Health Care Reform and the Budget Deficit

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I. The Budget Deficit

In recent months, many have expressed concern about the budget deficit. This is a concern that President Obama and his entire economic team share. Indeed, it would be hard not to be concerned. Just last week, Treasury and the Office of Management and Budget (OMB) reported that the final estimate of the fiscal year 2009 deficit was $1.4 trillion, or roughly 10 percent of GDP.[1] In the Mid-Session Review of the 2010 Budget issued last August, the Administration estimated that we were on a path that would result in a cumulative deficit over the ten-year budget window from 2010 to 2019 of $9 trillion.[2]

This projected ten-year deficit reflects three quite separate developments. First, a substantial fraction is the result of the terrible recession that began twenty-two months ago. Because tax revenues fall and spending on programs such as unemployment insurance rises when the economy sinks into a recession, the deficit naturally increases in these times—and provides automatic countercyclical stimulus. Unfortunately, even though we appear to have entered the recovery phase, unemployment is forecast to remain elevated for some time. As a result, weak economic conditions are predicted to have a negative impact on the deficit for the next several years.

Second, in response to the recession, the Administration and Congress have taken aggressive action. The $787 billion allocated to the American Recovery and Reinvestment Act

(ARRA) and the $700 billion of total resources available to the Troubled Asset Relief Program (TARP) sound enormous. And, they do represent some of the boldest countercyclical and financial rescue operations in history. But both of these are one-time actions, and so their impact on the long-run deficit is small. Indeed, using estimates from the Congressional Budget Office (CBO) of the cost of the ARRA, including the associated interest expenses, the Recovery Act accounts for only about 10 percent of the cumulative projected deficits over the next ten years.[3] Given that many of the TARP funds invested in banks last fall and winter are now being paid back with interest, its ultimate cost to the taxpayer is likely to be a fraction of its initial allocation. Furthermore, if these recovery actions prevented a calamitous economic collapse, as I firmly believe they have, they are in fact causing the deficit to be lower than it otherwise would have been, not higher.

Finally, by far the lion's share of the projected cumulative deficit is due to policy actions taken in the last Administration. Economists Alan Auerbach and William Gale find that policies from the last eight years that we failed to pay for, including cutting taxes, introducing a new entitlement program for prescription drug benefits, and fighting two wars, are contributing approximately $700 billion per year to the budget deficit.[4] Before those actions were taken, we had been on track to run large budget surpluses over the coming decade.[5] As a result, in the absence of these actions, we could have had an economic downturn as severe as the current one and responded to it as aggressively as we have, all while keeping the budget roughly balanced over the next ten years.

As large as the ten-year budget deficit is, it is just the tip of the iceberg. According to OMB, on our current path the budget deficit in 2019 is projected to be about 4 percent of GDP.[6] CBO projects that by 2035, it will be between 6 and 15 percent of GDP, depending on what one

assumes about the continuation of current policies; by 2050, between 8 and 22 percent.[7] Auerbach and Gale calculate that roughly half of the long-run deficit is due to the policy actions of the past eight years.[8] According to a study by the Center on Budget and Policy Priorities, just 3 percent of the long-run fiscal problem is due to the ARRA.[9] The rest of this yawning gap is due to projected rises in spending on entitlement programs, primarily Social Security, Medicare, and Medicaid. Some of this is the result of the aging of the population. But the far greater source is the fact that health care costs, both public and private, are rising much faster than GDP.

Whatever and whoever was responsible for the projected budget deficit, it is clearly the President's and Congress's responsibility to deal with it. It is simply not a problem that can be kicked down the road indefinitely. Obviously, we can't go back eight years and make more responsible choices. And, we can't take short-run contractionary actions that could endanger the recovery. We need to look forward and begin to put the nation on a more sustainable long-run fiscal path. Given the central role of rising health care expenditures, *any* solution to our long-run budget problem will simply have to include slowing the growth rate of health care costs.

II. Health Care Reform

Which brings me to health care reform. Some have argued that it is irresponsible to reform our health care system at a time when the budget deficit is so large and our long-run fiscal problems are so severe. I firmly believe the opposite: it is fiscally irresponsible *not* to do health care reform. To bury our head in the sand for even one more year and pretend that the problem of rising government health care expenditures will go away is simply untenable. We are on a collision course with reality. For the first time in decades, we have a chance to genuinely reform health care and expand health insurance coverage in this country. We must see reform through

to completion.

But, we must do reform well. We have a responsibility to make the health care system work better for all Americans and to expand coverage. However, any expansion or improvements in coverage must be completely paid for in the short run. More fundamentally, we have to put in place reforms that will genuinely and significantly slow the growth rate of costs. That is, reform must be at least budget-neutral over the next decade, and significantly budget-improving in the longer run.

So far, health reform legislation is on track to accomplish all three of these objectives. It is essential that the final legislation stay true to these fundamental goals.

There is substantial agreement about how to expand coverage and to improve the current system for those who already have insurance. The existing versions of reform legislation call for an expansion of Medicaid coverage. The legislation also involves the creation of an insurance exchange to sell quality, affordable coverage to small businesses and to individuals who do not currently have access to affordable coverage. This coverage will be subsidized for low- and middle-income families and individuals. It will be cheaper than the existing system because of substantially lower administrative costs and greater group-purchasing power from the 20 to 30 million Americans who are expected to obtain coverage through the exchange.

Versions of the legislation also include tax credits for small firms and shared responsibility requirements for large firms to encourage increases in employer-provided insurance. Likewise, the reform proposals emerging in Congress require individuals who can afford it to purchase health insurance coverage, just as we require everyone who drives to carry automobile insurance. The legislation puts in place sensible limitations on premium discrepancies by age, prohibits exclusions based on pre-existing conditions, caps annual out-of-

pocket costs, and eliminates lifetime limits on benefits.

These features of the legislation will expand access to coverage to the vast majority of Americans who do not currently have insurance. It will provide lower premiums for the thousands of small businesses struggling to provide coverage to their employees, and hence improve their ability to compete with larger firms and to attract the best workers. This impact—one that the Council of Economic Advisers (CEA) discussed in its July 25th report on "The Economic Effects of Health Care Reform on Small Businesses and Their Employees"—was only made more pressing by published reports yesterday that the status quo is leading to 15 percent premium increases for small businesses, meaning that even more of these businesses will be forced to choose between health coverage and higher wages for their workers.[10] And, reform legislation will give all Americans the security of knowing that there will always be a place where they can get the coverage they need at a reasonable price.

Though there is some variation across the different versions of the bill, we are also on track to meet the President's promise that health reform will not add one dime to the deficit. The five Congressional committees have identified hundreds of billions of dollars of savings in Medicare and Medicaid. These are not savings that reduce the quality of care; they are savings that come from reducing wasteful spending, improving incentives for coordinated care, and eliminating unwarranted taxpayer subsidies to private insurance companies bidding for Medicare contracts. The committees have also identified reasonable revenue sources, many of them within the health care system, to help pay for reform.

One of the most significant savings being discussed is a reduction in payments to private insurers for Medicare Advantage, a program through which seniors eligible for Medicare enroll in a private insurance plan paid for by the government. Because of a lack of competitive bidding

and artificially inflated rates, Medicare currently spends on average about 14 percent more per beneficiary in a Medicare Advantage plan than it does for Medicare beneficiaries in the traditional fee-for-service program.[11] Even this may understate the degree of overpayment. On-going research by economists at the CEA and the Treasury suggests that Medicare beneficiaries who enroll in Medicare Advantage plans tend to be healthier *prior to enrolling* than their counterparts who remain in traditional Medicare, to a degree that is not reflected in the CMS risk adjustment. As a result, one might expect the government to spend less on their health care, not 14 percent more. By reducing overpayments for Medicare Advantage, we can save tens of billions of dollars over the next decade, while at the same time reducing Medicare Part B premiums and maintaining the quality coverage provided to all Medicare beneficiaries.

Just a few weeks ago, CBO reported that the Senate Finance Committee's version of reform legislation would reduce the budget deficit by $81 billion over the ten-year budget window. More importantly, CBO found that the proposal had a surplus in the tenth year, which led them to conclude that the legislation would generate substantially larger savings in the second decade.[12] While the final legislation will, of course, be somewhat different from that passed by the Finance Committee, the fact that one version is even better than budget-neutral, shows that fiscally prudent health care reform that expands coverage to tens of millions of Americans and transforms our health care system to one that is higher quality and lower cost is possible.

III. Long-Term Cost Containment

Even more important than short-run fiscal prudence are the changes under consideration in reform legislation to slow the growth rate of health care costs over time. We must use this

reform effort to put in place changes that will improve efficiency and lower cost growth over the long term. Only by doing so will we prevent the budgetary catastrophe currently looming for our children and grandchildren.

The current proposals contain many of the measures health economists and medical experts think are likely to genuinely reduce the growth rate of health care costs.[13] Perhaps most fundamentally, the legislation plots a course to providing access to health insurance coverage for all Americans. This, together with new incentives for preventive care, makes it likely that we will reap the efficiency gains that are possible from replacing high-cost emergency-room care with a sensible promotion of healthier lifestyles and timely routine care.

The Senate Finance Committee bill includes a tax on high-priced insurance plans, suggested by Senator Kerry. A policy along these lines, designed carefully, will encourage both employers and employees to be more watchful health care consumers. It will discourage insurance companies from offering high-priced plans that would otherwise eat up larger and larger shares of workers' wages. A policy such as this is probably the number one item that health economists across the ideological spectrum believe is likely to stem the explosion of health care costs.[14]

Several of the current versions of health insurance reform include sensible payment reforms for doctors, hospitals, and other providers participating in Medicare. For example, bundling payments for an episode of care associated with an acute event, such as a heart attack or a hip fracture, is a common-sense change. It gives doctors and hospitals the right incentives to provide patients with efficient and high-quality care, and the information they need to manage the transition back home successfully. These incentives improve patient care and outcomes, while lowering costs in the long run.

Precisely because such reforms are so important for both cost containment and patient health, it is crucial to create an institutional structure that encourages and routinizes such innovations. That is why the President has endorsed the establishment of an Independent Medicare Advisory Council (IMAC). The IMAC would provide Congress each year with cost-saving recommendations that improve care and maintain benefits. By removing some of the political pressure around such reforms, the IMAC would make it easier for improvements to be made year after year.[15] Like the Kerry policy, this is another key innovation that could genuinely slow the growth rate of costs.

Another institutional structure that the President has emphasized as a potentially important source of cost containment is the inclusion of a public health insurance option in the exchange. Such an option would give individuals and small businesses the choice of a publicly-managed health insurance plan that competes on a level playing field with private insurers. Reports by the U.S. Government Accountability Office show that markets for health insurance are often highly concentrated, especially in rural states, giving insurers a high degree of market power and the ability to raise premiums.[16] A public health insurance option would be a credible entrant in concentrated markets, and would serve as a competitive, alternative choice, constraining the ability of insurers to raise premiums, and thus containing the growth rate of costs.

The measures that I have described, along with the other actions under consideration, would slow the growth rate of health care costs substantially. Let me emphasize again, however, that this slowing of cost growth is not coming from reductions in the quality of care. We are talking about cutting the fat out of our health care system, not the meat. The evidence that our current system has large inefficiencies, and thus that there are large potential savings, is

extremely strong. We have all heard the numbers describing how we spend a much larger share of our GDP on health care than any other developed country, but do not achieve better outcomes.[17] But even stronger evidence comes from comparisons among U.S. states. A large body of research shows that utilization of specific procedures and per capita health care spending vary enormously by geographic region, and that in many cases these variations are not associated with any substantial differences in health outcomes.[18] Factors such as differences in medical care prices, patient demographics, health status, and income levels cannot fully explain this variation.[19] These large differences in spending suggest that up to nearly 30 percent of Medicare's costs could be saved without adverse health consequences.[20] If these patterns apply to other populations, such as Medicaid enrollees and the privately insured, then it should be possible to slow the growth rate of total health expenditures substantially while improving patient outcomes.

IV. Benefits of Slowing the Growth Rate of Health Care Costs

In a report issued in June, the Council of Economic Advisers examined the economic benefits of a genuine sustained slowing of the growth rate of health care costs through improved efficiency.[21] The most fundamental and profound benefit was that slowing the growth rate of health care costs would free up resources that could be used to produce other things that society values—everything from education to infrastructure to ordinary goods and services that bring us pleasure. As a result, it would lead to sustained increases in standards of living over time.

To put these benefits in concrete terms, we calculated the effects of lower health care cost growth on family incomes. We found that even before considering the impact on the deficit and capital formation, these effects were very large. We estimated that slowing the growth rate of

costs through improved efficiency by one and a half percentage points would result in median family income as of 2020 that was nearly $2300 higher than it otherwise would have been, and median family income as of 2030 that was nearly $8000 higher (in constant dollars).[22]

For a typical family, many of these gains would show up in slower growth of their health insurance premiums. Over the past decade, take-home wages have been stagnating despite increasing worker productivity, in part because a larger and larger fraction of compensation is taking the form of health benefits. Without reform, take-home wages are predicted to eventually fall as skyrocketing costs magnify this effect. Slowing the growth rate of health care costs will enable firms to once again give raises in the form of take-home pay rather than more expensive health insurance.

We also estimated what slowing the growth rate of health care costs would likely mean for the path of the budget deficit. In making these calculations, we assumed, as the President promised, that any expansion in coverage would be paid for through other identified savings or revenue increases. We therefore assumed that any savings to the government from the impact of slower cost growth on government health care expenditures would go to deficit reduction. Our calculations showed that slowing the growth rate of health care costs by one and a half percentage points starting in 2014 would result in a budget deficit in 2020 that was 1 percent of GDP smaller than it otherwise would have been. By 2030, the impact is a reduction in the budget deficit of 3 percent of GDP; by 2040, it is a reduction of 6 percent of GDP.[23] These estimates make vivid the notion that the number-one thing we can do to help get the long-run budget deficit under control is to slow the growth rate of health care costs.

Now, slowing the growth rate of costs will not solve all of our long-run budget problems. Our population is aging and even lowering the growth rate of health care costs quite substantially

leaves them growing faster than GDP. As a result, other actions will also need to be taken. While health care reform may not be the "silver bullet," it clearly must be a significant part of the solution to our deficit woes. It is the key step that we can take right now to bring the long-run budget problem down to manageable proportions.

Recent CEA research suggests that the total fiscal impact of health care reform may be even larger than our baseline estimates suggest. As I have described, current draft legislation greatly expands access to health insurance coverage. This change is crucially important for state and local governments that currently pay for much of the care provided to the uninsured. Using a wide range of sources, including state reports, county records, and numerous phone surveys of local officials, the CEA has provided lower-bound estimates of the amount that sixteen states currently spend on care for those without insurance. We find that these sixteen states are spending at least $3.6 billion per year (in 2007 dollars) on this uncompensated care. We estimated that they are spending another $600 million on higher insurance premiums for state and local government employees because of the hidden tax uncompensated care adds to all private insurance premiums. All told, the states in our sample are spending at least $4.2 billion on care for the uninsured each year.[24]

Health care reform that expands insurance coverage will greatly reduce these state and local expenditures for uncompensated care. Indeed, we believe our measured expenditures are a reasonable estimate of the actual savings, even taking into account that reform will not eliminate all uncompensated care. This is true because we are virtually certain that there is a substantial amount of state and local spending on care for the uninsured that we have not yet identified.

Expanding our projections to all fifty states and the District of Columbia implies savings of roughly $116 billion to state and local governments between 2014 and 2019.[25] This means

that state and local governments would save substantially as a result of health care reform. Current draft legislation calls for state governments to share some of the cost of expanding coverage. For example, CBO estimates that under the Senate Finance Committee proposal, states will spend about $33 billion on increased Medicaid and the Children's Health Insurance Program (CHIP) over the same 2014-2019 period.[26] Even taking account of this cost, there is therefore a net savings to state and local governments of some $83 billion over six years. When you consider that we are paying for all of the Federal expenditures with other savings and revenue increases, this is $83 billion of additional government saving.

V. The Importance of Action

Some view health insurance reform as something we should do before or after tackling the deficit. My plea today is to view it as the most significant act we could take *to* tackle the deficit. Putting in place health care reform that genuinely slows the growth rate of costs is truly one of the largest and most important fiscal reforms we can undertake. It is something that has to be done, and the sooner the better.

The importance of health care reform is even greater when seen in the context of the other things going on in our economy. Though we see signs that economic recovery has begun, American workers are still suffering greatly. The unemployment rate reached 9.8 percent in September, and it is widely projected to remain high for a substantial time.

It would be penny-wise but pound-foolish to let concern about the deficit derail efforts to do whatever it takes to recreate the more than seven million jobs that have been destroyed since the recession began nearly two years ago. Slow recovery and prolonged high unemployment are not only devastating for individuals and families, they are ultimately bad for the deficit. The

longer people are unemployed, the more likely they are to end up permanently out of the labor force and eventually receiving assistance from other government programs. This is a terrible loss all the way around.

In health care reform, we have an opportunity to navigate the difficult path between long-run fiscal responsibility and sensible short-run macroeconomic policy. Done correctly, health care reform can genuinely slow the growth rate of health care costs and thus put us on a path to greatly reduced budget deficits in the long run. Informed observers will recognize that we have made the tough choices and put in place a plan that will help return us to fiscal prudence. The credibility we will gain from such bold action will be far greater than anything that could be achieved through small gestures taken in the midst of the worst recession in postwar history. Indeed, dealing with the looming budget deficits through effective health care reform is not simply the best way to go, it is likely the only way.

NOTES

[1] U.S. Department of the Treasury, "Joint Statement of Tim Geithner, Secretary of the Treasury, and Peter Orszag, Director of the Office of Management and Budget, on Budget Results for Fiscal Year 2009," http://www.ustreas.gov/press/releases/tg322.htm.

[2] Office of Management and Budget, *Mid-Session Review: Budget of the U.S. Government, Fiscal Year 2010*, Table 1, p. 7, http://www.whitehouse.gov/omb/budget/MSR/.

[3] CBO estimated that the non-interest costs of the ARRA over fiscal 2010-2019 would be $602.3 billion (Congressional Budget Office, "Cost Estimate for the Conference Agreement for H.R. 1," February 13, 2009, http://www.cbo.gov/ftpdocs/99xx/doc9989/hr1conference.pdf). Their estimate of the interest costs (which refer to a version of the bill that differed slightly from the final bill) over this period is $346.4 billion (Congressional Budget Office, "Estimated Costs of Additional Debt Service That Would Result from Enacting H.R. 1, the American Recovery and Reinvestment Act of 2009," January 27, 2009, http://www.cbo.gov/doc.cfm?index=9970). The total of $948.7 billion represents 10.5 percent of the estimated deficits of $9.05 trillion over the period 2010-2019 (Office of Management and Budget, *Mid-Session Review*, Table 1, p. 7).

[4] Alan J. Auerbach and William G. Gale, "The Economic Crisis and the Fiscal Crisis: 2009 and Beyond," unpublished paper, September 2009, Appendix Table 1, shows that in fiscal 2007 (which is prior to the anti-recessionary tax cuts enacted in 2008), policy changes enacted under the Bush Administration added $723 billion to the deficit. They also report that this figure was projected to grow over time (p. 17). Thus, the $700 billion per year figure appears conservative.

[5] CBO's ten-year budget estimates prepared in January 2001 projected large surpluses over the 2001-2011 period, with a surplus of 5.3 percent of GDP in 2011 (Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2002-2011*, January 2001, p.2, http://www.cbo.gov/ftpdocs/27xx/doc2727/entire-report.pdf). Their long-term budget projections prepared in October 2000 showed that then-current policy would lead to surpluses of roughly 4 percent of GDP each year over the period 2010-2020 (Congressional Budget Office, *The Long-Term Budget Outlook*, October 2000, pp. 8, 17, http://www.cbo.gov/ftpdocs/25xx/doc2517/Long-Term%20Budget%20Outlook.pdf).

[6] Office of Management and Budget, *Mid-Session Review*, Table 1, p. 7.

[7] Congressional Budget Office, *The Long-Term Budget Outlook*, June 2009, Table 1-2, p. 6, http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-LTBO.pdf. The low figures are from CBO's "extended-baseline scenario," which is based on current law (including no changes to the Alternative Minimum Tax and allowing the 2001 and 2003 tax cuts to expire). The high figures are from CBO's "alternative fiscal scenario," which "incorporate[es] some changes in policy that are widely expected to occur and that policymakers have regularly made in the past."

[8] Auerbach and Gale, "The Economic Crisis and the Fiscal Crisis," p. 17.

[9] Kris Cox, Kathy Ruffing, James Horney, and Paul Van de Water, "New CBPP Projections Reconfirm Federal Budget is on Unsustainable Path," Center on Budget and Policy Priorities, September 30, 2009, n. 3, http://www.cbpp.org/files/9-30-09bud.pdf. See also Paul Van de Water and Kris Cox, "Economic Recovery Bill Would Add Little to Long-Run Fiscal Problem," Center on Budget and Policy Priorities, January 16, 2009, http://www.cbpp.org/files/1-16-09bud.pdf. Auerbach and Gale ("The Economic Crisis and the Fiscal Crisis," p. 15), looking at a longer horizon, estimate that the figure is closer to 1 percent.

[10] Council of Economic Advisers, "The Economic Effects of Health Care Reform on Small Businesses and Their Employees," July 25, 2009, http://www.whitehouse.gov/assets/documents/CEA-smallbusiness-july24.pdf. The news report on small business premiums is from "Small Business Faces Sharp Rise in Health Costs," *New York Times*, October 25, 2009, p. 1.

[11] Medicare Payment Advisory Commission, "Report to Congress: Improving Incentives in the Medicare Program," June 2009, Table 7-1, p. 172, http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

[12] Congressional Budget Office, "Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended," October 7, 2009, Table 1, p. 3, http://www.cbo.gov/ftpdocs/106xx/doc10642/10-7-Baucus_letter.pdf.

[13] See Engelberg Center for Health Care Reform at Brookings, "Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth," August 2009, http://www.brookings.edu/~/media/Files/rc/reports/2009/0826_btc/0826_btc_fullreport.pdf. See also, Congressional Budget Office, *Budget Options Volume 1: Health Care*, December 2008, http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf.

[14] See, for example, Martin Feldstein and Benjamin Friedman, "Tax Subsidies, the Rational Demand for Insurance and the Health Care Crisis," *Journal of Public Economics*, 1977, 7(2): 155-178; Congressional Budget Office, *Budget Options Volume 1: Health Care*, December 2008, http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf; Lisa Clemens-Cope, Stephen Zuckerman, and Roberton Williams, "Changes to the Tax Exclusion of Employer-Sponsored Health Insurance Premiums: A Potential Source of Financing for Healthcare Reform," Urban Institute, June 2009, http://tpcprod.urban.org/uploadedpdf/411916_tax_exclusion_insurance.pdf; Jonathan Gruber, "Statement before the Senate Finance Committee," May 12, 2009, http://finance.senate.gov/Jon%20Gruber.pdf; Paul B. Ginsberg, "High and Rising Health Care Costs: Demystifying U.S. Health Care Spending," Robert Wood Johnson Foundation, Research Synthesis Report No. 16, October 2008, http://www.rwjf.org/files/research/101508.policysynthesis.costdrivers.rpt.pdf; John F. Cogan, R. Glenn Hubbard, and Daniel P. Kessler, "Evaluating Effects of Tax Preferences on Health Care Spending and Federal Revenues," National Bureau of Economics Research Working Paper No. 12733, December 2006, Table 3, p. 21, http://www.nber.org/papers/w12733; and Jonathan Gruber, "Taxes and Health Insurance," *Tax Policy and the Economy*, 2002, 16: 37-66, Table 5, p. 58.

[15] For the value of such a new institutional structure, see Engelberg Center for Health Care Reform at Brookings, "Bending the Curve: Effective Steps to Address Long-Term Health Care Spending Growth." See also, Congressional Budget Office, "Approaches for Giving the President Broad Authority to Change Medicare," July 25, 2009, p. 6, http://www.cbo.gov/ftpdocs/104xx/doc10480/07-25-IMAC.pdf. The CBO report states: "In particular, if the legislation were to provide IMAC with broad authority, establish ambitious but feasible savings targets, and create a clear fall-back mechanism for instituting across-the-board reductions in net Medicare outlays, CBO believes the council would identify steps that could eventually achieve annual savings equal to several percent of Medicare spending."

[16] Government Accountability Office, "Private Health Insurance: 2008 Survey Results on Number and Market Share of Carriers in the Small Group Health Insurance Market," February 27, 2009, http://www.gao.gov/new.items/d09363r.pdf.

[17] Gerard F. Anderson and Bianca K. Frogner, "Health Spending in OECD Countries: Obtaining Value per Dollar," *Health Affairs*, 2008, 27(6): 1718-1727.

[18] John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner, "Geography and the Debate over Medicare Reform," *Health Affairs*, 2002, Web Exclusive, W96-W113.

[19] See Elliott S. Fisher, Julie P. Bynum, and Jonathan S. Skinner, "Slowing the Growth of Health Care Costs – Lessons from Regional Variation," *New England Journal of Medicine*, 2009, 360(9): 849-852; Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas, and Étoile L. Pinder, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, 2003, 138 (4): 273-287; and Katherine Baicker and Amitabh Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs*, 2004, Web Exclusive, W4-184-W4-197.

[20] Wennberg, Fisher, and Skinner, "Geography and the Debate over Medicare Reform."

[21] Council of Economic Advisers, "The Economic Case for Health Care Reform," June 2, 2009, http://www.whitehouse.gov/administration/eop/cea/TheEconomicCaseforHealthCareReform/.

[22] Council of Economic Advisers, "The Economic Case for Health Care Reform," Table 2, p. 28.

[23] Council of Economic Advisers, "The Economic Case for Health Care Reform," Figure 14, p. 26.

[24] Council of Economic Advisers, "The Impact of Health Insurance Reform on State and Local Governments," September 15, 2009, Table 1, p. 6, http://www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf.

[25] Our estimate of savings for all fifty states and the District of Columbia is $11.0 billion in 2007. We then scale this estimate by the ratio of projected health care spending in each year between 2014 and 2019 to health care spending in 2007, to arrive at our estimate of $116 billion for the 2014 to 2019 period. The projection of health care spending is from Centers for Medicare and Medicaid Services, National Health Expenditure Projections, 2008-2018, Forecast Summary and Selected Tables, p. 1, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf.

[26] Congressional Budget Office, "Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended," p. 4.