

## The Urban Institute's Health Microsimulation Capabilities

The Health Insurance Policy Simulation Model (HIPSM) is a detailed microsimulation model of the health care system. It estimates the cost and coverage effects of proposed health care policy options. HIPSM is designed for quick-turn around analysis of policy proposals. It can be rapidly adapted to analyze a wide variety of new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of policy options at a number of points in time.

HIPSM was developed by researchers in the Health Policy Center and Urban-Brookings Tax Policy Center at the Urban Institute, a nonprofit, nonpartisan research organization. Funders of HIPSM's development include the Stoneman Family Foundation, the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and the Urban Institute. The Health Policy Center has a long history of health insurance simulation work, including extensive experience working with state and national policymakers to examine the impact, costs, and financing of alternative strategies to cover the uninsured. The HIPSM research team is unmatched in depth and breadth, and includes innovative researchers, economists, mathematicians, and other experienced policy experts.

Our most notable early work in health reform simulation, using a predecessor to the HIPSM model, provided a roadmap for the design of the landmark 2006 health care reform legislation in Massachusetts. That research garnered the prestigious Health Services Research Impact Award in 2007. More recently, HIPSM has been used to provide technical assistance for implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 for the states of Massachusetts, Missouri, New York, Virginia, and Washington as well as to the federal government. The model has been used in the analysis of policy options under the ACA such as SHOP exchanges, the future of employer-sponsored coverage, state government costs and savings, and those remaining uninsured under the ACA.

### An Overview of HIPSM

To evaluate how the health care system would be affected by policy changes, HIPSM simulates the decisions of employers, families, and individuals to offer and enroll in health insurance coverage. The model is designed to show the impact of policy on government and private health care spending, uncompensated care costs, private health insurance premiums, employer offers of coverage, and health insurance coverage. Detailed demographic and economic characteristics are based on multiple years of the Current Population Survey (CPS) Annual Social and Economic Supplement pooled together. Health care costs use data from many sources, such as the Medical Expenditure Panel Survey-Household Component (MEPS-HC) and the National Health Expenditure Accounts. The model includes a detailed simulation of Medicaid eligibility and enrollment, including eligibility rules for each state and an adjustment for the undercount of Medicaid on the CPS.

To calculate the impacts of reform options, HIPSM uses a flexible new simulation approach based on

the relative desirability of the health insurance options available to each individual and family under reform. The approach (known as a “utility-based framework”) allows new coverage options to be assessed without simply extrapolating from historical data, as in previous models. Within HIPSM, health insurance decisions made by individuals, families, and employers are calibrated to findings in the best empirical economics literature. Additional details can be found in the [Methodology Documentation](#).

The Urban Institute also has the capacity to do policy simulations for all states and even sub-state regions. HIPSM has been integrated with the American Community Survey (ACS-HIPSM) to estimate the effects of the ACA for all states and some sub-state regions. This model builds off of the Urban Institute's base HIPSM, which used the CPS as its core data set, matched to several other data sets including the MEPS-HC, to simulate changes under ACA. To create ACS-HIPSM, We combined the core behavioral components of the base HIPSM with the larger sample size on the ACS to create more precise estimates at state and sub-state areas. The modeling on the ACS-HIPSM produces

projections of coverage changes related to state Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The full documentation ACS-HIPSM in can be found in the [ACS-HIPSM Methodology Documentation](#)

## What Policies Can HIPSM Simulate?

The model's capabilities are broad, and include but are not limited to the following policies.

- The consequences over time of maintaining the status quo in the health care system;
- Medicaid/SCHIP eligibility expansions, with different eligibility rules for children, parents, and non-parents;
- Medicaid maintenance-of-eligibility options, including the ability to limit the change to certain types of eligibility, such as Section 1115 waivers;
- Health insurance exchanges in the nongroup and small group market;
- Other health insurance market reforms, including changes in premium rating rules and rules of issue;
- Income-related premium and/or cost-sharing subsidies for the non-group market, group market, and/or a new exchange;
- Plan choice between comprehensive and high-deductible plans, public plan options, and capability to model plans with differing levels of actuarial value;
- Individual mandates, pay-or-play employer mandates, and employer assessments;
- Tax credits for employer premium contributions;
- The Basic Health Program Option;
- Single payer systems;
- Reinsurance for high cost cases;
- Multi-year projections for enrollment and spending in Medicaid/CHIP and the exchanges.

## HIPSM Output

Since HIPSM is a simulation of the coverage choices of individuals and families, it produces detailed demographic, economic, and health care cost information for those enrolled in public and private insurance markets, as well as the uninsured. Common tabulations of these results include:

- Impacts on employer and individual coverage within and outside of exchanges, public coverage, and number of uninsured;
- Changes in coverage by commonly used risk factors such as age, income group, and health status;
- Characteristics and uncompensated care costs of those who remain uninsured (e.g., by immigration status, eligibility for public coverage, and health status);
- Medicaid participation rates among newly and already eligible persons;
- Changes in premiums and risk pools for employer and individual coverage;
- Premiums net of subsidies and out-of-pocket health care spending for subsidy-eligible individuals;
- Changes in health care costs for government, employers, and households.

## HIPSM Can Do State Level Analyses

In addition to national level estimates, HIPSM can generate reliable state-level estimates of each of these reform options. We have developed full state-specific versions of the model for Massachusetts, Missouri, New York, and Virginia.

For Washington State, we followed a different approach. Rather than building a full version of the model, we used HIPSM results to augment the Washington State Population Survey with eligibility for Medicaid, exchange subsidies, and the Basic Health Program, along with estimated enrollment in each program.

We can also produce state and sub-state level estimates with HIPSM-ACS. This approach takes substantially less time and money than a state-specific model, but is more limited in the kinds of options that can be addressed. For example, employer behavior is not modeled directly, so analysis related to the SHOP exchanges and future trends in employer coverage is not possible without the full model.

## Current and Future Analyses Using HIPSM

Analysis using HIPSM can assist policymakers at both the federal and state levels by assessing the impact of many different health reform options. Current and potentially new analyses include:

- Multi-year projections of coverage and costs for Medicaid and CHIP in a state. With the HIPSM/ACS integration, estimates can show the variation within a state. Impact of Medicaid maintenance-of-eligibility scenarios open to a state. Sensitivity analysis of take-up;
- Enrollment, risk pools, and premiums in the nongroup market overall and within the exchange. Eligibility for subsidized coverage and sensitivity analysis of take-up;
- SHOP exchange implementation options and their effects on enrollment and premiums. Possible changes in self-insurance under the ACA among small firms;
- Gains in coverage under the ACA and characteristics of the remaining uninsured by sub-state region—county-level where possible;
- Assessment of the feasibility of the Basic Health Program in a state;
- Longer term cost and coverage implications of various scenarios for the effectiveness of cost containment. Other related issues such as the impact on eligibility for subsidized coverage, the indexing formula for computing the amount of subsidies, and the high-cost premium excise tax
- The implications of eliminated the ACA's employer mandate..

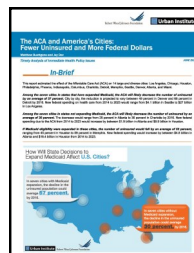
## HIPSM Briefs and Reports, 2009 – 2014



### Halbig v Burwell: Potential Implications for ACA Coverage and Subsidies

Linda J. Blumberg, John Holahan, Matthew Buettgens, July 2014.

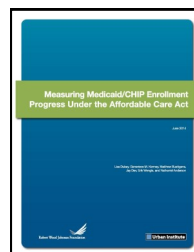
A ruling from the U.S. Court of Appeals for the D.C. Circuit on *Halbig v. Burwell* is imminent. The plaintiff claims a phrase in the ACA prohibits residents of states where the federal government is administering the health insurance Marketplace from receiving subsidies for purchasing insurance. With 34 states having chosen to leave administration of their Marketplaces to the federal government, a decision for the plaintiff could have broad implications. In 2016, 7.3 million people in these states are estimated to receive federal subsidies totaling \$36.1 billion, ranging up to \$4.8 billion in Florida and \$5.6 billion in Texas. [Read more](#)



### The ACA and America's Cities: Fewer Uninsured and More Federal Dollars

Matthew Buettgens, Jay Dev, June 2014.

This report estimated the effect of the Affordable Care Act (ACA) on 14 large and diverse cities: Los Angeles, Chicago, Houston, Philadelphia, Phoenix, Indianapolis, Columbus, Charlotte, Detroit, Memphis, Seattle, Denver, Atlanta, and Miami. For each city we estimated changes in health coverage under the ACA, particularly the resulting decline in the uninsured. We also estimated the additional federal spending on health care that would flow into these cities. For cities in states that have not expanded Medicaid eligibility, we provide estimates both with and without expansion. [Read more](#)

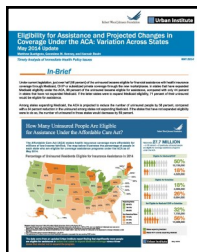


### Measuring Medicaid/CHIP Enrollment Progress Under the Affordable Care Act

Lisa Dubay, Genevieve M. Kenney, Matthew Buettgens, Jay Dev, Erik Wengle, Nathaniel Anderson, June 2014.

Since the beginning of the first open enrollment period under the Affordable Care Act (ACA) on October 2013 and April 2014, Medicaid/CHIP enrollment increased by 6.0 million. This accounts for almost half of enrollment increase projected by the Urban Institute's Health Insurance Policy Simulation Model to occur by the end of 2016 when the full ACA coverage effects are expected. Progress is

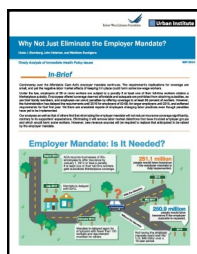
greater in states that expanded Medicaid but there is variation even among these states. This variation is likely due in part to differences in outreach and application assistance efforts by states and whether they used fast-track enrollment strategies. [Read full report](#)



### Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States : May 2014 Update

Matthew Buettgens, Genevieve M. Kenney, Hannah Recht, May 2014.

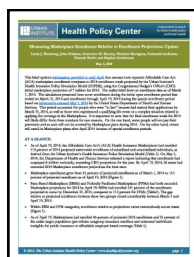
The authors estimate that in 2014, 56 percent of the uninsured became eligible for financial assistance with health insurance coverage through Medicaid, CHIP, or subsidized marketplace coverage. In states that expanded Medicaid eligibility, 68 percent of the uninsured became eligible for assistance, compared with only 44 percent in states that did not. Because of this difference in eligibility, the ACA is projected to reduce the number of uninsured people by 56 percent in states that expanded Medicaid, compared with only 34 percent in states that did not. The authors also provide estimates of what would happen if states that have not yet expanded Medicaid were to do so. [Read more](#)



### Why Not Just Eliminate the Employer Mandate?

Linda J. Blumberg, John Holahan, Matthew Buettgens, May 2014.

Employers of 50 or more workers are required to provide health insurance or pay a penalty. This requirement has been delayed until 2015 for employers with 100 and more workers and until 2016 for those with 50-99 workers. But there are reports of changes in employer labor practices, such as reducing the hours of part-time workers and concerns about increasing workforce above 50 workers. In this brief we argue that the employer mandate should simply be eliminated. We show that it would not reduce insurance coverage significantly, but it would eliminate the labor market distortions that have troubled employer groups and that could have negative effects on some workers. The penalties on employers do bring in some new revenues that would have to be replaced. [Read more](#)



### Measuring Marketplace Enrollment Relative to Enrollment Projections: Update

Linda J. Blumberg, John Holahan, Genevieve M. Kenney, Matthew Buettgens, Nathaniel Anderson, Hannah Recht, Stephen Zuckerman, May 2014.

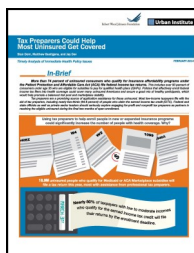
This brief compares Affordable Care Act Marketplace enrollment as of April 19, 2014 (the most recent state-specific data) to projected enrollment for 2014 and 2016 and estimates of the number of people eligible for subsidies. Nationally, by April 19, the Marketplaces had enrolled 115 percent of projected 2014 enrollment. Collectively, both State-Based Marketplaces (SBMs) and Federally Facilitated Marketplaces (FFMs) exceeded projected enrollment. However, there is considerable variation across the states within each group. [Read more](#)



### Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act

Stan Dorn, Julia Isaacs, Sarah Minton, Erika Huber, Paul Johnson, Matthew Buettgens, Laura Wheaton, February 2014.

The Affordable Care Act (ACA) has created new opportunities for health and human services programs to integrate eligibility determination, enrollment, and retention. Using two large microsimulation models—the Transfer Income Model, Version 3, and the Health Insurance Policy Simulation Model—we find considerable overlaps between expanded eligibility for health coverage and current receipt of human services benefits, particularly with Earned Income Tax Credits, the Supplemental Nutrition Assistance Program, and the Low-Income Home Energy Assistance Program. In an appendix, we identify specific data sharing strategies that seek to increase participation, lower administrative costs, and prevent errors. [Read full report](#)



### Tax Preparers Could Help Most Uninsured Get Covered

Stan Dorn, Matthew Buettgens, Jay Dev, February 2014.

More than 74% of uninsured consumers who qualify for ACA health coverage file federal income tax returns. This includes over 90% of consumers under age 35 who qualify for subsidies in health insurance marketplaces. Most low-income taxpayers use tax preparers, including 64.6% of EITC claimants, more than 78% of whom file by March 31,

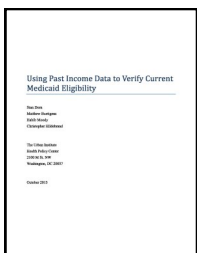
the final day of open enrollment. State and federal officials and private leaders concerned about ACA enrollment should seriously explore partnering with commercial and nonprofit tax preparers to reach the eligible uninsured and move towards a healthy, balanced risk pool. [Read more](#)



### Will Those With Cancelled Insurance Policies Be Better Off in ACA Marketplaces?

John Holahan, Linda J. Blumberg, Matthew Buettgens, January 2014.

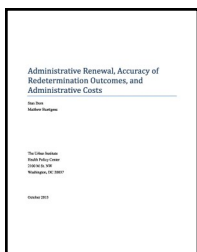
In recent months, there has been considerable focus on cancellations of nongroup health insurance policies. It is difficult to directly obtain data on premiums that individuals were paying prior to the ACA, but we can provide data on the premium cost to enrollees for the lowest cost bronze plans and the second lowest cost silver plans by age and income group in each state. We conclude that it would be difficult for the majority of individuals, particularly those qualifying for subsidies, to obtain coverage for a lower premium than those available in the Marketplaces today. Unsubsidized individuals, particularly those in older age groups, are more likely to face higher premiums. [Read more](#)



### Using Past Income Data to Verify Current Medicaid Eligibility

Stan Dorn, Matthew Buettgens, Christopher Hildebrand, Habib Moody, October 2013.

Using data from the 2008 Survey of Income and Program Participation, we find that information about past income and employment that is available to state Medicaid programs can potentially verify (a) initial financial eligibility for between 55 and 79 percent of eligible applicants and (b) renewed eligibility for between 60 and 71 percent of eligible enrollees. Verifying eligibility based on data matches, rather than documentation from consumers, could lower administrative costs; cut paperwork burdens for consumers, thereby increasing participation levels among those who qualify for help; and prevent eligibility errors. [Read full report](#)



### Administrative Renewal, Accuracy of Redetermination Outcomes, and Administrative Costs

Stan Dorn, Matthew Buettgens, October 2013.

When a Medicaid beneficiary ap-

proaches the end of a 12-month enrollment period, coverage should be "administratively renewed," according to ACA a regulation, if "reliable information" shows the beneficiary remains eligible. The beneficiary is sent a notice explaining the basis for renewal and the legal duty to make needed corrections. If none are forthcoming, coverage continues. We find that using administrative renewal should lower the number of mistaken outcomes if it is used with beneficiaries known to have an 80 percent or greater likelihood of eligibility. However, administrative renewal will change most mistakes from incorrect terminations to incorrect renewals. [Read full report](#)



### Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States

Matthew Buettgens, Genevieve M. Kenney, Hannah Recht, Victoria Lynch, October 2013.

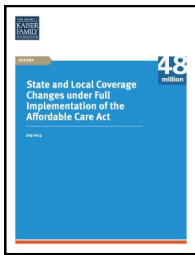
This report examines how many of the uninsured in each state would be eligible for health coverage assistance programs - i.e. Medicaid, the Children's Health Insurance Program and subsidized private coverage through the new health insurance marketplaces - under the Affordable Care Act. The report also estimates the anticipated decrease in the uninsured population under the ACA in each state. Finally, the report examines the share of those remaining uninsured under the ACA in each state who would be eligible for, but not enrolled in, assistance programs. [Read full report](#)



### No Wrong Door: Improving Health Equity and the Health Coverage Consumer Experience in Connecticut

Matthew Buettgens, Stan Dorn, September 2013.

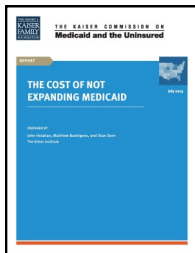
"No Wrong Door" (NWD) is a system that allows consumers to apply for health insurance through different agencies, and then seamlessly routes them to the program for which they qualify. We find that over the course of a year under the Affordable Care Act, NWD would prevent 36,000 Connecticut residents from losing health insurance coverage for at least part of the year. Connecticut's leaders have committed to full implementation of NWD by the end of 2015. If this commitment is fulfilled, significant gains will result for both state government and residents. However, monitoring implementation in the transition period is critical. [Read more](#)



## State and Local Coverage Changes Under Full Implementation of the Affordable Care Act

Genevieve M. Kenney, Michael Huntress, Matthew Buettgens, Victoria Lynch, Dean Resnick, August 2013.

The Affordable Care Act (ACA) includes many new policies intended to reduce the number of people without health insurance. This brief highlights new state and sub-state estimates of how the number and composition of individuals enrolled in Medicaid/CHIP would change with full implementation of the ACA, including the Medicaid expansion. These estimates provide more detail on the projected coverage changes under the ACA at the state level than in prior research and provide guidance on the areas that are likely to experience the largest declines in the uninsured and where the residual uninsured are likely to be concentrated. [Read full report](#)



## The Cost of Not Expanding Medicaid

John Holahan, Matthew Buettgens, Stan Dorn, July 2013.

As states make decisions about whether to implement the Medicaid expansion under the Affordable Care Act, this new analysis highlights the implications of these decisions for coverage, state finances, and providers. The results show that the decisions by as many as 27 states not to adopt the Medicaid expansion will leave 6.4 million people who could have been eligible for Medicaid uninsured. States that do not expand Medicaid will forego significant federal funding, which could have had a positive impact on state economies and general revenues. Moreover, hospitals in these states will receive substantially less revenue than they would have had the state expanded coverage while they will still have to serve a large uninsured population. These findings present a strong economic case for Medicaid expansion. [Read full report](#)

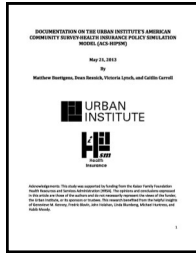


## It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate

Linda J. Blumberg, John Holahan, Matthew Buettgens, July 2013.

The Obama administration announced a 1-year delay in imposition of penalties for large employers who do not offer affordable coverage to their full-time workers under the Affordable Care Act (ACA). The announce-

ment led to some suggesting that the employer penalties amounted to a key component of the ACA, and others stating that it was "unfair" to delay employer penalties but to leave the penalty on individuals in place. However, our analysis shows that the ACA can achieve all its major objectives without the employer mandate. Conversely, the individual mandate is a central component of the law and its coverage expansion. [Read more](#)



## Documentation on the Urban Institute's American Community Survey Health Insurance Policy Simulation Model (ACS-HIPSM)

Matthew Buettgens, Dean Resnick, Victoria Lynch, Caitlin Carroll, June 2013.

The model documented here builds off of the Urban Institute's base HIPSM, which uses the Current Population Survey (CPS) as its core data set, matched to several other data sets including the Medical Expenditure Panel Survey-Household Component (MEPS-HC), to predict changes in national health insurance coverage and spending under ACA using a micro-simulation modeling approach. To create HIPSM-ACS, we apply the core behavioral estimates coming from base HIPSM to ACS records (using a series of HIPSM-estimated imputation models) to exploit the much larger sample size for more precise estimates at the state and sub-state level. [Read full report](#)



## Expanding Medicaid in Ohio: Analysis of Likely Effects

Stan Dorn, Matthew Buettgens, Caitlin Carroll, March 2013.

Adding Medicaid expansion to the remainder of the Patient Protection and Affordable Care Act (ACA) would increase Ohio's Medicaid costs between \$2.4 and \$2.5 billion during FY 2014 to 2022. The state could reduce \$1.5 billion in spending on medically needy adults, inpatient prison costs, and other services to the poor uninsured. Expansion would yield \$2.7 and \$2.8 billion in new revenue, including premium taxes, general revenue from economic activity generated by increased federal Medicaid dollars, and prescription drug rebates. Altogether, expansion would generate between \$1.8 and \$1.9 billion in net state budget gains while covering more than 400,000 uninsured. [Read full report](#)

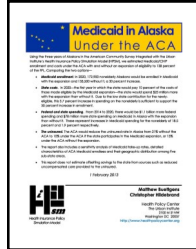


### The Financial Benefit to Hospitals from State Expansion of Medicaid (Research Report)

Stan Dorn, Matthew Buettgens, John Holahan, Caitlin Carroll, March 2013.

State decisions to expand Medicaid have important implications for hospitals. There are a number of provisions in the Affordable Care Act that will reduce hospital payments - lower rates of Medicare reimbursement and cut backs in Medicare and Medicaid disproportionate share hospital payments. On the other hand, hospitals stand to gain considerably from the added insurance coverage because of the Medicaid expansion. Fewer uninsured will mean higher revenues to hospitals. However, some newly covered Medicaid patients will have formally been privately insured. For these patients, Medicaid will typically pay less than private insurance. On balance, we show that for each \$1.0 in private revenue that the Medicaid expansion eliminates, hospitals Medicaid revenue increases by \$2.59. [Read full report](#)

specific version of its Health Insurance Reform Simulation Model (HIPSM) to support to the state in its effort to assess the implications of the implementation of the Affordable Care Act (ACA). Initial findings from this work were made available in March of 2012. The tables presented here provide sub-state analyses, focusing on those without insurance coverage of any kind prior to reform. We show the share of uninsured expected to gain coverage under the ACA, and include the distribution of characteristics for those anticipated to gain insurance of each type whenever sample sizes allow. [Read full report](#)



### Medicaid in Alaska Under the ACA (Research Report)

Matthew Buettgens, Christopher Hildebrand, February 2013

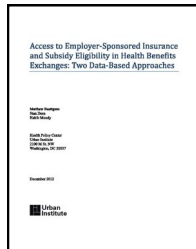
The authors simulate the effect of the Affordable Care Act (ACA) in Alaska, both with and without the Medicaid expansion. The ACA would reduce the uninsured rate in Alaska from 21% without the ACA to 10% under the ACA with the expansion, or 15% without the expansion. The Medicaid expansion would increase enrollment 30% by 2020, while state Medicaid spending on the nonelderly would only increase 3.7%. The report includes a sensitivity analysis of Medicaid take-up rates and detailed characteristics of new enrollees by sub-state region. [Read full report](#)



### Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance

Linda J. Blumberg, Matthew Buettgens, March 2013.

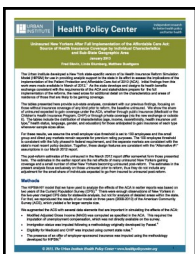
Insurers are calling attention to a potential "rate shock" that will push young adults out of the nongroup insurance market under the ACA due to limitations on premium differences by age. We compare the impact of the ACA's 3:1 rate band to a "looser" 5:1 alternative. Loosening the bands would have very little impact on out-of-pocket rates paid by the youngest purchasers once subsidies are taken into account. Also, the majority of young adults currently purchasing nongroup coverage will also be financially protected by the exchange subsidies, the ACA's Medicaid expansion, and the expansion of dependent coverage to young adults. [Read more](#)



### Access to Employer-Sponsored Insurance and Subsidy Eligibility in Health Benefits Exchanges: Two Data-Based Approaches

Matthew Buettgens, Stan Dorn, Habib Moody, December 2012.

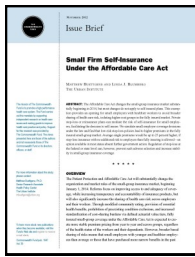
Consumers offered employer-sponsored insurance (ESI) can be ineligible for subsidies in health insurance exchanges (HIX). Until better ESI data become available, HHS proposes using post-enrollment audits, rather than pre-enrollment verification for this eligibility requirement. Using the Health Insurance Policy Simulation Model (HIPSM), we find that more than 70 percent of eligible consumers work for firms that do not sponsor ESI. HIXes could thus avoid the need to audit them by developing databases that show which employers sponsor ESI. Alternatively, HIXes could target non-ESI recipients for audits based on HIPSM results that show their relative likelihood of being offered ESI. [Read full report](#)



### Uninsured New Yorkers After Full Implementation of the Affordable Care Act: Source of Health Insurance Coverage by Individual Characteristics and Sub-State Geographic Area

Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, February 2013.

The Urban Institute developed a New York state-

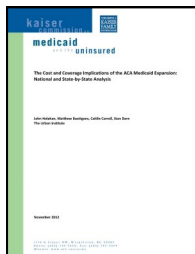


### Small Firm Self-Insurance under the Affordable Care Act

Matthew Buettgens and Linda J. Blumberg, November 2012.

The Affordable Care Act changes the small group insurance market substantially, but most of these changes do not apply to self-

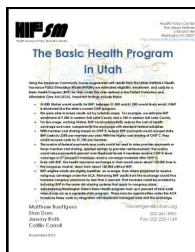
insured group plans. This exemption provides an opening for small employers with healthier workers to avoid broader sharing of health care risk, isolating higher-cost groups in the fully insured market. We simulate employer decisions under the ACA for a range of stop loss insurance plans, which mediate financial risk, and find that if low-risk stop loss policies are allowed, fully insured small group premiums could be higher by up to 25%. Regulation of stop loss could prevent such adverse selection. [Read more](#)



### The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis

John Holahan, Matthew Buettgens, Caitlin Carroll, and Stan Dorn, November 2012.

This paper examines the effect, by state, of the state's decision to adopt the Medicaid expansion. It also estimates the impact of the state's decision on Medicaid enrollment and the number of uninsured. The paper shows that if all states implement the Affordable Care Act (ACA) Medicaid expansion, the federal government will fund the vast majority of the increase in Medicaid states. Due to several provisions of the ACA, states will face increased enrollment even if they do not implement the Medicaid expansion. The additional cost of implementing the expansion is small relative to total state spending without the expansion and relative to large increases in federal funding and current state budget expenditures. [Read full report](#)



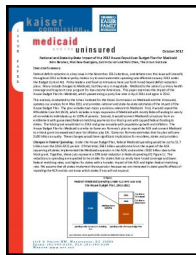
### The Basic Health Program in Utah

Matthew Buettgens, Stan Dorn, Jeremy Roth, and Caitlin Carroll, November 2012.

Using the American Community Survey augmented with results from the Urban Institute's Health

Insurance Policy Simulation Model, we estimated eligibility, enrollment, and costs for a Basic Health Program (BHP) for Utah under the Affordable Care Act. We find that 55,000 Utahns would qualify for BHP; between 31,000 and 41,000 would likely enroll. Fed-

eral BHP payments would likely exceed state costs, with the amount depending on BHP plan cost sharing. BHP would reduce the size of the nongroup exchange by about a quarter, leaving about 120,000 covered lives. [Read full report](#)



### National and State-By-State Impact of the 2012 House Republican Budget Plan for Medicaid

John Holahan, Matthew Buettgens, Caitlin Carroll and Vicki Chen, October 2012.

This analysis of the House Budget Plan that was passed in 2012 finds that repealing the Affordable Care Act (ACA) and converting Medicaid to a block grant would trigger significant decreases in federal Medicaid spending and could result in substantial reductions in enrollment and payments to providers compared to current projections. The analysis, conducted by the Urban Institute for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, updates a similar study from May 2011, which analyzed the House Budget Plan that passed that year. The new analysis provides national and state-by-state estimates of the impact of the 2012 House plan on federal spending, enrollment, states and providers. The reductions in federal spending for Medicaid would likely lead to increases in the number of Americans without health insurance and strain the safety net, even with additional flexibility for states to administer their programs. [Read full report](#)



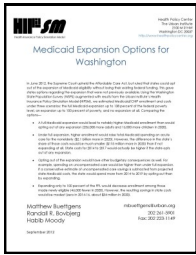
### Implications of the Affordable Care Act for American Business

Linda J. Blumberg, Matthew Buettgens, Judy Feder, John Holahan, October 2012.

Updated results from our Health Insurance Policy Simulation model show that, contrary to critics' claims,

the law has a negligible impact on total employer-sponsored coverage and costs, leaves large business costs-per-person-insured largely untouched and makes small businesses-for whom coverage expands the most-financially better off, through tax credits and market efficiencies that lower premiums. Only among mid-size businesses does the ACA noticeably increase costs, largely due to increased enrollment. Our simulation does not reflect ACA cost containment provisions that may contain private as well as public cost growth-potentially slowing the decline of employer-sponsored health insurance that has been occurring for more than a decade. [Read more](#)





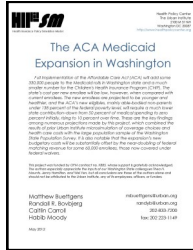
## Medicaid Expansion Options for Washington

Matthew Buettgens, Randall R. Bovbjerg, and Habib Moody, September 2012.

While upholding the Affordable Care Act, the Supreme Court ruled that states could opt out of the

Medicaid expansion without losing existing federal funding. In this report, we analyze Medicaid enrollment and costs for Washington under a full expansion to 138% FPL, expansion to 100% FPL, and no Medicaid expansion. By 2020, a full expansion would lead to 256,000 more adults and 16,000 more children enrolled than with no expansion. This would lead to \$2.1 billion more in total spending on Medicaid. However, the difference in the state share would only be \$115 million. Savings in uncompensated care could offset this increase. [Read more](#)

subsidies. We estimate the impact of several steps states can take to reduce churning and mitigate its adverse effects. This is the first churning study to consider employer coverage offers. [Read more](#)

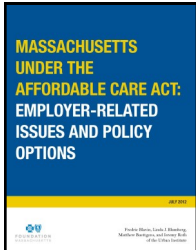


## The ACA Medicaid Expansion in Washington

Matthew Buettgens, Randall Bovbjerg, Caitlin Carroll and Habib Moody, May 2012.

Full implementation of the Affordable Care Act (ACA) will add some

330,000 people to the Medicaid rolls in Washington state and a much smaller number for the Children's Health Insurance Program (CHIP). The state's cost per new enrollee will be low, however, when compared with current enrollees. The new enrollees are projected to be younger and healthier, and the ACA's new eligibles, mainly able-bodied non-parents under 138 percent of the federal poverty level, will require a much lower state contribution—down from 50 percent of medical spending to zero percent initially, rising to 10 percent over time. These are the key findings among numerous projections made by this project, which combined the results of prior Urban Institute microsimulation of coverage choices and health care costs with the large population sample of the Washington State Population Survey. [Read more](#)

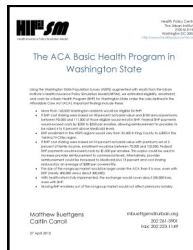


## Massachusetts under the Affordable Care Act: Employer-Related Issues and Policy Options

Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, and Jeremy Roth, July 2012.

Using the Health Insurance Policy Simulation Model, this report ana-

lyzes four policy options for assessing employers who do not provide affordable health insurance to their workers as Massachusetts brings its health reform law into compliance with the Affordable Care Act (ACA). Overall coverage and costs are similar across all options, but replacing the state's Fair Share Contribution (FSC) requirement with the ACA assessment would eliminate a source of state revenue. Similarly, maintaining the FSC for small employers only would raise one-fifth as much revenue as leaving the current assessment in place. [Read full report](#)



## The ACA Basic Health Program in Washington State

Matthew Buettgens, Caitlin Carroll, May 2012.

Using the Washington State Population Survey (WSPS) augmented with results from the Urban Institute's Health Insurance Policy Sim-

ulation Model (HIPSIM), we estimated eligibility, enrollment, and costs for a Basic Health Program (BHP) for Washington State under the rules defined in the Affordable Care Act (ACA). We find that more than 160,000 Washington residents would be eligible for BHP. Enrollment would be between 75,000 and 111,000. Even with BHP, the exchange in Washington would still cover about 250,000 lives, and BHP would not notably affect premiums in the individual market. [Read full report](#)



## Churning under the ACA and State Policy Options for Mitigation

Matthew Buettgens, Austin Nichols, and Stan Dorn, June 2012.

Many officials implementing the ACA are concerned about

"churning," the involuntary movement of consumers from one health plan or coverage system to another. Churning makes programs more costly to administer and interrupts continuity of coverage and care. Unless measures are taken to reduce churning, 27 million nonelderly people will be forced to change coverage systems from year to year, two-thirds of whom will move between Medicaid and ineligibility for all



## Health Reform Could Greatly Reduce Racial and Ethnic Differences in Insurance Coverage

Lisa Clemans-Cope, Genevieve Kenney, Matthew Buettgens, Caitlin Carroll, Fredric Blavin *Health Affairs*, May 2012.

Racial and ethnic differentials in uninsurance rates could be greatly reduced under the Affordable Care Act, potentially cutting the black-white differential by more than half and the Hispanic-white differential by just under one-quarter. Improving coverage for these populations will depend on states adopting policies that promote high enrollment in Medicaid/CHIP and new insurance exchanges. Coverage gains among Hispanics will depend on policies in California and Texas (where almost half of Hispanics live). If the projected coverage gains are realized, long-standing racial and ethnic differentials in access to care and health status could shrink considerably. This research was funded in part by the Annie E. Casey Foundation. [Read more](#)



### The Coverage and Cost Effects of Implementation of the ACA in New York State

Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, Jeremy Roth, April 2012.

The Affordable Care Act provides states with the opportunity to develop health benefit exchanges – structured marketplaces for the purchase of health insurance coverage by small employers and individual purchasers. The law provides an array of design choices to the states in an effort to allow the exchanges to reflect varying preferences across the country. This analysis uses the Health Insurance Policy Simulation Model (HIPSM) to delineate the cost and coverage implications of a standard implementation of the ACA in New York compared to the no reform case, along with the differential effects of a number of alternative design options.

[Read full report](#)



### The Individual Mandate in Perspective

Linda J. Blumberg, Matthew Buettgens, Judy Feder, March 2012.

The "individual mandate"-the requirement that individuals either have health insurance coverage or pay a fine-is both the best known and the least popular component of the Affordable Care Act (ACA). That people know about the mandate-and may even worry about it-is not surprising, given both the heated political controversy and the constitutional challenge surrounding this provision of the law. What may be surprising, however, is that if the ACA were in effect today, 94 percent of the total population would not have to newly purchase insurance or pay a fine. While a small number of people would be affected by the individual responsibility re-

quirement, the overall benefit to the population would be large, in terms of reducing premiums and increasing stability of insurance markets. [Read more](#)

quirement, the overall benefit to the population would be large, in terms of reducing premiums and increasing stability of insurance markets. [Read more](#)



### How Choices in Exchange Design For States Could Affect Insurance Premiums And Levels Of Coverage

Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, John Holahan, Stacey McMorrow, *Health Affairs*, February, 2012.

The Affordable Care Act calls for the creation of health insurance exchanges in each state, where individuals and small employers can purchase health insurance. States have considerable flexibility in how they design and implement their health insurance exchanges. This study analyzes several exchange design options using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), looking specifically at the cost and coverage implications of creating separate versus merged small group and non-group markets; eliminating age rating in these markets; removing the small employer credit; and defining the size threshold for the small group market at 50 versus 100 workers. [Read more](#)



### State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain

Fredric Blavin, Matthew Buettgens, Jeremy Roth, January 2012.

We use the Health Insurance Policy Simulation Model to explore the correlations between a state's progress toward implementing the Affordable Care Act and the anticipated benefits of the reform for state residents, as measured by the expected state gains in insurance coverage and federal subsidies. We group states in three categories based on the status of legislative action and the receipt of level 1 federal establishment grants. We find that states that have made the least progress in establishing health insurance exchanges are in general those that have the largest potential gains in coverage and federal subsidy dollars per capita. [Read more](#)

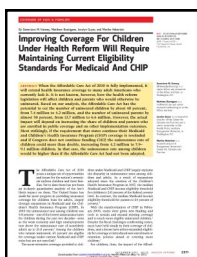


### Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care

Matthew Buettgens, Caitlin Carroll, January 2012.

The federal requirement for most Americans to have health insurance-the individual mandate-is an

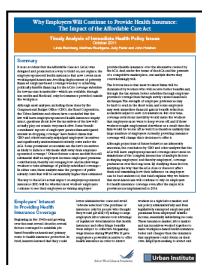
important part of how the ACA would reduce the number of uninsured. We use the Health Insurance Policy Simulation Model to estimate the effects of health reform with and without the mandate. With the mandate, the number of uninsured would decrease from 50 million to 26 million. Without a mandate, about 40 million would remain uninsured. Depending on the effectiveness of the health benefit exchanges in enrolling those eligible for subsidized coverage, exchange premiums would be 10 to 25 percent higher without a mandate. [Read more](#)



### Improving Coverage For Children Under Health Reform Will Require Maintaining Current Eligibility Standards For Medicaid And CHIP

Genevieve M. Kenney, Matthew Buettgens, Additional Authors, *Health Affairs*, December 2011.

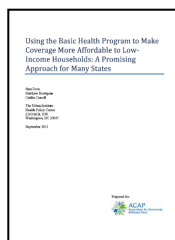
When the Affordable Care Act is fully implemented, it will extend health insurance coverage to many uninsured adult Americans. New analysis projects that the ACA will also cut the number of uninsured children by about 40 percent and the number of uninsured parents by almost 50 percent, provided states continue their Medicaid and CHIP coverage for children. However, if the maintenance of effort requirement is rescinded and if Congress does not continue funding CHIP, the uninsurance rate for children could be higher than it is today. [Read more](#)



### Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act

Linda Blumberg, Matthew Buettgens, Judy Feder and John Holahan. October 2011.

The Congressional Budget Office, the Rand Corporation, and the Urban Institute have estimated that the Affordable Care Act (ACA) will leave employer-sponsored coverage largely intact; in contrast, some economists and benefit consultants argue that the ACA encourages employers to drop coverage thereby making both their workers and their firms better off (a "win-win" situation). This brief's analysis shows that no such "win-win" situation exists and that employer-sponsored insurance will remain most workers' primary source of coverage. Analysis of three issues—the terms of the ACA, worker characteristics, and the fundamental economics of competitive markets—supports this conclusion. [Read full report](#)



### Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States

Stan Dorn, Matthew Buettgens, and Caitlin Carroll, September 2011.

We estimate national and state effects of implementing the Basic Health Program option in national health reform to provide near-poor adults with coverage like Medicaid and the Children's Health Insurance Program. Implemented nationally, such a policy would reduce these adults' annual premium and out-of-pocket costs from \$1,652 to \$196; lower the number of uninsured by 600,000; provide federal dollars that exceed baseline Medicaid/CHIP costs by 23 percent; reduce exchange enrollment from 9.8 to 8.2 percent of non-elderly residents; save states \$1.3 billion annually in Medicaid costs; and raise risk levels in individual markets. State policy choices could change these results. [Read full report](#)



### ACA and State Governments: Consider Savings as Well as Costs

Matthew Buettgens, Stan Dorn, and Caitlin Carroll, July, 2011.

This report finds that state governments are likely to spend \$92-129 billion less from 2014 to 2019 with implementation of the Affordable Care Act, thanks to provisions reducing the uninsured population and increasing federal support for health care previously financed by states. The authors find that, overall, the federal government would spend \$704 to \$743 billion more under reform from 2014 to 2019. Even after 2019, when the federal government's share of Medicaid costs declines to its permanent level, states will still come out ahead, realizing net savings in 2020 alone of \$12 to \$19 billion. [Read full report](#)



### The Effects of Health Reform on Small Businesses and Their Workers

Stacey McMorrow, Linda J. Blumberg, and Matthew Buettgens, June 2011.

This brief consolidates the results of several UI studies addressing the effects of the Affordable Care Act (ACA) on small firms. We find generally positive effects of the ACA on small employers and their workers. Employers with fewer than 50 workers will experience substantial savings on health costs; employers with 50 to 100 workers will see a very small cost increase. The smallest firms are expected to have higher offer rates, resulting

in a small increase in employer coverage. Small firm workers and their families will reap substantial benefits from the Medicaid expansion and subsidies to low-income families. [Read more](#)



### House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing

John Holahan, Matthew Buettgens, Vicki Chen, Caitlin Carroll, and Emily Lawton, May 2011.

The House Republican Budget Plan would make major changes to the structure of the Medicaid program. In this brief we estimate reductions in federal Medicaid spending due to both the repeal of the Affordable Care Act on Medicaid and the block grant provisions themselves. We find that the House Budget Plan would reduce federal spending by \$1.4 billion between 2012 and 2021, a cut of 34 percent relative to current law. The impacts are greatest in states that would have the largest coverage expansions due to the Affordable Care Act. We also estimate the loss of Medicaid coverage that would be likely under different assumptions of states' success in constraining spending. Finally we estimate the increase in state expenditures that would be necessary to maintain their current programs even assuming some cost containment success.

[Read full report](#)



### Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid

Matthew Buettgens, John Holahan, and Caitlin Carroll, March 2011.

In this report, the authors use the Institute's Health Insurance Policy Simulation Model (HIPSM) to predict results as if ACA were fully implemented in 2011 and contrast the results with the pre-reform baseline estimates for the year. They find that uninsurance rates among the nonelderly would decrease in all 50 states and in Washington, D.C., ranging from 1 percentage point in Massachusetts to 17 percentage points in Texas. There would be \$82.3 billion in new federal Medicaid and exchange subsidies flowing to the states, led by California (\$9.5 billion), Texas (\$8.2 billion) and Florida (\$6.7 billion).

[Read more](#)



### Who Will Be Uninsured After Health Insurance Reform?

Matthew Buettgens and Mark Hall, March 2011.

National health reform will expand insurance coverage by about 30 million people, reducing the number of uninsured by more than half.

In this report, the authors analyze the likely composition, state by state, of those who will remain uninsured. Of the nonelderly adults uninsured under national health reform, 37% would be eligible for Medicaid but not enrolled and 25% would be undocumented immigrants. Sixteen percent would be exempt from the individual mandate because they had no affordable insurance option. The authors find significant state and regional variation in the

characteristics of the uninsured. programs and for financing of uncompensated care would increase. The results differ among states depending on the distribution of employees by firm size and wage levels, the breadth of coverage in public programs, and projected population growth. [Read more](#)



### Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature

Bowen Garrett and Matthew Buettgens, January 2011.

Some have argued that the Patient Protection and Affordable Care Act would erode employer-sponsored insurance (ESI) by providing incentives for employers to stop offering coverage. Others have claimed that most businesses would face increased costs as a result of reform. A new study finds that overall ESI coverage under the ACA would not differ significantly from what coverage would be without reform. The average employer contribution per person covered by ESI would decrease by nearly 8 percent for small firms and would decrease slightly for larger firms. Total employer health care spending would be 0.6 percent lower under the ACA. [Read full report](#)

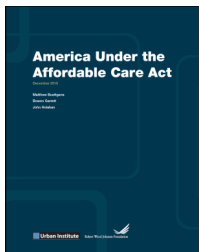


### Why the Individual Mandate Matters

Matthew Buettgens, Bowen Garrett, and John Holahan, December 2010.

With conflicting rulings about the constitutionality of the individual mandate in the Affordable Care Act (ACA), we are left to wonder: what would the ACA look like if its individual mandate was dropped? A new

report using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) shows that the number of uninsured would be cut by more than half with the mandate, but by only about 20 percent without the mandate. Uncompensated care would decline by \$42.4 billion under the ACA, but only by \$14.7 billion under reform without a mandate because of the large number of people remaining uninsured. [Read full report](#)

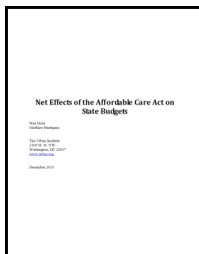


### America under the Affordable Care Act

Matthew Buettgens, Bowen Garrett, and John Holahan, December 2010.

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), the authors estimate how the Affordable Care Act would affect health insurance coverage and spending on acute care for the non-elderly. They find that, for example, under the ACA, the number of non-elderly adults without health insurance would decline by 27.8 million, the cost of uncompensated care provided to the uninsured would drop by 61 percent, the Medicaid expansion would enroll 16.8 million more people, and 43.8 million would be covered through health insurance exchanges (both non-group and SHOP).

[Read full report](#)



### Net Effects of the Affordable Care Act on State Budgets

Stan Dorn and Matthew Buettgens, December 2010.

The Affordable Care Act will affect state budgets in many ways. State Medicaid spending on low-income adults will increase between \$21.1 billion and \$43.2 billion during 2014-2019. But during this same period, the ACA will save states and localities between \$83.8 billion and \$153.0 billion by letting them (a) shift higher-income adults from Medicaid into coverage where subsidies are funded entirely by the federal government; and (b) substitute newly available federal Medicaid dollars for prior state and local spending on uncompensated care and mental health services. Altogether, net state and local gains will total between \$40.6 billion and \$131.9 billion. [Read more](#)

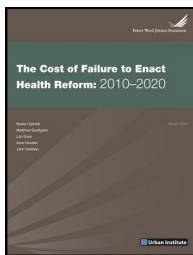


### The Effects of Large Premium Increases on Individuals, Families, and Small Businesses

Matthew Buettgens, Bowen Garrett, and John Holahan, March 2010.

Recent announcements of premium increases by key insurers have sparked suspicion that this could become a trend despite measures taken in the newly enacted federal health reform. This report uses HIPSM to illustrate the outcomes if such a trend were to occur. Specifically, it investigates the effects rates if premium increases were to exceed the rate of health care cost growth. It finds that such increases would adversely affect low- to middle- income families and older, nonelderly persons most. There would also be a significant loss of coverage among higher income families. Finally, fewer small employers would choose to offer insurance to their workers.

[Read full report](#)



### The Cost of Failure to Enact Health Reform: 2010-2020

Bowen Garrett, Matthew Buettgens, Lan Doan, Irene Headen, John Holahan, March 2010.

This report assesses the changes in coverage patterns and health care costs that will occur nationally if major reforms are not enacted. In the worst case examined there could be 59.7 million people uninsured by 2015. The number could swell to 67.6 million by 2020, up from an estimated 49.4 million in 2010. As premiums nearly double, employees in small firms would see offers of health insurance almost cut in half, dropping from 41 percent of firms offering insurance in 2010 to 23 percent in 2020. Individual spending could jump 34 percent by 2015 and 79 percent by 2020. [Read more](#)



### The Cost of Uncompensated Care with and without Health Reform

John Holahan and Bowen Garrett, March 2010.

This report uses HIPSM to investigate the cost of uncompensated care both with and without health reform. Currently, uncompensated care costs have significant budget implications for state and local governments. This report finds that over the next nine years, in both the Senate and the House bills, the number of uninsured people would decrease which would lower the cost of uncompensated care by billions of dollars. If the status quo is maintained over the same amount of time, however, the number of uninsured people would increase and the cost of uncompensated care would more than double. [Read full report](#)



### Making Health Reform More Affordable for Working Families: The Effect of Employee Choice Vouchers

Matthew Buettgens and Linda Blumberg, February 2010.

The federal reform law includes a barrier that excludes many lower-income workers with an offer of employer-sponsored health insurance from access to premium and cost-sharing subsidies. While the law provides for a limited use of employee choice vouchers, those using the vouchers will still be unable to access federal subsidies through the exchange. This brief uses HIPSM to investigate the effectiveness of adding subsidy eligibility for those with employee choice vouchers in order to make health care more affordable for such families, simulating two programs. It finds that these programs would make health coverage dramatically more affordable for the low-income families who take advantage of them without substantial changes in health care spending by either the government or employers. [Read more](#)

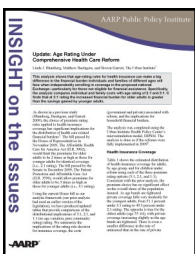


### Health Care Spending under Reform: Less Uncompensated Care and Lower Costs to Small Employers

Lisa Clemans-Cope, Bowen Garrett, and Matthew Buettgens, January 2010.

Modeling key coverage provisions of the House bill passed in November, this brief uses HIPSM to compare the distribution of health care spending under reform to that of the current system, in particular looking at how spending by employers of different sizes, government, families, and uncompensated care, would change. Results suggest that reform would lead to lower costs for small firms while expanding coverage among employees and their dependents. In addition, savings from decreases in uncompensated care under reform could provide significant spending offsets for federal and state governments.

[Read full report](#)



### Update: Age Rating under Comprehensive Health Care Reform

Linda Blumberg, Matthew Buettgens, and Bowen Garrett, January 2010.

Modeling key coverage provisions of the House bill passed in November, this brief uses HIPSM to produce updated tables that provide comparisons of the

distributional implications of different premium rating rules—allowing premiums for the older adults to be 3 times as high as those for younger adults (3:1 rating), limiting the highest premiums to be twice that of the lowest (2:1 rating), and no age variation in premiums (1:1 rating, also known as pure community rating). This brief summarizes the implications of the rating rule decision for insurance coverage, government and private costs associated with reform, and the implications for household financial burdens. [Read full report](#)



### Premium and Cost-Sharing Subsidies Under Health Reform: Implications for Coverage, Costs, and Affordability

Bowen Garrett, Lisa Clemans-Cope, Matthew Buettgens, December 2009.

This report uses HIPSM to estimate the distribution of coverage and costs, and household financial burdens, under health care reform legislation proposed by the Senate Finance Committee and under two alternative subsidy schedules: those specified in the Senate Leadership bill, and those specified in H.R. 3962, passed by the House of Representatives. This analysis shows that health care cost burdens can be substantial for those with modest incomes and significant health care needs. It shows how enhanced premium and cost-sharing subsidies could reduce burdens, while increasing overall coverage and government costs.

[Read full report](#)



### Age Rating under Comprehensive Health Care Reform

Linda Blumberg, Matthew Buettgens, and Bowen Garrett, October 2009.

This brief examines the premium rating rules that would be applied to non-elderly adults in an early version of the House health reform legislation, the House Tri-Committee health reform proposal. Some have proposed allowing premiums for the older adults to be as much as 5 times as high as those for younger adults (5:1 rating), while others would limit the highest premiums to be twice that of the lowest (2:1 rating). This analysis uses HIPSM to compare the financial implications of the premium rating choice (5:1, 2:1, and 1:1) for households of different ages, incomes, and sizes. [Read full report](#)



### The Cost of Failure to Enact Health Reform: Implications for States

Bowen Garrett, John Holahan, Lan Doan, and Irene Headen, September 2009.

This report uses HIPSM to estimate what would happen to insurance coverage and health care spending by government, employers, and individuals and families in all 50 states in the absence of reform. In all states, rates of employer sponsored insurance would fall, and Medicaid enrollment and the number of uninsured would increase. Employer spending would increase despite drops in coverage. Government spending for public health insurance programs and for financing of uncompensated care would increase. The results differ among states depending on the distribution of employees by firm size and wage levels, the breadth of coverage in public programs, and projected population growth. [Read full report](#)

### Achieving Quality, Affordable Health Insurance for All New Yorkers: An Analysis of Reform Options

Linda Blumberg, Bowen Garrett, Matthew Buettgens, Lisa Clemans-Cope, John Holahan, Aaron Lucas, Paul Masi, and Baoping Shang, July 2009.

Under contract to the State of New York, researchers used the HIPSM model to conduct analyses of four types of health care reforms being considered for state implementation: a single payer public health insurance option, an option for all New Yorkers to enroll in the state's Family Health Plus program, public-private hybrid options that simplify and expand existing public programs and reform private health insurance, and a market-based option that relies on regulatory flexibility and tax credits. The cost and coverage implications of state reform options falling into these four categories are presented in this report. The report also presents simulation results for the four policy options 5 and 10 years post implementation, and an analysis of supply-side constraints. [Read full report](#)

### About The Urban Institute

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### Health Reform: The Cost of Failure

John Holahan, Bowen Garrett, Aaron Lucas, and Irene Headen, May 2009.

This analysis uses HIPSM to estimate how coverage and cost trends would change between 2009 and 2019. The study examines three alternative scenarios that assume varying levels of income growth and increases in health care costs. This report projects that—if federal reform efforts are not enacted—within 10 years the cost of health care for businesses could double, and the number of uninsured Americans could reach 65.7 million—with middle-income families hardest hit. [Read full report](#)

### The Coverage and Cost Impacts of Expanding Medicaid

Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, May 2009.



This report uses HIPSM to quantify the impacts on coverage and cost of expanding Medicaid to cover more of the low-income uninsured, including adults, at various income levels and with improved participation rates. The analysis models two primary options to expand Medicaid eligibility to children and adults: (1) up to 250% of the federal poverty level (FPL) for children and 100% FPL for adults, and (2) up to 300% FPL for children and 150% for adults. The expansion for adults is also modeled with no change for children. [Read full report](#)