Health Policy Briefs

THE URBAN INSTITUTE

No. 17, December 2005

Lowering Financial Burdens and Increasing Health Insurance Coverage for Those with High Medical Costs

Linda J. Blumberg, Lisa Clemans-Cope, and Fredric Blavin

Low-income adults with high health costs and employer-sponsored health insurance spend 10 percent of their income on out-of-pocket expenses (excluding premiums); those with non-group coverage spend at least double that figure.

The distribution of health expenditures is highly skewed—the top 10 percent of spenders account for about 70 percent of total expenditures in the country, while the bottom 50 percent of spenders account for only 3 percent of expenditures (Berk and Monheit 2001). As a result, private insurers in a voluntary, unsubsidized market have strong incentives to avoid enrolling high-cost individuals. Insurers design plans—through benefits, cost-sharing, and provider networks—in an effort to enroll the most attractive health care risks. As medical costs escalate over time and particular plans become increasingly expensive because of the health risks of their enrollees, pressure mounts to modify cost-sharing and benefit packages so those in better health absorb less of the financial burden of those in worse health.

Health care expenses associated with high-cost medical cases in the United States are increasingly being shifted to the individual, a phenomenon exacerbated by recent trends in product design. Some examples of cost-shifting are high deductibles, tiered co-payments and co-insurance, significant differences in usual and customary fees as well as in the share of fees reimbursed for network and non-network providers, service-specific benefit caps and exclusions, and annual out-of-pocket maximums that exclude certain services. These features reduce the amount of health-related expenditures covered by insurance and increase the amount paid by those who use health care services the most: critically or chronically ill patients. The shift from insurance-covered costs to increased individual out-of-pocket payments is intended to moderate the rapid growth in medical expenditures overall by encouraging cost-consciousness in consumers. Evidence of this trend includes increased marketing and sales of products identified under the broad rubric of "consumer-driven health plans," which include health savings accounts (HSAs),[1] health reimbursement accounts (HRAs), high-deductible health plans, and other plans that offer less comprehensive benefits.

As the costs of medical care are spread less broadly, financial burdens for seriously ill individuals with high medical costs can increase dramatically. This shift can have significant negative effects, not only on the financial stability of families with high-cost members—evidenced by the large share of personal bankruptcies attributable to medical expenses (Himmelstein et al. 2005)—but also on access to necessary care, and ultimately on health outcomes for the sick. This brief identifies evidence of the severity of these problems and presents policy options designed to address them. This work includes numerous ideas and insights contributed by experts at a meeting convened to discuss these issues. Participants

included actuaries, insurance industry professionals, public policy analysts, economists, representatives of high-risk pools, and representatives of advocacy groups for those with specific illnesses.[2]

Empirical Evidence

There is substantial evidence that chronically ill individuals and others with high health costs face substantial financial burdens from health care spending, even when they are enrolled in health insurance. The estimates described here were computed using a three-year merged file of the Medical Expenditure Panel Survey–Household Component (MEPS-HC), 2000–2002. The MEPS-HC is nationally representative of the noninstitutionalized population and collects data on demographic characteristics, health conditions, health status, use of medical services, charges and payments, health insurance coverage, income and assets, and employment (AHRQ 2004). Each person is asked about the existence of select priority conditions.[3] We define relevant expenditures as those paid by insurance (public or private), by the individual, and by other government programs. A proxy for private insurance premiums, estimated using the MEPS–Insurance Component (MEPS-IC), is included only when indicated. All expenditures and incomes have been aged to year 2005 dollars.

High-cost individuals, defined as the top 20th percentile of the distribution of adult health care spending, have average annual total medical expenditures of at least $4,052. Over half of nonelderly adults with diabetes have annual medical expenditures that place them in the high-cost category. The same is true for almost half of those with heart disease, and roughly one-third of those with asthma, arthritis or joint pain, and high blood pressure (table 1). About 70 percent of high-cost individuals have at least one of the seven priority conditions reported in the MEPS-HC data, and 37 percent have multiple conditions (data not shown).

TABLE 1. Share of Population in Top 20% of Nonelderly Adult Medical Care Spenders by Priority Condition

	Total population	Share in top 20%	Number in top 20%
Priority condition			
Diabetes[a]	7,563,091	53.0%	4,008,544
Heart disease	10,386,490	48.6%	5,050,776
Asthma	15,664,443	32.9%	5,159,025
Arthritis/joint pain	52,972,795	32.5%	17,234,688
High blood pressure	29,375,902	38.3%	11,250,283
Emphysema	1,197,945	57.7%	691,423
Stroke	1,875,963	63.2%	1,185,226
No priority condition	93,591,554	11.3%	10,567,076

Source: Urban Institute analysis of a three-year MEPS-HC merged file (2000–2002).

Notes: Samples include adults age 19–64 with family incomes above $500. Individuals can have more than one priority condition. Adults in the top 20% of the distribution of adult health care spending have average annual medical expenditures of at least $4,052.

[a] The MEPS diabetes population estimate only includes diagnosed cases. Some published estimates include undiagnosed cases of diabetes.

The out-of-pocket financial burden on high-cost individuals, particularly those with modest incomes, can be substantial. The first three columns of table 2 show the share of income devoted to out-of-pocket medical expenses, excluding premium payments, for adults with different levels of income and total medical expenses; the next three columns include premium payments.[4] In general, the results in table 2 show a regressive pattern in which the percentage of income spent on medical expenses increases as income decreases.[5]

Within each income group, adults with high medical expenses spend about four times as much of their income on out-of-pockets costs as adults with medical expenses in the middle of the health care spending distribution. For the lowest income high-cost individuals, out-of-pocket expenses average two-thirds of their income; for those between 50 and 100 percent of the federal poverty level, the expenses amount to roughly 17 percent of their income. Figures reporting out-of-pocket costs as a share of income for the lowest income group are particularly dramatic and may be affected by the use of credit or savings to finance medical expenses, or by underreporting of income in the MEPS. If proxy values for premium payments are added, the relative financial burdens increase further.[6] In addition, the out-of-pocket expenditures tabulated here are done at the individual level; if more than one family member has large medical costs, the financial load is higher still.

Table 3 focuses on low-income adults in the high-cost group, showing out-of-pocket burdens by health insurance coverage. Even among adults predominantly covered by employer-sponsored health insurance, out-of-pocket payments account for 10 percent of income; this proportion increases to 16 percent of income when proxies for health insurance premiums are included. For those with predominantly non-group coverage during the year, out-of-pocket burdens are at least double that of those with employer-sponsored coverage. In fact, when premiums are included, the financial burden among

TABLE 2. Individual Out-of-Pocket Costs as a Share of Family Income by Income and Expenditure Group (percent)

	Excludes Private Premium Payments			Includes Private Premium Payments		
	Low $	Medium $	High $	Low $	Medium $	High $
Income						
< 50% of FPL	0.1	14.4	67.0	5.9	23.1	73.3
50–99% of FPL	0.0	4.0	16.5	1.3	6.8	18.5
100–199% of FPL	0.0	2.1	8.2	1.2	4.5	10.8
200–299% of FPL	0.0	1.1	4.8	1.4	3.4	7.2
300%+ of FPL	0.0	0.5	2.4	1.1	1.9	3.8

Source: Urban Institute analysis of a three-year MEPS-HC merged file (2000–2002).

FPL = federal poverty level.

Notes: Samples include adults age 19–64 with family incomes above $500. Low $ includes adults in the bottom 20%, medium $ in the middle 21% to 79%, and high $ in the top 20% of adult medical care spenders. Adults in the top 20% of the distribution of adult health care spending have average annual medical expenditures of at least $4,052.

non-group individuals is approximately the same as for individuals who are predominantly uninsured. Noteworthy as well is that high-cost, low-income individuals with public coverage carry significant out-of-pocket financial burdens, averaging more than 12 percent of income.

While the previous tables provide insights into the situations of those with the highest medical spending in a year, it is important to remember that some high-need individuals may not appear as high-cost because they are unable to afford necessary care. Consequently, table 4 shows the number and share of families reporting that at least one member had recently gone without needed medical care because the family needed money to buy food, clothing, or to pay for housing.[7] We provide these figures by income category and various levels of health care need.

Among families with predominantly private insurance coverage throughout the year, almost two million families reported forgoing needed care for financial reasons. Ten percent of low-income families with predominantly private coverage report a member going without needed care. Families with predominantly public insurance have even higher rates of forgone care due to financial burden: 14 percent over all income groups. As expected, uninsured families report the most financial difficulties accessing care: nearly 25 percent of low-income uninsured families reported forgone care, and almost 20 percent of uninsured families across all income groups did so.

Families in which someone has a priority medical condition or is in fair or poor health are twice as likely to forgo care than families with no health problems. Twenty-one percent of low-income families where at least one member has one or more of the MEPS-HC priority medical conditions report going without health care for financial reasons. This proportion is compared with 10 percent of those with no medical conditions in the family. Over five million families with a priority condition report going without care, and this is with a limited set of priority conditions. Almost one-quarter of low-income families with at least one member in fair or poor health report going without care for financial reasons, double the share of families with no member in fair or poor health that do so. Even middle-income families report difficulty accessing care when a member has a priority condition or a family member is in fair or poor health.

Given the financial difficulties facing individuals and families with substantial medical needs, policy initiatives that provide targeted subsidies for insurance premiums are required to meet the needs of high-cost, high-risk populations, particularly those with high levels of need and low or moderate incomes.

Policy Options

While the government can subsidize those with high health care needs in many ways, we categorize those options into two general groups: (1) approaches that subsidize coverage obtained through existing private insurance carriers; and (2) approaches

TABLE 3. Individual Out-of-Pocket Costs as a Share of Family Income by Predominant Health Insurance Coverage: Low-Income Adults in the Top 20% of Adult Medical Care Spenders (percent)

	Excludes private premium payments	Includes private premium payments
Predominant coverage		
ESI	9.7	16.3
Non-group	19.3	47.8
Public	12.4	12.6
Uninsured	50.3	50.6

Source: Urban Institute analysis of a three-year MEPS-HC merged file (2000–2002).

Notes: Samples include adults age 19–64 with family incomes above $500. Adults in the top 20% of the distribution of adult health care spending have average annual medical expenditures of at least $4,052. Low-income adults have incomes below 200% of the federal poverty level.

TABLE 4. Families Forgoing Medical Care for Financial Reasons, by Predominant Coverage, Health Status, and Income

	Income			
	< 200% of FPL	200–400% of FPL	400%+ of FPL	Total
Predominant family coverage is private				
Percent forgoing care	10%	4%	1%	3%
Number forgoing care	618,659	828,920	430,664	1,878,243
Predominant family coverage is public				
Percent forgoing care	15%	12%	5%	14%
Number forgoing care	1,091,434	170,436	19,259	1,281,129
Predominantly uninsured family				
Percent forgoing care	25%	18%	9%	20%
Number forgoing care	1,706,375	781,594	210,732	2,698,701
At least one priority condition in family				
Percent forgoing care	21%	9%	3%	9%
Number forgoing care	3,052,631	1,666,275	672,833	5,391,740
No priority conditions in family				
Percent forgoing care	10%	4%	1%	5%
Number forgoing care	932,869	465,886	191,640	1,590,395
At least one family member in fair or poor health				
Percent forgoing care	24%	13%	4%	15%
Number forgoing care	2,536,300	1,019,468	319,444	3,875,212
No family member in fair or poor health				
Percent forgoing care	11%	5%	2%	5%
Number forgoing care	1,457,075	1,113,245	545,871	3,116,190

Source: Urban Institute analysis of a two-year MEPS-HC merged file (2000–2001).

Notes: Samples include adults age 19–64 with family income above $500. Health insurance coverage is the predominant source of coverage in the family unit.

The MEPS question asks if at least one member had recently gone without needed medical care because the family needed money to buy food or clothing, or to pay for housing. This question was not asked in 2002.

that subsidize coverage in an insurance context distinct from existing markets and open only to individuals (and possibly their dependents) that qualify based on health status. In this brief, we outline one policy option in each general category as examples of initiatives that can improve the coverage and access to care of those with high-cost illnesses. Both options discussed here specifically target individuals whose health care costs constitute a large share of income and minimize disruption of existing private insurance systems.

In recent years, one frequently discussed policy option for addressing the problems of insuring high-cost individuals in private insurance markets is publicly funded reinsurance (Blumberg and Holahan 2004; Kerry for President 2004; Swartz 2002). Government reinsurance would fund some portion of the medical costs associated with high-cost individuals (for example, 75 percent of costs above $35,000 a year per individual) and finance that spending through broad-based taxation. Such a program could be limited to particular insurance markets, such as small group and non-group insurance, where high-risk individuals or groups often cannot obtain health insurance. The policy motivation behind public reinsurance is that the cost associated with very expensive cases would be spread across a broad swath of the population, thereby reducing premiums to some extent across the board and reducing the impact of very high cost cases on premiums charged in relatively small insurance risk pools. Such a policy should not, however, be expected to decrease the incentives for private insurers to underwrite and attempt to select the best health care risks for enrollment. Consequently, reinsurance policies alone should not be expected to increase access to insurance for those with serious medical histories.

Discussions with insurance industry and actuarial experts during our meeting made it very clear that insurers would not change their underwriting and risk selection behavior even if publicly funded reinsurance were available. Because the attachment points (the level at which reinsurance kicks in—$35,000 in the example above) on these policies are

generally set far above the costs associated with someone of average health care risk, the incentives to enroll the best risks would remain as strong as they are today. As a consequence, the examples of policy approaches presented here do not include government reinsurance alone as a potential strategy. While broader spreading of risk at these levels is a reasonable goal in itself, the objectives of the proposals presented here are more extensive and include a significant increase in access and affordability of coverage for high-cost adults and families.

Option 1. Assignment of Risk to Existing Insurance Carriers Combined with Government Subsidies

The main thrust of this approach is that high-cost individuals can apply for random assignment to a private insurance carrier operating within their market area. Insurers would be assigned a share of those eligible for the new program in proportion to their market share. Both group and non-group insurers would be required to participate in order to sell insurance of any type in the private market. Individuals would be eligible for this program based on rules similar to those used to qualify for high-risk pools, such as a list of specific diagnoses or denial of coverage from a private insurer. Eligibility could be broadened to include those with out-of-pocket medical expenses exceeding a threshold or those who have been offered substandard coverage by private insurers—such as benefit riders excluding treatment for particular conditions or body parts. Eligibility could also be limited to low- and middle-income individuals—for example, those with incomes up to 300 percent of the federal poverty level.

The government would determine which benefit package would be offered to eligible individuals. Administrative burden on insurers would be limited if the required package were defined as the carrier's most popular plan (this is consistent with regulations under the Health Insurance Portability and Accountability Act, or HIPAA); however, that type of benefit definition is unlikely to best suit the needs of eligible populations. Without a standard definition of benefits, coverage offered by particular carriers may be sparse, a problem identified with many HIPAA plans. Instead, the government could define a comprehensive benefit package with well-defined limits on cost-sharing responsibilities, providing stronger financial protection for the targeted population. The trade-off is that carriers would incur higher administrative costs when offering an insurance package that is not part of their regular business.[8]

Under a voluntary health insurance system, designing a reform requires considering the impact of new programs on incentives for all individuals to purchase insurance coverage. Providing open access to subsidized insurance for those with particular conditions or high levels of spending may create a disincentive for healthy individuals to purchase health insurance. Pre-existing condition exclusion periods under the new program may reduce such disincentives but would impose heavy financial penalties on those with chronic conditions and could lead to serious adverse health consequences. Experience with Maryland's high-risk pool, which eliminated pre-existing condition exclusions entirely, suggests that it may be feasible to offer full access to benefits without restrictions. Alternatively, one could consider imposing income-related financial penalties on the previously uninsured, with virtually no penalty for the low-income chronically ill. The income-related penalty option is one way to provide appropriate incentives to those who could afford coverage while healthy without curtailing access to necessary care when seriously ill.

Carriers would be required to charge the same premiums that would be charged to a person of standard risk in the plan provided to each eligible. Individuals would pay income-related premiums with the government paying the balance. Ideally these subsidies would limit individuals' direct premium contributions to a specified share of family income. Each carrier could participate in a new reinsurance pool, and a substantial share of the claims (e.g., 90 percent) for the eligible population that exceed 100 percent of standard would be reimbursed through this pool.[9] The costs of the reinsurance pool should most likely be borne jointly through premiums paid by insurers and by government. The higher the share of these costs paid for by government, the larger the public cost of the new program and the lower the incentives for insurers to effectively manage the high-cost cases. Increasing the share of reinsurance premiums paid by carriers would produce stronger incentives for innovation in effective management of high-cost cases, with larger carriers opting out of the pool if they develop cost-saving strategies beyond what carriers in the pool can achieve. However, the higher the share paid for by the carriers, the greater the disincentive for the healthy to continue to purchase health insurance coverage at current levels, since program costs would then be more heavily financed by those paying for private insurance.

Option 2. Federal Financing of State High-Risk Pools Combined with Federal Guidelines on Benefits and Eligibility

Thirty-two states currently have active high-risk pools (Abbe 2005). These pools vary considerably from

state to state in their size, eligibility rules, benefits provided, premium pricing, waiting periods, and exclusions for pre-existing conditions. While the pools share a common goal of providing insurance coverage to those unable to access it in current private insurance markets, they also share the constraint of very limited funding to support assistance for the high-cost population they are designed to serve. As a consequence, state high-risk pools insure only about 180,000 people combined (less than 2 percent of the market on average), with over half of that enrollment attributable to pools in just four states (Abbe 2005).

A commitment of federal financial support and uniform guidelines for eligibility and benefits could go a long way toward improving high-risk pools' abilities to serve low- and middle-income individuals with high-cost medical needs. This type of federal commitment would provide strong incentives for states without high-risk pools to develop them.

Restructured high-risk pools would have no enrollment caps. Similar to the discussion in option 1, mechanisms could be put in place that would balance incentives for the healthy to continue to purchase coverage without imposing onerous pre-existing condition exclusion periods that could hamper access to services. Access to coverage in the pools would be based on a federally defined set of priority medical conditions. Eligibility could also be allowed for those with medical costs exceeding a threshold amount or for those denied coverage by outside carriers. Benefit packages would be comprehensive, would include prescription drugs and devices, and would have explicit limits on cost-sharing with no benefit maximums. Premiums would be charged according to an income-related schedule, ideally limiting individual contributions to a specified percentage of income. Benefit costs in excess of premiums would be financed by the federal government or jointly by the federal government and the states. States could be required to maintain responsibility for administrative costs associated with the risk pools as a condition of federal funding.

Conclusions

There are numerous options for subsidizing health care coverage for high-cost, high-risk populations. These risk subsidy options can all be combined with low-income subsidies to further reduce the cost of care and coverage for people of modest means. Premiums and cost-sharing can be subsidized for this population to enable them to purchase coverage through existing private insurance carriers. However, some regulation of eligibility, guaranteed issuance of policies for eligibles, benefits offered, and premium pricing would be required to ensure that the targeted individuals can access sufficient benefits. Considerable thought must also be given to ensure that the excess costs associated with high-cost, high-risk individuals are spread as broadly as possible. Such approaches keep existing private insurers involved and may carry less stigma than programs specifically designated for high-cost enrollees. But insurers may bristle at additional regulations and oversight, particularly regarding benefit packages and premium pricing, leading to trade-offs between administrative complexity and the ability to best serve the needs of enrollees.

Subsidized coverage outside existing private markets can be offered to high-cost individuals through improved high-risk pools; expansions of the Medicare, Medicaid, or SCHIP programs; or entirely new insurance mechanisms. These approaches decrease administrative complexity appreciably compared with using existing private carriers, but they may separate coverage of family members and require that programs be made available in each state. To treat assistance for those with high medical needs equitably, federal standards for eligibility, benefits, and financial assistance must be applied.

Neither policy option described in this brief would be considered a minor, incremental reform. Either would lead to a significant redistribution of private costs and would increase public spending on health care. However, both approaches can be implemented incrementally, for example, by initially targeting even one chronic disease or condition, such as diabetes.

Regardless of the approach taken, the need is clear. Mounting empirical evidence, policy research, and reports in the popular press attest that the U.S. health care system is currently inadequate to ensure access to care for those with the greatest health care needs.[10] Many insured as well as uninsured high-cost individuals are at financial risk and at risk for poor health outcomes as a result. Also, many purchasers of private non-group insurance do not understand the very limited protection from risk that the complex products they are buying provide. The exact nature of these limited policies becomes evident only when a significant health care need arises.

These circumstances can only worsen as employer and individual purchasers of insurance continue to opt for health insurance plans with higher cost-sharing requirements and stricter limits, trends driven by medical inflation and new tax incentives. Increases in the share of the population with chronic diseases, diabetes in particular, highlight the growing share of the population that is vulnerable. Options are available for expanding financial and medical pro-

tection for those most in need; they just have yet to receive the attention they deserve from policymakers.

Notes

1. Health savings accounts provide incentives for individuals, particularly those in the highest tax brackets, to purchase medical care outside an insurance arrangement.
2. In addition to the authors, the participants were John Bertko, Randall Bovbjerg, Tom Boyer, Len Burman, Gary Claxton, Beth Fuchs, Earl Hoffman, John Holahan, Karl Ideman, Jim Mays, Len Nichols, Karen Pollitz, Ward Sanders, Christine Schmidt, Mary Beth Senkewicz, Tom Stoiber, Kathy Thomas, Cori Uccello, Tim Waidmann, and Steve Zuckerman.
3. The priority conditions are diabetes, asthma, high blood pressure, heart disease, stroke, emphysema, and arthritis or joint pain.
4. We exclude those reporting the very lowest incomes (less than $500 a year) from this analysis to avoid presenting statistics more reflective of extremely low income than of high relative health expenses.
5. See Galbraith et al. (forthcoming) for a discussion of the regressive gradient in financial burden across income groups.
6. Proxy values for health insurance premiums were computed in the following manner. Average employee contributions for employer-sponsored health insurance from the MEPS-IC were associated with those reporting employer-based coverage by state and firm size. Premium payments were reduced for those with partial year coverage. For those with non-group coverage, 80 percent of the total (employer + worker shares) MEPS-IC premium for the smallest firm size in the state was assigned. Only 80 percent of the premium was used, presuming that non-group coverage is less comprehensive than group coverage. Premiums are prorated for the number of months covered.
7. Results in table 4 are from a two-year merged file of the 2000 and 2001 MEPS-HC. The question on forgone medical care was not asked in 2002.
8. Additional administrative costs to insurers can be mitigated by defining required benefits in such a way that allows carriers to simply modify some of their internal cost-sharing structures. For example, if a carrier has a three tiered co-payment for prescription drugs, forcing the carrier to offer a two-tiered co-payment for particular eligibles might be administratively complex. Instead, the reform guidelines could permit the carrier to maintain its existing tiered structure but limit the co-pays to some fraction of existing levels, thereby reducing the carrier's new administrative burden.
9. The remaining 10 percent would be absorbed by each carrier, presumably by spreading the costs across all of its insured population.
10. For example, see Achman and Chollet (2001), Merlis (2002), Pollitz et al. (2001), and Pollitz et al. (2005). In the popular press, see Cable News Network, "Wal-Mart Memo: Unhealthy Need Not Apply," October 26, 2005 (http://money.cnn.com/2005/10/26/news/fortune500/walmart/index.htm); Christopher J. Gearon, "High Deductible, High Risk: 'Consumer-Directed' Plans a Health Gamble," *Washington Post*, October 18, 2005, page HE01; and John Leland, "Being a Patient: When Health Insurance Is Not a Safeguard," *New York Times*, October 23, 2005.

References

Abbe, Bruce, ed. 2005. *Comprehensive Health Insurance for High-Risk Individuals: A State-by State Analysis*. Fergus Falls, MN: Communicating for Agriculture and the Self-Employed in cooperation with the National Association of State Comprehensive Health Insurance Plans.

Achman, Lori, and Deborah Chollet. 2001. *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*. New York: The Commonwealth Fund.

Agency for Healthcare Research and Quality (AHRQ). 2004. "Overview of the Medical Expenditure Panel Survey." http://www.meps.ahrq.gov/WhatIsMEPS/Overview.HTM#HC.

Berk, Marc L., and Alan C. Monheit. 2001. "The Concentration of Health Care Expenditures, Revisited." *Health Affairs* 20(2): 9–18.

Blumberg, Linda, and John Holahan. 2004. "Government as Reinsurer: Potential Impacts on Public and Private Spending." *Inquiry* 41: 130–43.

Galbraith, A., S. Wong, S. Kim, and P. Newacheck. Forthcoming. "Out-of-Pocket Financial Burden for Low-Income Families with Children: Socioeconomic Disparities and Effects of Insurance." *Health Services Research*.

Himmelstein, David U., Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler. 2005. "MarketWatch: Illness and Injury as Contributors to Bankruptcy." *Health Affairs* web exclusive, Feb. 2: W5-63–73.

John Kerry for President, Inc. 2004. "Affordable Health Care for All." http://www.johnkerry.com/issues/health_care/.

Merlis, Mark. 2002. *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity*. New York: The Commonwealth Fund.

Pollitz, Karen, Richard Sorian, and Kathy Thomas. 2001. *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* Menlo Park, CA: Henry J Kaiser Family Foundation.

Pollitz, Karen, Eliza Bangit, Kevin Lucia, Mila Kofman, Kelly Montgomery, and Holly Whelan. 2005. *Falling Through the Cracks: Stories of How Health Insurance Can Fail People with Diabetes*. Alexandria, VA: American Diabetes Association.

Swartz, Katherine. 2002. "Government as Reinsurer for Very-High-Cost Persons in Nongroup Health Insurance Markets." *Health Affairs* web exclusive, Oct. 23: W380–82.

About the Authors

Linda J. Blumberg is an economist and senior research associate in The Urban Institute's Health Policy Center. She has published numerous articles on issues related to private health insurance, interactions between private and public insurance coverage, and health care financing and reform.

Lisa Clemans-Cope joined the Urban Institute in 2004 as a research associate in the Health Policy Center. She has been involved in developing the Health Insurance Reform Simulation Model for simulating and evaluating state and national reform proposals.

Fredric Blavin is a research assistant at the Urban Institute. His research focuses on analyses of the private health insurance market.

THE URBAN INSTITUTE
2100 M Street, NW
Washington, DC 20037

Nonprofit Org.
U.S. Postage
PAID
Permit No. 8098
Ridgely, MD

Address Service Requested

For more information,
call Public Affairs:
202-261-5709
or visit our web site,
http://www.urban.org.
To order additional copies
of this publication, call
202-261-5687
or visit our online bookstore,
http://www.uipress.org.

The Urban Institute's Health Policy Center (HPC) was established in 1981 to study the public policy issues surrounding the dynamics of the health care market and health care financing, costs, and access. Research topics include health insurance coverage and costs, incentives for public and private provider reimbursement, reform of the long-term care system, and malpractice tort law and insurance. HPC researchers also examine Medicare and Medicaid benefits and proposals, assess proposed reforms in the private medical market, and study ways to expand health insurance coverage for children, among other issues.

The Health Policy Briefs series provides analysis and commentary on key health policy issues facing the nation. Topics include Medicare and Medicaid policy, changes in private health care markets, strategies for expanding health insurance, and the rising costs of health care. The series will include both data briefs and perspectives on national debates.

This work was funded by a grant from the Robert Wood Johnson Foundation. The authors are grateful to all who participated in a September 2005 meeting to discuss issues related to this topic: John Bertko, Randall Bovbjerg, Tom Boyer, Len Burman, Gary Claxton, Beth Fuchs, Earl Hoffman, John Holahan, Karl Ideman, Jim Mays, Len Nichols, Karen Pollitz, Ward Sanders, Christine Schmidt, Mary Beth Senkewicz, Tom Stoiber, Kathy Thomas, Cori Uccello, Tim Waidmann, and Steve Zuckerman. In particular, Tom Stoiber and Karen Pollitz provided detailed comments and suggestions on an earlier version of this paper and both contributed significantly to our thinking on this topic.

THE URBAN INSTITUTE
2100 M Street, NW
Washington, DC 20037

Phone: 202-833-7200
Fax: 202-467-5775
E-mail: pubs@ui.urban.org