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The Cost of Failure to Enact Health Reform: 2010–2020

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Overview

The U.S. House of Representatives and the U.S. Senate have passed separate comprehensive health reform bills, but enactment of a final law remains uncertain. Last year, we reported on the economic implications for the nation and individual states if the health reform effort were to fail. In this paper, we update our earlier national analyses. We present new findings on the composition of the uninsured in 2020 without reform, the offers of health benefits by employers, and the increase in costs to different payers.

This report makes clear that the cost of failure would be high and the status quo is probably unsustainable. The analysis shows that if federal reform efforts fail, over the next decade, the percent of the population that is uninsured will increase, employer-sponsored coverage will continue to erode, spending on public programs will balloon, and individual and family out-of-pocket costs will rise.

Using the Urban Institute's Health Insurance Policy Simulation Model, we examined the effects of maintaining the status quo on coverage and costs for three scenarios:

1. **Worst case —** slow growth in incomes and continuing high growth rates for health care costs;
2. **Intermediate case —** somewhat faster growth in incomes, but a lower growth rate for health care costs;
3. **Best case —** full employment, faster income growth, and even slower growth in health care costs.

Under any scenario, the analysis shows a tremendous economic strain on individuals and employers of all sizes. While all income levels would be affected, middle-income families would be hardest hit. Within 10 years, under the worst-case scenario, we estimate that:

- **The number of uninsured Americans would increase from 49.4 million in 2010 to 59.7 million in 2015 and 67.6 million in 2020.** If states were to cut back eligibility for public coverage or make the enrollment process more difficult, the number of uninsured would be even higher. Even in the best case, the number of uninsured would rise to 57.9 million in 2020.
- **A larger share of the uninsured would come from middle- and higher-income families.** The share of the uninsured from families with incomes higher than 200 percent of the federal poverty level (FPL) would rise from 44 percent to 56 percent in 2020.
- **Premiums would become increasingly expensive for employers and their workers.** Premiums for both single and family policies would more than double by 2020, increasing from $4,800 to $10,300 for single policies and from $12,100 to $25,600 for family policies. Even in the best case, single premiums would rise to $7,800 and family premiums would rise to $19,500 by 2020, increasing much faster than incomes.
- **Offers of coverage would fall significantly for workers in small and medium firms.** Small firm workers would see offer rates almost cut in half, dropping from 41 percent to 23 percent in 2020. Workers in medium-size firms would see offer rates fall from 90 percent to 75 percent. Overall, the rate

of employer sponsored insurance coverage would fall from 56 percent in 2010 to 48 percent of nonelderly Americans in 2020. Even in the best case, the rate of employer sponsored insurance coverage would fall to 53 percent in 2020.

» **Medicaid and Children's Health Insurance Program (CHIP) enrollment and costs would increase substantially.** Enrollment would increase from 45.4 million in 2010 to 58.2 million in 2020, an increase of 12.8 million nonelderly Americans. Medicaid and CHIP spending for the nonelderly would increase from $278 billion in 2010 to $576 billion in 2020, an increase of 108 percent. Even in the best case, spending would increase by 59 percent to $442 billion in 2020.

» **Employers would see large increases in premium costs.** Employer premium spending would increase from $430 billion in 2010 to $851 billion in 2020, a 98 percent increase. Even in the best case, employer premium spending would increase by 67 percent in ten years. These increases would be even higher if employer coverage rates were to hold steady over this period rather than decline as predicted.

» **Uncompensated care costs would more than double.** The cost of uncompensated care would increase from $64 billion in 2010 to $140 billion in 2020. In the best case, the cost of uncompensated care would increase by 74 percent and total $111 billion in 2020. Together with increased spending on Medicaid and CHIP, this would mean higher federal, state, and local taxes even without reform.

» **Health care costs paid directly by families would increase significantly.** Individual and family spending on premiums and out-of-pocket health care costs would increase from $315 billion in 2010 to $564 billion in 2020. In the best case, these costs would rise to $471 billion by 2020.

Introduction

The U.S. House of Representatives and the U.S. Senate have passed separate comprehensive health reform bills, but enactment of a final law remains uncertain.[1] Last year, we reported on the economic implications for the nation and individual states if the health reform effort were to fail.[2, 3] We estimated changes in private and public coverage and the number of uninsured. Further, we estimated the increase in spending by businesses, individuals, and government. In this paper, we update our earlier national analyses. We present new findings on the composition of the uninsured in 2020 without reform, the offers of health benefits by employers, and the increase in costs to different payers.

In previous reports, we showed that health care costs, health insurance premiums, and out-of-pocket health spending were likely to continue to grow in the absence of reform. There is evidence of deceleration of cost growth because of the recession, though there have also been reports of substantial premium increases. As the economy improves, there is reason to believe that the cost to employers, individuals, and families will continue to increase at rates similar to those we've experienced in recent years. Historically and in long-term projections by the Centers for Medicare and Medicaid Services (CMS), health costs tend to rise two percentage points faster than gross domestic product (GDP).

To the extent health care costs and premiums grow faster than incomes, employers will be less likely to offer coverage and individuals will be less likely to take up coverage when offered. Nongroup coverage will fall as well. Those eligible for Medicaid and CHIP will be more likely to enroll due to increasing premiums and out-of-pocket health care costs in private insurance and declining employer insurance coverage. Continued increases in income inequality will also lead to greater Medicaid enrollment as more people fall below eligibility thresholds.

Greater public program enrollment will increase federal and state spending. The decline in employer-sponsored insurance (ESI) will result in an increase in the number of uninsured. This will mean increases in the amount of uncompensated care (medical care received by the uninsured and not paid for by themselves, including donated care and bad debt) and associated spending by state and local governments for those without coverage.[4] The end result is that there are likely to be significant changes in the distribution of health insurance coverage and increases in spending both privately and publicly.

In this paper, we use the Health Insurance Policy Simulation Model (HIPSM) to estimate the likely changes in coverage and health care costs that will occur nationally from 2010 to 2020 in the absence of health insurance coverage reform and measures to restrain cost growth. We make estimates under three alternative scenarios, which vary assumptions about health care costs and premium growth as well as unemployment, income growth, and changes in income inequality for 2015 and 2020.[5] We asked the following questions:

1) How many people will have employer-sponsored insurance in 2015 and 2020? What will happen to employer spending on health insurance premiums? To what extent will workers continue to have access to health benefits through their jobs?

2) How many people will obtain coverage under Medicaid given changes in incomes, health care costs, and declines in employer coverage? How much will spending on public insurance (e.g. Medicaid and CHIP) increase?

3) How many people will be uninsured in 2015 and 2020? How will the cost of uncompensated care change over time given changes in the number of uninsured?

4) What will the composition of the uninsured look like in ten years compared to now if health reform fails in terms of income, age, and health status?

Data and Methods

HIPSM models the behavior of employers and individuals and their decisions to offer and take up coverage. The model is designed to show the impact of policy changes on firms' decisions to offer coverage, individuals' decisions to leave current private coverage and enroll in Medicaid, and decisions by the uninsured to take up new coverage when eligible. The model uses data from several national data sets. It relies primarily on 2004 data from the 2005 Current Population Survey (CPS) Annual Social and Economic Supplement, but data from several other surveys are matched to the CPS. The model includes a detailed simulation of Medicaid eligibility and enrollment, including the most important eligibility rules for each state. In the model, we also adjust for the undercount of Medicaid on the CPS. The behavioral effects in the model are calibrated to findings in the empirical economics literature.[6]

To obtain a current baseline, we grow the coverage estimates from 2004 to 2008 given actual changes in coverage and population growth between 2004 and 2008 as measured by the CPS. Then to reflect worsening economic conditions between 2008 and 2010 we apply estimates from Holahan and Garrett to estimate the impact of higher unemployment rates on changes in health insurance coverage over that period.[7] We use new estimates of health care cost growth from the CMS Office of the Actuary.[8] The effects of recent updates are modest, but they limit comparability of these results to results from the earlier papers.

In implementing the growth rate assumptions described below within HIPSM, we use the model to generate behavioral responses to the cumulative amount of health care cost growth, net of income growth, that is assumed to occur between 2010 and 2015 and 2020. This rise in the relative price of health care and health insurance premiums is modeled as a "reform" within the baseline year. As private health insurance premiums rise, coverage becomes less affordable and demand falls. Fewer firms offer coverage and fewer workers take up their ESI offers. Fewer individuals purchase nongroup coverage. Those who are eligible for Medicaid or CHIP become more likely to enroll. More people become uninsured. Given these behavioral responses, we then age the population to 2015 and 2020 by making adjustments to the weights of the observations in the HIPSM output file. The reweighting adjustments take into account the assumptions for changes in employment, incomes, offer rates, and changes in the population by age and gender cells. Further description of the model and methods is presented in *Health Reform: The Cost of Failure*.[9]

The Three Alternative Scenarios

We used three alternative scenarios to project changes in health care costs and coverage between 2010 and 2015. These are based on a series of assumptions that are shown in the top panel of *Table 1.* The worst case assumes that the unemployment rate does not return to full employment levels by 2015, that income growth is slow, and that health care costs will grow somewhat faster than projected by CMS actuaries. We also assume in the worst and intermediate cases that firm offer rates fall–a factor seen in the prior recession, which has the effect of lowering

Table 1: Growth Rate Assumptions Under Each of Three Scenarios, by 5-Year Period

	Unemployment rate at end of period	Employment rate at end of period	Income growth (average annual growth)	CPI (average annual growth)	Medicaid health care spending per capita (average annual growth)	Private health spending per capita (average annual growth)	Private premiums (average annual growth)	Out-of-pocket health care costs (average annual growth)	Additional decline in ESI offer rate due to recession
2010 to 2015									
Scenario 1 (Worst):	7.1%	61.2%	1.0%	2.0%	6.0%	7.0%	8.0%	3.5%	Yes
Scenario 2 (Intermediate):	6.1	62.0	1.5	2.0	5.0	6.0	7.0	3.0	Yes
Scenario 3 (Best):	5.1	62.8	2.0	2.0	4.0	5.0	5.0	2.5	No
2015 to 2020									
Scenario 1 (Worst):	5.1	62.8	1.5	2.0	6.0	7.0	8.0	3.5	No
Scenario 2 (Intermediate):	5.1	62.8	2.0	2.0	5.0	6.0	7.0	3.0	No
Scenario 3 (Best):	5.1	62.8	2.5	2.0	4.0	5.0	5.0	2.5	No

Source: Urban Institute analysis, HIPSM 2010.

Table 2: Changes in Coverage Across Years (Nonelderly Population, in Millions)

	2010		2015		2020	
	N	%	N	%	N	%
Worst Case						
ESI	150.2	55.9%	143.4	51.8%	137.6	48.3%
Non-Group	14.8	5.5%	12.9	4.6%	12.2	4.3%
Medicaid	45.4	16.9%	51.8	18.7%	58.2	20.4%
Medicare	4.5	1.7%	4.6	1.7%	4.7	1.7%
Other	4.3	1.6%	4.4	1.6%	4.5	1.6%
Uninsured	49.4	18.4%	59.7	21.6%	67.6	23.7%
Total	**268.7**	**100.0%**	**276.9**	**100.0%**	**284.8**	**100.0%**
Intermediate Case						
ESI	150.2	55.9%	146.7	53.0%	144.5	50.8%
Non-Group	14.8	5.5%	13.1	4.7%	12.7	4.5%
Medicaid	45.4	16.9%	50.7	18.3%	55.9	19.6%
Medicare	4.5	1.7%	4.6	1.6%	4.6	1.6%
Other	4.3	1.6%	4.4	1.6%	4.5	1.6%
Uninsured	49.4	18.4%	57.5	20.7%	62.5	21.9%
Total	**268.7**	**100.0%**	**276.9**	**100.0%**	**284.8**	**100.0%**
Best Case						
ESI	150.2	55.9%	150.4	54.3%	151.8	53.3%
Non-Group	14.8	5.5%	14.1	5.1%	13.4	4.7%
Medicaid	45.4	16.9%	49.5	17.9%	52.6	18.5%
Medicare	4.5	1.7%	4.6	1.6%	4.5	1.6%
Other	4.3	1.6%	4.4	1.6%	4.5	1.6%
Uninsured	49.4	18.4%	54.0	19.5%	57.9	20.3%
Total	**268.7**	**100.0%**	**276.9**	**100.0%**	**284.8**	**100.0%**

Source: Urban Institute analysis, HIPSM 2010.

employer coverage. The best case assumes that unemployment rates return to approximately full employment, that income growth is faster, that health care costs grow at slower rates, and that there is no additional decline in firm offer rates due to the recession. The intermediate case assumes that unemployment rates continue to be relatively high and that incomes and health care costs grow at rates between the worst and best case.

We make a similar set of assumptions between 2015 and 2020 (bottom panel of Table 1). In general, unemployment rates are assumed to be lower and income growth faster. Otherwise the forecasts for changes in general inflation and health care spending are the same between the two periods. For the full ten year period in each scenario, we assume that the long-standing trend of increased income inequality will continue. The growth rates are based on forecasts made by the Congressional Budget Office, CMS, the Blue Chip consensus forecasts, and Economy.com.[10]

Changes in Coverage

Table 2 shows the projected number of people with each type of health insurance and the number of uninsured in 2010, 2015, and 2020 under each of the three scenarios. Over time, in the absence of reform, more people will be uninsured or have public coverage and fewer will be covered through private insurance. In particular:

» **The number of uninsured will rise.** In the worst case, the number of uninsured Americans would increase from 49.4 million in 2010 to 59.7 million in 2015 and to 67.6 million in 2020. Nearly one in four Americans under age 65 would be uninsured in 2020. In the best case, the number of uninsured grows to to 54.0 million in 2015 and 57.9 million in 2020, approximately one in five Americans under age 65. All of these estimates assume that states would continue to maintain current eligibility levels for public coverage. If they were to cut back eligibility or make the enrollment process more difficult, the number of uninsured would be even higher.

» **The percent of Americans with employer-sponsored.** In all three scenarios, we see a decline in ESI coverage rates. The ESI rate would fall from 56 percent in 2010 to 48 percent in 2020 in the worst case and to 53 percent in the best case.

» **Medicaid and CHIP enrollment will rise.** Medicaid and CHIP coverage would increase substantially with enrollment increasing from 45.4 million in 2010 to 58.2 million in 2020 in the worst-case scenario, an increase of 12.8 million nonelderly Americans covered under public programs. Even in the best case, enrollment would increase by 7.2 million persons.

Changes in Uninsured Rates and the Composition of the Uninsured

Table 3 shows the composition of the uninsured population by income group, age group, and health status in 2010 and in 2020 under both the best and worst case scenarios. It also shows the percent of individuals who are uninsured within each group. We find that:

» **Middle-income families will be hardest hit by coverage declines.** In the worst case, the uninsured rate for those in families with incomes from 200 to 399 percent of the federal poverty level (FPL) would rise by 9 percentage points, from 19 percent to 28 percent. The number of uninsured people in this income group would increase by 7.3 million people. In the best case, the uninsured rate would rise to 23 percent.

» **Higher-income families will also see steep increases in rates of uninsurance.** The rate of uninsurance for those in families with incomes 400 percent of the FPL or more would increase from 7 percent in 2010 to 13 percent in the worst case and 9 percent in the best case in 2020.

» **The rate of uninsurance among lower-income families will remain at high levels.** In the best and worst cases, those in families with incomes less than 200 percent of the FPL will continue to have high uninsurance rates of 33 to 34 percent. Uninsurance rates are stable as eligible individuals increasingly shift to public coverage. This assumes that states maintain Medicaid eligibility at current levels.

» **A larger share of the uninsured will come from middle- and higher-income families.** As a result of the pattern of uninsurance rate increases, in the worst case more than half the uninsured (53 percent) will have incomes of more than 200 percent of the FPL in 2020, whereas such families currently comprise an estimated 44 percent of the uninsured. Even in the best case, the uninsured will increasingly consist of middle and higher-income Americans. Being mostly ineligible for Medicaid or CHIP, middle- and higher-income families who lose private coverage would become uninsured, whereas many eligible lower-income individuals would obtain coverage through Medicaid or CHIP.

Table 3: Changes in the Composition of the Uninsured (Nonelderly Population, in Millions)

	2010 Baseline			2020 Best Case			2020 Worst Case		
	N	Percent of uninsured	Uninsured rate	N	Percent of uninsured	Uninsured rate	N	Percent of uninsured	Uninsured rate
Income Group									
<200% FPL	27.8	56%	34%	30.9	53%	34%	31.8	47%	33%
200-399% FPL	13.8	28%	19%	16.3	28%	23%	21.1	31%	28%
>400% FPL	7.8	16%	7%	10.7	19%	9%	14.7	22%	13%
Age Group									
0 - 18	7.5	15%	9%	8.9	15%	10%	10.7	16%	12%
19 - 24	9.3	19%	35%	10.5	18%	39%	10.8	16%	40%
25 - 34	10.8	22%	28%	12.4	21%	30%	13.9	21%	33%
35 - 44	9.1	18%	21%	10.8	19%	23%	12.7	19%	27%
45 - 54	7.8	16%	17%	9.4	16%	19%	11.9	18%	24%
55 - 64	4.8	10%	15%	6.0	10%	18%	7.6	11%	22%
Health Status									
Excellent/Very Good/Good Health	43.7	88%	18%	52.0	90%	20%	61.4	91%	24%
Fair/Poor Health	5.7	12%	22%	5.9	10%	22%	6.2	9%	22%
Total	**49.4**	**100%**	**–**	**57.9**	**100%**	**–**	**67.6**	**100%**	**–**

Source: Urban Institute analysis, HIPSM 2010.

Table 4: Premiums and Offer Rates of Employer-Sponsored Insurance (Nonelderly Population)

	2010 Baseline	2020 Best Case	2020 Worst Case
Total ESI premiums			
Single policy	$4,800	$7,800	$10,300
Family policy	$12,100	$19,500	$25,600
Percent of workers offered ESI			
Small firms (1-49)	41.4%	33.4%	22.7%
Medium firms (50-999)	90.0%	84.7%	74.8%
Large firms (1000+)	99.1%	99.1%	97.9%

Source: Urban Institute analysis, HIPSM 2010.

» **Uninsured rates will be higher for individuals of every age, with steep rises for adults age 45 and over.** The uninsured rate for adults age 45 to 54 would increase from 17 percent in 2010 to 19 percent in 2020 in the best case and 24 percent in the worst case. For adults age 55 to 64, the uninsured rate would increase from 15 percent in 2010 to 18 percent in the best case and 22 percent in the worst case in 2020. While the value of health insurance increases as people get older, many over age 45 would lose access to coverage through their employers while nongroup premiums would become increasingly unaffordable. For children age 18 and below, Medicaid and CHIP would limit the rise in uninsurance rates to a 3 percentage point increase in ten years in the worst case.

» **The uninsured population will shift somewhat toward older age groups.** Young adults age 19 to 24 have the highest rate of uninsurance in each year and scenario. They will, however, become a smaller share of the uninsured population in 2020 in both the best and worst cases. The share of uninsured age 35 to 64 will be higher in 2020 in the worst case, with only minor changes in the best case.

» **Uninsured rates will rise for those in better health.** Among people in excellent, very good, or good health, the uninsured rate would rise from 18 percent in 2010 to 20 percent in the best case and 24 percent in the worst case. Currently, those in fair or poor health are more likely to be uninsured than those in better health. Among people in fair or poor health, the uninsured rate would remain fairly stable over time at 22 percent. This is because those with higher health care needs who currently have coverage would be more likely to continue their coverage as premiums increase. As a result, those continuing to have private health insurance will be an increasingly less healthy population in 2020.

Changes in Premiums and Offer Rates of Employer-Sponsored Insurance

Table 4 shows projected average single and family premiums for employer-sponsored coverage in 2010 and in 2020 under both the best and worst case scenarios. Average total premiums are reported, summing the portions paid by employer and employee. The table also reports projections of the percent of workers who are offered health insurance benefits by their employers, separately by firm size.

» **Premiums will become increasingly expensive for employers and their workers.** In the worst case, premiums for both single and family policies more than double by 2020, increasing from $4,800 to $10,300 for the single policy and from $12,100 to $25,600 for family policies.[11] Even in the best case scenario, there is a large increase in the price of both policies by 2020 with single policy premiums rising to $7,800 and family policy premiums rising to $19,500. Premium growth would greatly exceed growth in incomes. The median income for families who continue to have ESI would increase from $68,100 in 2010 to $75,500 in the worst case and $81,400 in the best case in 2020.

» **Offer rates will fall significantly for workers in small and medium firms.** As premiums more than double, small firm workers would see offer rates almost cut in half by 2020 in the worst case scenario, dropping from 41 percent of workers with offers to 23 percent. Medium firm workers fare a bit better, but still see a significant decline in offer rates, dropping from 90 percent in 2010 to 75 percent in 2020. The declines in offer rates are less dramatic in the best case scenario, but by 2020 there is still significant erosion in the offer rates for workers in small and medium firms.

» **Large firms will mostly continue offering coverage, but the burden of that coverage will rise.** Offer rates for workers in large firms hold steady at 99 percent in the best case but fall slightly to 98 percent in the worst case. However, as noted above, premiums will increase considerably by 2020 in both cases, thus increasing the economic burden of employer coverage. Rising health insurance costs will limit potential wage increases for these workers.

Growth in Health Care Spending

Table 5 shows estimates of changes in spending by different payers in the health care system. Results are presented for each of the three scenarios.

» **Large increases in state and federal Medicaid and CHIP spending.** Medicaid and CHIP expenditures on acute care services for the nonelderly would grow substantially both because of increased enrollment and because of higher health care costs. In the worst case, Medicaid and CHIP spending for the nonelderly would increase from $278 billion in 2010 to $576 billion in 2020, an increase of 108 percent. In the best case, spending would increase by 59 percent to $442 billion. This assumes states maintain current eligibility levels. If they do not, Medicaid enrollment and spending will be lower but the uncompensated care costs cited below will be higher.

» **Much higher uncompensated care costs.** In the worst case, the cost of uncompensated care would increase by 119 percent, from $64 billion in 2010 to $140 billion in 2020. In the best case, the cost of uncompensated care would increase by 74 percent and total $111 billion in 2020. Together with the increased spending for Medicaid and CHIP, this would inevitably mean higher federal, state, and local taxes even without reform.

» **Large increases in employer spending.** Under all three scenarios there would be substantial increases in employer premium spending, despite deceases in ESI coverage. We estimate that employer spending on premiums would increase from $430 billion in 2010 to $851 billion in 2020 in the worst case and $719 billion in the best case.[12] Employer spending would increase even more if employers continued to offer coverage at the same rate they do now.

» **Higher health care costs for families.** Individual and family spending on premiums and out-of-pocket health care costs would increase significantly–from $315 billion in 2010 to $564 billion in 2020 in the worst case and to $471 billion in the best case due to higher premium and out-of-pocket health care costs.

Table 5: Aggregate Health Care Spending Across Years for the Nonelderly Population (in Billions)

	2010	2015	% change 2010-2015	2020	% change 2015-2020	% change 2010-2020
Worst Case						
Medicaid/SCHIP	$278	$403	45.1%	$576	43.1%	107.6%
Uncompensated Costs	$64	$97	52.3%	$140	43.5%	118.5%
Employer	$430	$608	41.5%	$851	40.0%	98.1%
Individual and Family	$315	$422	34.1%	$564	33.6%	79.2%
Intermediate Case						
Medicaid/SCHIP	$278	$375	35.0%	$509	35.7%	83.2%
Uncompensated Costs	$64	$90	41.4%	$121	33.6%	88.9%
Employer	$430	$596	38.6%	$820	37.6%	90.8%
Individual and Family	$315	$408	29.6%	$529	29.6%	68.0%
Best Case						
Medicaid/SCHIP	$278	$353	27.2%	$442	25.2%	59.3%
Uncompensated Costs	$64	$84	31.6%	$111	32.1%	73.9%
Employer	$430	$560	30.3%	$719	28.4%	67.3%
Individual and Family	$315	$387	22.8%	$471	21.8%	49.6%

Source: Urban Institute analysis, HIPSM 2010.

Conclusion

Without significant reform that makes health insurance more accessible and affordable while reducing the rate of health care cost growth over time, the number of uninsured and health care spending would both increase dramatically. The ranks of the uninsured would increasingly be filled with middle-income, higher-income, and older individuals who have coverage now. Medicaid enrollment would increase because of the erosion of private coverage. Costs per enrollee would also increase because of medical care inflation. As a result, the cost of financing public programs would place added burden on taxpayers. The rising cost of caring for a growing number of uninsured persons through safety net programs would also add to taxpayer burdens. Employers would face sharply increasing health care premiums and as a result, many small and medium-sized firms would stop offering coverage. For employers who still offer coverage, these additional costs would be passed onto workers as lower wages over time. In the short-term, business profitability for those who still offer coverage would be adversely affected. Finally, individuals and families would face higher out-of-pocket costs for premiums and health care services, along with higher tax burdens.

We recognize that health reform itself would also be costly. If reforms like those recently passed by the House and Senate are enacted, government expenditures would increase more than they would without reform because of increases in Medicaid eligibility and enrollment and subsidies to low-income people. Increases in Medicaid spending would be tempered because there would be less erosion of private insurance and coverage would be available through the exchanges. Spending on uncompensated care for the uninsured would also fall. The increases in government expenditure would also be affected by the cost containment provisions ultimately enacted. Employer spending would also grow under reform, though it should be lower for small firms who have access to exchanges and tax credits. Comprehensive health reform would stem the continuous erosion in the number of Americans with health care coverage and make coverage more affordable for a large number of lower-income families. Reform would also decrease financial pressures on the hospitals and clinics that provide care to the uninsured, reduce many system inefficiencies, and ultimately improve the health and financial security of Americans. While enacting health reform will be difficult and expensive, the cost of failure is also high and probably unsustainable.

Endnotes

[1] The Affordable Health Care for America Act (H.R. 3962) was passed by the House of Representatives on November 7, 2009. The Patient Protection and Affordable Care Act (H.R. 3590) was passed by the Senate on December 24, 2009.

[2] John Holahan, Bowen Garrett, Irene Headen, and Aaron Lucas. "Health Reform: The Cost of Failure," The Robert Wood Johnson Foundation and the Urban Institute, May 21, 2009. http://www.rwjf.org/files/research/costoffailure20090529.pdf.

[3] Bowen Garrett, John Holahan, Lan Doan, and Irene Headen. "The Cost of Failure to Enact Health Reform: Implications for States," The Robert Wood Johnson Foundation and the Urban Institute, September 30, 2009. http://www.urban.org/url.cfm?ID=411965.

[4] Most uncompensated care is paid by government through Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, graduate medical education payments, various other federal programs, and state and local tax appropriations. The remainder is covered by hospitals and health care providers. See Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs* Web Exclusive, August 25, 2008. http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.5.w399.

[5] For more detail on the assumptions for each scenario, see Holahan et al. "Health Reform: The Cost of Failure."

[6] The behavioral modules in HIPSM represent individual and family demand for health insurance coverage through a utility-based approach in which each individual is assigned a utility value that measures the relative desirability of each health insurance option. These utilities then shape decisions when reform options are introduced. Among individuals, families, and employers, the responsiveness of health insurance decisions to changes in health insurance options and premiums are calibrated in HIPSM to findings in the empirical economics literature. For example we establish targets for: take-up rates for Medicaid/CHIP coverage for newly eligible individuals, ESI premium elasticities of take up conditional on firms offering, firm premium elasticities of offering coverage, and nongroup premium elasticities. We then calibrate the behavioral responses for individuals and firms in the model to meet our targets. All of the targets are within reasonable ranges as set forth by Sherry Glied, Dahlia K. Remler, and Joshua Graff Zivin, "Inside the Sausage Factory: Improving Estimates of the Effects of Health Insurance Expansion Proposals," *Milbank Quarterly*. 80(4): 603-635, 2002.

[7] John Holahan and Bowen Garrett, "Rising Unemployment, Medicaid and the Uninsured," Policy Brief, Washington, DC: Kaiser Commission on Medicaid and the Uninsured. January 2009. http://www.kff.org/uninsured/upload/7850.pdf.

[8] For data up to 2008, see Center for Medicare and Medicaid Services, Office of the Actuary. "National Health Expenditure Aggregate, Per Capita, Percent Distribution, and Annual Percent Change by Source of Funds: Selected Calendar Years 1960-2008," http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf. For 2009 and 2010 projections, see Christopher Truffer, Sean Keehan, Sheila Smith, Jonathan Cylus, Andrea Sisko, John A. Poisal, Joseph Lizonitz, and M. Kent Clemens, "Health Spending Projections Through 2019: The Recession's Impact Continues," *Health Affairs*. 29(3). February 2010.

[9] Holahan et al. "Health Reform: The Cost of Failure."

[10] See for example, Congressional Budget Office, "Budget and Economic Outlook: Fiscal Years 2010-2020," Washington, DC, January 2010. http://www.cbo.gov/ftpdocs/108xx/doc10871/BudgetOutlook2010_Jan.cfm.

[11] The baseline family policy premium of $12,054 represents a blend of single-plus-one policies and policies for larger families, which is why it is somewhat less than the $13,375 average premium for a family of four in 2009 reported in Kaiser Family Foundation/Health Research & Education Trust, "Employer Health Benefit: 2009 Annual Survey," September, 2009. http://ehbs.kff.org/.

[12] Reported figures are for employer premium contributions only. Employers contribute 79 percent of the total premium on average, though small firms often contribute substantially less.