



# Increased Costs During Retirement Under the Romney-Ryan Medicare Plan

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## Introduction

Former Massachusetts Gov. Mitt Romney and Rep. Paul Ryan (R-WI) want to convert our nation's Medicare program into a voucher system for people who are under 55 years of age.<sup>1</sup> Under their plan seniors beginning in 2023 would receive vouchers to purchase health insurance from private insurance companies or from traditional Medicare. If premiums for traditional Medicare or the private plan they choose cost more than the voucher amount, then seniors would have to pay the difference themselves.

The Romney-Ryan plan would also convert the joint state-federal Medicaid program into a so-called block grant program, designating a reduced amount of funds for each state. And the Romney-Ryan plan would repeal the Affordable Care Act, which reduces drug costs and Medicare premiums and increases access to preventive services for all seniors.

Using data from the nonpartisan Congressional Budget Office and other government agencies along with parameters from published academic research studies, this study analyzes the impact of the Romney-Ryan plan on current and future seniors and shows that the increase in health care costs under the Romney-Ryan plan would be financially debilitating for all seniors. We detail these findings in the pages that follow, but briefly here are the findings.

Gov. Romney and Rep. Ryan claim that no one over 55 will be affected by their health care plan. This claim is false. Their plan would harm all seniors. The Romney-Ryan plan would hurt current seniors in two important ways:

- **Increased drug costs and higher Medicare premiums.** By repealing the Affordable Care Act, the Romney-Ryan plan would raise health care costs in retirement by \$11,000<sup>2</sup> for the average person who is 65 years old today.

- **Increased long-term care costs, including increased costs for nursing home care, because of cuts to Medicaid.** A substantial share of Medicaid spending pays for health care costs for Medicare beneficiaries. The Romney-Ryan Medicaid cuts mean a loss of over \$2,500 annually for seniors currently on Medicare who also rely on Medicaid. Unlike the Medicare voucher system that would begin in 2023 the cuts to Medicaid would begin almost immediately.

For seniors who will become eligible for Medicare after 2022, the financial harm would be even worse.

- **Increasingly unaffordable costs for all seniors who qualify for Medicare after 2022.** For seniors turning 65 in 2023, Medicare costs during retirement would increase by \$59,500 in 2012 dollars under the Romney-Ryan plan. Because under the Romney-Ryan plan the amount of seniors' vouchers will not keep pace with rising health care costs, these numbers are even worse for future generations. In today's dollars seniors who qualify for Medicare in 2030 would see an increase of \$124,600 in Medicare costs over their retirement. Seniors who qualify for Medicare in 2040 will see an increase of \$216,600. And by 2050 newly eligible seniors will pay \$331,200 more in Medicare costs over their retirement.
- **Additional costs from private plans cherry picking healthier patients.** Three-fourths of all Medicare beneficiaries are currently in traditional Medicare.<sup>3</sup> The Romney-Ryan plan would include traditional Medicare as an option in the proposed program, but the costs for seniors who choose to remain in the traditional Medicare program would likely increase even more sharply than for seniors who chose a private plan. Most analysts expect the traditional Medicare plan to attract Medicare beneficiaries with the greatest health needs. In that case, Medicare would no longer enjoy a balanced risk pool and seniors choosing traditional Medicare could wind up paying an extra \$29,000 on average over their retirement lifetime above and beyond the costs described above.

These estimates are conservative because we modeled the plan that Rep. Ryan released—and that Gov. Romney endorsed—earlier this year. As the Congressional Budget Office has estimated, Rep. Ryan's original 2011 plan would result in increased costs that are several orders of magnitude greater than those modeled here.

Let's examine each of these troubling consequences in turn.

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## Increased costs for current seniors

### Increased drug costs and higher premiums

The Affordable Care Act saves money for both current and future seniors, but Gov. Romney has promised to repeal the Affordable Care Act if he is elected president. Repealing the Affordable Care Act will harm the 36 million current seniors in the traditional Medicare program in four ways.

First, cost sharing for parts A (hospital care) and B (physician services) will increase because the Affordable Care Act's adjustments to payment rates for health care providers other than physicians will be repealed. Since costs per hospitalization or nursing home stay will rise, the costs that beneficiaries have to pay will also rise.

Second, this change will lead to increases in premiums paid by beneficiaries for Medicare part B.

Third, the "donut hole" in the prescription drug plan, which will be closed by the Affordable Care Act, would be reopened, meaning both current and future seniors would pay more for the medicines they need.

Finally, cost sharing for preventive services, which is eliminated under the Affordable Care Act, would be reinstated, meaning that seniors would have to pay for important preventive care, including cancer screenings that they now access for free.

Despite Gov. Romney and Rep. Ryan's claims that their plan will not affect current seniors, estimates of the costs to seniors of repealing the Affordable Care Act suggests that annual costs for current seniors in traditional Medicare would rise by more than \$200 in 2013, and that added cost would increase to more than \$700 in 2021.<sup>4</sup>

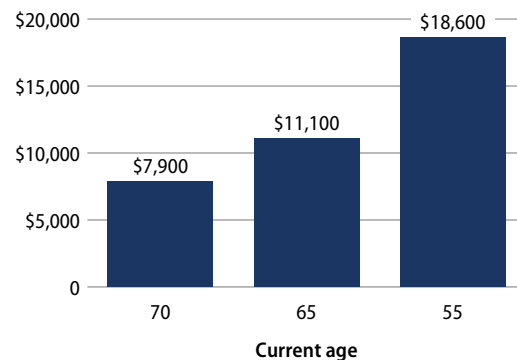
To assess the long-term impact of these cost increases on seniors, we used the Social Security Administration's life tables to translate these annual increases into Medicare costs over the course of their retirement. To account for inflation, we express all future amounts in 2012 dollars.

Figure 1 shows our results.

We estimate that a current 70 year old will pay nearly \$8,000 more for Medicare in retirement as a result of the Romney-Ryan plan. A current 65 year old will pay over \$11,000 more for Medicare in retirement. And a current 55 year old will pay over \$18,000 more for Medicare in retirement.

**FIGURE 1**  
**The costly consequences of repealing the Affordable Care Act**

Increase in health spending during retirement for enrollees in traditional Medicare in 2012 dollars



Source: Authors' calculations based on Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Medicare Beneficiary Savings and the Affordable Care Act (2012); Social Security Administration, "Actuarial Life Tables," available at <http://www.ssa.gov/oact/STATS/table4c6.html>.

## Increased long-term care costs, including nursing home costs

Gov. Romney and Rep. Ryan propose turning Medicaid into a block grant and cutting Medicaid spending by indexing the growth of the program to economy-wide inflation and population growth. The Congressional Budget Office estimates that by 2022, federal spending on Medicaid will fall 35 percent relative to a baseline that excludes the Medicaid expansion in the Affordable Care Act. By 2030 federal Medicaid spending will be 49 percent lower than the non-Affordable Care Act baseline.

Because the Romney-Ryan plan would not implement reforms that reduce health spending overall, but only reduce the amount that the federal government will pay toward that spending in Medicaid, states and Medicaid beneficiaries will have to shoulder the total burden of the 49 percent reduction in federal spending. This would have a significant effect on seniors, as 9 million Medicare recipients currently depend on Medicaid funds, including 1.9 million seniors who rely on Medicaid to support their long-term care needs.<sup>5</sup>

To focus on how the Romney-Ryan plan affects current seniors, we focus only on Medicare beneficiaries who are 65 or older. Currently, 23 percent of Medicaid expenditures are paid on behalf of seniors who are also enrolled in Medicare. We apply this percentage to the total Medicaid cuts (excluding the increased Medicaid expansion under the Affordable Care Act) in the first 10 years of the Romney-Ryan budget.<sup>6</sup> We then divide this product by the projected number of seniors who would rely on Medicaid over the next 10 years.<sup>7</sup>

On average, the Romney-Ryan Medicaid cuts would mean an annual decrease of \$2,500 in benefits for each senior who relies on Medicaid to help pay for long-term care. To compensate for these cuts, either seniors or their families would have to pay more for their current levels of care or be forced to cut back on care.

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## Increased costs for future seniors

Beginning in 2023 the Romney-Ryan plan would convert Medicare spending into “premium support,” providing vouchers to beneficiaries to purchase either a private health insurance plan or the traditional Medicare plan. Private insurance plans would submit bids for how much they would charge to provide coverage. The voucher would be tied to the premium of the private plan with the second-lowest cost, or the premium for traditional Medicare—whichever is lower. If beneficiaries choose a plan that costs more than the voucher, they must pay the difference.

In some geographic areas traditional Medicare might make the lowest bid, but in others some private plans might make lower bids. In areas where private plans make bids

that are lower than the cost of traditional Medicare, the voucher would be tied to the premium of a private plan. As a result many beneficiaries would be forced to pay sharply higher premiums to stay in traditional Medicare.

The Romney-Ryan plan not only would shift costs to seniors who wanted to stay in a traditional Medicare plan but would also increase costs to all seniors. The plan would set the initial voucher amount at \$7,500 in 2023. The plan caps the rate of growth in the voucher amount to the rate of growth of gross domestic product plus 0.5 percentage points.<sup>8</sup> This growth rate is much slower than the projected growth in health care costs, which means that the voucher would become increasingly insufficient to cover the costs of insurance, therefore shifting an increasing share of insurance premium costs to seniors. There are no provisions in the Romney-Ryan plan that would be expected to reduce the rate of growth of these costs.

Seniors will face higher costs not only because of this cost shift from the government but also because the Romney-Ryan plan increases system-wide costs by promoting private insurance that will be more costly than the existing Medicare system. The Romney-Ryan plan would cost more than the current Medicare system because, as the Congressional Budget Office has documented, private insurance companies have higher profits and administrative costs than Medicare does, and because the plan would reduce the market share, and therefore the purchasing power, of traditional Medicare.<sup>9</sup>

Gov. Romney and Rep. Ryan claim that privatizing Medicare will increase competition among health plans, allowing market forces to lower costs. But the Romney-Ryan plan does not address underlying health care costs or consider that the health care market functions differently than other consumer markets. Ample evidence exists that premium support would not foster the type of competition that reduces prices. The Congressional Budget Office concludes that premium-support plans would achieve much of their federal savings from “increases in the premiums paid by beneficiaries, not from increases in the efficiency of health care delivery.”<sup>10</sup>

There also is evidence that “Medicare beneficiaries are less responsive to differences in premiums when choosing a health plan than the privately insured population is, so plans may have less incentive to compete on the basis of premiums in the Medicare market than in the privately insured market.”<sup>11</sup> These concerns have played out in the part D market, where most savings achieved by the program are a result of factors other than competition, including lower enrollment and greater generic utilization.<sup>12</sup>

## Increased costs to all seniors who qualify for Medicare after 2022

Because the Romney-Ryan voucher would grow more slowly than health care costs, seniors would become responsible for a greater share of the premium over time.<sup>13</sup> We find that the Romney-Ryan plan's cost-shifting effect alone would raise the average health care bill:

- For seniors reaching age 65 in 2023 by \$32,900
- For seniors reaching age 66 in 2030 by \$73,600<sup>14</sup>
- For seniors reaching age 67 in 2040 by \$139,100
- For seniors reaching age 67 in 2050 by \$225,200

This significant increase in health care costs for seniors in the future due to this cost-shifting effect would consume 8 percent of their lifetime Social Security benefits for those turning 65 in 2023, 17 percent of lifetime Social Security benefits for those turning 66 in 2030, 30 percent of lifetime Social Security benefits for those turning 67 in 2040, and 42 percent of lifetime Social Security benefits for those turning 67 in 2050.

The Romney-Ryan plan would also raise system-wide health care costs, adding even more to what seniors would pay under this plan. As the share of the population participating in traditional Medicare declines, Medicare's market share would fall and neither Medicare nor any single private insurer would have sufficient market share to negotiate provider prices as low as Medicare can achieve now. In addition, with more private insurance companies involved in Medicare, administrative costs and profits would rise.

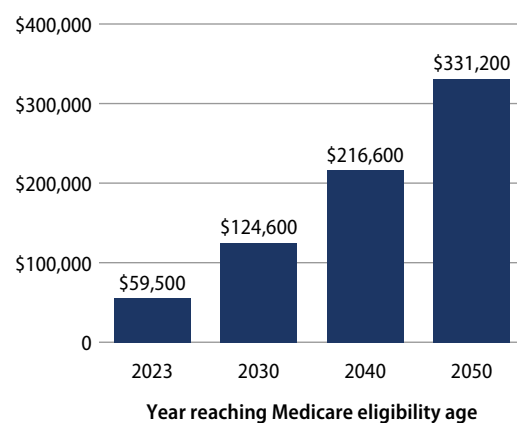
In analyzing the 2011 version of the Ryan plan, the Congressional Budget Office projected that these factors would raise Medicare costs by 39 percent starting in 2022.<sup>15</sup> Because there is considerable uncertainty about how many seniors would switch to the private plans and how rapidly Medicare's bargaining power would decline, we decided to be conservative and assume that costs would rise by only half as much as in the CBO model, and that it would take 10 years for the loss in bargaining power to phase in. Even with these conservative assumptions, we find very large additional costs for seniors. The total additional retirement cost to seniors who reach retirement age after 2022 under the Romney-Ryan plan is shown in Figure 2.

Once you add the system-wide costs to the cost-shifting effects listed above the total increase is:

- \$59,500 for seniors reaching age 65 in 2023
- \$124,600 for seniors reaching age 66 in 2030
- \$216,600 for seniors reaching age 67 in 2040
- \$331,200 for seniors reaching age 67 in 2050

**FIGURE 2**  
**The costly consequences of the Romney-Ryan voucher system for future seniors**

Increase in health care costs during retirement for beneficiaries under the Romney-Ryan plan in 2012 dollars



Source: Authors' calculations based on Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan" (2012); Congressional Budget Office, "The 2012 Long Term Budget Outlook" (2012).

While retirees' incomes will also increase over time as the cost-of-living adjustment to Social Security rises, it will not increase as rapidly as these required payments. The total additional costs to seniors would consume 15 percent of lifetime Social Security benefits by 2023, 29 percent by 2030, 46 percent by 2040, and 62 percent by 2050.

### Additional costs from private plans cherry picking healthier patients

The impact of the Romney-Ryan plan would be even greater for seniors who want to remain in traditional Medicare. Over time, the costs associated with enrolling in traditional Medicare under the Romney-Ryan voucher system are likely to rise, potentially quite dramatically. The figures above reflect costs for the average Medicare patient, whether they are enrolled in traditional Medicare or a private plan. But the traditional Medicare program is likely to attract a disproportionate share of Medicare patients with the greatest health needs because these patients are most dependent on the broad choice of providers available in traditional Medicare.

Since the mid-1980s, private Medicare plans have attracted the healthiest, lowest-cost enrollees from the Medicare population—a phenomenon known as “adverse selection.”<sup>16</sup> This trend would accelerate under the Romney-Ryan plan. If less healthy, more costly beneficiaries are left behind in traditional Medicare, then premiums for traditional Medicare would rise. In turn, more beneficiaries would leave traditional Medicare, causing premiums to rise further, and so on—creating a so-called “death spiral.”

The Romney-Ryan plan would adjust the voucher for health status—redistributing payments from plans with healthier enrollees to plans with less healthy enrollees. This “risk adjustment” mechanism would certainly help, but would still be insufficient at controlling costs. Current risk-adjustment methods are still far from perfect. The current risk-adjustment model used to calculate payments to Medicare Advantage plans can account for only 11 percent of the total variation in Medicare enrollees' annual costs.<sup>17</sup> Current methods tend to overpay plans with healthier enrollees and underpay plans with less healthy enrollees. Moreover, recent studies show that private health plans have become increasingly sophisticated at manipulating how they code the health status of their patients, undermining the risk-adjustment procedures.<sup>18</sup>

Thus, even with risk adjustment, premiums for traditional Medicare would likely rise and enrollment would likely decline over time under the Romney-Ryan plan. This outcome is made more probable by the fact that the Romney-Ryan plan would not require private plans to provide a standard set of benefits—allowing them to design benefits that attract healthier beneficiaries.

To our knowledge, there is only one peer-reviewed study, “The Distributional Consequences of a Medicare Premium Support Proposal,” by University of California-

Los Angeles professor Thomas Rice and health consultant Katherine A. Desmond, that analyzes the effects of a Medicare voucher system that both retains traditional Medicare and uses risk adjustment to calculate payments to plans.<sup>19</sup> This study simulates the additional costs that enrollees would face if they wish to remain in traditional Medicare under various assumptions about the effectiveness of risk adjustment.

The plan modeled in this study and Romney-Ryan are remarkably similar in that both are premium support plans with risk adjustment and a traditional Medicare option. Some differences will doubtlessly occur, but we do not believe these differences are likely to change our results.<sup>20</sup> Moreover, we focus on the results that use the most favorable assumptions for the Romney-Ryan plan. We use the Rice-Desmond results and update them to reflect expected Medicare costs in 2022 instead of 1996, the baseline year they use. Table 1 shows the additional costs that would be paid in each calendar year by participants in traditional Medicare because of adverse selection.

**TABLE 1**  
**Additional costs of the Romney-Ryan plan for traditional Medicare enrollees**

Additional costs associated with remaining in traditional Medicare based on different risk-adjustment effectiveness

Year	25 percent risk-adjustment effectiveness		50 percent risk-adjustment effectiveness		75 percent risk-adjustment effectiveness	
	Additional FFS costs (\$)	Percent decrease in FFS share	Additional FFS costs (\$)	Percent decrease in FFS share	Additional FFS costs (\$)	Percent decrease in FFS share
2023	1,470 <sup>21</sup>	1.2%	1,400	1.2%	1,330	0.0%
2024	1,540	3.6%	1,430	2.4%	1,330	1.2%
2025	1,628	7.1%	1,460	4.8%	1,340	2.4%
2026	1,730	10.7%	1,510	6.0%	1,350	2.4%
2027	1,870	14.3%	1,570	9.5%	1,360	3.6%
2028	2,050	19.0%	1,620	11.9%	1,370	4.8%
2029	2,270	25.0%	1,690	15.5%	1,380	6.0%
2030	2,540	31.0%	1,780	19.0%	1,400	7.1%
2031	2,860	36.9%	1,880	22.6%	1,410	8.3%
2032	3,280	44.0%	2,000	26.2%	1,420	9.5%
2037	6,970	75.0%	2,890	50.0%	1,510	17.9%
2042	14,420	91.7%	4,450	71.4%	1,650	28.6%

Notes: This table updates the results in Table 2 in Rice and Desmond for expected Medicare costs in 2023 and puts all costs in 2012 dollars. In their original table, 1996 is the base year (so 1997 would be the first year in their table). We adjust their results to reflect Medicare costs in 2023 by taking the total Part A and Part B (their analysis excludes the cost of prescription drugs) in 1995 and the Medicare Trustees' projection of these costs in 2021 (while we would ideally want to adjust using 1997 and 2023, the Trustees' report does not publish numbers for these years, and using a slightly different 26-year span is likely to produce very similar cost growth). We further update years beyond 2023 with the Congressional Budget Office's projections of Medicare per capita growth.

Even assuming highly successful risk-adjustment of 75 percent, far beyond what policy-makers have currently achieved, added lifetime retirement costs from adverse selection would likely exceed \$29,000 in 2012 dollars.



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## Conclusion

Under the Romney-Ryan plan, all Americans would be forced to spend substantially more money on health care during their retirements—from tens of thousands of dollars for current seniors to hundreds of thousands of dollars more for future seniors. Those who are unable to afford these significantly increased health care costs would be forced to reduce other retirement spending or forgo necessary care.

There is no question that the long-term costs of medical care need to be addressed. But forcing seniors to shoulder the entire burden of rising health care costs is not the solution. A better, more just solution is to address the underlying causes of high health care costs, reducing costs overall, and enabling everyone to pay less without compromising access. The Affordable Care Act takes many steps in this direction, but as we have outlined elsewhere, there is more to be done to make the system more efficient overall and create better value for both individuals as well as the government.<sup>22</sup>

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## Endnotes

- 1 People who turn 55 later this year will also be grandfathered into the pre-Romney-Ryan Medicare plan.
- 2 All figures rounded to the nearest hundred dollars.
- 3 Henry J. Kaiser Family Foundation, "Kaiser Slides: Analysis of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage enrollment files," 2011, Slide 10, available at <http://facts.kff.org/chart.aspx?ch=1755>.
- 4 Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Savings and the Affordable Care Act*, Assistant Secretary of Planning and Evaluation Issue Brief, February 2, 2012.
- 5 Henry J. Kaiser Family Foundation, "Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-based Settings" (2011), available at <http://www.kff.org/medicaid/upload/7576-02.pdf>
- 6 For total Medicaid cuts see the House Republican budget, p. 42, available at <http://www.budget.house.gov/uploaded-files/pathtoprosperty2013.pdf>.  
  
See also: Kaiser Family Foundation, "5 Key Questions and Answers about Medicaid" (2012), Figure 15, available at <http://www.kff.org/medicaid/8162.cfm>. Figure 15 documents that 23 percent of Medicaid spending is used to finance the care of seniors on Medicare. Note that excluding the ACA is appropriate because much of the increased Medicaid funds are used to expand coverage to young adults, not Medicare dual-eligibles.
- 7 Henry J. Kaiser Family Foundation, "Medicare's Role for Dual Eligible Beneficiaries" (2012), available at <http://www.kff.org/medicare/upload/8138-02.pdf>. The Medicare Trustees do not publish projections of the Medicare population broken down by aged/disabled status and Medicaid status. We thus take the share of current Medicare recipients who are on Medicaid (20 percent) and multiply this by the share of this population that is aged as opposed to disabled (61 percent), to find the current share of Medicare beneficiaries who are both on Medicaid and aged (12.2 percent). All these numbers come from Kaiser Family Foundation's analysis. We then multiply the 2012 Trustees' reports projections for total Medicare enrollment by 12.2 percent to obtain projections for the aged dual-eligible population.
- 8 Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan" (2012), p. 3, available at [http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan\\_Specified\\_Paths\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf).
- 9 Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan" (2011), p. 21.
- 10 Congressional Budget Office, "Budget Options Volume I: Health Care" (2008), p. 121.
- 11 Congressional Budget Office, "Designing a Premium Support System For Medicare" (2006), p. 36.
- 12 Jack Hoadley, Kaiser Family Foundation, "Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition" (2012).
- 13 Congressional Budget Office, "The 2012 Long Term Budget Outlook" (2012). We simulate the magnitude of this cost shift using standard economic and demographic methods. We assume that average medical costs increase according to the rate projected by the Congressional Budget Office. The Congressional Budget Office (CBO) projects medical cost growth as the growth of per capita GDP plus an excess cost growth factor that declines from 1.6 percentage points annually to 1.0 percentage points annually over time (The Congressional Budget Office's projected growth rate includes anticipated increases in physician fees that would maintain access to care).  
  
See also: Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," (2012). The CBO also provides estimates for the Medicare costs of people when they first enter the Medicare program. We simulate lifetime spending based on these costs and projections of the life expectancy of beneficiaries provided by the Social Security Administration.
- 14 The Romney-Ryan plan also gradually increases the age of Medicare eligibility to 67.
- 15 Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan."
- 16 See, for example, K.M. Langwell and J.P. Hadley, "Evaluation of the Medicare competition demonstrations," *Health Care Financing Review* 11 (2) (1989): 65-80; Physician Payment Review Commission, "Testimony of Gail R. Wilensky," Statement before the U.S. House of Representatives Subcommittee on Health, Committee on Ways and Means, February 24, 1997; M.M. Mello and others, "Understanding biased selection in Medicare HMOs," *Health Services Research* 38 (3) (2003): 961-992; and Amber Batata, "The effect of HMOs on fee-for-service health care expenditures: evidence from Medicare revisited," *Journal of Health Economics* 23 (5) (2004): 951 - 963.
- 17 Gregory C. Pope and others, "Risk adjustment of Medicare capitation payments using the CMS-HCC model," *Health Care Financing Review* 25 (4) (2004): 119-141.
- 18 Government Accounting Office, "Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices," (2012), available at <http://www.gao.gov/assets/590/587637.pdf>.  
  
This recent General Accounting Office study on so-called "intensive-coding" by MA plans to artificially increase their enrollees' risk scores and thus their payments from Medicare.
- 19 Thomas Rice and Katherine Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy and Law* 29 (6) (2004):1187-1226, available at <http://jhppl.dukejournals.org/content/29/6/1187.abstract>
- 20 The difference that seems most likely to arise is that Rice and Desmond assume no geographic price adjustment and we suspect that the Romney-Ryan plan would likely follow the current Medicare Advantage structure and vary voucher amounts locally. Adverse selection against fee-for-service is likely to happen in each local market, so this difference is unlikely to affect our results. However, for this reason, we only use Rice and Desmond's results on national averages and not their state-by-state breakdown of the effects of such a policy.
- 21 These figures have been rounded to the nearest tens of dollars.
- 22 Zeke Emanuel and others, "A Systemic Approach to Containing Health Care Spending," *The New England Journal of Medicine*, August 2012, available at <http://www.nejm.org/doi/full/10.1056/NEJMs1205901>.