KANSAS HEALTH INSTITUTE

THE IMPACT OF UNDERINSURANCE ON KANSANS
CONVENING SUMMARY

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EXECUTIVE SUMMARY

The Kansas Health Institute (KHI) hosted a convening to discuss *The Impact of Underinsurance on Kansans* on January 23, 2009.

The convening was the first phase of KHI's examination of underinsurance in Kansas. While much attention has been devoted to addressing issues affecting uninsured Kansans, far less has been focused on those who are underinsured. KHI sponsored a convening to encourage dialogue, enhance understanding of underinsurance and its impact on Kansans, create consensus among participants about defining and measuring underinsurance, and identify salient policy implications.

Forty-four people participated, representing the general public, media, the Legislature, the legal profession, the insurance industry, hospitals, health policy research, health foundations, the health care industry, and the advocacy community.

Keynote Speaker

Lynn Blewett, Ph.D., associate professor at The University of Minnesota School of Public Health, served as the keynote speaker. In her presentation, Blewett discussed the problems associated with defining and measuring underinsurance, Kansas data, and policy implications. She presented findings of her research examining out-of-pocket spending on health care expenses for the nation, Kansas and other Midwestern states. She also talked about how policy decisions, such as implementing limited benefits plans, can exacerbate rather than resolve the problems posed by underinsurance.

Expert Panel

Jim McLean, Vice President for Public Affairs, KHI, facilitated a panel discussion among experts. Panel members included Blewett; John Hooge, J.D.; Paul Uhlig, M.D.; and Linda Sheppard, J.D.

All of the expert panel members agreed that underinsurance is a significant problem in Kansas. Hooge, a Lawrence attorney specializing in bankruptcy, said he had numerous clients with between $150,000 and $200,000 in medical debt. Uhlig, a Wichita physician who founded Project Access in Kansas, spoke to the need for systemic change in health care. Both Hooge and Uhlig shared their personal experiences of being underinsured. Sheppard, director of the Accident and Health Division of the Kansas Insurance Department, discussed the role the insurance department played in helping consumers understand their insurance and rights to appeal. Blewett confirmed that the experiences expressed by the panel were consistent with her research.

Consumer Panel

The consumer panel was composed of Andrea Nelson, 31, who lived with her three sons in Goodland; Teresa Brandenburg, 24, who lived with her husband and son in Russell; and Roger Griffin, 62, who lived with his wife in Lyons. Each panelist talked about their personal experiences of being underinsured.

Defining and Measuring Underinsurance in Kansas

There has, heretofore, not been general agreement about an approach to defining and measuring underinsurance. This lack of agreement is exemplified by policy discussions being derailed by debate about the definition and measurement of underinsurance. Therefore, groups of participants completed an exercise intended to find general areas of agreement from which an understanding of what it means to be underinsured can emerge. Using framework for assessing the adequacy of health insurance coverage Blewett presented, i.e., the economic, structural, and attitudinal dimensions of health insurance, groups participating in this exercise found areas of commonality in agreement, disagreement, and being undecided.

The groups agreed with this overall definition of underinsurance:

> Being underinsured means someone has inadequate health insurance coverage to address the financial expenses associated with health care services, resulting in financial strain, medical debt, or postponing needed care due to cost.

The majority of participants agreed with an economic definition and measurement of underinsurance though there was disagreement about which economic measures best captured what it means to be underinsured. For example, while everyone agreed that the amount of co-pays, deductible and co-insurance can determine if someone is underinsured, fewer than half agreed that the delay of recommended health care due to cost was an acceptable measure of being underinsured. The majority of participants also agreed that other characteristics of a person's health insurance, such as whether needed health care services were covered, were also important elements in determining whether a person is underinsured. All participants disagreed with using an attitudinal approach, based on an individual's perceptions of coverage adequacy, to determine whether an individual is underinsured.

Policy Surrounding Underinsurance

Two themes emerged from a policy discussion: *Medical Debt* and *Medical and Insurance Provider Practices.* Participants offered policy suggestions salient to these areas.

CONVENING SUMMARY

The Kansas Health Institute (KHI) hosted a convening to discuss *The Impact of Underinsurance on Kansans* in Topeka, Kansas on January 23, 2009, from 9:00 am to 4:00 pm. Forty-four people attended the event, which took place at the Marvin Auditorium in the Topeka and Shawnee County Public Library.

Background

While much attention has been devoted to addressing issues affecting uninsured Kansans, far less has been focused on those who are underinsured. Although the purpose of health insurance is to provide affordable access to health and medical services, the costs associated with these services have increased while the types and scope of covered services have decreased. It is therefore not surprising that recent studies show that underinsured persons frequently postpone or forgo recommended health care or cut back on needed prescription medications because of costs. In addition, many incur substantial medical debt, which in extreme cases, can force people into bankruptcy.

Structure for Convening

The convening was the first phase of KHI's examination of the challenges faced by underinsured Kansans. Purposes of the convening included:

- Encouraging dialogue;
- Enhancing knowledge of underinsurance and its impact on Kansans;
- Creating consensus among participants about defining and measuring underinsurance; and
- Identifying policy implications.

The 44 participants represented the general public, the media, the Legislature, the legal profession, the insurance industry, hospitals, health policy research, health foundations, the health care industry, and the advocacy community.

Keynote Speaker

Gina Maree, vice president for Health Policy, KHI, opened the convening by welcoming participants and introducing the keynote speaker, Lynn Blewett, Ph.D., associate professor at the University of Minnesota School of Public Health. Blewett directs the State Health Access Data Assistance Center (SHADAC) where she produces targeted health policy research with a focus on state issues, and provides technical assistance in facilitating the use of data in creating state health policies.

In her presentation, Blewett discussed the problems associated with defining and measuring underinsurance, Kansas data, and policy implications.

One challenge facing any discussion of underinsurance, according to Blewett, is that some people think that the purpose of health insurance is to provide comprehensive health care coverage while others think its purpose is only to provide catastrophic coverage. She provided a framework for defining and measuring underinsurance with three dimensions: economic, structural, and attitudinal.

Blewett described findings of her research examining out-of-pocket spending on health care expenses for the nation, Kansas and other Midwestern states. She presented findings of her recent research examining the percentage of privately-insured Kansas families whose out-of-pocket expenses for health care exceeded 10 percent of their family income. Among families with children under age 19, the percentage of families whose out-of-pocket spending for their children's health care exceeded 10 percent increased from 3.3 percent in 2001 to 4.0 percent in 2004. This is a greater increase than either Colorado or Missouri, and runs counter to Oklahoma, Nebraska and the nation as a whole, for which the percentage decreased. In contrast, among adults in the privately-insured families, the 2.3 percentage point increase from 2001 to 2004 was lower than the increases in all neighboring states except Nebraska. It was also less than the national increase.

Blewett discussed the relationship between different health insurance plans and underinsurance. She talked about employer-sponsored health insurance compared to insurance coverage bought in the individual market, highlighting the national decline in the former from 64.2 percent in 2000 to 59.7 percent in 2006. Because employer-sponsored insurance generally is less expensive and has better benefits than plans purchased in the individual market, this decline may be one of the causes of the increase in the percentage of people who are underinsured.

Blewett concluded her presentation with a discussion of the debate about whether the reduced costs associated with limited health benefit options really help to expand health care among the uninsured, and how policies intended to help persons gain access to health care may actually lead to more people becoming underinsured. Finally, she talked about the necessity of thoughtful and careful examination of what constitutes adequate health insurance so policymakers can focus their efforts on addressing this growing problem. She said:

> "Without careful examination and understanding of what constitutes adequate [health insurance coverage], policymakers and employees may simply substitute one problem for another by increasing access to affordable insurance even as they increase the number of people for whom health insurance fails to provide adequate benefits."

Expert Panel

Jim McLean, Vice President for Public Affairs, KHI, facilitated a panel discussion among experts. Panel members included Blewett; John Hooge, J.D., a Lawrence attorney specializing in bankruptcy; Paul

Uhlig, M.D., a Wichita physician who founded Project Access in Kansas; and Linda Sheppard, J.D., director of the Accident and Health Division of the Kansas Insurance Department.

Hooge said that medical debt too often is the reason clients seek his services, indicating, “It is a horrendous problem.” When asked about the percentage of bankruptcies among his clients due to medical debt, he responded, “I would think about 30 percent.” He added that it was difficult to make an exact determination from looking at items on schedules of debt because many people put their medical debt on credit cards. Hooge also said he has numerous clients who have between $150,000 and $200,000 in medical debt. In discussing problems that consumers face, Hooge said, “I think insurance companies routinely deny claims thinking few people will appeal. A lot of people don’t know how to appeal and they certainly can’t afford an attorney.”

Uhlig supported Hooge’s assessment of the impact of underinsurance on Kansans, agreeing that “the evidence is overwhelming that (medical debt and underinsurance) is a problem.” Uhlig said that while he serves people regardless of their insurance status, other practitioners with large practices run by business managers cannot. Uhlig said business models and time spent billing and submitting claims are inefficient and barriers to care for Kansans. As an example, he described a colleague’s practice that requires five full-time employees for the practice’s billing and insurance transactions.

Uhlig shared his opinion about the need for change in medical practice to reduce the cost of providing care and to improve the quality of care provided. As an advocate of a team approach and collaboration among service providers, he said, “I’ve watched competition drive the heart and the compassion” from medical care. Uhlig believes the challenge is “taking the lid off the way care is provided” and cited models for doing so. He said that changes in medical care are often inexpensive; however, if implemented can save millions of dollars and thousands of lives. He described outcomes of the Keystone Initiative implemented in intensive care units in Michigan. Medical professionals working together and taking two minutes to complete a checklist prior to surgeries over an 18-month period dramatically reduced the rate of infections. Roughly 1,600 patient lives, 81,000 hospital days, and 170 million dollars were saved.

Hooge and Uhlig’s remarks shared commonalities. Both told personal stories of being underinsured. Hooge’s wife has chronic health problems and incurs sizeable out-of-pocket expenses. Uhlig’s son has cerebral palsy and unmet equipment needs. The two men agreed about the need for systemic change. “We need a drastic change in medical coverage nationwide,” Hooge said. Uhlig added, “I don’t see any trajectory, except toward a single-payer system.” Uhlig acknowledged the reality of financial constraints. He said everyone faces challenges and everyone’s pockets are empty (i.e., employers, individuals, hospitals, and legislators).

Sheppard discussed the role the insurance department played in helping consumers understand their health insurance and rights to appeal decisions. She also said that understanding insurance coverage

is often difficult for people and confirmed that her office has talked with many individuals experiencing financial and coverage problems.

Sheppard discussed differences between large- and small-group insurance markets. She explained advantages in the large-group insurance market compared to the small-group market. For example, because large employers have the ability to spread risk among a larger pool of people, insurance companies are more willing to negotiate with them. In addition, larger employers generally can pay a greater portion of employees' premiums. In contrast, small groups do not have this power and have to make difficult decisions about what they can and cannot afford. Based on those decisions, small groups often purchase plans with inferior benefits and high out-of-pocket expenses.

Blewett confirmed that the experiences of the panelists were consistent with her research. She spoke to challenges that people with low incomes face when trying to secure adequate health care coverage, explaining that they often cannot afford individual market policies and do not qualify for public insurance programs. She also responded to audience questions about ways to measure underinsurance and the challenges of finding equitable policy solutions.

Luncheon

To facilitate diverse exchanges of knowledge and ideas, participants were assigned seats around 10 tables for the remainder of the day. During lunch, some participants completed an exercise intended to promote understanding about the challenges faced by people who are underinsured. Others engaged in discussion regarding the information presented in the morning.

Consumer Panel

A consumer panel followed lunch. The panelist were Andrea Nelson, 31, who lived with her three sons in Goodland; Teresa Brandenburg, 24, who lived with her husband and son in Russell; and Roger Griffin, 62, who lived with his wife in Lyons.

Each panelist, who had cumulative debt due to out-of-pocket medical expenses, talked about their personal experiences of being underinsured and the challenges and frustrations of maneuvering the complex system of health care.

Some of the concerns expressed by panelists were:

- Lack of information about the cost of medical services;
- Inability to negotiate fees and discounts with providers (especially hospitals) like insurance companies;
- Inability to make reasonable payment plans with hospitals;
- Bad credit ratings from medical debt turned over to collection agencies;
- Difficulty tracking bills from multiple providers and insurance paperwork; and

- Distress from interactions with collectors

"People are not speaking up because they think no one cares."

Andrea Nelson accumulated more than $11,000 in medical debt from high deductibles and uncovered services, primarily for hospital expenses incurred over the first three years of her twins' lives. She did not know the cost of these services but knew they were needed for her boys' survival. She reported that the hospital would not discount their charges or negotiate an affordable payment plan. Instead, they insisted on monthly payments between $700 and $1,000. She mortgaged her home to pay this debt. Nelson said she thought she had paid all her medical debt, only to find the hospital had not included the full amount owed as requested. Nelson, a former Chamber of Commerce director, now works for an engineering firm. She said that her struggle to pay living expenses, medical debt, and recurring medical costs worsened after the garnishment of funds from her bank accounts and a sizeable portion of her salary. She said that her credit standing is ruined. She worries about how to pay for needed neurological care for one of her sons living with cerebral palsy. Nelson forgoes her own health care needs to meet those of her boys. She was treated for cervical cancer more than eight years ago and has not sought recommended follow-up care. Although Nelson's former husband is legally responsible for their children's medical expenses, she says creditors will not pursue him because he lives in another state. Although telling her story was difficult at times, Nelson said that "people are not speaking up because they think no one cares. I am speaking up because I'm upset with the way the hospital treated me." Nelson identified the love she and her boys share as the most important part of life but she struggles with feeling like a bad parent because she can't give her children all they need.

"Sometimes they [collectors] bring me to tears because they treat you like you don't want to pay your debts. It's embarrassing to be a hard-working family and have to go through this."

Teresa Brandenburg purchased an individual health plan after she graduated from college. She and her husband wanted to start a family. Throughout her pregnancy, she understood that she was covered by her health insurance policy. However, after her son was born, the insurance company advised that they would not pay for her obstetric expenses. The insurance company informed her that she had put an incorrect weight on her application that did not match the weight from her medical record taken two months after the policy was issued. Brandenburg said that she honestly thought she put the accurate weight on the application. The insurance company added an obesity rider to the policy. She said she was healthy, ate well, and exercises. She added that she comes from a family of large farm women. The audience erupted in laughter when Brandenburg said, "you don't put a 110-pound woman behind cows." She was shocked by the staggering amount of expense incurred as well as her inability to negotiate a discount like insurance companies do and develop a

payment plan with the hospital. Both Brandenburg and her husband hold jobs in addition to farming. However, they continue to have difficulty paying medical debt resulting from her pregnancy and other medical expenses such as her husband's farm accidents, along with living expenses. She described the confusion and frustration of dealing with bills from multiple providers. She said she was surprised to get bills from five different providers related to one procedure. She said that the stress of medical debt has affected her family, marriage, and the joy of having a newborn. Although Brandenburg and her husband still struggle and their credit is ruined, she talked about their family's strengths.

"You've got insurance and you feel good about it until you have to use it. Then you are underinsured the first time you use it."

Roger Griffin contracted West Nile virus eight years ago from a mosquito bite. "You've got insurance and you feel good about it until you have to use it," Griffin said. "Then you are underinsured the first time you use it." He said he tried very hard to pay accumulated medical debt and out-of-pocket costs for continuing care. He recently saw a new specialist who ordered additional diagnostic tests. Griffin said he was not informed about the cost of the services. He believes the initial physician's office visit will cost hundreds, based on past experiences, and is concerned about the expense of the tests. He, too, identified the challenges of tracking bills and insurance claim statements. Griffin has been the patient of a local physician for many years. At one time, his physician's office would not book an appointment because of an errant, unpaid bill. After he paid the bill and attempted to make an appointment, they refused again because he had been delinquent in paying the bill. When he wrote the physician, the problem was resolved but the events were very embarrassing. Griffin farmed for 40 years but had to give it up because of pain, fatigue, arthritis, and complications from the disease. Griffin can only work part-time and worries about how he will pay his medical bills, let alone save for retirement, "if there is such a thing." He says it's tough but he is OK.

When panelists were asked what would have helped them, they did not identify things one might imagine such as assistance paying financial obligations. They identified improvements in how they were treated. Brandenburg said it would have been helpful if persons seeking payment would have talked to her "like I am a human being."

These stories put a human face on a very real problem. "These stories are humbling because it could be any of us," said Maree, of KHI. "We could all be a mosquito bite, accident, or severe illness away from being in similar situations."

Defining and Measuring Underinsurance in Kansas

There has, heretofore, not been general agreement about an approach to defining and measuring underinsurance. This lack of agreement is exemplified by policy discussions that are derailed by debate about the definition and measurement of underinsurance. Therefore, following the consumer panel, groups of participants completed an exercise intended to find general areas of agreement from which an understanding of what it means to be underinsured could emerge.

Group members engaged their critical thinking and collaborative decision-making skills to reach group consensus about defining and measuring underinsurance. Each group reviewed 15 statements about what constitutes underinsurance. One example: "The amount of co-pays, deductible and co-insurance can determine if someone is underinsured." The groups weighed the pros and cons of 15 statements about underinsurance. Group members determined if they agreed, disagreed, or were undecided about each statement. The goal was to have as few undecided outcomes as possible.

Areas of commonality in agreement, disagreement, and being undecided are noted in Table 1 in Appendix A. Each number in the table represents one of five groups. Each group had between four and six members. The groups used the framework for assessing the adequacy of health insurance coverage presented by Blewett, i.e., the economic, structural, and attitudinal dimensions of health insurance. The following summarizes the findings of the groups:

General Definition

The groups agreed with this overall definition of underinsurance:

> Being underinsured means someone has inadequate health insurance coverage to address the financial expenses associated with health care services, resulting in financial strain, medical debt, or postponing needed care due to cost.

Economic – Using Financial Measures to Define Underinsurance

Typically, economic criteria are used to define and measure underinsurance. Therefore, eight of the statements for this exercise focused on an economic characteristic of health insurance coverage. There was agreement that an individual or family's income compared to their medical expenses provided a criterion of being underinsured. More specifically, 80 percent of the groups agreed with the statement that someone whose out-of-pocket medical expenses equal to 10 percent or more of their household income is underinsured. All of the groups agreed that the amount of co-pays, deductible and co-insurance can determine if someone is underinsured. The groups also agreed that families with very low incomes having out-of-pocket health care expenses equal to or greater than 5 percent of their income are underinsured. In contrast, only 20 percent agreed with the statement

that a person’s health plan deductibles exceeding 5 percent of the household income meant the person is underinsured.

Although the groups agreed that satisfying the economic criteria was a necessary condition for being underinsured, they believed that meeting these criteria alone was insufficient. In addition to satisfying the economic criteria, the groups believed that at least some structural criteria were also necessary to justify the claim that a person was underinsured. One group illustrated this thinking by making hand-written notations on two financial statements, indicating agreement with the exercise statements only if structural criteria were also satisfied.

The groups’ views on defining and measuring underinsurance differed slightly from common approaches in the literature. Although insurance premiums are generally not included in calculating out-of-pocket expenses, 60 percent of the groups thought insurance premiums should be included. While not accessing care because of cost concerns is a common indicator elsewhere, 60 percent of the groups disagreed it should be included. This outcome may be attributable to the statement wording. If the word “needed” rather than “recommended” had been used, the response might have differed.

Exercise participants struggled most with the issue of financial risk. The statement, “being at risk for spending a defined percent of their annual income on health care should be an indicator that someone is underinsured,” triggered a great deal of discussion. Twenty percent of the groups agreed with the statement, 40 percent disagreed, and 40 percent were undecided. This topic was discussed as a large group at the end of the exercise. Opinions differed about whether being at-risk alone was a sufficient determinant of being underinsured. The participants discussed the challenges of preventing underinsurance if an underinsured state can be determined only after it has occurred. In discussion, people framed risk analogous to homeowner’s insurance. If you have a $200,000 home insured for $50,000, people agreed, you are underinsured. If the statement had been analyzed after this discussion, the outcome might have differed.

Structural – Using Health Insurance Benefit Packages to Define Underinsurance

Five statements focused on health insurance benefits as a measure of underinsurance. The majority of exercise participants agreed with using one or more structural criteria to assess the adequacy of health insurance coverage. Eighty percent agreed that inadequate benefits and uncovered medically-necessary procedures were indicators of underinsurance. Although the groups were divided about whether an extremely wealthy individual with inadequate benefits who is easily able to pay for health care is underinsured, 60 percent of the groups believed the individual is not underinsured. Sixty percent agreed that assessing the adequacy of health insurance coverage requires identification of a “benchmark plan” against which to make such assessments. The groups discussed the challenges of coming to agreement about the nature of the benchmark plan. All groups disagreed with the statement that an insured person who cannot access health care for any reason is underinsured.

Attitudinal – Using Individual Perceptions of Coverage Adequacy to Define Underinsurance

All groups disagreed with the one statement focused on attitude. This statement was, simply, "if someone perceives their benefits to be inadequate, they are underinsured." Group discussion focused on the realization that anyone not receiving desired benefits would be underinsured, if this was part of the definition.

Policy Surrounding Underinsurance

Policy Discussion

The last session of the convening addressed policy implications. Discussion focused on policies or practices that might have prevented the situations described by members of the consumer panel or helped others in similar circumstances. Participants agreed that the problem of underinsurance can best be addressed through a collaborative effort of consumers, medical providers, insurance companies and policymakers. Strategically bringing these groups together to find solutions that might benefit everyone is necessary to truly address this growing problem.

Two themes emerged from the discussion: *Medical Debt* and *Medical and Insurance Provider Practices*.

Suggested Policy Options to Address Medical Debt

Medical debt court. Like other specialized courts (e. g., mental health court, drug court), a medical debt court could provide a venue for legal processes sensitive to the circumstances surrounding medical debt and could offer legal options to prevent bankruptcy or home foreclosure due to medical debt. This court could work closely with the provider community to identify alternative ways to resolve medical debt.

Regulations Addressing Collections. Policies could limit the practice of providers turning over for collection unpaid bills of consumers with medical debt if they develop and follow a payment plan. Providers could be required to negotiate with consumers to develop reasonable payment plans. If a consumer's account then had to be turned over for collections for medical debt, devised policies could prevent the individual's credit rating from being affected. Collection agency practices surrounding medical debt collections could also be better regulated to ensure that collectors interact with consumers courteously and eliminate harassing practices. In addition, there was some concern about the practice of providers encouraging consumers to put medical debt on credit cards. This would need to be addressed when considering regulations that focus on medical debt and collections.

Suggested Policy Options for Medical and Insurance Provider Practices

Community Benefit. Policies intended to regulate providers who receive tax breaks for not-for-profit status could be strengthened. For example, providers could be required to inform consumers about the cost of services and options for free care and to negotiate rates and reasonable payment plans. The State could make certain that not-for-profit organizations comply with such policies.

Medical Provider Practices. All medical providers could be required to inform consumers about the cost of services and options for free care and to negotiate rates and reasonable payment plans.

Insurance Provider Practices. Insurance companies could be required to provide clear written and verbal explanations about everything a health insurance policy does not cover. Although some mandates are in place, they could be enhanced to require clearer, more detailed information than the general coverage categories.

Next Steps

The Kansas Health Institute will begin a year-long research effort using both qualitative and quantitative methods to determine, to the extent possible, the nature and prevalence of underinsurance in Kansas. We will conduct 50 semi-structured interviews of underinsured individuals representing Kansans across the state. We will also conduct 10 in-depth interviews to obtain a deeper understanding of how underinsurance affects individual and family well-being. We will keep people informed of our efforts through quarterly issue alerts and launching of a Web page focused on the underinsured. At the conclusion of our research, KHI will reconvene this group and others to report our findings and further discuss policy implications.

Participants are encouraged to utilize the convening information to enhance public discussion of the problem of underinsurance.

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- The REACH Healthcare Foundation — A non-profit charitable organization dedicated to improving access to quality health care for poor and medically underserved people.
- The Sunflower Foundation: Health Care for Kansans — A Topeka-based philanthropic organization with the mission to serve as a catalyst for improving the health of Kansans.
- The United Methodist Health Ministry Fund — A foundation based in Hutchinson with the following mission: “Healthy Kansans through cooperative and strategic philanthropy guided by Christian principles.”
- The Wyandotte Health Foundation — A private charitable organization located in Kansas City, Kansas, that has this mission: “To promote and improve the health of Wyandotte County citizens, particularly the indigent, through grants and collaborative efforts.”

Appendix A

Table 1. Underinsurance Definition n/%

Statement	Agree	Disagree	Undecided
General Dimension			
Being underinsured means someone has inadequate health insurance coverage to address the financial expenses associated with health care services, resulting in financial strain, medical debt, or postponing needed care due to cost.	5 (100%)	0	0
Economic Dimension			
The amount of co-pays, deductible and co-insurance can determine if someone is underinsured.	5 (100%)	0	0
If a family with a very low income has out-of-pocket medical expenses equal to or more than 5 percent of their income, they are underinsured.	5 (100%)	0	0
An individual/family's income compared to their medical expenses should be considered when determining if they are underinsured.	4 (80%)	1 (20%)	0
If someone has out-of-pocket medical expenses equal to 10 percent or more of their household income, they are underinsured.	4 (80%)	1 (20%)	0
If someone has health plan deductibles more than 5 percent of their household income, they are underinsured.	1 (20%)	4 (80%)	0
Insurance premiums should be included when determining if someone is underinsured.	3 (60%)	2 (40%)	0
If someone delays or does not get recommended health care due to cost concerns, they are underinsured.	2 (40%)	3 (60%)	0
Being at risk for spending a defined percent of their annual income on health care should be an indicator that someone is underinsured.	1 (20%)	2 (40%)	2 (40%)
Structural Dimension			
If someone has health insurance but the benefits are not adequate to cover needed services, they are underinsured.	4 (80%)	1 (20%)	0
If a medically necessary procedure is not covered by someone's policy, they are underinsured.	4 (80%)	1 (20%)	0
If someone is extremely wealthy, can easily pay for health care, and has a health insurance plan that does not cover medically necessary care, that person is underinsured.	1 (20%)	3 (60%)	1 (20%)
A benchmark health insurance plan should be used to compare benefits to determine if someone is underinsured.	3 (60%)	1 (20%)	1 (20%)
If someone has health insurance but cannot gain access to health care for any reason, they are underinsured.	0	5 (100%)	1
Attitudinal Dimension			
If someone perceives their benefits to be inadequate, they are underinsured.	0	5 (100%)	0