The Effects of Large Premium Increases on Individuals, Families, and Small Businesses

Summary

Recent announcements of increases in private nongroup insurance premiums for 2010 that were many times the national rate of health care cost growth have attracted attention from the Obama administration, Congress, and the press. Several employer benefit specialists predict smaller but sizable increases in employer-sponsored insurance (ESI) premiums in the near future. Health care cost growth is a factor, but the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary and others project that the rate of cost growth will slow through 2010 as a result of the recession. In this report, we examine the effects on coverage, costs, and small employer decisions to offer insurance under different scenarios for general increases in individual and ESI premiums. We begin with a baseline scenario for 2010, in which premium increases from the preceding year are driven by rates of cost growth projected by CMS. We then simulate two scenarios in which premiums rise at a significantly faster rate than baseline premium growth: an intermediate scenario in which ESI premiums increase 6 percent for large firms, 10 percent for small firms, and 20 percent in the individual market, and the largest increase scenario, with ESI premiums rising 9 percent for large firms, 20 percent for small firms, and 30 percent in the individual market.

The analysis finds that, relative to the baseline, the simulated premium increases would:

- Result in 1.9 million Americans becoming uninsured with intermediate premium increases and 3.3 million with the largest increases;

- Affect low- and middle-income persons the most because of losses of private coverage; there would be reductions in private nongroup coverage for this group of more than 15 percent with intermediate increases and more than 20 percent with the highest increases.

- Cause as many as 1.3 million older, nonelderly persons (45 to 64) to lose coverage, an increase of 10.2 percent in the uninsured among this group; 1.4 million younger adults (18 to 44) also lose coverage, an increase of 4.7 percent in the uninsured;

- Lead to some adverse selection in the private nongroup market; those losing nongroup coverage due to the premium increases above those in the baseline would have substantially lower costs on average than those retaining their coverage. Large premium increases can themselves create the need for future premium increases above the overall rate of health care cost growth as healthier individuals drop coverage and the average cost of the remaining insured increases;

- Raise overall health care spending by $18.1 billion with intermediate premium increases and by $38.6 billion with the highest increases;

- Pressure employers to either decrease their premium contributions or pay most of the additional costs due to premium increases above the growth of health care costs. If premium contribution rates do not change, total health care spending by employers would increase by $13.5 billion (3.1 percent) with intermediate premium increases and $27.3 billion (6.4 percent) with the highest increases;

- Reduce the number of small firms offering insurance to their workers. For firms with less than 10 workers, the highest premium increases would cause the ESI offer rate to drop by more than 10 percent.

Robert Wood Johnson Foundation

Urban Institute

Introduction

Recent announcements of increases in private nongroup insurance premiums for 2010 that were many times the national rate of health care cost growth have attracted attention from the Obama administration, Congress, and the press.[1] Several employer benefit specialists predict smaller but sizable increases in employer-sponsored insurance (ESI) premiums in the near future.[2] In this report, we examine the effects of such premium increases on coverage, costs, and the decisions by small firms to offer ESI. Most attention paid to this issue has focused on the justifiability of specific increases. That is not our purpose here. We focus on the effects, which we model as national premium increases in excess of the growth in national health care cost. The Centers for Medicare and Medicaid Services (CMS) actuaries and others project that the rate of cost growth will slow through 2010 due to the recession (see Methods below). Indeed, 2008, the latest year of available data, saw a record low increase in health costs.[3]

We simulate two alternative scenarios that introduce national premium increases significantly higher than those resulting from CMS projections of medical costs. The premium increases that have gotten the most attention recently are those of large insurers in a single state, but insurers in many states have recently announced similarly large increases.[4] Many people are concerned that this could become a general trend. Even the largest nongroup premium increases we simulate are somewhat less than the headline-grabbing increases announced by some insurers. Large increases in some places would likely be offset by smaller increases elsewhere, but the overall average premium would still increase at a much higher rate than health care costs. Also, some recently projected increases in ESI premiums were, in fact, national in scope.[5]

We begin with a baseline in which premium increases from 2009 to 2010 are driven by increases in health care costs and projected changes in economic and demographic factors. For example, CMS projects that per capita National Health Expenditures (NHE) will grow by 3 percent from 2009 to 2010. Given the lag between claims and insurance policy renewals, we base premium increases from 2009 to 2010 on the per capita NHE growth from 2008 to 2009, projected to have been 4.8 percent. This baseline is then compared to simulations using two higher premium growth scenarios for 2009 to 2010:

1. *Intermediate premium increases:* ESI premiums increase 6 percent for large firms, 10 percent for small firms, and 20 percent for the nongroup (individual) market. Underlying health care cost increases and other changes from 2009 to 2010 are assumed to be the same as in the baseline.

Table 1. 2010 Coverage by Income (Nonelderly, in millions)

Income Group	Employer Sponsored			Private Non-group			Public Coverage			Uninsured			Total
	Baseline	Difference after increase	Percent change	Baseline	Difference after increase	Percent change	Baseline	Difference after increase	Percent change	Baseline	Difference after increase	Percent change	
Intermediate premium increases: 6% large firm ESI, 10% small firm ESI, 20% private nongroup													
Less than 133% FPL	6.5	0.0	0.0%	3.0	-0.5	-16.7%	27.0	0.1	0.4%	19.6	0.4	2.0%	56.1
133-399% FPL	48.6	-0.2	-0.4%	5.5	-0.9	-16.4%	21.2	0.2	0.9%	22.0	0.9	4.1%	97.3
400% FPL or more	95.1	-0.2	-0.2%	6.3	-0.4	-6.3%	6.1	0.0	0.0%	7.8	0.6	7.7%	115.3
Total	**150.2**	**-0.5**	**-0.3%**	**14.8**	**-1.8**	**-12.2%**	**54.3**	**0.4**	**0.7%**	**49.4**	**1.9**	**3.8%**	**268.7**
Largest premium increases: 9% large firm ESI, 20% small firm ESI, 30% private nongroup													
Less than 133% FPL	6.5	-0.1	-1.5%	3.0	-0.7	-23.3%	27.0	0.2	0.7%	19.6	0.6	3.1%	56.1
133-399% FPL	48.6	-0.6	-1.2%	5.5	-1.1	-20.0%	21.2	0.2	0.9%	22.0	1.5	6.8%	97.3
400% FPL or more	95.1	-0.7	-0.7%	6.3	-0.5	-7.9%	6.1	0.0	0.0%	7.8	1.2	15.4%	115.3
Total	**150.2**	**-1.4**	**-0.9%**	**14.8**	**-2.3**	**-15.5%**	**54.3**	**0.4**	**0.7%**	**49.4**	**3.3**	**6.7%**	**268.7**

Source: Urban Institute analysis, HIPSM 2010.

Note: Premium increases are modeled as if they were fully implemented in 2010, and estimates are for that single year.

Table 2. 2010 Coverage by Age (Nonelderly, in millions)

Income Group	Employer Sponsored			Private Non-group			Public Coverage			Uninsured			Total
	Baseline	Difference after increase	Percent change	Baseline	Difference after increase	Percent change	Baseline	Difference after increase	Percent change	Baseline	Difference after increase	Percent change	
Intermediate premium increases: 6% large firm ESI, 10% small firm ESI, 20% private nongroup													
Children, < 18	37.9	-0.1	-0.3%	3.0	-0.3	-10.0%	28.5	0.0	0.0%	6.9	0.4	5.8%	76.3
18 - 44	60.9	-0.2	-0.3%	6.8	-0.7	-10.3%	14.4	0.1	0.7%	29.8	0.8	2.7%	111.9
45 - 64	51.3	-0.1	-0.2%	5.0	-0.7	-14.0%	11.5	0.0	0.0%	12.7	0.8	6.3%	80.5
Total	**150.2**	**-0.5**	**-0.3%**	**14.8**	**-1.8**	**-12.2%**	**54.3**	**0.4**	**0.7%**	**49.4**	**1.9**	**3.8%**	**268.7**
Largest premium increases: 9% large firm ESI, 20% small firm ESI, 30% private nongroup													
Children, < 18	37.9	-0.4	-1.1%	3.0	-0.5	-16.7%	28.5	0.2	0.7%	6.9	0.7	10.1%	76.3
18 - 44	60.9	-0.6	-1.0%	6.8	-0.9	-13.2%	14.4	0.1	0.7%	29.8	1.4	4.7%	111.9
45 - 64	51.3	-0.4	-0.8%	5.0	-1.0	-20.0%	11.5	0.1	0.9%	12.7	1.3	10.2%	80.5
Total	**150.2**	**-1.4**	**-0.9%**	**14.8**	**-2.3**	**-15.5%**	**54.3**	**0.4**	**0.7%**	**49.4**	**3.3**	**6.7%**	**268.7**

Source: Urban Institute analysis, HIPSM 2010.

Note: Premium increases are modeled as if they were fully implemented in 2010, and estimates are for that single year.

2. *Largest premium increases:* ESI premiums increase 9 percent for large firms, 20 percent for small firms, and 30 percent for the nongroup (individual) market. Underlying health care cost increases and other changes from 2009 to 2010 are assumed to be the same as in the baseline.

Adverse selection caused by the recession is often asserted as a cause for sharp premium increases. While the Health Insurance Policy Simulation Model (HIPSM) does simulate many recession effects, it cannot capture certain employment effects. We do not simulate the labor market and the specific characteristics of jobs being lost or employers going out of business. Job loss could potentially cause adverse selection not captured in our results. However, it would not necessarily do so.[6]

Methods

To estimate the effects of the premium scenarios, we use the Urban Institute's Health Insurance Policy Simulation Model.[7] HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms.[8]

In this analysis, we focus on changes from 2009 to 2010 assuming no change in health policy from current law before health reform; our scenarios differ only in the premiums private insurers charge. 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.[9]

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. 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.[10] For health spending, we use the changes in the National Health Expenditure accounts, including projections for 2009 and 2010 by the CMS Office of the Actuary.[11]

Results

Coverage by Income Group

In table 1, we show the impact on coverage of the two alternative premium increase scenarios. The results are shown for three different income groups: those with incomes below 133 percent of the federal poverty level (FPL), those with incomes between 133 and 399 percent of the FPL, and people with incomes reaching 400 percent of the FPL or more.[12] The pattern of

Table 3. 2010 Average Costs of the Nonelderly by Selected Coverage Changes

Coverage at Baseline	Coverage under premium scenario	Intermediate Premium Increases		Largest Premium Increases	
		Persons	**Average Total Costs**	**Persons**	**Average Total Costs**
Private Nongroup					
	Employer Sponsored	395,000	2,624	542,947	2,427
	Private Non-group	12,739,651	2,414	12,015,164	2,427
	Public Coverage	247,242	2,204	297,764	2,334
	Uninsured	1,426,964	1,117	1,953,971	1,032
Employer Sponsored					
	Employer Sponsored	148,950,492	4,198	147,821,564	4,195
	Private Non-group	219,016	4,256	381,979	3,072
	Public Coverage	369,575	3,425	412,113	3,412
	Uninsured	676,681	1,648	1,599,999	1,789

Source: Urban Institute analysis, HIPSM 2010.

Note: Premium increases are modeled as if they were fully implemented in 2010, and estimates are for that single year.

* Average insured cost for the uninsured is uncompensated care

coverage changes is similar for both scenarios, so we concentrate on the largest premium increase to illustrate the results.

Low-income groups would have the greatest loss in private insurance—counting both employer-sponsored insurance (ESI) and nongroup insurance. For the two lowest income groups, there would be losses of about 1 percent in ESI coverage, but more than 20 percent in nongroup coverage. Overall, there is a decline of 1.4 million persons with employer-sponsored insurance, mostly in the middle and highest income groups. Since there is much less ESI coverage among the lowest income group, there is much less to lose. Another 2.3 million people would lose private nongroup coverage, about 15 percent relative to the baseline. Of this, 700,000 are in the lowest income group and 1.1 million in the middle-income group. Finally, there would be an increase of 3.3 million uninsured Americans, a roughly 7 percent increase relative to the baseline. Of this, 600,000 are in the low-income group, 1.5 million are in the middle-income group, and 1.2 million are in

the highest income group. The highest income group has the largest increase in percentage terms, just over 15 percent.

Changes in Coverage by Age

Table 2 shows the effect of increases in premiums on three age groups: children under 18, adults ages 18 to 44, and adults ages 45 to 64. As with table 1, the pattern is the same across both premium increase scenarios, so we focus on the largest premium increase. ESI coverage declined in a relatively uniform way across all age groups, by about 1 percent. A large share of the decline in private nongroup coverage is among those ages 45 to 64, which fell by 20 percent. In this age group, 1.0 million fewer Americans had nongroup coverage under the higher premium growth scenario compared to the baseline scenario. Nongroup coverage among younger adults declined by 900,000 (a 13 percent reduction). The remaining 500,000 person decline in nongroup coverage with the higher premium growth was among children, a 17 percent drop.
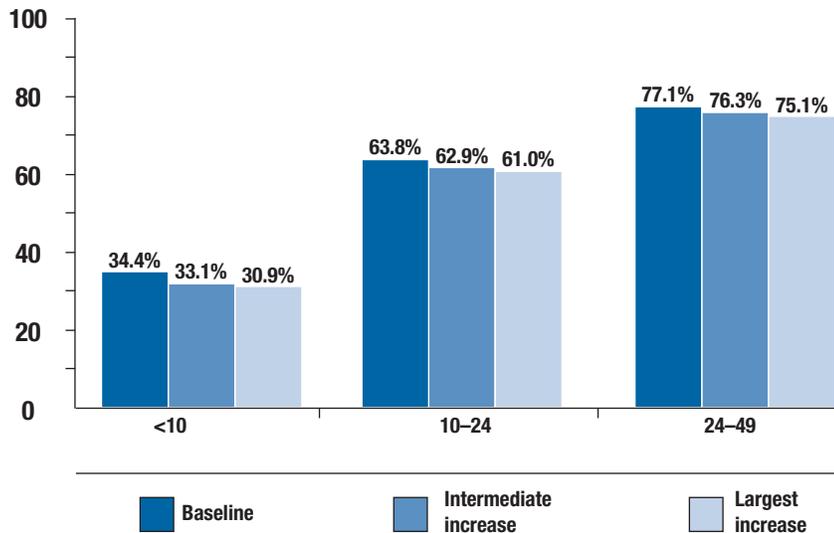
More children picked up public coverage in response to the higher

premiums than did other groups. As a result, there was an increase of only 700,000 uninsured children. Increases in public coverage offset less of the decline in private coverage for both adult categories, since public program eligibility is much more limited for adults under current law before health reform. Thus, there was an increase of 1.4 million in the number of uninsured young adults and 1.3 million more uninsured older adults due to the higher premiums. In percentage terms, the increase in the uninsured was substantially higher in older than younger adults—10.2 versus 4.7 percent, since many more young adults were uninsured to begin with.

Changes in Coverage and Average Health Care Costs

In table 3, we examine some of the transitions in coverage from the 2010 baseline to the scenarios with increased premiums. For those with baseline nongroup coverage, by far the most common change in coverage is becoming uninsured. Much smaller numbers respond to premium and cost increases by either enrolling in Medicaid or purchasing

Figure 1. ESI Offer Rates for Small Firms

Figure 1. ESI Offer Rates for Small Firms. Bar chart showing ESI offer rates by firm size category. For <10 employees: Baseline 34.4%, Intermediate increase 33.1%, Largest increase 30.9%. For 10–24 employees: Baseline 63.8%, Intermediate increase 62.9%, Largest increase 61.0%. For 24–49 employees: Baseline 77.1%, Intermediate increase 76.3%, Largest increase 75.1%.

Source: Urban Institute analysis HIPSM 2010

ESI coverage instead. Those deciding to drop nongroup coverage and become uninsured (about 2 million under the largest increase) have noticeably lower costs than those keeping their policies, $1,032 versus $2,427, under the largest premium increase. Thus, the premium increases will induce some adverse selection, and the largest increase will produce the most adverse selection. This will be mitigated somewhat by new nongroup enrollees who lost offers of ESI coverage (about 382,000 under the largest increase). These people have significantly higher costs on average ($3,072 under the largest increase) than those who would stay in nongroup coverage.

Most people with ESI coverage in the baseline stay with that coverage. We see that, as with nongroup coverage, those becoming uninsured have on average lower health costs than those remaining. However, this is such a small percentage of the ESI market that adverse selection would be insignificant overall.

Table 3 does not include those in the baseline who are either uninsured or have public coverage since very few

of these change their coverage type in response to the premium increases.

Aggregate Costs

Next, we examine the effects of premium increases on overall health care costs (table 4). Government costs increase only slightly because the increases in public coverage that would occur as a result of the higher premiums are relatively small. Because there are more uninsured, uncompensated care costs increase by $2.7 billion (4.2 percent) in the largest premium increase. Employer spending increases the most, $27.3 billion (6.4 percent), under the largest increase; because employers pay a substantial share of workers' premiums, they are greatly affected by the premium increases. With higher premiums, fewer workers enroll in ESI, but the resulting decrease in employer costs is outweighed by the higher prices paid on behalf of those workers still enrolling in ESI. Total individual spending increases by $7.8 billion (2.4 percent) under the largest premium increase. This relatively small increase occurs because those with ESI—a large majority of insured—are

generally paying only a small fraction of the full premiums.[13] Those who enroll in Medicaid see spending decline and those who become uninsured use less health care and thus have lower spending. The intermediate premium increase results in an increase of $18.1 billion in health care spending. In the higher premium increase scenario, the increase is $38.6 billion. The premium increases that we analyze reduce coverage and increase overall health care spending.

Small Firm Offer Rates

Finally, we examine employer offer rates by small firms, defined as those with fewer than 50 workers (figure 1). The largest premium increases result in a decline of offer rates by 3.5 percentage points among firms with fewer than 10 employees relative to the baseline; a change of about 10 percent. In firms with between 25 and 49 workers, offer rates decline by 2 percentage points or 2.5 percent. Large-firm offer rates (not shown) decline very slightly.

Discussion

In summary, our analysis finds that, relative to the baseline, the simulated premium increases would result in 1.9 million Americans becoming uninsured with intermediate premium increases and 3.3 million with the largest increases. The loss of private coverage would fall most heavily on low- and middle-income persons; there would be reductions in private nongroup coverage for this group of more than 15 percent with intermediate increases and more than 20 percent with the highest increases. Under the highest premium increases, 1.3 million older, nonelderly persons (age 45 to 64) would lose coverage, an increase of 10.2 percent in the uninsured among this group. And 1.4 million younger adults (18 to 44) also lose coverage, an increase of 4.7 percent in the uninsured.

The premium increases would lead to some adverse selection in the private nongroup market; those losing

nongroup coverage due to the premium increases above those in the baseline would have substantially lower costs on average than those retaining their coverage. Large premium increases can themselves create the need for future premium increases above the overall rate of health care cost growth as healthier individuals drop coverage and the average cost of the remaining insured thus increases.

The simulated increases would raise overall health care spending by $18.1 billion with intermediate premium increases and by $38.6 billion with the highest increases. Employers would be pressured to either decrease their premium contributions or pay most of the additional costs due to premium increases above the growth of health care costs. If premium contribution rates do not change, total health care spending by employers would increase by $13.5 billion (3.1 percent) with intermediate premium increases and $27.3 billion (6.4 percent) with the highest increases. Finally, the number of small firms offering insurance to their workers would be reduced in both scenarios. For firms with fewer than ten workers, the highest premium increases would cause the ESI offer rate to drop by more than 10 percent.

Regardless of their cause, premium increases greatly in excess of the national rate of growth for health care costs should concern employers, who could bear up to three-quarters of the resulting financial burden. We find little overall loss of employer coverage; rather, employers make higher contributions to health insurance. This could lead many to reduce the share they contribute to their workers' premiums or to lower the comprehensiveness of the insurance packages offered.[14]

Those who purchase in the nongroup market are most affected. On average, there is a decline of 15.5 percent in nongroup coverage, with reductions of over 20 percent for low- and middle-income Americans. Those over age 45 are also particularly affected adversely. Those purchasing ESI could pay higher costs

Table 4. 2010 Health Care Spending of Government, Employers, Families and Uncompensated Care (in billions)

	Intermediate Premium Increases	Largest Premium Increases
Total Government Spending (federal + state)		
Baseline	$277.7	$277.7
Medicaid/SCHIP After Increase	$278.3	$278.5
Net Change After Increase	$0.6	$0.8
% Change After Increase	0.2%	0.3%
Uncompensated Care		
Baseline	$63.9	$63.9
After Increase	$65.3	$66.6
Net Change After Increase	$1.4	$2.7
% Change After Increase	2.2%	4.2%
Employer Spending		
Baseline	$429.7	$429.7
After Increase	$443.2	$457.0
Net Change After Increase	$13.5	$27.3
% Change After Increase	3.1%	6.4%
Individual and Family Spending		
Baseline	$315.0	$315.0
After Increase	$317.6	$322.8
Net Change After Increase	$2.6	$7.8
% Change After Increase	0.8%	2.5%
Aggregate Change	**$18.1**	**$38.6**

Source: Urban Institute analysis, HIPSM 2010.

Note: Premium increases are modeled as if they were fully implemented in 2010, and estimates are for that single year.

than simulated here if their employers reduce premium contributions.

Considering individuals and families, premium increases like those considered here would have a noticeable effect even on those with high incomes, but would have the most harmful impact on families below 400 percent of the FPL and persons age 45 to 64. Individuals and families would spend almost $8 billion more on health care under the highest premium growth assumptions.

Government and health providers are also affected. Increases in private

insurance premiums do, in fact, result in higher government costs by leading people to drop coverage and enroll in public programs or become uninsured. The largest premium increases simulated would add $3.5 billion dollars in uncompensated care and Medicaid/CHIP spending. In sum, large premium increases, such as those recently announced and projected, would seriously exacerbate the problems all health care payers currently face and ultimately increase costs for hospitals and health care providers.

Notes

1 For example, HealthReform.gov, "Insurance Companies Prosper, Families Suffer: Our Broken Health Insurance System" (Washington, DC: U.S. Department of Health and Human Services, 2010), http://www.healthreform.gov/reports/insuranceprospers/index.html.

2 For example, Towers Perrin, "Towers Perrin Health Care Cost Survey Shows Employer-Sponsored Medical Benefit Costs to Rise 7% to Over $10,000 for the First Time," press release, October 8, 2009, http://www.towersperrin.com/tp/showdctmdoc.jsp?country=global&url=Master_Brand_2/USA/Press_Releases/2009/20091008/2009_10_08.htm.

3 For data up to 2008, Centers 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.

4 HealthReform.gov.

5 Towers Perrin.

6 As far as adverse selection in the ESI market, it is by no means certain that the jobs being lost are predominantly those held by people with low health care costs (e.g., the young). The nongroup market is more complicated, since there are both exits and entrances. Among those with nongroup coverage in the baseline who lose their jobs, those dropping coverage will likely have somewhat lower than average costs. However, job loss among those with ESI in the baseline will lead to a significant number of new entrants in the nongroup market. It is not clear what effect this would have on average.

7 A description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), http://www.urban.org/url.cfm?ID=411905.

8 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.

9 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 coverage to their workers, 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 in 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, no. 4 (2002): 603–35.

10 For details, see Bowen Garrett, Matthew Buettgens, Lan Doan, Irene Headen, and John Holahan, "The Cost of Failure to Enact Health Reform: 2010–2020 (Updated)" (Washington, DC: The Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412049. Estimates of the effect of higher unemployment on coverage come from John Holahan and Bowen Garrett, "Rising Unemployment, Medicaid, and the Uninsured" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2009), http://www.kff.org/uninsured/upload/7850.pdf. Additional projections are taken from the Congressional Budget Office, "Budget and Economic Outlook: Fiscal Years 2010–2020" (Washington, DC: CBO, 2010), http://www.cbo.gov/ftpdocs/108xx/doc10871/BudgetOutlook2010_Jan.cfm.

11 For data up to 2008, CMS Office of the Actuary. 2010 projections from Christopher J. 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, no. 3 (2010): 522-529.

12 In the 48 contiguous states and the District of Columbia, the 2009 federal poverty level is $14,570 for a family of two and $22,050 for a family of four. The 2009 levels will be in effect until at least the end of March 2010. For more information, see http://aspe.hhs.gov/poverty/09poverty.shtml.

13 HIPSM does not currently simulate changes in employer shares contributed to ESI as a consequence of premium increases. Consequently, if employers did reduce the share they contribute, more of the price increase could be placed on individuals and families.

14 See, for example, Drew Altman, "When Premiums Go Up 39%," Pulling It Together, No. 33, Kaiser Family Foundation, 2010, http://www.kff.org/pullingittogether/031010_altman.cfm.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic, and governance problems facing the nation. For more information, visit www.urban.org.

About the Robert Wood Johnson Foundation

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, meaningful, and timely change. For more than 35 years, the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit www.rwjf.org.