THE BIGGEST LOSERS, HEALTH EDITION

Who Would Be Hurt the Most by a Failure to Enact Comprehensive Reforms?

Timely Analysis of Immediate Health Policy Issues

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Summary

The fate of health care reform is now highly uncertain. The momentum for reconciling the two bills passed by the House of Representatives and the Senate stalled, leading the President to put a compromise proposal forward. Still, the original motivation and rationale for the reforms appears to have become obscured, as have an understanding of what the proposals would do and who would benefit from them. This brief describes the groups with the most to lose if comprehensive health care reform is not enacted—people who either lack coverage today or who are required to pay the most for health insurance and medical care. Based on 2008 data, these groups include:

- 13.1 million self-employed people;
- 47.8 million people employed in firms of fewer than 100 workers;
- 26.9 million non-elderly people working part-time and 20.8 million people working full-time but for only part of the year;
- 96.2 million non-elderly people in families with incomes below 200 percent of the federal poverty level; another 74.3 million living in families with incomes between 200 and 400 percent of the poverty level;
- Millions of people with significant health problems, including the highest spending 5 percent of the US population, who account for about 50 percent of total health expenditures. This concentration of health care costs limits access to affordable, meaningful coverage for them as well as many others with less expensive conditions, including many older working-age adults and early retirees.

In addition, 14.8 million people were unemployed, as of January 2010, and this number is expected to remain high for several years.

Reform's combination of Medicaid expansions for the very low-income, subsidies for the purchase of exchange-based coverage for those up to 400 percent of the FPL, broader-based sharing of risk, and administrative economies of scale reaped from exchanges would make coverage affordable for the vast majority of individuals without access to employer-based coverage, irrespective of age, health-status, or employment status.

Some of the people in those groups overlap, not all are uninsured, and not all those with incomes that would make them eligible for financial assistance would avail themselves of the federal subsidies and expanded public programs at the same time. But all would have the reforms as at least a backstop, e.g., if they lost employer-based coverage, the reforms would limit their financial burdens and ensure them access to meaningful coverage that many would not have otherwise.

To walk away from the proposals developed, including the individual mandate, insurance exchanges, regulatory reforms of insurance markets, expanded public insurance eligibility, and premium and cost-sharing subsidies for the modest income, does even greater harm than leaving these populations in the difficult circumstances in which they find themselves today. That is because without legislative change, the cost of medical care will continue to grow faster than incomes, just as it has in recent memory. As a consequence, not only would the numbers of uninsured and the under-insured grow as premiums for meaningful coverage became increasingly expensive, but the cost of obtaining care with direct out-of-pocket payments would become even more of a financial burden over time. Finally, the increasing numbers of individuals seeking charity care and public coverage would put yet more financial pressures on state, local, and federal government, as well as on the health care system as a whole.

Urban Institute

Introduction

According to an Urban Institute analysis, without any policy changes, by 2019, the number of uninsured would increase from 18.4 percent of the nonelderly population in 2009 to 23.2 percent under the worst case scenario and 20.1 percent under the best case.[1] The fate of health care reform is now highly uncertain. The momentum for reconciling the two bills passed by the House of Representatives[2] and the Senate[3] stalled, leading the President to put a compromise proposal forward. Still, the health care reform conversation has become more focused on political strategy, process, and opinion polling. This has obscured the original motivation and rationale for the reforms, the understanding of what the proposals would do and who would benefit from them. In this brief, we describe the groups with the most to lose if comprehensive health care reform is not enacted—people who either lack coverage today or who are required to pay the most for health insurance and medical care. These include:

- workers in small firms, including those offered employer-sponsored insurance (ESI);
- people who are not offered ESI;
- people who have or had significant health problems;
- older working-age adults and early retirees; and
- people with low incomes.

Individuals and their dependents falling into these categories would see significant benefits from the types of reforms proposed. In addition, many people not currently in these groups could be in such situations in the future, when they would also have a considerable amount to lose in the absence of comprehensive reform. While there are differences in the proposals, each includes a requirement to obtain health insurance coverage, expansion of eligibility for the Medicaid program, substantial changes to regulations governing private health insurance markets, development of health insurance exchanges, and the provision of federal subsidies for the purchase of insurance coverage.

The following sections consider each group listed above, explaining the disadvantages it faces under the current system and the advantages it would reap under reform. Where possible, we highlight the size of these groups today.

Small Employers and Their Workers

Problems for Small Businesses under the Current System

Small employers and their workers are currently at a significant disadvantage in purchasing health insurance coverage. An estimated 47.8 million people were employed in firms of fewer than 100 workers in 2008.[4] Just 57.3 percent of them had employer-based coverage, and in the absence of reform, the share with ESI could fall by as much as 12 percent by 2019.[5] While the analysis on which this estimate is based did not provide estimates separately by firm size, the recent trends shown in table 1 suggest that much of this decline would be concentrated among small employers. In table 1, we see that between 2000 and 2008, the share of private-sector employers offering health insurance to their workers held relatively steady for

Table 1. Percent of private-sector establishments that offer health insurance by firm size and wage: 2000-2008

	Total	Fewer than 10	10-24 employees	25-99 employees	100-999 employees	1000+ employees
All firms						
2000	59.3%	39.6%	69.3%	84.5%	95.0%	99.2%
2008	56.4%	35.6%	66.1%	81.3%	95.4%	98.9%
Percentage Change:	-4.9%	-10.1%	-4.6%	-3.8%	0.4%	-0.3%
50% or more of employees are low wage						
2000	42.5%	25.4%	46.3%	73.5%	94.2%	96.4%
2008	41.8%	18.4%	36.6%	60.1%	91.4%	98.0%
Percentage Change:	-1.6%	-27.6%	-21.0%	-18.2%	-3.0%	1.7%
Fewer than 50% of employees are low wage						
2000	64.7%	50.2%	83.4%	92.4%	96.9%	99.4%
2008	63.8%	44.0%	79.3%	91.8%	97.6%	99.4%
Percentage Change:	-1.4%	-12.4%	-4.9%	-0.6%	0.7%	0.0%

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2000 and 2008 Medical Expenditure Panel Survey-Insurance Component.

employers of 100 or more workers but fell significantly for small employers, with the declines greatest for the smallest employers.

Small employers face high administrative costs, limited ability to share health care risk; and a lower-wage workforce than is employed by large firms. All three challenges interact to make small employers much less likely to offer health insurance coverage to their workers and pay more for the same benefits than do larger firms.[6] As table 1 also shows, the disparity in the likelihood of small versus large employers offering health insurance coverage is substantial and growing, with the greatest disparities for low-wage firms.

Advantages under Reform for Small Businesses

The reform proposals would lower the cost of insurance coverage for many small employers and would make coverage more affordable for many of their workers. The proposals would create health insurance exchanges through which small employers (those with fewer than 100 workers) and their employees could purchase health insurance coverage.[7] Buying coverage through exchanges would likely lower the administrative costs of small employer coverage by lowering marketing expenses and incentives to change insurance plans (i.e., churning). Broad-based risk spreading within an exchange and market reforms would drastically reduce year-to-year variation in premiums and the resulting churning across insurers. These changes should lead to premium savings for small employers offering coverage to their workers.

Health insurance spreads risk by using revenue collected from premiums paid by people when they are healthy to pay the claims of people when they are sick. In this way, risk spreading makes the cost of coverage more predictable for everyone and makes medical bills more affordable for people when they are sick. However, because of the skewed distribution of health spending, insurers have powerful financial incentives to segregate risks rather than spread them, when permitted by state law. Insurers will charge some small groups higher premiums as a consequence of their health care utilization history and expected future costs. Market regulations are required to prevent risk-selecting behavior by insurers. For example, community-rating rules prohibit insurers from charging higher premiums, at issue and at renewal, based on health status or claims experience. Under the proposed reforms, requirements for modified community rating would be implemented. The proposals would limit small group and individual purchaser premium variations to specified age bands (2:1 under the House bill and 3:1 under the Senate) and prohibit the use of other factors, such as industry, gender, health status, and claims experience.[8] The 2:1 rating in the House bill would limit the premiums for older adults to be no more than 2 times as high as those for younger adults for identical coverage, while the Senate's 3:1 rating would allow a threefold difference in premiums between older and younger adults. These changes would make coverage significantly more affordable for many small employers and their workers. Some small employers currently receiving favorable rates due to a healthy pool of workers could face higher premiums than they do today, but administrative savings associated with the exchange would partially offset such increases. In any case, the increases would be expected to be small since the costs would be spread broadly across a larger insured population.

Even under reform, small employers would remain less likely to offer ESI than large employers as a consequence of having a lower-wage workforce. However, under the President's proposal and under both bills, significant financial assistance would be provided for individuals and families not obtaining coverage from their employer, as indicated at the outset of the brief. Specifically, each proposal would expand eligibility for public insurance coverage through the Medicaid program to all those with incomes up to 133 percent of the federal poverty level (FPL) under the Senate bill and to 150 percent of the FPL under the House bill. For those with incomes up to 400 percent of the FPL without ESI offers, the proposals would provide subsidies to lower the premiums associated with the purchase of exchange-based insurance coverage. Subsidies to reduce the out-of-pocket cost-sharing responsibilities for those buying coverage through the exchange would also be available to many low-income families.[9]

People without Employer-Sponsored Insurance Offers

Over 90 million people in the United States do not have access to insurance coverage through an employer (either their own or that of a family member); of these, 43 percent, or about 39 million, are uninsured.[10] The population without employer-sponsored insurance offers is diverse, comprising workers in small firms (discussed in the last section) and their dependents; intermittent, seasonal, and part-time workers who are often not eligible for an employer offer; and new workers who often do not qualify for ESI or who face waiting periods for coverage. In addition, the unemployed, the self-employed, and those unattached to the labor force are generally left without an ESI option. As of January 2010, 14.8 million people were unemployed in the United States.[11] As of 2008, 13.1 million nonelderly people were self-employed, 26.9 million nonelderly people worked part-time, and 20.8 million people worked full-time but for only part of the year.[12]

Problems under the Current System for People without Employer Offers

Those without access to ESI who wish to obtain health insurance coverage are generally left to purchase coverage in nongroup (sometimes called "direct pay") insurance markets since about 70

percent do not qualify for Medicaid or Children's Health Insurance Program (CHIP) coverage under current rules.[13] Adverse selection is a serious problem in nongroup markets, causing insurers to avoid, to the extent that the law allows, the enrollment of individuals with significant expected health care needs. Because regulation of nongroup markets is left largely to the states, there is significant variation across the country, although many issues have plagued nongroup markets in almost all states.[14] These issues include lack of guaranteed issue and practices like issuing policies with benefit riders or permanent exclusions of coverage, rescissions of coverage based on claims filed, medical underwriting, limited-benefit packages combined with high cost sharing, and a lack of transparency in the details of coverage that make value-based shopping difficult if not impossible.

For those denied coverage in the nongroup market due to preexisting health conditions, alternatives are limited. While 33 states had high-risk pools for medically uninsurable individuals by the end of 2008,[15] many of these suffer from problems not unlike those in the private nongroup insurance markets. Due to limited public financing, premiums are often expensive, cost-sharing requirements are high, preexisting conditions can be excluded from coverage for a significant time (during which medical care for these conditions has to be paid for out of pocket), some also have low annual benefit caps, and some have caps on the number of people that can be enrolled. Fewer than 200,000 people were enrolled in high-risk pools across the country in 2008, with about 60 percent of that enrollment occurring in just six states. The largest pool in Minnesota had roughly 27,000 enrollees, while five of the pools had fewer than 1,000 enrollees.

In addition, there is currently very limited eligibility for public health insurance programs, particularly for adults. Eligibility rules for Medicaid vary considerably by state; however, nationally only 19 percent of uninsured adults are eligible for the program.[16]

Taken together, the opportunities for health insurance coverage outside employment are limited and, in the case of nongroup and high-risk pool coverage, significantly flawed. As health care costs continue to grow absent reform initiatives to contain them, the share of the population with access to employer-based offers of coverage will continue to fall. Without the payment rate discounts that insurers negotiate with providers, those forced to purchase medical care directly without coverage will feel the greatest brunt of the growth in medical costs, creating further impediments to obtaining affordable access to necessary care.

Advantages under Comprehensive Reform for People without Employer Offers

Under the reform proposals, most individuals would have to enroll in health insurance coverage, if affordable coverage was available, and all nongroup insurers would be required to issue policies to all individuals. Regulations would prohibit insurers from denying coverage to any applicant and charging different premiums based upon expected need for health care services.[17] In addition, insurers could no longer include benefit riders that would permanently exclude coverage for particular conditions, nor could they impose preexisting condition exclusion periods, and the proposals would clarify that insurers are prohibited from rescinding policies unless the applicant has engaged in fraud. Health care risk would be spread broadly through the premiums of all those insured, and the purchase of individual coverage through the health insurance exchange would reduce administrative costs. The federal government would set minimum standards for health insurance coverage, such that all coverage purchased in the nongroup market would include the necessary benefits to ensure meaningful coverage (i.e., there would be no policies sold that did not include prescription drug coverage, maternity care, etc).

In addition, we expect significant improvements in transparency and accountability in insurance practices under these proposals, and the exchange would play a central role in these advances. One important task of the exchange would be to provide more and better information about health insurance than consumers have available today. Plans would be grouped into a few categories by actuarial value to make it easier for consumers to compare across options—the Massachusetts Connector does this today. The exchange would produce a web site and brochures making plan comparison documents available that highlight differences in key plan features, such as deductibles, co-pays, and benefit limits. Similar detailed plan comparison documents are prepared today for participants in the Massachusetts Connector, the Federal Employees Health Benefits Program, California public employees and retirees, and senior citizens purchasing Medicare supplemental policies or HMOs, among others. Through its transparency and disclosure requirements, an organized health insurance marketplace also would be much better able to verify compliance with rules that promote risk spreading. A coordinated effort with state departments of insurance would benefit those continuing to purchase coverage outside an exchange.

Particularly Vulnerable Populations

Problems under the Current System for the Most Vulnerable People

Certain other groups are also vulnerable to the flaws in our current health care system. Low-income people have difficulty purchasing even administratively efficient health insurance coverage.The cost of meaningful coverage is simply too high relative to their incomes. In 2008, 96.2 million nonelderly people lived in families with incomes below 200

percent of the FPL.[18] Almost a third of them were uninsured. Those with high medical needs generally do not have access to sufficient or even any coverage in the nongroup insurance market, and thus often have no alternative source of insurance without an offer from an employer. And if a small firm employs a high-need person, that firm's premium may be unaffordable if the high-cost person is enrolled. Much depends upon the state in which the firm is located, the size of the firm, and the health status of the other workers employed there. The distribution of health expenditures is highly skewed, with the highest-spending 5 percent of the U.S. population accounting for just under half of total health expenditures.[19] Thus, their inclusion or exclusion from an insurance pool can have substantial impacts on premiums, and their inability to obtain coverage can have critical implications for their own health and well-being.[20] Older adults and those wishing to retire early may find themselves in similar circumstances as those with high medical needs, since expected medical costs increase with age, and insurers build these expectations into premiums, even for older adults who have been in good health.

Advantages under Reform for the Most Vulnerable People

Under reform, the Medicaid expansions and subsidies provided for purchasing exchange-based coverage would significantly lower the financial burdens low-income people face in obtaining insurance. In the case of the lowest income population—those made eligible for the Medicaid program—coverage would be made available at almost no cost. The coverage availability and affordability problems older adults and those with high medical needs face would be redressed by new insurance market regulations that would spread the costs across all of those who are insured. This would be done through a combination of approaches, including a requirement that all individuals be insured, guaranteed issue of policies, prohibiting premium rating based on health status, eliminating preexisting condition exclusion periods, and developing health insurance exchanges. These improvements would apply regardless of whether an individual wished to obtain coverage independently through the nongroup insurance market or whether they purchased coverage through a small employer. Many of these changes would apply to larger firms as well, although the proposals vary on that metric.

Reducing Future Uncertainty for Everyone

In the near term, many people would not see much change to their insurance coverage if comprehensive reform were implemented. Most prominently, these would include workers in large firms and their dependents who have ESI coverage today. These families would continue to obtain coverage the way they do now after reform. As of 2008, 50.3 million workers in private-sector firms of 100 or more workers had employer-based coverage, as did an additional 18.4 million public-sector workers.[21]

As of 2008, there were 7.5 million uninsured adults between the ages of 19 and 24. Today's uninsured young and healthy individuals would be required to obtain coverage under reform if it was deemed affordable for them. While this might increase their out-of-pocket costs in the short run, the vast majority would be eligible for financial assistance under the proposals, significantly limiting any new financial burdens that the individual mandate might create.[22] In addition, 4.4 million uninsured nonelderly people had incomes in excess of 400 percent of the FPL in 2008. Many of these people would also be required to purchase coverage after reform, without additional financial assistance. Some would benefit from the new insurance-market reforms and exchanges, thus making coverage more affordable for them than is the case today, but others would obtain coverage unwillingly.

The current system gives some individuals and small groups an advantage, and it can reward those in excellent health with lower premiums. While broader-based risk pooling may increase premiums for some of them in the short run, administrative savings from reform will offset some or all of that increase, and should also reduce concerns that many have with regard to year-to-year variations in premiums. In addition, any premium increases due to broader-based risk pooling should be small, as the costs associated with including higher need people would be spread widely across a large number of insured people, particularly in the case of an individual mandate. The mandate is also likely to bring more healthy individuals and groups into the insurance risk pools, lowering the average costs of those covered and hence lowering premiums as well.

While at any particular time, many people do not fall into any of the categories of vulnerable individuals outlined previously—they have good incomes, are in good health, are young or relatively so, or work for larger firms that offer insurance coverage—this will not necessarily always be the case. Life and employment circumstances change over time, everyone ages, and we are all at risk of being part of the vulnerable population at some point in the future. The value of comprehensive health care reform is not simply for those who benefit at a particular time, but to ensure that all individuals have affordable access to adequate health insurance coverage over the course of their lifetimes—regardless of employment, age, or health status.

Discussion

Many people have a considerable amount to gain from the types of reforms that have been proposed in the House and Senate bills and by the President. Those who would reap particular advantages include those employed by small firms, those without offers of employer-sponsored insurance (e.g., the unemployed, the self-

employed, those not working full time, low-income workers, and high-turnover workers), those with significant medical needs, low-income people, older adults, and early retirees. The following numbers put the size of these populations in context:

- As of January 2010, 14.8 million people were unemployed;[23]
- In 2008, 13.1 million nonelderly people were self-employed;[24]
- In 2008, 47.8 million people were employed in firms of fewer than 100 workers;[25]
- In 2008, 26.9 million nonelderly people worked part-time and 20.8 million people worked full-time but for only part of the year;[26]
- In 2008, 96.2 million nonelderly people lived in families with incomes below 200 percent of the federal poverty level. Another 74.3 million lived in families with incomes between 200 and 400 percent of the poverty level;[27]
- The highest-spending 5 percent of the U.S. population account for about 50 percent of total health expenditures,[28] limiting access to affordable, meaningful coverage for them as well as many others with less expensive conditions.

The combination of Medicaid expansions for the very low income, subsidies for the purchase of exchange-based coverage for those up to 400 percent of the FPL, broader-based sharing of risk, and administrative economies of scale reaped from exchanges would make coverage affordable for the vast majority of individuals without access to employer-based coverage, irrespective of age, health status, or employment status.

Some of the people in those groups overlap, not all are uninsured, and not all those with incomes that would make them eligible for financial assistance would avail themselves of the federal subsidies and expanded public programs at the same time. But all would have the reforms as at least a backstop; for example, if they lost employer-based coverage, the reforms would limit their financial burdens and ensure them access to meaningful coverage that many would not have had otherwise.

To walk away from the proposals developed, including the individual mandate, insurance exchanges, regulatory reforms of insurance markets, expanded public insurance eligibility, and premium and cost-sharing subsidies for those with modest incomes, does even greater harm than leaving these populations in the difficult circumstances in which they find themselves today. That is because without legislative change, the cost of medical care will continue to grow faster than incomes, just as it has in recent memory. As a consequence, not only would the numbers of uninsured and the underinsured grow as premiums for meaningful coverage become increasingly expensive, but the cost of obtaining care with direct out-of-pocket payments would become even more of a financial burden. Finally, the increasing numbers of individuals seeking charity care and public coverage would put yet more financial pressures on state, local, and federal government, as well as on the health care system as a whole.

Notes

1 John Holahan, Bowen Garrett, Irene Headen, Aaron Lucas, *Health Reform: The Cost of Failure* (Washington, DC: The Urban Institute, 2009), http://www.urban.org/url.cfm?ID=411887.

2 Affordable Health Care for America Act (H.R. 3962) introduced October 20, 2009. http://docs.house.gov/rules/health/111_ahcaa.pdf.

3 The Patient Protection and Affordable Care Act, introduced as a "substitute" amendment of H.R. 3590 on November 18, 2009. http://democrats.senate.gov/reform/patient-protection-affordable-care-act-as-passed.pdf.

4 The Henry J. Kaiser Family Foundation. 2009. *The Uninsured, A Primer: Key Facts about Americans without Health Insurance, Supplemental Data Tables,* http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

5 Based upon trends in population composition, income, medical costs, and employment, Urban Institute analysts estimated that the share of all nonelderly persons in the United States with employer-based insurance would fall from 56.1 percent in 2009 to 53.9 percent under the best case scenario assumptions, 51.4 percent under the medium case, or 49.2 percent under the worst case by 2019. Their worst case scenario would constitute a relative drop in employer-based coverage of 12.3 percent. John Holahan, Bowen Garrett, Irene Headen, Aaron Lucas, 2009. op cit. http://www.urban.org/UploadedPDF/411887_cost_of_failure.pdf.

6 For a more thorough delineation of the issues facing small employer in the health insurance context and the potential impacts of reform, see Linda J. Blumberg and Stacey McMorrow. 2009. *What Would Health Care Reform Mean for Small Employers and Their Workers?* Urban Institute Policy Brief, Timely Analysis of Immediate Health Policy Issues, http://www.urban.org/url.cfm?ID=411997.

7 For a full discussion of health insurance exchanges and their roles in health care reform, see Linda J. Blumberg and Karen Pollitz. 2009. *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals,* Urban Institute Policy Brief, Timely Analysis of Immediate Health Policy Issues, http://www.urban.org/url.cfm?ID=411875.

8 An additional rating factor under H.R. 3590 would allow smokers to be charged premiums up to 50 percent higher than that for nonsmokers of the same age. In addition, the Senate proposal allows employers to vary insurance premiums by up to 30 percent for employee participation in various "wellness" programs.

9 See Bowen Garrett, Lisa Clemans-Cope, and Matthew Buettgens. 2010. *Premium and Cost-Sharing Subsidies under Health Reform: Implications for Coverage, Costs, and Affordability,* Urban Institute Policy Brief, Timely Analysis of Immediate Health Policy Issues, http://www.urban.org/url.cfm?ID=411992.

10 Urban Institute tabulations of the 2007 Medical Expenditure Panel Survey Household Component (MEPS-HC).

11 U.S. Department of Labor, Bureau of Labor Statistics. 2010. Employment Situation Summary, Economic News Release, February 5, http://www.bls.gov/news.release/empsit.nr0.htm.

12 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

13 Simulations based on the Urban Institute Health Policy Center Medicaid/CHIP Eligibility Model using data from the 2008 Annual Social and Economic Supplement to the Current Population Survey.

14 One notable exception to many of the issues raised here is the nongroup market in the state of Massachusetts. Comprehensive health reform has already been implemented there, and the problems discussed here have been addressed either completely or to a great extent.

15 The Henry J. Kaiser Family Foundation. 2008. *State Health Facts, Your Source for State Health Data,* "State High Risk Pool Programs and Enrollment, December 2008," data collection and analysis by Eliza Bangit and Karen Pollitz, Health Policy Institute, Georgetown University, http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7.

16 Calculated based on separate estimates for uninsured parents and uninsured childless adults. See Lisa Dubay, Allison Cook, and Bowen Garrett. 2009. *How Will Uninsured Childless Adults Be Affected by Health Reform?* Kaiser Commission on Medicaid and the Uninsured Issue Paper, http://www.kff.org/healthreform/upload/7972.pdf; and Lisa Dubay, Allison Cook, and Bowen Garrett. 2009. *How Will Uninsured Parents Be Affected by Health Reform?* Kaiser Commission on Medicaid and the Uninsured Issue Paper, http://www.kff.org/healthreform/upload/7973.pdf.

17 The extent to which insurance market reforms apply to carriers selling coverage to large employers varies across the bills.

18 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

19 Samuel H. Zuvekas and Joel W. Cohen. 2005. "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs,* vol. 26, no. 1, pp. 249–257.

20 Previous analyses have shown, however, that it is not only the very highest spenders that are excluded from coverage or made substandard offers of coverage. See Karen Pollitz, Richard Sorian and Kathy Thomas. 2001. *How Accessible Is Individual Health Insurance for People in Less-than-Perfect Health?* Report for The Henry J. Kaiser Family Foundation.

21 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

22 Linda J. Blumberg, Matthew Buettgens, and Bowen Garrett. 2009. *Age Rating under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens,* Urban Institute Policy Brief, Timely Analysis of Immediate Health Policy Issues, http://www.urban.org/uploadedpdf/411970_age_rating.pdf.

23 U.S. Department of Labor, Bureau of Labor Statistics. 2010. op cit. http://www.bls.gov/news.release/empsit.nr0.htm.

24 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

25 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www. kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

26 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

27 The Henry J. Kaiser Family Foundation. 2009. op cit. http://www.kff.org/uninsured/upload/7451-05_Data_Tables.pdf.

28 Samuel H. Zuvekas and Joel W. Cohen. 2005. *Health Affairs,* op cit.

About the Author and Acknowledgements

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