



Health Insurance Reform Project Identifies New Ideas to Improve Federal Health Policy—Voluntary Chronic Care Improvement Programs and Tax Credits

Health Insurance Reform Project: Medicare, Access, and Quality

SUMMARY

The Health Insurance Reform Project (HIRP) worked to develop and advance new ideas to improve federal health policy, focusing primarily on improving quality in Medicare and expanding health insurance coverage nationally. Project staff identified ideas that could move policy forward, convened seven meetings of leading experts and developed 22 publications (14 journal articles, two book chapters, four issue briefs and two reports) to advance the ideas.

Key Results

Project staff reported the following key results:

- The project helped conceptualize voluntary chronic care improvement programs as a way to improve quality performance for Medicare. The Centers for Medicare & Medicaid Services (CMS) designed the programs to serve people who are enrolled in fee-for-service Medicare and who have multiple chronic conditions, including congestive heart failure and complex diabetes. Congress authorized development and testing of voluntary chronic care improvement programs in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.
- The project brought the concept of tax credits to expand health insurance coverage to the uninsured into the policy debate and stimulated discussion on the ways in which tax credits could be used to cover low-income people.

In 2005, the voluntary chronic care improvement programs, now called Medicare Health Support, began with nine programs serving approximately 180,000 beneficiaries (see [Appendix 1](#) for more information about these programs). Tax credits for low-income families to buy health insurance are a key component of the Bush administration's budget proposal, released in February 2005. Also in 2005, the National Governors' Association

decided to use the "Medicaid plus tax credits" strategy as the framework for discussions with the Bush administration to expand health care coverage.

Funding

The Robert Wood Johnson Foundation (RWJF) provided \$1,007,042 million to support the project from 2001 to 2003 through three unsolicited grants (Grant ID#s 041223, 041828 and 048295).

THE PROBLEM

By 2001, national health policy had become increasingly partisan, gridlocked and focused on short-term political objectives. Researchers at George Washington University expected continued change and turmoil in the health care industry and in government-private sector relations.

The Health Insurance Reform Project—a nonprofit, nonpartisan program based at George Washington University and funded by RWJF—had been helping policy-makers and others in the health care field understand the changes and innovations occurring in the health care/insurance markets, particularly in Medicare and coverage for people without health insurance, since its establishment in 1995. The project provided a neutral forum for long-range thinking meant to stimulate, educate and help build consensus around ideas that can help move policy forward.

From 1995 to 2001, the project focused on four areas:

- Medicare reform
- supporting consumers in decision-making about health care
- major trends and paradigms in health care nationally
- tax credits for the uninsured.

Project staff researched and drafted papers, convened meetings of leading experts to deliberate the issues discussed in the draft papers, and then revised and published the papers. RWJF provided three grants totaling \$1.8 million (see [Grant Results](#) on ID#s 027243, 030390, and 035292).

According to RWJF Program Officer Nancy Barrant, the Health Insurance Reform Project "produced critical thinking and ideas influencing national health care policy." The project's contributions included work related to the future governance of Medicare, Medicare reform, policy implications of new prescription drugs and rising drug spending, options for reducing the number of uninsured workers, the scope of coverage for

Medicare beneficiaries with disabilities, improved cancer care, issues related to consumer choice among health plans and retirement planning for baby boomers.

RWJF STRATEGY

RWJF supports efforts to achieve stable and affordable health care coverage for all Americans. The Health Insurance Reform Project (HIRP) produced critical thinking and ideas designed to influence national health care policy. This project sought to foster thoughtful, nonpartisan examination of national health care issues and to build consensus around ways to resolve them.

Under Grant ID#s 027243, 030390 and 035292, HIRP provided analysts with a wide degree of latitude in selecting significant and timely topics. (See [Grant Results](#).)

HIRP worked in two areas of interest to RWJF: (1) the design and implementation of a federally sponsored, large-scale demonstration of improving quality performance under the Medicare program; and (2) targeted research on the design and implementation of tax credits to expand coverage to the uninsured and the redesign of Medicaid.

THE PROJECT

The Health Insurance Reform Project continued its work to develop and advance new ideas to improve federal health policy, focusing primarily on improving quality in Medicare and expanding health insurance coverage nationally, under three *unsolicited* grants (Grant ID#s 041223, 041828 and 048295). Project staff "identified ideas that could move forward, and gave them enough weight that they could get carried forward," according to Barrand.

Under the first grant (Grant ID# 041223), the Health Insurance Reform Project focused on expanding health care coverage, improving Medicare, improving fee-for-service Medicare, promoting the health of people with disabilities and improving quality through consumer information services. Project staff and a consultant developed 18 publications (10 journal articles, two book chapters, three research briefs, two reports and one background paper) and convened seven meetings of national experts from government, academia and the private sector.

Three meetings focused on disease management in fee-for-service Medicare. Participants included senior staff from the Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Quality and Research, who had the opportunity to discuss clinical and research design issues with each other and with outside experts. Project staff also testified on flexible benefits tax credits before the U.S. House of Representatives Committee on Ways and Means, Subcommittee on Health, upon written request from Committee Chair Representative Nancy Johnson.

Under the second and third grants (Grant ID#s 041828 and 048295), the Health Insurance Reform Project narrowed its primary focus to:

- The design and implementation of a federally sponsored, large-scale demonstration of improving quality performance under Medicare
- Targeted research on the design and implementation of tax credits to expand coverage to the uninsured

Project staff and a consultant also worked on:

- Medicare promoting quality improvement by paying for performance
- Strategies to improve consumer information
- The need for new national health strategies to improve health status and encourage the use of evidence-based medicine, particularly for Medicare enrollees in different geographic locations

Project activities included:

- Publishing six articles.
- Providing technical assistance to the CMS, at its request, in the design of a Medicare quality improvement demonstration which incorporates disease management.
- Organizing meetings with senior CMS staff and an insurance company and a disease management firm to enable CMS to learn more about managing population-based disease management programs.
- Producing a proposal for Medicaid reform that uses tax credits to expand health care coverage nationally.
- Working with Senate Finance Committee staff to identify issues in extending the health care tax credit to laid-off workers.

The Health Insurance Reform Project contracted with independent consultant Lynn Etheredge for work under these three grants.

RESULTS

The project's most significant results related to work to improve Medicare quality performance and to use tax credits to expand health coverage for the uninsured, according to Barrand. Project staff reported the following results to RWJF:

Improving Medicare Quality Performance:

- **The project helped conceptualize voluntary chronic care improvement programs as a way to improve quality performance for Medicare.** The Centers for Medicare

and Medicaid Services designed the programs to serve people who are enrolled in fee-for-service Medicare and who have multiple chronic conditions, including congestive heart failure and complex diabetes. Congress authorized development and testing of voluntary chronic care improvement programs in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. According to the CMS, "the programs will help participants adhere to their physicians' plans of care and obtain the medical care they need to reduce their health risks. By better managing and coordinating the care of these beneficiaries, the new Medicare initiative will help reduce health risks, improve quality of life, and provide savings to the program and the beneficiaries." The CMS oversees the programs, which are operated by health care organizations chosen through a competitive selection process. The health care organizations offer self-care guidance and support to these beneficiaries. The programs run for three years and will be evaluated through randomized controlled trials. For more information about the program design, which the CMS and the Health Insurance Reform Project co-developed, see [Appendix 2](#).

Tax Credits to Expand Coverage to the Uninsured:

- **The project brought the concept of tax credits to expand health insurance coverage to the uninsured into the policy debate and stimulated discussion on the ways in which tax credits could be used to cover low-income people.** "The project contributed significantly to the issue of tax credits for coverage of low-income people," said Barrand. "Any legislation that dealt with tax credits had the project's fingerprints on it."
- **Senators Grassley and Baucus introduced this bill, the Health Care Tax Credit Expansion Act of 2003.** The act sought to make people receiving unemployment compensation eligible for a tax credit for health insurance costs. The House of Representatives passed the bill, but the Senate did not.
- **The project produced a proposal for Medicaid reform which used tax credits to expand health care coverage nationally.** The proposal included an extensive reform agenda, including a new federal-state partnership, "needs-based" eligibility, a "Medicaid plus tax credits" strategy for covering the uninsured, and long-term care incentives. According to Project Consultant Etheredge, the proposal has attracted interest from key legislators. See [Findings](#) for more information about the proposal.

Other Results

The researchers also reported the following results to RWJF:

- **The project brought the concept of "paying for performance" into the policy debate and stimulated discussion of this concept.** New understanding of "paying for performance" formed the basis for a new national system for hospital reporting which requires hospitals to report on their performance against a set of quality measures in order to receive increased payments. This system was established in the

Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Etheredge called this a "new national system for quality assurance."

- **The National Library of Medicine, the American College of Physicians and the American Society of Internal Medicine created a Web-based patient information program, the Health Information Prescription program.** Internists use customized prescription pads to point patients to first-rate online health information in the National Library of Medicine's [MEDLINEplus database](#). A pilot test in three states was planned; the first pilot test began in 2003 in Iowa.
- **Researchers proposed a nonprofit national health channel.** The health channel would provide high-quality health information to fill information needs, rather than focusing on maximizing the number of viewers. Possible programs could include living with disability, what to do when you are diagnosed with cancer or diabetes, a Medicare hour, and programs by disease associations such as the American Heart Association.

Findings

Project staff reported the following key findings in selected publications and to RWJF:

Improving Medicare Quality Performance:

- **Population-based disease management represents a shift from Medicare as a regulator and a bill-paying program to Medicare as a catalyst for improving the health of its beneficiaries.** "This changes entirely the incentives, dynamics, support structure and use of data. Medicare is getting more data by investing more in prevention, but in the framework of accountability for outcomes," said Project Director Sandra Foote. (Etheredge and Foote)
- **"Under fee-for-service Medicare, a range of innovative program models could be developed and tested to identify cost-effective means of helping various subgroups of chronically ill beneficiaries and their providers improve health and cost outcomes."** Structuring population-based disease management programs would mean tying contractor "payments to performance in achieving measurable, population-based goals for quality improvement, savings and beneficiary and provider satisfaction." Such a method "would permit the federal government to make substantial new investments in improving chronic care nationally without increasing net Medicare costs." (*Health Affairs*, July 2003)
- **Providers of population-based disease management programs have the flexibility to provide support services which are customized to each beneficiary's needs and preferences.** (Foote)

Tax Credits to Expand Coverage to the Uninsured:

- **A new federal-state partnership—a new Medicaid program—is suggested for coverage of the uninsured and long-term care. Such a program will bridge large gaps in eligibility and coverage among the states.** "National standards have always played a role in Medicaid's development, in coverage (e.g., infants and pregnant women), in benefits (e.g., nursing homes), and in quality (e.g., long-term care facility regulations). Despite such important federal initiatives, Medicaid has grown in patchwork fashion, with much diversity among states. Without a national framework, there will continue to be indefensible coverage gaps and inequities, even as Medicaid spending continues to rise." (*Health Affairs*, August 2003)
- **"Medicaid has already outgrown its original design as medical aid for welfare case-assistance populations. A new Medicaid program could offer health insurance for lower-income people based on need and integrate Medicaid coverage with new health insurance tax credits. It could offer self-directed home and community-based care for disabled people of all ages, within a new financing framework for long-term care benefits."** See [Appendix 3](#) for details. (*Health Affairs*, August 2003)
- **"New and effective measures to assist the uninsured are increasingly necessary. Health insurance tax credits for laid-off workers, built around the Trade Act compromise, could help millions of deserving, uninsured Americans and may be one of the most promising options for bipartisan action."** Trade legislation provides a federal income tax credit covering 65 percent of health insurance premiums for workers who are laid off due to foreign competition. "With some revisions, these elements of the Trade Act could be incorporated into a broader credit for involuntarily unemployed workers generally, whether or not their layoffs were due to trade policy." Laid-off workers could use a tax credit to buy coverage if they do not have access to group coverage (e.g., through former employers, their spouses' employers or programs such as Medicaid). "This would give all tax credit beneficiaries access to health coverage through existing mechanisms, without any new health plan contracts or market reforms." (*Economic and Social Research Institute Current Policy Series*, February 2003)

Other findings:

- **"Payment for performance should become a national priority and Medicare payments should lead in this effort, with an immediate priority for hospital care."** "A major initiative by Medicare to pay for performance can be expected to stimulate similar efforts by private payers." (*Health Affairs*, 2003)

Communications

Project staff published 16 journal articles, including in *Health Affairs*, *Economic and Social Research Institute Current Policy Series*, and *Western Journal of Medicine*; two book chapters; four research briefs; and two reports about the project, and disseminated these publications to the health policy community, including through a project Web site

(the project Web site is no longer operational; however, many publications from HIRP and an HIRP bibliography are available through the National Health Policy Forum's Web site [publications page](#)).

The project sponsored seven meetings with experts from government, academia and the private sector. Project staff testified before the U.S. House of Representatives and made presentations at local conferences and meetings. Several media stories and editorials discussed the work done under this project, including in *The New York Times*, the *Chicago Tribune*, and *Business Insurance*. See the [Bibliography](#) for details.

LESSONS LEARNED

1. **Public and private sector health leaders are eager to discuss constructive new approaches to address major national health policy issues.** The Health Insurance Reform Project was able to engage many national experts in the public and private sector by behaving professionally and having a wide range of contacts. (Project Director)
2. **Given the enormous influence that the federal government wields over health and health care nationally, it is crucial, yet difficult, to involve staff of federal agencies in collaborative, strategic thinking about new federal health policy options.** Staff of federal agencies have little time and discretionary money, and lack the contacts, to foster the development of creative ideas and collaborative exchanges of ideas among experts. The Health Insurance Reform Project brought federal staff together with experts from academia and the private sector, providing networking opportunities and the ability to learn about and discuss new ideas. (Project Director)

AFTERWARD

The Health Insurance Reform Project worked with the CMS to implement the voluntary chronic care improvement programs under another RWJF grant (see [Grant Results](#) on ID# 048827; 2003–2004). Project staff helped the CMS obtain input on disease management and design of the demonstration from private-sector experts, and helped structure the demonstration. In June 2004, Project Director Sandra Foote joined the CMS to direct Medicare Health Support; she has since been promoted to senior adviser for chronic care improvement.

Phase I of the voluntary chronic care improvement program, now called Medicare Health Support, began with nine programs serving approximately 180,000 beneficiaries in 2005 (see [Appendix 1](#) for more information about these programs). Phase II will expand successful Phase I programs or program components to additional regions, possibly nationally. According to the CMS, "These awards mark a major milestone in the shift toward prevention and quality improvement for chronically ill beneficiaries under Medicare Fee-For-Service. This initiative is an important component of modernizing and

strengthening Medicare." More information about Medicare Health Support is available on the CMS's [Web site](#).

Tax credits for low-income families to buy health insurance are a key component of the Bush administration's budget proposal, released in February 2005. The budget proposed spending \$140 billion over 10 years to expand health coverage to millions more Americans, including through tax credits. The budget proposal includes a traditional health insurance tax credit, a health insurance tax credit with health savings accounts and state purchasing pools (for more information, see [Appendix 4](#)). In February 2005, the National Governors' Association decided to use the "Medicaid plus tax credits" strategy as the framework for discussions with the Bush administration to expand health care coverage.

The concept of paying for performance is gaining acceptance; in 2005, the National Center for Quality Assurance expected approximately 98 percent of hospitals to report on these quality measures adopted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and physicians' groups nationwide want to develop quality measurement and reporting systems, according to Etheredge. Pilot tests of the Health Information Prescription program began in Louisiana (in 2004) and Florida (in 2005) and there is interest in expanding the program, according to Etheredge. Discussions about developing a national health channel are ongoing between Etheredge, foundations and other interested parties.

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APPENDIX 1

Medicare Health Support Programs

Health Care Organizations and Areas Served

- Humana, Inc: Central Florida
- XLHealth Corporation: Tennessee
- Aetna Health Management, LLC: Chicago, Illinois
- Lifemasters Supported SelfCare, Inc.: Oklahoma
- McKesson Health Solutions, LLC: Mississippi
- CIGNA HealthCare: Georgia
- Health Dialog Services Corporation: Pennsylvania
- American Healthways, Inc.: Washington, D.C., and Maryland
- Visiting Nurse Service of New York Home Care and United HealthCare Services, Inc., Evercare: New York City: Queens and Brooklyn

Program Highlights

- The programs are intended to help increase adherence to evidence-based care, reduce unnecessary hospital stays and emergency room visits and help participants avoid costly and debilitating complications and co-morbidities.
- The programs will offer self-care guidance and support to chronically ill beneficiaries to help them manage their health, adhere to their physicians' plan of care and assure that they obtain medical care that they need to reduce their health risks.
- The programs will include collaboration with participants' providers to enhance communication of relevant clinical information.
- Participation will be entirely voluntary. Eligible beneficiaries do not have to change plans or providers to participate. Beneficiaries will be able to stop participating at any time. These programs do not restrict access to care and they will be provided at no charge to participants.
- The new programs are NOT single-disease focused. They will be designed to help participants manage all their health problems.

APPENDIX 2

Key Aspects of the Medicare Voluntary Chronic Care Improvement Program (now called Medicare Health Support)

The following key aspects of the chronic care improvement program were identified and outlined by the Health Insurance Reform Project and the CMS, according to project staff:

- CMS will adopt a radically new approach to contracting and data management to help selected chronically ill populations improve their clinical and financial outcomes. The new approach entails setting measurable, population-based goals for quality improvement and costs, tracking progress and tying contractor payment to results.
- The program is focused mainly on helping chronically ill beneficiaries improve their self-care, but awardees will also be tasked with improving clinical information support for participants' physicians.
- The statute is fairly prescriptive in terms of program objectives and some important program elements (e.g., regional, large-scale, population-based, care management plans, fees at risk for performance), but it is also deliberately designed to allow a wide range of new interventions to improve chronic care outcomes.
- Program design assures that awardees will focus on developing interventions that are likely to improve clinical outcomes and beneficiary and provider satisfaction and to generate savings. The statute requires that awardees agree to performance standards on all three of these dimensions of performance across their assigned target populations and have fees at risk for results. Evaluation will be done through randomized controlled trials.
- This program design—putting fees at risk against savings guarantees—allows the federal government to open up a major new source of funding for innovation in chronic care with a fairly high degree of certainty of a positive return on investment in the three-year period. Funding for the chronic care improvement programs will come directly from the Medicare trust fund and is unlimited, except by a cap on outlays (net of savings) of \$100 million at any one time.
- The programs will be voluntary, nonrestrictive and will not require that eligible beneficiaries change plans or providers, or pay extra to participate. The programs are not new benefits, so the CMS can modify the programs over time to keep improving them. Finally, chronic care improvement awardees will not be required to accept insurance risk. Only their fees will be at risk and only in relation to the difference in outcomes between the experimental and control groups in their regions.

APPENDIX 3

A New Medicaid Program (as reported in Health Affairs, 2003)

- **Needs-based Medicaid:** Eligibility would be based primarily on need for financial assistance to pay for medical care. Categorical eligibility (which excludes people who are expected to work, such as adult singles and couples) would be eliminated, national eligibility standards related to the federal poverty level would be established and raised over time. National spend-down eligibility, buy-ins to Medicaid as a high-risk pool and Medicaid as reinsurance for catastrophic cases would be established. National spend-down eligibility ensures that a person or family could qualify for Medicaid if income, after deducting medical expenses, met national eligibility standards. Affordable coverage could be expanded by allowing people to buy-in to Medicaid and as a subsidy for qualified high-risk people. Medicaid could offer reinsurance coverage for all catastrophically high-cost cases.
- **"Medicaid plus tax credits" to cover the uninsured:** One of the most promising strategies for covering the uninsured is "Medicaid plus tax credits" in which the uninsured can use tax credits to purchase private health coverage. One suggestion is that states develop systems modeled after the Federal Employees Health Benefits Program in which people who are eligible for Medicaid and tax credits could choose among group health insurance plans and Medicaid enrollment.
- **Medicaid long-term care:** Medicaid expansions to improve long-term care could focus on three areas: (1) expanded eligibility to protect against catastrophic expenses and assist adults and children with disabilities; (2) coverage of alternatives to institutional care; and (3) more national financing for long-term care. Eligibility can be expanded by allowing people with disabilities to buy in to Medicaid so they can qualify for needed health and long-term care benefits, and by expanding the use of income-related premiums, cost sharing and spend-down protection. Home and community-based services could be offered as a standard benefit, as an alternative to nursing home care.
- **Possible financing sources:** Medicaid's future role in long-term care should be part of a long-term care system that relieves huge state fiscal burdens on Medicaid and provides equitable financing. Options include the structure being considered for Medicare drug benefits: a basic Medicare entitlement and catastrophic coverage, an expanded Medicaid program, and private insurance opportunities. New financing sources include reforms of the estate tax, and an increase in the Social Security Disability Insurance wage base.
- **Quality:** Medicaid could be managed as a health program as well as a financing program. It could measure health status and quality of care paid for by Medicaid funds, and it could be accountable for adopting policies and projects that improve quality of care and health status.

- **Administration:** A new Medicaid program needs a new federal government home, new capabilities and new federal-state relations. It should have an equal administrative standing to the CMS, a comparably ranked administrator and more staff resources. It needs an organized, systematic effort through which all state Medicaid programs—and federal policy-makers—can learn from experience and improve the program. A new Medicaid program would benefit from a new federal-state forum for studies and discussion of Medicaid issues.

APPENDIX 4

Health Care Tax Credits in the Bush Administration 2005 Budget Proposal (Source: White House)

Affordable Health Care for Low-Income Families:

- **Traditional Health Insurance Tax Credit**—With this option, the credit would pay for 90 percent of the cost of the premium for standard coverage (up to a maximum of \$1,000 for an individual and \$3,000 for a family of four).
- **Health Insurance Tax Credit with HAS**—This would allow individuals to use a portion of the credit to pay the premiums for a high-deductible health plan, while putting the remaining portion of the credit in an HSA. The money in the HSA would belong to the individual and would be used to pay for medical expenses. Unspent funds would roll over for use in the following year.
- **State Purchasing Pools**—To help low-income individuals purchase coverage with the health insurance tax credit, the administration proposes providing \$4 billion in grants to states to establish purchasing pools.

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