effect on employer coverage and yet can yield a substantial amount of revenue.

In addition, the financial effects of capping the tax exclusion fall primarily on the highest-income groups, making this a relatively progressive change in the tax code. Caps at the 75th

Table 4. Options for Increases in Revenue (billions of dollars)

2010-2019	
	Government Revenue
Cap on Exclusion for ESI at the 75th Percentile	
Indexed to CPI, income tax revenue	456.2
Indexed to CPI, income and payroll tax revenue	722.4
Indexed to GDP, income tax revenue	224.1
Indexed to GDP, income and payroll tax revenue	354.3
Employer assessment	
4% payroll tax, no cap	427.4
4% payroll tax, capped at Social Security wages	307.9
Tax rate varies with worker wages, no cap	569.7
Tax rate varies with worker wages, capped at Social Security wages	391.1
Sin Taxes^a	
Sugar-sweetened beverages, add excise tax of 3¢ per 12 oz	51.4
Cigarettes, increase excise tax by \$1 per pack, adjusted for CHIPRA tax	34.1
Alcohol, increase excise tax to \$16 per proof gallon	61.0
Income Tax Options	
Raise all tax rates on ordinary income by 1 percentage point ^b	508.5
Limit the tax rate at which itemized deductions reduce taxable liability for all deductions except charitable contributions ^c	232.9
Extension of individual share of Medicare tax to cover unearned income ^d	434.7
Raise the income tax on ordinary taxable income over \$1 million for joint filers and \$500,000 for individuals by 5 percentage points ^e	224.3

^a From Congressional Budget Office, "Budget Options Volume 1: Health Care," December 2008, Chapter 11, p. 192-196. To estimate a tax implemented in 2010, a growth rate was calculated from years 2011 to 2013 annual estimates and 2009-2018 total revenue estimate. The first year after implementation is revenues are adjusted upward). The estimated revenue from cigarette taxes is adjusted to account for increased tobacco taxes under CHIPRA legislation by subtracting JCT estimated revenue under CHIPRA from baseline revenue estimates (Joint Committee on Taxation, "Estimated Revenue Effects of the Internal Revenue Code Provisions Contained in H.R. 2, Fiscal Years 2009-2018, As Amended by the Senate on January 29, 2009.

^b The Congressional Budget Office, "Budget Options," February 2007, Chapter 3, page 277. While CBO estimates were for years 2008 to 2012, the estimates shown are the CBO estimates for 2010 to 2012 (unadjusted) projected out using the average growth rate required to obtain the CBO estimate for total revenues from 2008 to 2017.

^c Base estimates from the Joint Committee on Taxation, "Estimated Budget Effects of the Revenue Provisions Contained in the President's Fiscal Year 2010 Budget Proposal," 30 March 2009. Estimates are adjusted to retain full deductions for charitable contributions by subtracting the weighted average share of total deductions taken for charitable contributions for taxpayers with over \$200,00 in income from 2006 IRS data, Internal Revenue Service, "Table Gross Income, Tax Year 2006."

^d Citizens for Tax Justice. 2009. "Progressive Revenue Options to Fund Health Care Reform."

^e Congressional Budget Office, "Budget Options." February 2007.

percentile of premiums, indexed either to the CPI or the GDP, would provide revenues of \$722 billion or \$354 billion, respectively, over 10 years.¹⁹ Of this, \$456.2 billion and \$224.1 billion would be increased income-tax revenues that could be used to help finance health care reform. The difference represents payroll tax revenues that we assume would be dedicated to financing Social Security and Medicare.

Employer Assessments. The second option is to place an assessment on employers who do not provide insurance coverage. Generally termed an employer pay-or-play mandate, this option would impose an assessment on all employers, which could be offset dollar for dollar by contributions toward their workers' health insurance. Those who do not obtain coverage through an employer would obtain coverage through the exchange or through Medicaid. Employer assessments can generate a significant amount of money but are difficult to design and can have adverse effects on workers' wages and employment. Economists agree that payroll taxes imposed on employers will eventually be passed back to workers through reduced wages or employment.

We estimate that the revenue that could be generated under a 4 percent payroll assessment on firms with 10 or more workers could yield \$427.4 billion over the 2010–2019 period. If the assessment is only applied to Social Security wages, it would generate \$307.9 billion over the 10-year time period. A more progressive employer assessment that ranged from 2 to 6 percent and increased with worker wages would yield \$569.7 billion over 2010–2019, or \$391.1 billion with a cap at the Social Security wage level. The option with the assessment that varies with worker wages would have a more modest impact on the wages and employment of low-wage workers.

Sin Taxes. We analyzed a variety of “sin” taxes, that is, excise taxes on such products as tobacco, alcohol, and sugar-sweetened beverages. These types of sin taxes already exist; the proposal is

to increase them to higher levels. Using estimates from a variety of sources, we calculate that a modest set of taxes on sugar-sweetened beverages, cigarettes, and alcohol would provide \$146.5 billion in federal revenues over 10 years.²⁰ While sin taxes tend to be fairly regressive, with their financial burden falling more heavily on those with lower incomes, the positive benefits of health care reform will disproportionately help the low-income population as well, making the overall impact of reform still a progressive one.

Income Taxes. Finally, we examined three alternative income tax options. The first is a 1 percentage point increase in the income tax rate for each tax bracket. This strategy would generate \$508.5 billion in revenue over 10 years.²¹ The approach would be somewhat regressive—a 1.0 percentage point increase in tax rates would generate a much higher percentage tax increase for taxpayers in lower brackets than in higher brackets. Additionally, many higher-income tax payers would be subject to the alternative minimum income tax, which would not increase under this proposal. However, much of the benefit from health reform would go to lower-income groups and it is worth taking into account the full distributional effects of financing and program benefits.

A second proposal would limit the tax benefit of itemized deductions to 28 percent as proposed in President Obama's 2010 budget. This proposal would be quite progressive as it would only affect taxpayers in tax brackets above 28 percent;²² however, the proposal has been strongly opposed because of its potential negative consequences on charitable donations.²³ We provide an estimate for a proposal that did not limit the deductibility of charitable contributions. With this exemption, the limit on deductibility would generate roughly \$233 billion over 10 years.

The third option would extend the 1.45 percent Medicare tax, currently levied

only on wage income, to all income. By treating unearned income the same as earned income for this health tax purpose, an additional \$434.7 billion could be raised over 10 years.²⁴

The fourth option would create a new income tax bracket for those with incomes above \$500,000 for individuals and \$1 million for joint filers. The marginal tax rate for this bracket would be 44.5 percent, assuming the end of the Bush era tax cuts for higher-income taxpayers. This change would yield \$224 billion in new revenues over the 10-year period and could generate substantially more if the income thresholds were lowered. Options that shift the financing burden to the highest-income groups may have political appeal to some but are at odds with approaches taken by other nations that have financed health coverage with broad-based consumption or payroll taxes.

Conclusions

We conclude that there are a variety of ways to raise money to pay for health reform. All of the proposals taken together would yield more money than is needed to support comprehensive reform and near-universal coverage (Table 5). But all impose costs on certain subpopulations and almost all would consequently be strongly opposed by some groups. There are clearly tradeoffs. The fewer savings options adopted (or scored by CBO), the more other measures such as the public plan must be relied on. If the public plan is politically unacceptable, or if there is an unwillingness to reallocate safety net funds or to enact malpractice reforms, then it is more necessary to rely on new revenues. There are also hard choices on revenue measures including the cap on the tax exclusion of employer contributions to health insurance, an employer assessment, or income taxes – each option carrying very different distributional consequences. However, by spreading the costs across an array of savings and revenue options, the burden can be spread broadly and reform can be fully paid for.

Table 5. Total Funds for Reform (billions of dollars)

2010-2019		
	Government Savings	Total Savings ^a
Estimated Available Funds		
High ^b	3,331.5	3,945.6
Low ^c	2,377.8	2,791.5
Cost of Reform Less Estimated Available Funds		
High ^b	- 1,524.5	- 2,138.5
Low ^c	- 570.7	- 984.4

^a Total savings include savings to the government, as well as those that accrue to individuals with private health insurance coverage.

^b High estimates of available funds include all savings from reductions in payments to Medicare and Medicaid and delivery system reforms, as well as savings from Medicare payment rates +10%; income tax revenue from a cap on exclusion for ESI at the 75th percentile, indexed to the CPI; revenue from an employer assessment that varies with worker wages and has no cap; all sin tax revenue; and revenue from raising all tax rates on ordinary income by 1 percentage point.

^c Low estimates of available funds include all savings from reductions in payments to Medicare and Medicaid and delivery system reforms, as well as savings from Medicare payment rates +2%; income tax revenue from a cap on exclusion for ESI at the 7th percentile, indexed to the GDP; revenue from a 4% employer payroll tax, capped at Social Security Wages; all sin tax revenue; and revenue from raising the income tax on ordinary taxable income over \$1 million for joint filers and \$500,000 for individuals by 5 percentage points.

Notes

- 1 Medicare Payment Advisory Commission, "Medicare Payment Policy: Report to Congress" (Washington, DC: MedPAC, 2009), 258.
- 2 Congressional Budget Office, "Information on the Options for the Medicare Advantage Program's Benchmarks for Federal Payments" (Letter to the Honorable Mike Crapo, May 18, 2009).
- 3 MedPAC, *Report to the Congress*, Chapter 2B.
- 4 Melinda Beeuwkes Buntin, Stephen Zuckerman, Robert Berenson, Anant Patel, and Teryl Nuckols, "An Investigation of Eight High-Utilization, High-Growth Physician Services Provided to Medicare Beneficiaries" (submitted for publication).
- 5 Congressional Budget Office, *Budget Options: Volume 1, Health Care* (Washington, DC: CBO, 2008).
- 6 MedPAC, *Report to the Congress*.
- 7 Congressional Budget Office, *Budget Options*.
- 8 Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs" *Health Affairs* (2008 web exclusive): w399-w415.
- 9 Randall Brown, "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses" (Princeton, NJ: Mathematica Policy Research, 2009); Mary D. Naylor, Dorothy A. Brooten, Roberta L. Campbell, Greg Maislin, Kathleen M. McCauley, and J. Sanford Schwartz, "Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial," *Journal of the American Geriatrics Society* 52(2004): 675-84; Eric A. Coleman, Carla Parry, Sandra Chalmers, and Sung-Joon Min, "The Care Transitions Intervention: Results of a Randomized

Clinical Trial," *Archives of Internal Medicine* 166 (2006): 1822-28; Kate R. Lorig, Philip Ritter, Anita L. Stewart, David S. Sobel, Byron William Brown Jr., Albert Bandura, Virginia M. Gonzalez, Diana D. Laurent, and Halsted R. Holman, "Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes," *Medical Care* 39, no. 11 (2001): 1217-23; John R.C. Wheeler, Nancy K. Janz, and Julia A. Dodge, "Can A Disease Self-Management Program Reduce Health Care Costs? The Case of Older Women with Heart Disease," *Medical Care* 41, no. 6 (2003): 706-15; Chad Boulton, Jean Giddens, Katherine Frey, Lisa Reider, and Tracy Novak, *Guided Care: A New Nurse-Physician Partnership in Chronic Care* (New York: Springer Publishing Company, 2009).

- 10 James D. Lubitz and Gerald F. Riley, "Trends in Medicare Payments in the Last Year of Life," *The New England Journal of Medicine* 328, no. 15 (1993): 1092-96; Christopher Hogan, June Lunney, Jon Gabel, and Joanne Lynn, "Medicare Beneficiaries' Costs of Care in the Last Year of Life," *Health Affairs* 20, no. 4 (2001): 188-95.
- 11 Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology" (Washington, DC: CBO, 2008), <http://www.cbo.gov/doc.cfm?index=9168>.
- 12 Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *American Journal of Managed Care* 10, no. 11 (2004): 828-36.
- 13 Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals" (Washington, DC: CBO, 2008); Louise B. Russell, "Preventing Chronic Disease: An Important Investment, but Don't Count on Cost Savings," *Health Affairs* 28, no. 1 (2009): 42-45.

- 14 Congressional Budget Office, "Key Issues," 138.
- 15 Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice," January 8, 2004, <http://www.cbo.gov/ftpdocs/49xx/doc4968/01-08-MedicalMalpractice.pdf>.
- 16 Daniel P. Kessler and Mark McClellan, "Do Doctors Practice Defensive Medicine?" *Quarterly Journal of Economics* 111, no. 2 (1996): 353-90; Fred J. Hellinger and William E. Encinosa, "The Impact of State Laws Limiting Malpractice Damage Awards on Health Care Expenditures," *American Journal of Public Health* 96, no. 8 (2006): 1375-81; Frank A. Sloan, Stephen S. Entman, Bridget A. Reilly, Cheryl A. Glass, Gerald B. Hickson, and Harold H. Zhang, "Tort Liability and Obstetricians' Care Levels," *International Review of Law and Economics* 17, no. 2 (1997): 245-60; Lisa Dubay, Robert Kaestner, and Timothy Waidmann, "The Impact of Malpractice Fears on Cesarean Section Rates," *Journal of Health Economics* 18, no. 4 (1999): 518-19; Janet Currie and W. Bentley MacLeod, "First Do No Harm? Tort Reform and Birth Outcomes," *Quarterly Journal of Economics* 123, no. 2 (2008): 795-830.
- 17 John Holahan and Linda J. Blumberg, "Is the Public Plan Option a Necessary Part of Health Reform?" (Washington: The Urban Institute, 2006), <http://www.urban.org/url.cfm?ID=411915>.
- 18 Initial federal assistance to develop a reserve fund will be required, but could be paid back through premium assessments for public plan enrollees over a period of years.
- 19 Lisa Clemans-Cope, Stephen Zuckerman, and Robertson Williams, "Changes to the Tax Exclusion of Employer-Sponsored Health Insurance Premiums: A Potential Source of Financing for Health Reform" (Washington, DC: The Urban Institute, 2009), <http://www.urban.org/url.cfm?ID=411916>.
- 20 Congressional Budget Office, *Budget Options*. Estimates from the Joint Committee on Taxation were adjusted by the authors to reflect the 2010-2019 period.
- 21 Based on estimates from the Congressional Budget Office, "Revenue Options" in *Budget Options* (chapter 3), <http://cbo.gov/ftpdocs/78xx/doc7821/02-23-BudgetOptions.pdf>.
- 22 Calculated from the Tax Policy Center, "Individual Income Tax Parameters, 2009 Individual Income Tax Rates, Standard Deductions, Personal Exemptions, and Filing Thresholds" (Washington, DC: The Urban-Brookings Tax Policy Center, 2008), <http://taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=474>. This income level reflects the standard deduction for a married couple filing jointly plus four times the personal exemption.
- 23 For instance, M. Feldstein, "A Deduction from Charity," *The Washington Post*, March 25, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/03/24/AR2009032402462.html>.
- 24 Citizens for Tax Justice, "Progressive Revenue Options to Fund Health Care Reform," May 21, 2009, <http://www.ctj.org/pdf/healthcarefinancing.pdf>.

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