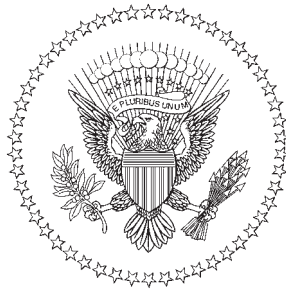


Exhibit 18

ECONOMIC
REPORT
OF THE
PRESIDENT



TRANSMITTED TO THE CONGRESS
FEBRUARY 2010

TOGETHER WITH
THE ANNUAL REPORT
OF THE
COUNCIL OF ECONOMIC ADVISERS

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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.

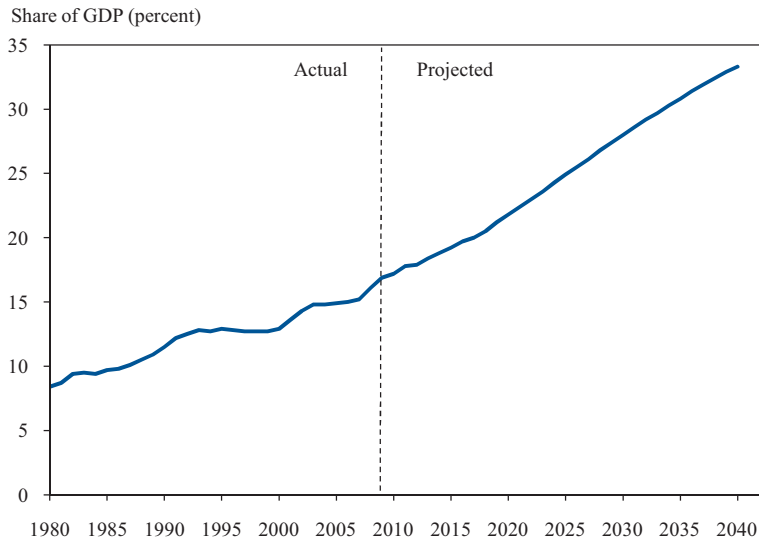
Rising Health Spending in the United States

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).

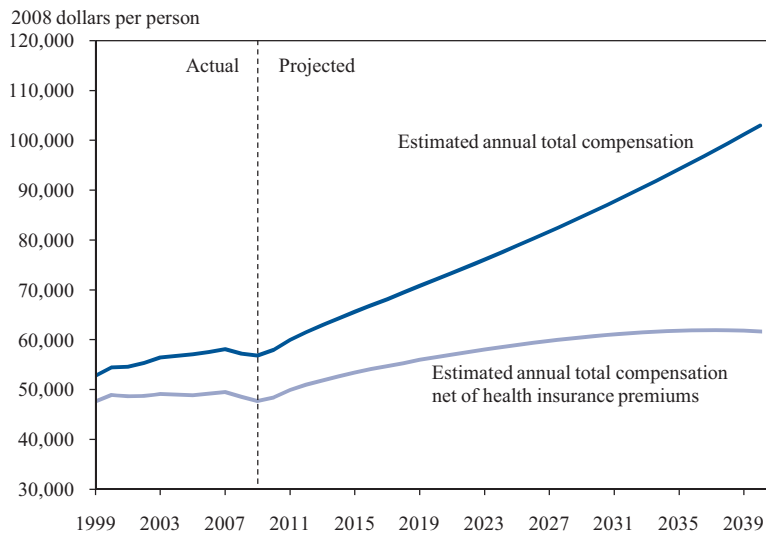
increases in employer-sponsored health insurance premiums have resulted in much lower wage growth for workers.

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).

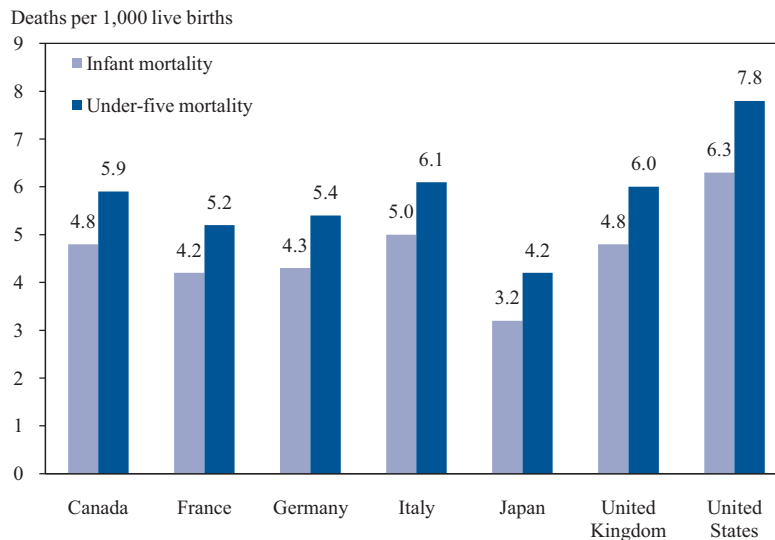
Variations in spending tend to be more dramatic in cases where medical experts are uncertain about the best kind of treatment to administer. For instance, in the absence of medical consensus over the best use of imaging and diagnostic testing for heart attacks, use rates vary widely geographically, leading 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

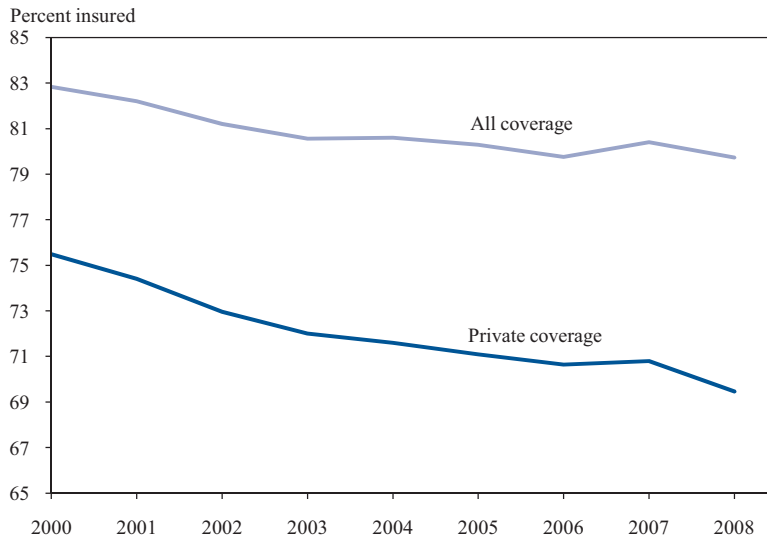
The preceding analysis shows that at an aggregate level, there are major inefficiencies in the current health care system. But, because of the nature of the market failures in health care, the current system works particularly poorly in certain parts of the economy and places disproportionate burdens 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).

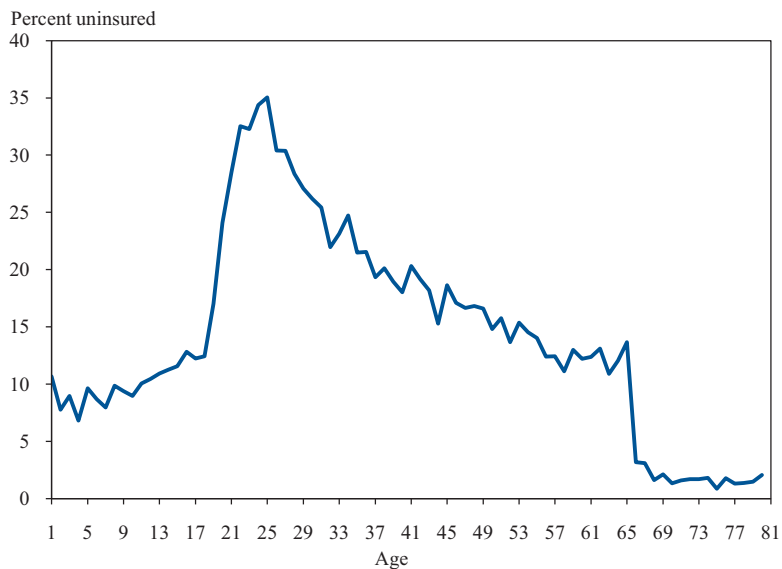
Although roughly half of the 2000–2008 decline in private coverage displayed in Figure 7-4 has been offset by an increase in public health insurance, the share of non-elderly adults without health insurance nevertheless rose from 17.2 to 20.3 percent. In other words, approximately 5.9 million more adults 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



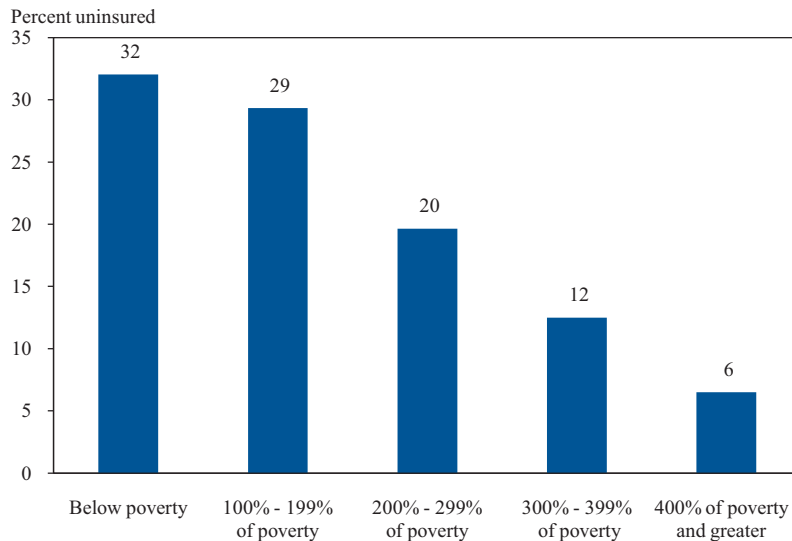
Source: Department of Commerce (Census Bureau), Current Population Survey, Annual Social and Economic Supplement.

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

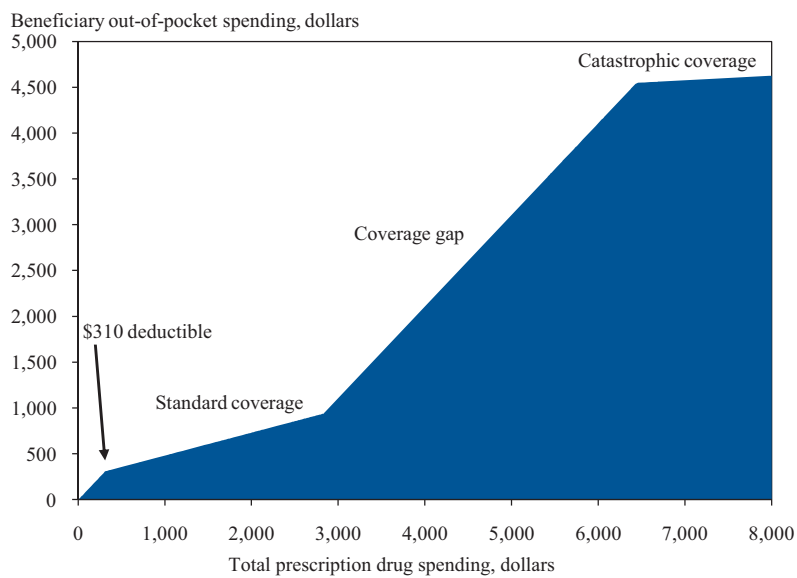


Source: Department of Commerce (Census Bureau), Current Population Survey, Annual Social and Economic Supplement.

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