



C H A P T E R 7

REFORMING HEALTH CARE

In recent years, rising health care costs in the United States have imposed tremendous economic burdens on families, employers, and governments at every level. The number of people without health insurance has also risen steadily, with recent estimates from the Census Bureau indicating that more than 46 million were uninsured in 2008.

With the severe recession exacerbating these problems, Congress and the President worked together during the past year to enact several health care policies to cushion the impact of the economic downturn on individuals and families. For example, just two weeks after taking office, the President signed into law an expansion of the Children's Health Insurance Program (CHIP), which will extend health insurance to nearly 4 million low- and middle-income uninsured children by 2013. Additionally, legislation that increased funding for COBRA (Consolidated Omnibus Budget Reconciliation Act) health insurance coverage allowed many working Americans who lost their jobs to receive subsidized health insurance for themselves and their families, helping to reduce the number of uninsured below what it otherwise would have been.

In late 2009, both the House and the Senate passed major health reform bills, bringing the United States closer to comprehensive health insurance reform than ever before. The legislation would expand insurance coverage to more than 30 million Americans, improve the quality of care and the security of insurance coverage for individuals with insurance, and reduce the growth rate of costs in both the private and public sectors. These reforms would improve the health and economic well-being of tens of millions of Americans, allow employers to pay higher wages to their employees and to hire more workers, and reduce the burden of rising health care costs on Federal, state, and local governments.

THE CURRENT STATE OF THE U.S. HEALTH CARE SECTOR

Although health outcomes in the United States have improved steadily in recent decades, the U.S. health care sector is beset by rising spending, declining rates of health insurance coverage, and inefficiencies in the delivery of care. In the United States, as in most other developed countries, advances in medical care have contributed to increases in life expectancy and reductions in infant mortality. Yet the unrelenting rise in health care costs in both the private and public sectors has placed a steadily increasing burden on American families, businesses, and governments at all levels.

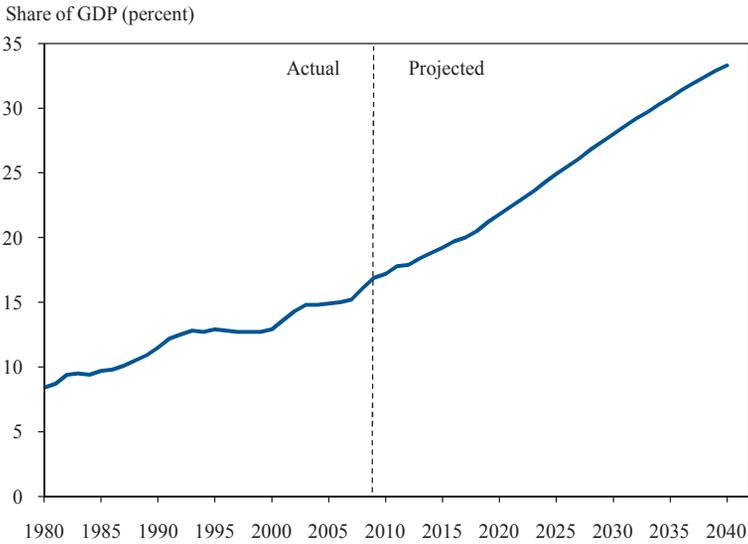
Rising Health Spending in the United States

For the past several decades, health care spending in the United States has consistently risen more rapidly than gross domestic product (GDP). Recent projections suggest that total spending in the U.S. health care sector exceeded \$2.5 trillion in 2009, representing 17.6 percent of GDP (Sisko et al. 2009)—approximately twice its share in 1980 and a substantially greater portion of GDP than that of any other member of the Organisation for Economic Co-Operation and Development (OECD). As shown in Figure 7-1, estimates from the Congressional Budget Office (CBO) in June 2009 projected that this trend would continue in the absence of significant health insurance reform. More specifically, CBO estimated that health care spending would account for one-fourth of GDP by 2025 and one-third by 2040 (Congressional Budget Office 2009d).

The steady growth in health care spending has placed an increasingly heavy financial burden on individuals and families, with a steadily growing share of workers' total compensation going to health care costs. According to the most recent data from the U.S. Census Bureau, inflation-adjusted median household income in the United States declined 4.3 percent from 1999 to 2008 (from \$52,587 to \$50,303), and real weekly median earnings for full-time workers increased just 1.8 percent. During that same period, the real average total cost of employer-sponsored health insurance for a family policy rose by more than 69 percent (Kaiser Family Foundation and Health Research and Educational Trust 2009).

Because firms choose to compensate workers with either wages or benefits such as employer-sponsored health insurance, increasing health care costs tend to “crowd out” increases in wages. Therefore, these rapid

Figure 7-1
National Health Expenditures as a Share of GDP



Source: Congressional Budget Office (2009d).

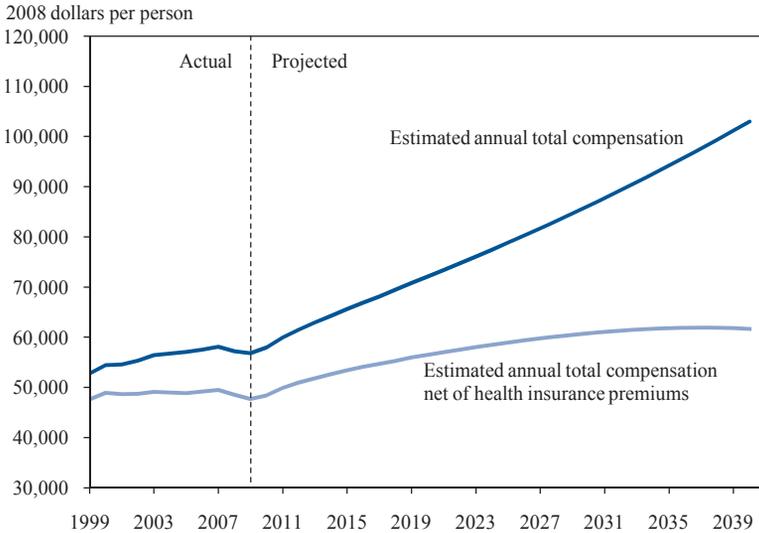
increases in employer-sponsored health insurance premiums have resulted in much lower wage growth for workers.

When considering these divergent trends, it is also important to remember that workers typically pay a significant share of their health insurance premiums out of earnings. According to data from the Kaiser Family Foundation, the average employee share for an employer-sponsored family policy was 27 percent in both 1999 and 2008. In real dollars, the average total family premium increased by \$5,200 during this nine-year period. Thus, the amount paid by the typical worker with employer-sponsored health insurance increased by more than \$1,400 from 1999 to 2008. Subtracting these average employee contributions from median household income in each year gives a rough measure of “post-premium” median household income. By that measure, the decline in household income swells from 4.3 percent to 7.3 percent (that is, post-premium income fell from \$50,566 to \$46,879).

This point is further reinforced when one considers the implications of rapidly rising health care costs for the wage growth of workers in the years ahead. As Figure 7-2 shows, compensation net of health insurance premiums is projected to grow much less rapidly than total compensation,

with the growth eventually turning negative by 2037.¹ Put simply, if health care costs continue to increase at the rate that they have in recent years, workers' take-home wages are likely to grow slowly and eventually decline.

Figure 7-2
Total Compensation Including and Excluding Health Insurance



Note: Health insurance premiums include the employee- and employer-paid portions.
Sources: Actual data from Department of Labor (Bureau of Labor Statistics); Kaiser Family Foundation and Health Research and Educational Trust (2009); Department of Health and Human Services (Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends), 2008 Medical Expenditure Panel Survey-Insurance Component. Projections based on CEA calculations.

Rising health care spending has placed similar burdens on the 45 million aged and disabled beneficiaries of the Medicare program, whose inflation-adjusted premiums for Medicare Part B coverage—which covers outpatient costs including physician fees—rose 64 percent (from \$1,411 to \$2,314 per couple per year) between 1999 and 2008. During that same period, average inflation-adjusted Social Security benefits for retired workers grew less than 10 percent. Rising health insurance premiums are thus consuming larger shares of workers' total compensation and Medicare recipients' Social Security benefits alike.

¹ The upper curve of Figure 7-2 displays historical annual compensation per worker in the nonfarm business sector in constant 2008 dollars from 1999 through 2009, deflated with the CPI-U-RS. Real compensation per worker is projected using the Administration's forecast from 2009 through 2020 and at a 1.8 percent annual rate in the subsequent years. The lower curve plots historical real annual compensation per person net of average total premiums for employer-sponsored health insurance during the same period. The assumed growth rate of employer-sponsored premiums is 5 percent, which is slightly lower than the average annual rate as reported by the Kaiser Family Foundation during the 1999 to 2009 period.

The corrosive effects of rising health insurance premiums have not been limited to businesses and individuals. Increases in outlays for programs such as Medicare and Medicaid and rising expenditures for uncompensated care caused by increasing numbers of uninsured Americans have also strained the budgets of Federal, state, and local governments. The fraction of Federal spending devoted to health care rose from 11.1 percent in 1980 to 25.2 percent in 2008. In the absence of reform, this trend is projected to continue, resulting in lower spending on other programs, higher taxes, or increases in the Federal deficit.

The upward trend in health care spending has also posed problems for state governments, with spending on the means-tested Medicaid program now the second largest category of outlays in their budgets, just behind elementary and secondary education. Because virtually all state governments must balance their budgets each year, the rapid increases in Medicaid spending have forced lawmakers to decide whether to cut spending in areas such as public safety and education or to increase taxes.

If health care costs continue rising, the consequences for government budgets at the local, state, and Federal level could be dire. And as discussed in Chapter 5, projected increases in the costs of the Medicare and Medicaid programs are a key source of the Federal Government's long-term fiscal challenges.

Market Failures in the Current U.S. Health Care System: Theoretical Background

As described by Nobel Laureate Kenneth Arrow in a seminal 1963 paper, an individual's choice to purchase health insurance is rooted in the economics of risk and uncertainty. Over their lifetimes, people face substantial risks from events that are largely beyond their control. When possible, those who are risk-averse prefer to hedge against these risks by purchasing insurance (Arrow 1963).

Health care is no exception. When people become sick, they face potentially debilitating medical bills and often must stop working and forgo earnings. Moreover, medical expenses are not equally distributed: annual medical costs for most people are relatively small, but some people face ruinously large costs. Although total health care costs for the median respondent in the 2007 Medical Expenditure Panel Survey were less than \$1,100, costs for those at the 90th percentile of the distribution were almost 14 times higher (Department of Health and Human Services 2009). As a result, risk-averse people prefer to trade an uncertain stream of expenses for medical care for the certainty of a regular insurance payment, which buys a policy that pays for the high cost of treatment during illness or injury. Economic theory and

common sense suggest that purchasing health insurance to hedge the risk associated with the economic costs of poor health makes people better off.

Health insurance markets, however, do not function perfectly. The economics literature documents four primary impediments: adverse selection, moral hazard, the Samaritan's dilemma, and problems arising from incomplete insurance contracts. In a health insurance market characterized by these and other sources of inefficiency, well-designed government policy has the potential to reduce costs, improve efficiency, and benefit patients by stabilizing risk pools for insurance coverage and providing needed coverage to those who otherwise could not afford it.

Adverse Selection. In the case of adverse selection, buyers and sellers have asymmetric information about the characteristics of market participants. People with larger health risks want to buy more generous insurance, while those with smaller health risks want lower premiums for coverage. Insurers cannot perfectly determine whether a potential purchaser is a large or small health risk.

To understand how adverse selection can harm insurance markets, suppose that a group of individuals is given a choice to buy health insurance or pay for medical costs out-of-pocket. The insurance rates for the group will depend on the average cost of health care for those who elect to purchase insurance. The healthiest members of the group may decide that the insurance is too expensive, given their expected costs. If they choose not to get insurance, the average cost of care for those who purchase insurance will increase. As premiums increase, more and more healthy individuals may choose to leave the insurance market, further increasing average health care costs for those who purchase insurance. Over time, this winnowing process can lead to declining insurance rates and even an unraveling of health insurance markets. Without changes to the structure of insurance markets, the markets can break down, and fewer people can receive insurance than would be optimal. Subsidies to encourage individuals to purchase health insurance can help combat adverse selection, as can regulations requiring that individuals purchase insurance, because both ensure that healthier people enter the risk pool along with their less healthy counterparts.

Under current institutional arrangements, adverse selection is likely to be an especially large problem for small businesses and for people purchasing insurance in the individual market. In large firms, where employees are generally hired for reasons unrelated to their health, high- and low-risk employees are automatically pooled together, reducing the probability of low-risk employees opting out of coverage or high-risk workers facing extremely high premiums. In contrast, small employers cannot pool risk across a large group of workers, and thus the average risk

of a given small firm's employee pool can be significantly above or below the population average. As such, similar to the market for individual insurance described above, firms with low-risk worker pools will tend to opt out of insurance coverage, leaving firms with high-risk pools to pay much higher premiums.

Moral Hazard. A second problem with health insurance is moral hazard: the tendency for some people to use more health care because they are insulated from its price. When individuals purchase insurance, they no longer pay the full cost of their medical care. As a result, insurance may induce some people to consume health care on which they place much less value than the actual cost of this care or discourage patients and their doctors from choosing the most efficient treatment. This extra consumption could increase average medical costs and, ultimately, insurance premiums. The presence of moral hazard suggests that research into which treatments deliver the greatest health benefits could encourage doctors and patients to adopt best practices.

Samaritan's Dilemma. A third source of inefficiency in the insurance market is that society's desire to treat all patients, even those who do not have insurance and cannot pay for their care, gives rise to the Samaritan's dilemma. Because governments and their citizens naturally wish to provide care for those who need it, people who lack insurance and cannot pay for medical care can still receive some care when they fall ill. Some people may even choose not to purchase insurance because they understand that emergency care may still be available to them. In the context of adverse selection, a low insurance rate is a *symptom* of underlying inefficiencies. Viewed through the lens of the Samaritan's dilemma, in contrast, the millions of uninsured Americans are one *source* of health care inefficiencies.

The burden of paying for some of this uncompensated care is passed on to people who do purchase insurance. The result is a "hidden tax" on health insurance premiums, which in turn exacerbates adverse selection by raising premiums for individuals who do not opt out of coverage. One estimate suggests that the total amount of uncompensated care for the uninsured was approximately \$56 billion in 2008 (Hadley et al. 2008).

Incomplete Insurance Contracts. Many economic transactions involve a single, straightforward interaction between a buyer and a seller. In many purchases of goods, for example, the prospective buyer can look the good over carefully, decide whether or not to purchase it, and never interact with the seller again. Health insurance, in contrast, involves a complex relationship between an insurance company and a patient that can last years or even decades. It is not possible to foresee and spell out in detail every contingency that may arise and what is and is not covered.

When individuals are healthy, their medical costs are typically lower than their premiums, and these patients are profitable for insurance companies. When patients become ill, however, they may no longer be profitable. Insurance companies therefore have a financial incentive to find ways to deny care or drop coverage when individuals become sick, undermining the central purpose of insurance. For example, in most states, insurance companies can rescind coverage if individuals fail to list any medical conditions—even those they know nothing about—on their initial health status questionnaire. Entire families can lose vital health insurance coverage in this manner. A House committee investigation found that three large insurers rescinded nearly 20,000 policies over a five-year period, saving these companies \$300 million that would otherwise have been paid out as claims (Waxman and Barton 2009).

A closely related problem is that insurance companies are reluctant to accept patients who may have high costs in the future. As a result, individuals with preexisting conditions find obtaining health insurance extremely expensive, regardless of whether the conditions are costly today. This is a major problem in the individual market for health insurance. Forty-four states now permit insurance companies to deny coverage, charge inflated premiums, or refuse to cover whole categories of illnesses because of preexisting medical conditions. A recent survey found that 36 percent of non-elderly adults attempting to purchase insurance in the individual market in the previous three years faced higher premiums or denial of coverage because of preexisting conditions (Doty et al. 2009). In another survey, 1 in 10 people with cancer said they could not obtain health coverage, and 6 percent said they lost their coverage because of being diagnosed with the disease (USA Today, Kaiser Family Foundation, and Harvard School of Public Health 2006). And the problem affects not only people with serious medical conditions, but also young and healthy people with relatively minor conditions such as allergies or asthma.

System-Wide Evidence of Inefficient Spending

While an extensive literature in economic theory makes the case for market failure in the provision of health insurance, a substantial body of evidence documents the pervasiveness of inefficient allocation of spending and resources throughout the health care system. Evidence that health care spending may be inefficient comes from analyses of the relationship between health care spending and health outcomes, both across states in our own Nation and across countries around the world.

Within the United States, research suggests that the substantially higher rates of health care utilization in some geographic areas are not

associated with better health outcomes, even after accounting for differences in medical care prices, patient demographics, and regional rates of illness (Wennberg, Fisher, and Skinner 2002). Evidence from Medicare reveals that spending per enrollee varies widely across regions, without being clearly linked to differences in either medical needs or outcomes. One comparison of composite quality scores for medical centers and average spending per Medicare beneficiary found that facilities in states with low average costs are as likely or even more likely to provide recommended care for some common health problems than are similar facilities in states with high costs (Congressional Budget Office 2008). One study suggests that nearly 30 percent of Medicare’s costs could be saved if Medicare per capita spending in all regions were equal to that in the lowest-cost areas (Wennberg, Fisher, and Skinner 2002).

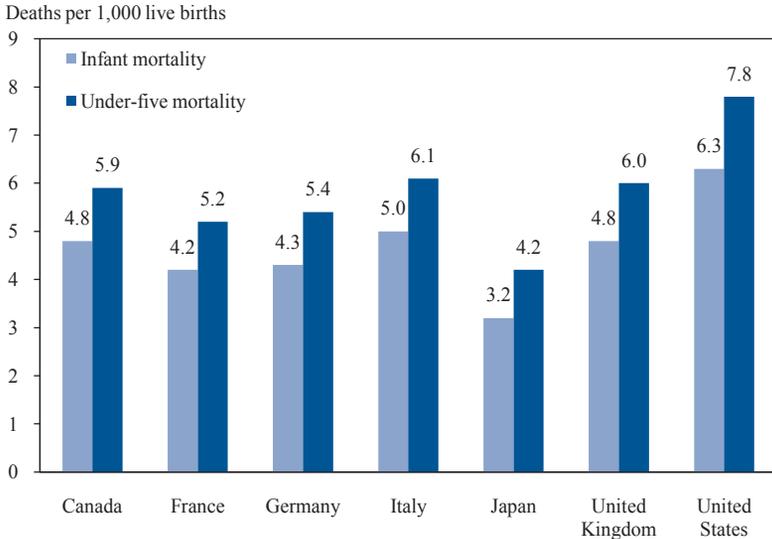
Variations in spending tend to be more dramatic in cases where medical experts are uncertain about the best kind of treatment to administer. For instance, in the absence of medical consensus over the best use of imaging and diagnostic testing for heart attacks, use rates vary widely geographically, leading to corresponding variation in health spending. Research that helps medical providers understand and use the most effective treatment can help reduce this uncertainty, lower costs, and improve health outcomes.

Overuse of “supply-sensitive services,” such as specialist care, diagnostic tests, and admissions to intensive care facilities among patients with chronic illnesses, as well as differences in social norms among local physicians, seems to drive up per capita spending in high-cost areas (Congressional Budget Office 2008). Moral hazard may help to explain some of the overuse of services that do not improve people’s health status.

Health care spending also differs as a share of GDP across countries, without corresponding systematic differences in outcomes. For example, according to the United Nations, the estimated U.S. infant mortality rate of 6.3 per 1,000 infants for the 2005 to 2010 period is projected to be substantially higher than that in any other Group of Seven (G-7) country, as is the mortality rate among children under the age of five, as shown in Figure 7-3 (United Nations 2007). This variation is especially striking when one considers that the United States has the highest GDP per capita of any G-7 country. Although drawing direct conclusions from cross-country comparisons is difficult because of underlying health differences, this comparison further suggests that the United States could lower health care spending without sacrificing quality. Similarly, life expectancy is much lower in the United States than in other advanced economies. The OECD estimated life expectancy at birth in 2006 to be 78.1 years in the United States

compared with an average of 80.7 in other G-7 countries (Organisation for Economic Co-operation and Development 2009).

Figure 7-3
Child and Infant Mortality Across G-7 Countries



Source: United Nations (2007).

Recent research suggests that differences in health care systems account for at least part of these cross-country differences in life expectancy. For example, one study (Nolte and McKee 2008) analyzed mortality from causes that could be prevented by effective health care, which the authors term “amenable mortality.” They found that the amenable mortality rate among men in the United States in 1997–98 was 8 percent higher than the average rate in 18 other industrialized countries. The corresponding rate among U.S. women was 17 percent higher than the average among these other 18 countries. Moreover, of all 19 countries considered, the United States had the smallest decline during the subsequent five years, with a decline of just 4 percent compared with an average decline of 16 percent across the remaining 18. The authors further estimated that if the U.S. improvement had been equal to the average improvement for the other countries, the number of preventable deaths in the United States would have been 75,000 lower in 2002. This finding suggests that the U.S. health care system has been improving much less rapidly than the systems in other industrialized countries in recent years.

A further indication that our health care system is in need of reform is that satisfaction with care has, if anything, been declining despite the substantial increases in spending. Not surprisingly, this decline in satisfaction has been concentrated among people without health insurance, whose ranks have swelled considerably during the past decade. For example, from 2000 to 2009, the fraction of uninsured U.S. residents reporting that they were satisfied with their health care fell from 36 to 26 percent. And not only has dissatisfaction with our health care system increased over time, it is also noticeably greater than dissatisfaction with systems in many other developed nations (Commonwealth Fund 2008).

Declining Coverage and Strains on Particular Groups and Sectors

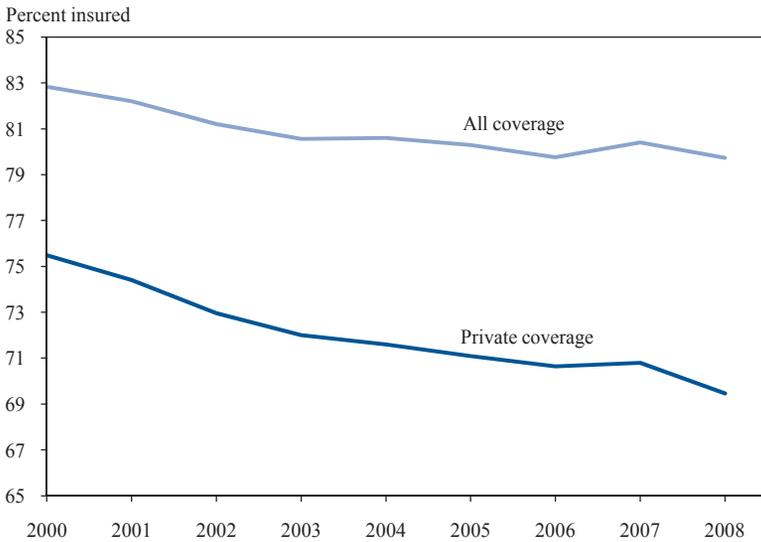
The preceding analysis shows that at an aggregate level, there are major inefficiencies in the current health care system. But, because of the nature of the market failures in health care, the current system works particularly poorly in certain parts of the economy and places disproportionate burdens on certain groups. Moreover, because of rising costs, many of the strains are increasing over time.

Declining Coverage among Non-Elderly Adults. The rapid increase in health insurance premiums in recent years has caused many firms to stop offering health insurance to their workers, forcing employees either to pay higher prices for coverage in the individual market (which is often much less generous than coverage in the group market) or to go without health insurance entirely. According to the Kaiser Family Foundation, between 2000 and 2009, the share of firms offering health insurance to their workers fell from 69 to 60 percent. Furthermore, 8 percent of firms offering coverage in 2009 reported that they were somewhat or very likely to drop coverage in 2010.

Largely because of these falling offer rates, private health insurance coverage declined substantially during this same period. As shown in Figure 7-4, the fraction of non-elderly adults in the United States with private health insurance coverage fell from 75.5 percent in 2000 to 69.5 percent in 2008.

These numbers, however, provide just a snapshot of health insurance coverage in the United States because they measure the fraction of people who are uninsured at a point in time and thus obscure the fact that a large fraction of the population has been uninsured at some point in the past. According to recent research, at least 48 percent of non-elderly Americans were uninsured at some point between 1996 and 2006 (Department of the Treasury 2009).

Figure 7-4
Insurance Rates of Non-Elderly Adults



Source: DeNavas-Walt, Proctor, and Smith (2009).

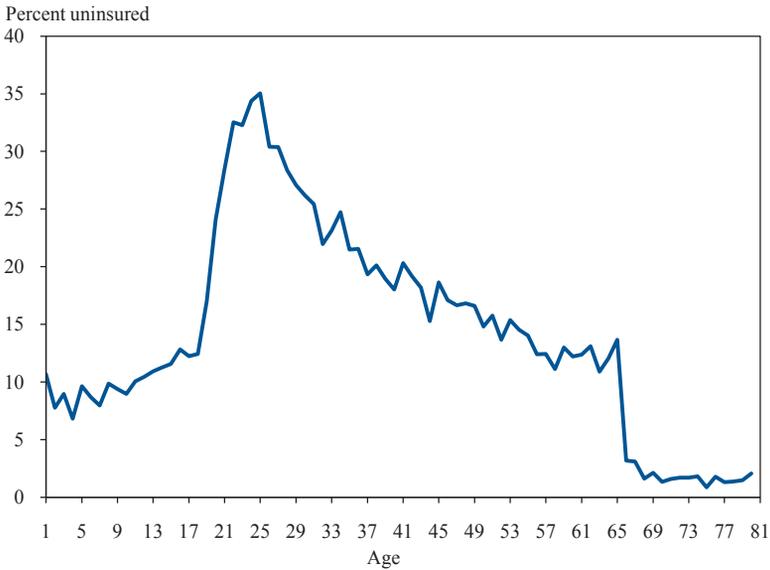
Although roughly half of the 2000–2008 decline in private coverage displayed in Figure 7-4 has been offset by an increase in public health insurance, the share of non-elderly adults without health insurance nevertheless rose from 17.2 to 20.3 percent. In other words, approximately 5.9 million more adults were uninsured in 2008 than would have been had the fraction uninsured remained constant since 2000. The decline in private health insurance coverage was similarly large among children, although it was more than offset by increases in public health insurance (most notably Medicaid and CHIP), so that less than 10 percent of children were uninsured by 2008 (DeNavas-Walt, Proctor, and Smith 2009).

The generosity of private health insurance coverage has also been declining in recent years. For example, from 2006 to 2009, the fraction of covered workers enrolled in an employer-sponsored plan with a deductible of \$1,000 or greater for single coverage more than doubled, from 10 to 22 percent. The increase in deductibles was also striking among covered workers with family coverage. For example, during this same three-year period, the fraction of enrollees in preferred provider organizations with a deductible of \$2,000 or more increased from 8 to 17 percent. Similar increases in cost-sharing were apparent for visits with primary care physicians. The fraction of covered workers with a copayment of \$25 or more for an office visit with a primary care physician increased from 12 to 31 percent from 2004 to 2009. These rising costs in the private market

fall disproportionately on the near-elderly, who have higher medical costs but are not eligible for Medicare. A recent study found that the average family premium in the individual market in 2009 for those aged 60–64 was 93 percent higher than the average family premium for individuals aged 35–39 (America’s Health Insurance Plans 2009).

Low Insurance Coverage among Young Adults and Low-Income Individuals. Figure 7-5 shows the relationship between age and the fraction of people without health insurance in 2008. One striking pattern is the sharp and substantial rise in this fraction as individuals enter adulthood. For example, the share of 20-year-olds without health insurance is more than twice that of 17-year-olds (28 percent compared with 12 percent).

Figure 7-5
Percent of Americans Uninsured by Age



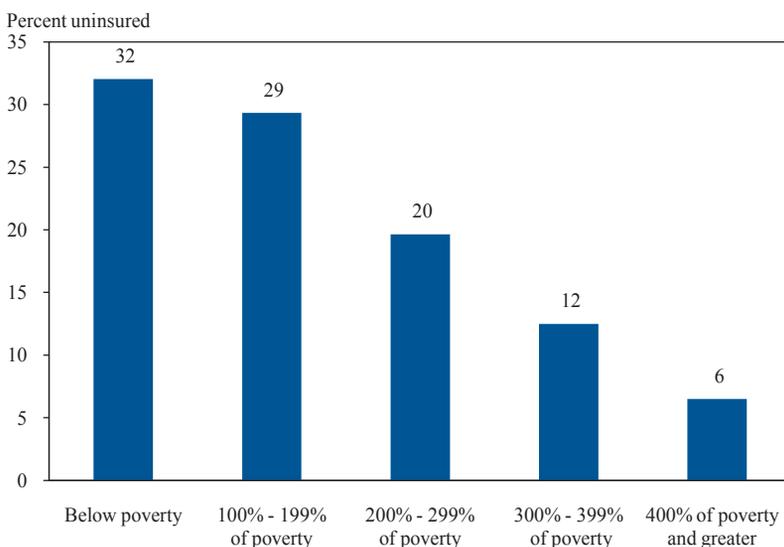
Source: Department of Commerce (Census Bureau), Current Population Survey, Annual Social and Economic Supplement.

Adverse selection is clearly a key source of this change. Many teenagers obtain insurance through their parents’ employer-provided family policies, and so are in large pools. Many young adults, in contrast, do not have this coverage and are either jobless or work at jobs that do not offer health insurance; thus, they must either buy insurance on the individual market or go uninsured. As described above, health insurance coverage in the individual market can be very expensive because of adverse selection. Many young adults also have very low incomes, making the cost of coverage

prohibitively high for them. Furthermore, because they are, on average, in very good health, young adults may be more tolerant than other groups of the risks associated with being uninsured.

The burden of rising costs also falls differentially on low-income individuals, who find it more difficult each year to afford coverage through employer plans or the individual market. Indeed, as shown in Figure 7-6, low-income individuals are substantially more likely to be uninsured than their higher-income counterparts. As the figure shows, non-elderly individuals below the Federal poverty line (\$10,830 a year in income for an individual and \$22,050 for a family of four in 2009) were five times as likely to be uninsured as their counterparts above 400 percent of the poverty line in 2008. These low rates of insurance coverage increase insurance premiums for other Americans because of the “hidden tax” that arises from the financing of uncompensated care.

Figure 7-6
Share of Non-Elderly Individuals Uninsured by Poverty Status

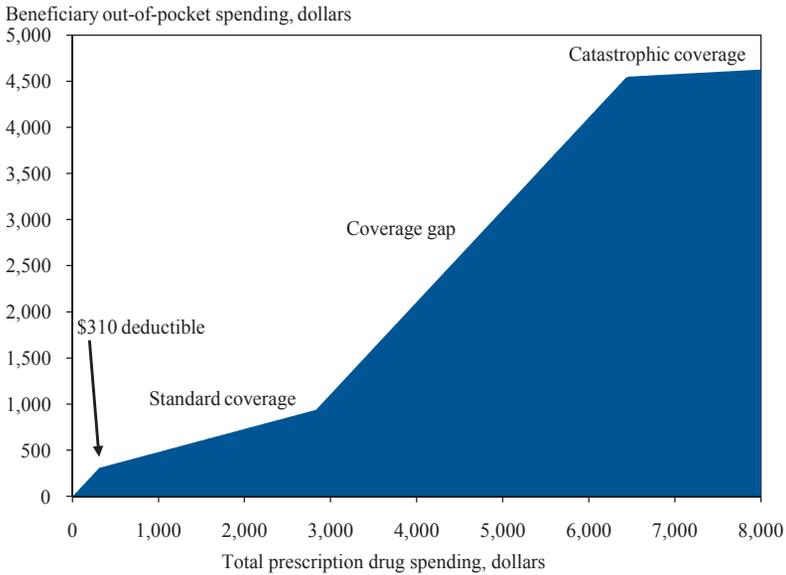


Source: Department of Commerce (Census Bureau), Current Population Survey, Annual Social and Economic Supplement.

The Elderly. Even those over the age of 65 are not protected from high costs, despite almost universal coverage through Medicare. Consider prescription drug expenses, for which the majority of Medicare recipients have coverage through Medicare Part D. As shown in Figure 7-7, after the initial deductible of \$310, a standard Part D plan in 2010 covers 75 percent

of the cost of drugs only up to \$2,830 in annual prescription drug spending. After that, enrollees are responsible for all expenditures on prescriptions up to \$6,440 in total drug spending (where out-of-pocket costs would be \$4,550), at which point they qualify for catastrophic coverage with a modest copayment. Millions of beneficiaries fall into this coverage gap—termed the “donut hole”—every year, and as a result many may not be able to afford to fill needed prescriptions.

Figure 7-7
Medicare Part D Out-of-Pocket Costs by Total Prescription Drug Spending



Note: Calculations based on a standard 2010 benefit design.
Source: Medicare Payment Advisory Commission, Part D Payment System, October 2009.

In 2007, one-quarter of Part D enrollees who filled one or more prescriptions but did not receive low-income subsidies had prescription drug expenses that were high enough to reach the coverage gap. For that reason, 3.8 million Medicare recipients reached the initial coverage limit and were required to pay the full cost of additional pharmaceutical treatments received while in the coverage gap, despite having insurance for prescription drug costs. One study found that in 2007, 15 percent of Part D enrollees in the coverage gap using pharmaceuticals in one or more of eight major drug classes stopped taking their medication (Hoadley et al. 2008).

Small Businesses. As described earlier, adverse selection is a serious problem for small businesses, which do not have large numbers of workers to pool risks. This problem manifests itself in two forms. The first is high costs. Because of high broker fees and administrative costs as well as adverse selection, small firms pay up to 18 percent more per worker for the same policy than do large firms (Gabel et al. 2006). The second is low coverage. Employees at small businesses are almost three times as likely as their counterparts at large firms to be uninsured (29 percent versus 11 percent, according to the March 2009 Current Population Survey). And among small businesses that do offer insurance, only 22 percent of covered workers are offered a choice of more than one type of plan (Kaiser Family Foundation and Health Research and Educational Trust 2009).

In recent years, small businesses and their employees have had an especially difficult time managing the rapidly rising cost of health care. Consistent with this, the share of firms with three to nine employees offering health insurance to their workers fell from 57 to 46 percent between 2000 and 2009.

As discussed in a Council of Economic Advisers report issued in July 2009, high insurance costs in the small-group market discourage entrepreneurs from launching their own companies, and the low availability of insurance discourages many people from working at small firms (Council of Economic Advisers 2009c). As a result, the current system discourages entrepreneurship and hurts the competitiveness of existing small businesses. Given the key role of small businesses in job creation and growth, this harms the entire economy.

Taken together, the trends summarized in this section demonstrate that in recent years the rapid rise in health insurance premiums has reduced the take-home pay of American workers and eaten into increases in Medicare recipients' Social Security benefits. Fewer firms are electing to offer health insurance to their workers, and those that do are reducing the generosity of that coverage through increased cost-sharing. Fewer individuals each year can afford to purchase health insurance coverage. The current system places small businesses at a competitive disadvantage. And finally, the steady increases in health care spending strain the budgets of families, businesses, and governments at every level, and demonstrate the need for health insurance reform that slows the growth rate of costs.

HEALTH POLICIES ENACTED IN 2009

Since taking office, the President has signed into law a series of provisions aimed at expanding health insurance coverage, improving the quality of care, and reducing the growth rate of health care spending. The

American Recovery and Reinvestment Act of 2009 provided vital support to those hit hardest by the economic downturn while helping to ensure access to doctors, nurses, and hospitals for Americans who lost jobs and income. At the same time, legislation extended health insurance coverage to millions of children, and improvements in health system quality and efficiency benefited the entire health care system. These necessary first steps have set the stage for a more fundamental reform of the U.S. health care system, one that will ensure access to affordable, high-quality coverage and that genuinely slows the growth rate of health care spending.

Expansion of the CHIP Program

Just two weeks after taking office, the President signed into law the Children's Health Insurance Program Reauthorization Act, which provides funding that expands access to nearly 4 million additional children by 2013. This guarantee of coverage also kept millions of children from losing insurance in the midst of the recession, when many workers lost employer-sponsored coverage for themselves and their dependents. An examination of data from recent surveys by the Centers for Disease Control and Prevention found that private coverage among children fell by 2.5 percentage points from the first six months of 2008 to the first six months of 2009. Despite the fall in private coverage, however, fewer children were uninsured during that six-month period in 2009, in large part because public coverage increased by 3 percentage points (Martinez and Cohen 2008, 2009).

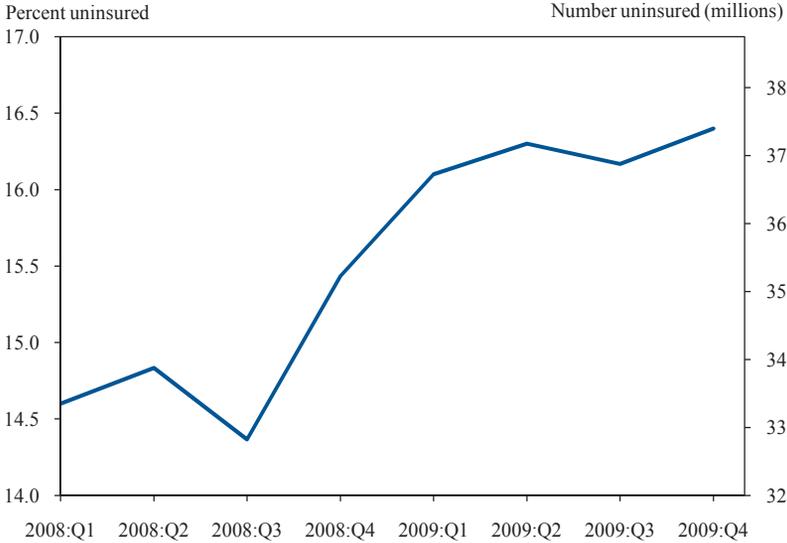
Approximately 7 million children (1 in every 10) were uninsured in 2008 (DeNavas-Walt, Proctor, and Smith 2009). Once fully phased in, the CHIP reauthorization legislation signed by the President will lower that number by as much as half from the 2008 baseline. In the future, this new legislation will enhance the quality of medical care for children and improve their health. Research has convincingly shown that expanding health insurance to children is very cost-effective, because it not only increases access to care but also substantially lowers mortality (Currie and Gruber 1996a, 1996b).

Subsidized COBRA Coverage

In part because of the difficulty of purchasing health insurance on the individual market (owing to adverse selection), most Americans get health insurance through their own or a family member's job. And what is true for dependent children is true for their parents: when economic conditions deteriorate, the number of people with employer-sponsored health insurance tends to fall. However, unlike the case with children, during the current recession public coverage has only offset part of the reduction

in private health insurance coverage among adults. Thus, the fraction of adults without health insurance has increased. Figure 7-8 uses survey data from Gallup to show that from the third quarter of 2008 to the first quarter of 2009, the share of U.S. adults without health insurance rose by 1.7 percentage points, from 14.4 to 16.1 percent, representing an estimated increase of 4.0 million uninsured individuals.

Figure 7-8
Share Uninsured among Adults Aged 18 and Over



Source: Gallup-Healthways Well-Being Index, January 2010.

When workers at large firms lose their jobs, COBRA provisions give them the right to continue existing coverage for themselves and their families. However, they are often required to pay the full premium cost with no assistance from former employers and without favorable tax treatment of their insurance benefits. Thus, although a large fraction of workers who lose their jobs can still purchase health insurance through COBRA at group rates, many elect not to do so, likely because the coverage is not affordable to a family with a newly laid-off wage earner.

One provision of the American Recovery and Reinvestment Act addressed the recession-induced drop in employer-sponsored health insurance by subsidizing COBRA coverage so that individuals pay only 35 percent of their premium, with the Federal Government covering the remaining 65 percent. This large subsidy may partially explain why the growth in the share of American adults without health insurance slowed dramatically from

the first to the fourth quarter of 2009, even while the unemployment rate continued to rise. While the average rate of uninsurance in 2009 was still 1.4 percentage points higher than the average in 2008, the rate was fairly constant throughout 2009. Thus, while the CHIP expansion was providing stable coverage to millions of children who would otherwise have lost it, the COBRA subsidy was further reinforcing access to coverage for working parents and families who faced unemployment.

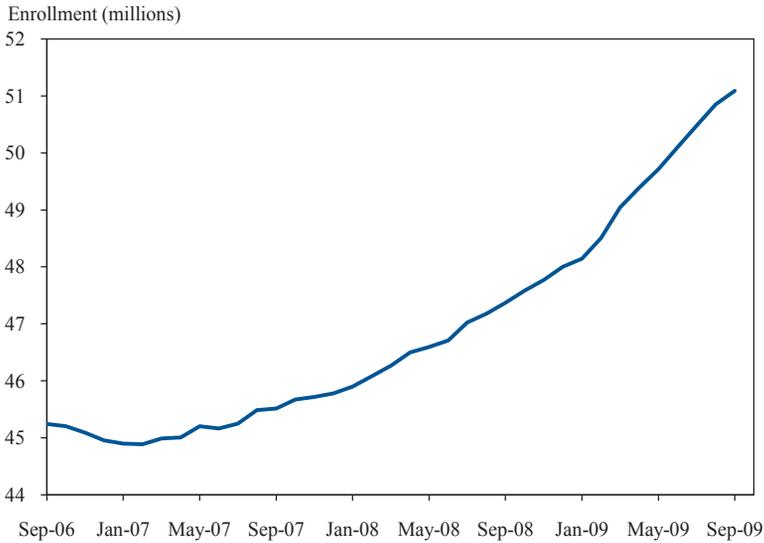
Temporary Federal Medical Assistance Percentage (FMAP) Increase

Historically, declines in employer-sponsored health insurance have led to increases in the number of people who qualify for public health insurance through programs such as Medicaid, which insured 45.8 million U.S. residents in December 2007. Because almost half of all Medicaid spending is typically financed by state governments, state Medicaid spending tends to rise substantially when economic conditions deteriorate. Coupled with the recession-induced drop in state tax revenues, these increases in Medicaid enrollment place a considerable strain on state budgets. And because virtually every state is required to balance its budget each year, increases in Medicaid enrollment often leave states with little choice but to raise taxes, lay off employees, reduce spending on public safety, education, and other important priorities, or reduce Medicaid benefits, provider payments, or eligibility. These policies are especially problematic when the economy is in severe recession, because they can stifle economic recovery.

Figure 7-9 uses administrative data from all 50 states and the District of Columbia to contrast the growth in Medicaid enrollment in the months leading up to the start of the recession in December 2007 with the corresponding growth during the recession.² An examination of the data displayed in the figure reveals that, after growing from 45.2 million in September 2006 to 45.8 million in December 2007, the number of Medicaid recipients increased much more rapidly in the subsequent 21 months, and stood at 51.1 million in September 2009. This represents an increase of 253,000 Medicaid recipients per month during the recession, versus an average increase of just 36,000 per month in the preceding 15 months.

² Data on state Medicaid enrollment were derived from direct communication between the Council of Economic Advisers and state health departments in 50 states and the District of Columbia. Monthly enrollment from September 2006 through September 2009 was reported by all states with the exception of Vermont in the first 10 months considered. For each month from September 2006 through June 2007 in Vermont, the state's July 2007 Medicaid enrollment was used.

Figure 7-9
Monthly Medicaid Enrollment Across the States



Source: Information from individual state health departments, compiled by CEA.

To help states pay for an expanding Medicaid program without raising taxes or cutting key services, one important component of the Recovery Act was a temporary increase in each state’s Federal Medical Assistance Percentage (FMAP), the share of Medicaid spending paid by the Federal Government. This fiscal relief allowed states to avoid cutbacks to their Medicaid programs or other adjustments that would have exacerbated the effects of the recession. The increased FMAPs were larger for states where unemployment increased the most, because their financial strains were greatest. To qualify for the increased FMAPs, states were required to maintain Medicaid eligibility at pre-recession levels.

A recent report by the Kaiser Family Foundation confirms that support from the Recovery Act—as well as the expansion of coverage for children enacted several weeks earlier in February 2009—was essential to preserving the ability of states to offer health insurance coverage to those most in need. In fact, more than half the states expanded access to health insurance coverage for low-income children, parents, and pregnant women in Medicaid and CHIP in 2009 (Ross and Jarlenski 2009).

Recovery Act Measures to Improve the Quality and Efficiency of Health Care

Beyond supporting jobless workers and their families in the midst of the recession, the Recovery Act addressed structural weaknesses in the health care system by investing in its infrastructure and its workforce. These investments will help to build a health care system with lower costs and better health outcomes for the long term.

For example, the Recovery Act invested \$2 billion in health centers for new construction, renovation of existing facilities, and expansion of coverage. An additional \$500 million was allocated to bolster the primary care workforce to improve access to primary care in underserved areas. The Act provided a further \$1 billion in funding for public health activities to improve prevention and to incentivize wellness initiatives for those with chronic illness; both measures are aimed at improving the quality of care and ultimately bringing down costs. The Act also increased spending on comparative effectiveness research by \$1.1 billion, to give doctors and patients access to the most credible and up-to-date information about which treatments are likely to work best.

One final component of the Recovery Act was the Health Information Technology for Economic and Clinical Health Act, which expanded the adoption and use of health information technology through infrastructure formation, information security improvements, and incentives for adoption and meaningful use of certified health information technology. This investment in developing computerized medical records will reduce health care spending and improve quality while securing patients' confidential information.

These investments build a foundation for comprehensive health insurance reform by adding to the ranks of doctors, nurses, and other health care providers, especially in critical fields like primary care, and in areas of the country with the greatest need for a more robust medical workforce. Moreover, the investments in comparative effectiveness research and health information technology will make it much easier for information and quality improvements to spread rapidly between doctors, medical practices, and hospitals across the public and private sectors. When combined with the wide range of delivery system changes included in health insurance reform legislation, these investments are expected to contain costs and improve quality over the long run.

In summary, legislation passed in 2009 helped extend or continue health insurance coverage for the workers, families, and children affected by the current recession. Rather than focusing solely on today's crisis, the

legislation lays the groundwork for a reformed health care system that addresses the weaknesses, flaws, and inefficiencies of the status quo.

2009 HEALTH REFORM LEGISLATION

As this *Report* goes to press, Congress has come closer to passing comprehensive health insurance reform than ever before, with major bills having passed both the House and the Senate. As of this writing, whether those bills will lead to enactment of final legislation in the near future is uncertain. Nonetheless, the bills contain important features that would expand coverage, slow the growth rate of costs while improving the quality of care, and benefit individuals, businesses, and governments at every level. This section discusses the major features of the two bills—the House’s Affordable Health Care for America Act and the Senate’s Patient Protection and Affordable Care Act.

Insurance Market Reforms: Strengthening and Securing Coverage

Both the House and the Senate bills contain important features that would immediately expand coverage and increase access to preventive care. The legislation would also strengthen regulation of the health insurance market, improve consumer protections, and secure coverage for more than 30 million Americans. These regulations would correct insurance market failures by preventing health insurers from responding to adverse selection by raising rates and denying coverage, thus stabilizing risk pools to secure access to affordable coverage.

Both versions of the legislation provide immediate Federal support for a new program to provide coverage to uninsured Americans with preexisting conditions. Combined with strong new consumer protections, these measures would ensure that millions of Americans can immediately purchase coverage at more affordable prices despite their personal medical history or health risks. Health insurance reform also makes immediate investments in community health centers, which would improve access to coverage among the most vulnerable populations. Both the House and Senate versions of reform immediately create reinsurance programs for employer health plans, providing coverage for early retirees to prevent them from becoming uninsured before they are covered by Medicare. Additionally, reform legislation would immediately begin to reform delivery systems for health care and improve transparency and choice for consumers. For example, the Senate proposal would create a website that would help

consumers compare coverage options by summarizing important aspects of each insurance contract in a consistent and easy-to-understand format.

New laws would help cover millions of young adults as they transition into the workforce by requiring insurers to allow extended family coverage for dependents through their mid-20s. The CBO and the Joint Committee on Taxation estimate that this requirement would lower average premiums per person in the large-group market by increasing the number of relatively healthy low-cost people in large-group pools (Congressional Budget Office 2009a).

In the years following reform, legislation would put into place strong new consumer protections to prevent denials of coverage or excessive costs for the less healthy. Insurers would be required to renew any policy for which the premium has been paid in full. Insurers could not refuse to renew because someone became sick, nor could they drop or water down insurance coverage for those who are or become ill. To prevent insurers from charging excessively high rates to the less healthy, reform legislation would also enact adjusted community rating rules for premiums.

Banning such treatment of individuals with preexisting conditions would not only allow insurance markets to better help individuals hedge against the risk of health care costs, but may also make the U.S. labor market more efficient. Without such protections, adults with preexisting conditions may be reluctant to change insurance providers and expose themselves to increased premiums. Workers who receive health insurance through their employers may therefore be less willing to change jobs, creating “job lock” that discourages desirable adjustments in the labor market.

In both versions of reform legislation, these provisions are linked with incentives for individuals to obtain coverage and for firms to insure their workers. While preventing insurance companies from discriminating based on preexisting conditions will help some of the neediest members of our society, in isolation these reforms could increase costs for individuals without preexisting conditions, potentially aggravating adverse selection. Without a responsibility to maintain health insurance coverage, individuals could forgo purchasing coverage until they fell ill, and thus not contribute to a shared insurance risk pool until their expected costs rose sharply. However, with restrictions on exclusions for preexisting conditions in place, high-cost individuals who sign up after falling ill could obtain coverage at low premiums. Thus, individuals who had contributed toward coverage would be faced with higher costs, potentially driving even more individuals out of coverage. To prevent a spiral of increasing costs and decreasing insurance rates resulting from adverse selection, both the House and the Senate bills establish a principle of joint individual and employer responsibility to

obtain and provide insurance, and would provide subsidies and tax credits that would assist in this process.

The bills would address other features of many health plans that limit their ability to help individuals insure against financial risk. Currently, insurers can put yearly and lifetime limits on coverage. For people with diseases such as cancer, life-saving treatment is often very costly, and exceeding annual and lifetime benefit limits can lead to bankruptcy. This problem is especially severe in the individual and small-group markets, where insurers have more discretion in designing policies. Insurance plans that allow individuals to bankrupt themselves may be socially inefficient because of the Samaritan's dilemma: medical bills that are unpaid when a patient becomes bankrupt impose a hidden tax on other participants in the health care market.

In addition to these insurance market reforms, legislation passed by Congress would require coverage of preventive care and exempt preventive care benefits from deductibles and other cost-sharing requirements in Medicare and private insurance. Evidence suggests that not only are certain preventive care measures cost-effective, but they can also help to prevent diseases that are responsible for roughly half of yearly mortality in the United States (Mokdad et al. 2004). Some measures, such as smoking cessation programs, discussing aspirin use with high-risk adults, and childhood immunizations, may even lower total health care spending (Maciosek et al. 2006). Because many people change insurance companies several times over the course of their lives, insurance companies may underinvest in preventive care that is cost-effective but does not reduce medical costs until far in the future. By encouraging all insurance companies to invest in preventive care, health insurance reform would increase the efficiency of the health care sector.

Finally, reform legislation takes steps to make prescription drug coverage more affordable and secure for senior citizens. The legislation would increase the initial coverage limit under Medicare Part D by \$500 in 2010 and also provide 50 percent price discounts for brand-name drugs in the "donut hole" discussed earlier. This discount would allow many Medicare Part D recipients to reduce their out-of-pocket spending on prescription drugs. Not only would fewer beneficiaries have to pay the full cost of their prescription drugs while in the donut hole, but those who do reach this coverage gap would also benefit from increased coverage before reaching that point.

In summary, within the first few years after passage, reform legislation in Congress would guarantee coverage for those with preexisting conditions, reform private insurance markets with strong consumer protections that

would stabilize risk pools and mitigate adverse selection, and strengthen public coverage under Medicare.

Expansions in Health Insurance Coverage Through the Exchange

Central to both the House and the Senate bills is the health insurance exchange, which would allow individuals and employees of small businesses to choose among many different insurance plans. The exchange would provide a centralized marketplace to allow individuals, families, and small firms to pool together and purchase coverage much like larger firms do today, improving consumer choice and increasing pressure on insurers to offer lower prices and more generous benefits to attract customers. In its first year of operation, the exchange would be open to qualified individuals and small businesses.

Individuals and small businesses, which might otherwise purchase health insurance in the individual or small-group markets, would benefit from the economies of scale and greater buying leverage in the exchange, which could result in much lower premiums. The exchange would also provide transparent information on plan quality, out-of-pocket costs, covered benefits, and premiums for each offered plan, enabling individuals to select the plan that best fits their and their family's needs. The availability of easy-to-compare premium information would provide a powerful incentive for health insurers to price competitively, thus making coverage more affordable for participants in the exchange.

The new exchange would be especially beneficial for small business employees, who, as described earlier, face particularly severe challenges in the health insurance market. The bills would enable small businesses that meet certain criteria to purchase insurance through the exchange, allowing them and their workers to buy better coverage at lower costs. Moreover, many small businesses that provide health insurance for their employees would receive a tax credit to alleviate their disproportionately higher costs and to encourage coverage. The tax credit would lower the cost of coverage by as much as 50 percent. Reform would make it easier for small businesses to recruit talented workers and would also increase workers' incentives to start their own small businesses. A recent analysis of the Senate bill by the CBO found that premiums for a given amount of coverage for the same set of people or small businesses would fall in the individual and small-group markets as a result of reductions in administrative costs and increased competition in a centralized marketplace (Congressional Budget Office 2009a).

Most individuals who select a plan in the exchange would be eligible for subsidies that reduce the cost of their coverage. In both the House and

Senate bills, subsidies would be available to certain individuals and families with incomes below 400 percent of the Federal poverty line. The premium and out-of-pocket spending subsidies for plans purchased in the exchange would be larger for lower-income families, many of whom cannot afford the cost of a private plan. In addition, individuals with incomes below about 133 to 150 percent of the poverty line would be eligible for health insurance through the Medicaid program.

In the exchange, Federal subsidies would be tied to premiums for relatively lower-cost “reference” plans. Beneficiaries would, however, be able to buy more extensive coverage at an additional, unsubsidized cost.

Economic and Health Benefits of Expanding Health Insurance Coverage

CBO analyses of both the House and Senate bills indicate that, in part because of the creation of the exchanges and the expansion in Medicaid, more than 30 million Americans who would otherwise be uninsured would obtain coverage as a result of reform. These coverage expansions would improve not only the health and the economic well-being of affected individuals and families, but also the broader economy.

A comprehensive body of literature demonstrates that being uninsured leads to poorer medical treatment, worse health status, and higher mortality rates. Across a range of acute conditions and chronic diseases, uninsured Americans have worse outcomes, higher rates of preventable death, and lower-quality care. Additionally, being uninsured imposes on families a significant financial risk of bankruptcy caused by medical expenses.

Evidence from the state of Massachusetts—which expanded health insurance to all but 2.6 percent of its population in a 2006 reform effort—finds that expanding coverage increased regular medical care and lowered financial burdens for residents who gained coverage. Only 17.4 percent of adults with family incomes of less than 300 percent of the Federal poverty line reported forgoing care because of costs in 2008, compared with 27.3 percent in the pre-reform baseline in 2006 (Long and Masi 2009).

Taken together, this evidence strongly suggests that expanding coverage for Americans through health insurance reform would directly benefit millions of families by giving them access to the care they need to maintain their health without substantial financial burdens and risks. Moreover, because of the fixed costs of developing health care infrastructure such as trauma centers, increasing the share of people with health insurance can improve health outcomes for people with insurance as well.

Beyond the improvements for individuals and families, coverage expansions would produce benefits that extend throughout the entire economy. A CEA report in June 2009 estimated that economic gains from reduced financial risk for the uninsured totaled \$40 billion per year (Council of Economic Advisers 2009a). Moreover, the CEA report found an economic value of more than \$180 billion per year from averting preventable deaths caused by a lack of insurance. Taken together, these gains would far exceed the cost of extending coverage to the currently uninsured population.

The economic benefits of expanding coverage would extend to labor markets in the form of reduced absenteeism and greater productivity. According to the 2009 March Current Population Survey, 18.7 million non-elderly adults report having one or more disabilities that prevent or limit the work they can perform; of that total, 3.1 million lack health insurance. Approximately 50 percent of non-elderly adults who work report having at least one serious medical condition. Previous research has documented the indirect costs to employers of health-related productivity losses. Some of the costliest conditions—depression, migraines, and asthma—can often be effectively managed with prescription medications made more affordable by health insurance. This suggests that expanding access to coverage would improve productivity and labor supply by creating a healthier workforce that would lose fewer hours to preventable illnesses or disabilities.

Reducing the Growth Rate of Health Care Costs in the Public and Private Sectors

The House and Senate bills contain a number of provisions that would reduce the growth rate of health care spending in both the public and private sectors. Both bills create pilot programs in Medicare to bundle provider payments for an episode of care rather than for individual procedures. Under bundled payments, Medicare would provide a single reimbursement for an entire episode of care rather than multiple reimbursements for individual treatments. This payment strategy would give providers, organized around a hospital or group of physicians, a stronger incentive to coordinate and provide quality care efficiently rather than carry out low-value or unnecessary treatments and procedures. Recent research in the *New England Journal of Medicine* suggests that bundled payments could improve quality and substantially reduce health care spending (Hussey et al. 2009). The Department of Health and Human Services would be given authority to expand or extend successful pilot programs without additional legislative action.

Both bills also include measures that directly reduce waste in the current health care system. One example of such waste is the substantial overpayment to Medicare Advantage plans, which are currently paid an average of 14 percent more per recipient than traditional Medicare. The reform bills would reduce these overpayments, saving more than \$100 billion between 2010 and 2019 (Congressional Budget Office 2009b). Reducing the overpayments would also lower Medicare recipients' Part B premiums below what they otherwise would be and would extend the solvency of the Medicare Trust Fund.

Another component of the legislation that has the potential to slow the growth rate of health care spending is the Independent Payment Advisory Board included in the Senate bill. This board would have the authority to propose changes to the Medicare program both to improve the quality of care and to reduce the growth rate of program spending. Absent Congressional action, these recommendations would be automatically implemented.

Using the the CEA analysis of the House and Senate bills along with projections from CBO about the level of Federal spending on Medicare, Medicaid, and CHIP, it is possible to estimate the effect of reform on the growth rate of Federal health care spending. Recent CEA analyses of the House and Senate bills find that reform would lower total Federal spending on Medicare, Medicaid, and CHIP by 2019 below what it otherwise would have been (Council of Economic Advisers 2009b). Moreover, between 2016 and 2019, both bills would lower the annual growth rate of Federal spending on these programs by approximately 1.0 percentage point. State and local governments would also benefit financially from health insurance reform, as described in Box 7-1.

Box 7-1: The Impact of Health Reform on State and Local Governments

Although slowing the growth in health care costs will help the long-run fiscal situation of the Federal Government, some observers worry about how reform will affect state and local governments. To help ensure that virtually all Americans receive health insurance, both the Senate and the House bills call for expanding Medicaid eligibility. Because Medicaid is partly funded by states, some state officials fear that the state fiscal situation will deteriorate as a consequence of reform.

As documented by a CEA report published in September (Council of Economic Advisers 2009d), however, health insurance reform would

Continued on next page

Box 7-1, continued

improve the fiscal health of state and local governments in at least three important ways. First, state and local governments are already spending billions of dollars each year providing coverage to the uninsured; these costs would fall significantly as a consequence of health reform. Second, encouraging all individuals to become insured would reduce the hidden tax paid by providers of health insurance. Because state and local governments employ more than 19 million people, the total savings from removing the hidden tax is likely to be substantial. Third, an excise tax on high-cost plans would boost workers' wages by billions of dollars each year and thus increase state income tax revenues.

To understand the net consequences of reform for the fiscal health of state and local governments, the CEA studied the impact of reform for 16 states that are diverse along many important dimensions: geographic, economic, and demographic. For every state studied, health reform would result in substantial savings for state and local governments.

In addition to these public savings, the reform proposals would reduce the growth of health care costs in the private sector. One important mechanism through which reform could reduce these costs is the excise tax on high-cost insurance plans included in the Senate bill. Under current tax law, employer compensation in the form of wages is subject to the income tax, while compensation in the form of employer-provided health care benefits is not. Individuals may therefore have an incentive to obtain more generous health insurance than they would if wages and health insurance faced more equal tax treatment. Absent other incentives for individuals to obtain insurance, the preferential tax treatment of health insurance may be beneficial, because it encourages firms to provide health insurance to their workers and facilitates pooling. Nonetheless, placing no limit on this subsidy likely leads to health insurance that is more generous than would be efficient in some cases.

To help contain the growth in the cost of these plans without jeopardizing the risk-pooling benefits, the Senate bill would impose a tax on only the most expensive employer-sponsored plans. Although only a small share of plans would be affected, CEA estimates based on data from the CBO suggest that the excise tax on high-cost insurance plans would reduce the growth rate of annual health care costs in the private sector by 0.5 percentage point per year from 2012 to 2018. The excise tax would encourage workers and their firms' human resources departments to be more watchful consumers and would give insurers a powerful incentive to

price competitively. And to the extent that bundling, accountable care organizations, and other delivery system reforms in both the House and Senate bills would spill over to the private sector, it is likely that the rate of growth of health care spending in the private sector would fall by considerably more than 0.5 percentage point per year. Lower increases in private health insurance premiums would lead to substantially higher take-home earnings for workers.

Reform would also reduce private spending on health care in other important ways. As noted, encouraging all individuals to obtain health insurance would likely reduce average costs for people who are insured. Reducing the hidden tax on health insurance premiums imposed by uncompensated care for the uninsured, for example, would reduce the financial burden not only on state and local governments, but also on individuals. CBO estimates of the Senate legislation find that reform has the power to reduce small-group premiums by up to 2 percent and even large-group premiums by up to 3 percent. And according to research by the Business Roundtable, reforms similar to those included in both the House and Senate bills could reduce employer-sponsored health insurance costs for family coverage by as much as \$3,000 per worker by 2019 relative to what those costs otherwise would have been.

The Economic Benefits of Slowing the Growth Rate of Health Care Costs

Reform as envisioned in both the House and Senate bills passed in late 2009 would substantially lower the growth rate of health care spending. Of course, spending would increase in the very short run as coverage was extended to more than 30 million Americans who would otherwise be uninsured. But, according to the CBO, these temporary increases would soon be more than offset by the slowdown in the growth rate of spending, with the net savings increasing over time (Congressional Budget Office 2009b, 2009c).

A report released by the CEA in June 2009 demonstrated that slowing the growth rate of health care costs would raise U.S. standards of living by freeing up resources that could be used to produce other goods and services. An examination of the cost reduction measures contained in the Senate bill suggests that the typical family would see its income increase by thousands of dollars per year by 2030. Total GDP would be substantially higher as well, driven upward by both increased efficiency and increased national saving.

Slowing the growth rate of health care costs would also lower the Federal budget deficit. Projections by the CBO of both the House and the Senate legislation suggest that the bills would lower the deficit substantially

in the upcoming decade, and even more in the next decade. These savings would obviate large tax increases or cuts in other important priority areas. As discussed in Chapter 5, it would be the single most important step toward addressing the Nation's long-run fiscal challenges.

Finally, reform that genuinely slows the growth of health care costs could increase employment for a period of time by lowering the unemployment rate that is consistent with steady inflation. These effects could be important, with CEA estimates suggesting an increase of more than 300,000 jobs for a period of time if health care costs grew by 1 percentage point less each year.

CONCLUSION

In recent years, health care costs in the Nation's private and public sectors have been rising at an unsustainable rate, and the fraction of Americans who are uninsured has steadily increased. These trends have imposed tremendous burdens on individuals, employers, and governments at every level, and the problems have grown yet more severe during the past two years with the onset of the worst recession since the Great Depression.

Last year, the President signed into law several policies that have cushioned the worst of the economic downturn, including an expansion in the Children's Health Insurance Program and an extension of COBRA coverage for displaced workers and their families. Other policies, such as increased funding for health information technology, will improve the long-run efficiency and quality of the health care sector.

Legislation passed by both the House and the Senate in late 2009 would expand health insurance coverage to tens of millions of Americans while slowing the growth rate of health care costs. These reforms would improve the health and the economic well-being of individuals and families, help small businesses, stimulate job creation, and ease strains on Federal, state, and local governments imposed by rapidly rising health care costs.

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