

# Family Coverage

Could family coverage trigger government-sponsored health care? Comprehensive universal access to health insurance may not be on the minds of American families, but it captivates the likes of Michael Moore who prefer Cuban-style health care to American. The fascination extends beyond Hollywood. It is also high on the “To Do” list of the Democratic congressional leadership. A pattern seems to be emerging regarding proposed health care legislation: Create a new health care entitlement for low-income and middle-class children and their parents with annual family incomes up to \$82,600. Ironically tens of thousands of these families who take up the new entitlement would then have to pay the Alternative Minimum Income Tax, a 1989 federal law targeting tax loopholes for the wealthy.<sup>1</sup> At the same time, the Democratic Party is proposing to lower the age for Medicare, the health care entitlement for seniors, with the hope of eventually creating a federal “Medicare for all” program. Moreover, they are actively involved in dismantling effective strategies that model private sector and competitive initiatives within the entitlement programs. The current social and political climate seems inauspiciously reminiscent of the early 90’s – the last time there was a national discussion over solutions to a health care delivery. But there is one big difference this time: the bargaining chip is the family, starting with insurance for children in middle-class families!

Illustration 1: Top Health Care Issues	
Health care costs	43
Uninsured/access to care	34
Medicare/prescription	15
Lack of high-quality health care	11
Government role in health care	8

Source: Harvard School of Public Health/Robert Wood Johnson Foundation, “Americans’ views of the health care system.” poll April 2006

The national priority should focus on affordable health insurance for insured and uninsured families; not on creating government-controlled programs to ensure all Americans receive a *one-size-fits-all* insurance policy. Public opinion during the past several years has not placed health care at the top of the list of concerns. But among individuals who rank it as a top concern (Illustration 1) rising health care costs head their list.<sup>2</sup>

This general attitude, moreover, runs concurrent with soaring health care spending with annual double-digit growth. The heated inflationary trend has cooled in the last few years, yet overall health care spending remains unsustainably high. Although the macro-economics is abstract to many families, the effect on them is real. This is a glimpse at the big picture. Health spending is now \$2.2 trillion that translates to more than 16% percent of the GDP. If these dollars were proportioned across the population, it would be \$7,110 for each individual in the U.S.<sup>3</sup> According to the Congressional Budget Office, the federal government now spends one-fifth of all federal tax revenues on Medicare and Medicaid.<sup>4</sup> Thus, it should come as no small surprise that when American families express concern, it is about the high cost of health care as it affects their family budgets. What is surprising, however, is that the political leadership in Congress chooses to focus on a different priority, comprehensive universal health insurance (CUI).

Now more than ever family policy should assess what impact changes to the health care delivery system might have on essential functions of family formation, economic support, childrearing, and care-giving. This paper breaks down the complexities of health insurance from a family perspective,<sup>5</sup> attaching significance to the role of personal responsibility in the health care “system,” and presents key criteria that will help analyze the merits of congressional action on health insurance. This analysis bolsters the policy position that new laws should promote policies of personal ownership of health plans that make all families more self-sufficient, rather than perpetuate the drawbacks of third-party payment approaches — whether they are government-controlled public insurance or employer-sponsored health insurance.

## **I. Health insurance is a family matter**

A. *Third-party payments adversely affect family health insurance.* Self-sufficient families are responsible for making decisions about their well-being. This is a fundamental assumption for health care with wide ramifications. Economists also point out that health care is the only market structured to separate the person receiving the service from the individual or party providing the service, from the private agency or government paying for it. This “third-party” payer approach to insurance does not serve the family well. It functions to remove family members from decision making about their health care. In addition, it insulates families from understanding the true cost of medical goods and services. The National Center for Policy Analysis, for instance, estimates that families pay only 15 cents on the health dollar (i.e. 15 percent of health care spending); third-party payers account for 85 cents on the health care dollar (i.e. 85 percent of health care spending).<sup>6</sup> A significant consequence is overconsumption, resulting in rising cost for *all* families. This development occurs through preventing relevant information about costs and prices to influencing behavior in the market. Another subtle effect that goes unchecked is a slow, gradual, but persistent removal of personal responsibility from these important decisions. This moral hazard – as health economists call it – not only makes families indifferent to prices, but induces family dependence on the paying or sponsoring entity, whether it is the government or employer. As such, this distortion creates a host of inefficiencies and other problems in the health insurance market, discussed below.

B. *Health insurance can contribute to family self-sufficiency.* Second, health insurance contributes to good health. Family members are more likely to seek medical attention before conditions worsen and have an established relationship with a family doctor. Children of insured parents receive appropriate care.<sup>7</sup> Researchers have conducted hundreds of studies showing the correlation between health insurance and health. Health insurance grants access to health care, and when the quality of care is high, overall health status is better. The evidence supporting this causal chain, however, is based on 11 quasi-experimental studies. It seems reasonable to follow the lead of Helen Levy of the University of Michigan's Economic Research Initiative on the Uninsured and David Meltzer of the University of Chicago who conclude that there is a "small, positive effect" of insurance coverage on health outcomes, particularly among vulnerable populations.<sup>8</sup> But, politicians anxious to promote CUI need to recognize that the science does not support any particular approach to reform. Levy and Meltzer caution that there is *no evidence* at this time that would allow us to make comparative judgments about health insurance in contrast with other types of interventions that might prove more effective to improving health.<sup>9</sup> Cuba along with certain European countries and Canada have achieved universal coverage through government control, but despite Michael Moore's protests to the contrary in *Sicko*, his new documentary, these countries have not achieved universal access to *care*. By contrast, the American delivery system with its mix of private sponsorship and public assistance to the needy does not provide universal coverage, but existing federal emergency health care statutes provide universal access high quality care.

C. *Family budgets eroded—not maxed out — by rising health care costs.* Third, surely part of family self-sufficiency is to avoid financial insecurity that may result from a serious or catastrophic illness or buying high priced health care out-of-pocket. Without insurance a family is exposed significant medical debt. Critics of free market health care, such a presidential candidate John Edwards, are quick to point out that American families are "terrified" about losing the "American Dream" because of the high cost of health care. Barack Obama, another presidential front runner for 2008 in the Democratic Party, has publicized the plight of "Amy and Lane" who because of Lane's cancer treatments, have come to the brink of *medical bankruptcy*. To him their plight symbolizes an America whose citizens are helplessly confronting the strain of needlessly exorbitant health care cost. Indeed some policy analysts claim that American families are borrowing to stay healthy, paying out-of-pocket medical bills with credit cards thereby linking credit card debt to medical expenses<sup>10</sup> and another study asserts that medical debt is responsible for half of all family bankruptcies, mostly affecting the middle-class.<sup>11</sup> The solution in all cases is CUI.

But allegations about medical indebtedness have not held up to scrutiny. There methodology suffers from sample selection errors.<sup>12</sup> Similarly assertions about medical bankruptcy have been overstated. An analysis of data from the Survey of Consumer Finances shows The U.S. Trustees Program in the U.S. Department of Justice, which oversees bankruptcy nationwide, found that reported medical debt "did not seem to

be a major factor in the vast majority of cases.” In more than half the cases, the filers reported no medical debt. As to the magnitude of medical debt causing bankruptcy, the report also found that “The average medical debt listed per debtor was \$2,582, or about 5.6 percent of the total general unsecured debt.”<sup>13</sup>

Nevertheless, the family budget is pinched by the high price of health care, and there are cases where families are destroyed from catastrophic illnesses, but the general picture of a troubled health care system is not one where families – as a matter of widespread practice — are waist deep in medical debt.

## II. Sources of Family Insurance Coverage

Insured and uninsured status is dynamic; family members can change, maintain, or lose insurance through shifts in age, employment, income, or marital status. Distinguishing the uninsured and chronically uninsured is useful to understanding the fluidity of insurance status. Studies that examine a “spell” of being uninsured for more than 12 months would be 30 percent of the current estimate of 45 million. Most uninsured individuals lack insurance for four months or less.<sup>14</sup>

Members in family households, too, can be uninsured continuously for a full-year, or they can come into and out of insurance during the year. The insurance experiences of children are distinctively contingent on the insurance status of the parent(s) because of employer-sponsored dependent coverage. Using the most recent Current Population Survey conducted by the U.S. Census Bureau, FRC produced the following statistical picture for the insurance status of family members:

- Nearly 249 million (85 percent) of Americans are insured. The number of these individuals living in family households is 209 million (84 percent).
- The number of non-elderly Americans without insurance in 2005 is 44.8 million (15.3 percent). The number of uninsured individuals living in family households, as opposed to living alone or with an unrelated adult, is 35 million (78 percent).<sup>15</sup>

There are *patterns* of health insurance coverage within families. In 2000 there were approximately 67 million families comprising married couples with and without children at home (38 million of them were parent-child families), according to an Institute of Medicine report.<sup>16</sup> The vast majority of families have whole-family coverage, meaning that all the family members were insured (Illustration 2).

Marriage correlated positively with having the fewest families with some or none of its members insured. With respect to families with children, 26.3 million individuals in parent-child families (18 percent) were either uninsured or living with an uninsured family member.

**Illustration 2: Patterns of Coverage in Families and among Family-Related Members**

<b>Family Type</b>	<b>Number</b> <i>(in thousands)</i>	<b>Percent of</b> <b>Overall Total</b>	<b>Percent Within</b> <b>Family Type</b>
<b>Two-parent</b>	<b>26,442</b>	<b>31.2</b>	
• All insured	22,427		84.8
• Some insured	2,393		9.0
• None insured	1,622		6.1
<b>Married, w/o kids at home</b>	<b>23,681</b>	<b>27.9</b>	
• All insured	20,010		84.5
• Some insured	2,196		9.3
• None insured	1,475		6.2
<b>Single-parent</b>	<b>12,118</b>	<b>14.3</b>	
• All insured	8,637		71.3
• Some insured	1,929		15.9
• None insured	1,552		12.8
<b>Living w/family members</b>	<b>5,837</b>	<b>6.9</b>	
• All insured	4,647		79.6
• Some insured	—		—
• None insured	1,191		20.4

Source: Committee on the consequences of Uninsurance. *Health Insurance matters*, p.32  
 Institute of Medicine of the National Academy of Sciences (2002)  
 Based on March supplement to the 2001 Current Population Survey

An additional 5.8 million individuals living with an adult family caretaker would be at risk of being uninsured. Examples would include a grandparent caring for a grandchild or an adult child supporting a minor sibling. Nearly 80 percent of these relatives have coverage. There apparently is no data on the source of insurance, but if it is a private source we can conclude that they qualify for dependent care under the IRS rules. This leaves about 1.2 million or 20 percent uninsured. Further research might help better understand the underlying reason.

Likewise, there are different *sources* of health insurance, involving the government or private sector. Moreover, there can even be variations of coverage for family members between and within these sources. A child could be enrolled in a state’s children health insurance program, another on Medicaid, while the parent is covered through his or her job. This complexity prompts some health care analysts to characterize the insurance structure in the U.S. as a “patchwork,” conjuring up the notion that families fall through the *warp and woof* of the American system. After describing the sources of insurance, we will review the weaknesses associated with private insurance.

**A. Government insurance programs.** Government programs cover individuals rather than whole families. The government acts as a third-party payer. Thus, these programs have the same problem as mentioned above.

- **Medicare.** The US Congress established the Medicare program in 1965. It is the federal entitlement program for individuals 65 years and older, and certain persons with disabilities. At its inception the program had a Part A for in-patient hospitalization, skilled nursing care, home health, and hospice care paid by payroll taxes, and a Part B for physician services paid through premiums. When Congress modernized Medicare in 2004 it transformed Part C, also called Medicare Advantage, to provide elderly with wider choice of private sector health plans. That same year the Bush Administration urged a reluctant Congress in passing Part D, more commonly known as the prescription drug benefit. Part D has provided important evidence that pro-competition within government programs – unlike Part A and B, can be effective in controlling prices while expanding choice. Medicare is the health insurance for nearly 44 million persons. The Medicare Trustees assess the program cost at \$440 billion.<sup>17</sup>
- **Medicaid.** The US Congress also established the Medicaid program in 1965. The program is a means-tested, entitlement program for mothers and children with very limited financial means, as well as people with disabilities. Children and their parents account for 40 of the 55 million enrollees. It is the largest insurance program for children covering 1 in 4 children, or more than 28 million. Services include acute care and long-term care. It covers only *legal* immigrants who have resided in the country for *five* years. The federal government requires state to provide certain medical services. States can provide additional optional medical services. The funding is shared jointly between the federal and state governments. The federal government pays 50 to 76 cents of the state's Medicaid expenditures. The federal contribution is about \$200 billion.<sup>18</sup>
- **Children's Health Insurance (CHIP).** The US Congress established the CHIP program through the Balanced Budget Act of 1997. The purpose of this program was to expand health insurance to uninsured children who lived in families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. Children in low-income families up to 200 percent of the federal poverty (\$34,340 for a family of three) are eligible.

Like the Medicaid program, CHIP is jointly financed by the federal and state governments – though the federal contribution to CHIP is actually higher than Medicaid (paying between 65 to 83 cents of every CHIP dollar). Unlike Medicaid, SCHIP is *not* an entitlement program. The federal law sets a limit on total funds that can be distributed to states, regardless how much states may spend. Furthermore, CHIP is a block grant, allowing states greater flexibility than under Medicaid to determine the rules for eligibility, design of benefits, and types of coverage. With respect to coverage, states can – and have – used SCHIP funds to cover adults (understood as parents and non-parents).

The federal share of the cost has been about \$40 billion over the past decade. (Congress authorized \$5 billion per year or \$25 billion over five years.) This law expires in 2007. CHIP enrolled approximately 6.7 million children during this period. In addition,

waivers to CHIP have allowed coverage for about 670,000 adults (about 72 percent parents and 28 percent childless adults).

**B. Private health insurance.** Private coverage is employer-sponsored group health insurance (ESHI) and non-group individual health insurance (individual). There are examples of private health insurance dating back more than 200 years, but group insurance really accelerated toward the end of World War II.

- **Employer-sponsored group health insurance (ESHI).** Most American families have their insurance through the workplace. FRC's analysis of data from the 2006 Current Population Survey (CPS) for 2005 shows that about 61 percent of family members (153 million) who have health insurance obtain coverage through ESHI – either from their own job or through that of a family member. The IRS code confers a special tax treatment for employer to sponsor health insurance as a fringe benefit to recruit and retain an experienced workforce. Section 105 of the IRS code specifically permits employers to contribute to health benefit of the employed individual, as well as the spouse and dependents. Traditional ESHI defines a family-based “insurance unit” consistent with the IRS tax consideration. A family-based insurance unit can differ from a more recent notion being advocated as a “family-defined responsibility unit.” A grandparent's care for a grandchild, for instance, may not be an insurance unit, unless the grandparent has legal guardianship and the grandchild is a *dependent* under the definition of the IRS code. A similar example may result in a case whether an adult child is caring for a minor sibling or an elderly parent (unless the elderly parent is covered by Medicare or Medicaid).

Employers and the health plans decide whether to offer insurance to family members, the type of plan, and who is eligible. Employers offer insurance to families as a pre-tax fringe benefit. They typically pay a portion of the premium with the employee responsible for the balance. Business workers make convenient insurance groups because they permit a wider distribution of risk. Larger numbers permit economies of scale, thus reducing the cost of the insurance. An insurer's principle concern in contracting with an employer is to organize groups so that most the insured members are healthy, thus avoiding what the industry calls adverse selection. Larger employers (with more than 50 employees) routinely provide health insurance. Small employers have a more difficult time offering insurance. Businesses with fewer than 10 employees are less likely to offer their employees health insurance as a fringe benefit.

- **Individual Non-group (Individual).** Families who are not attached to an employer group can seek insurance through a non-group plan (sometimes called an “individual plan”). In non-group or individual plans, families purchase *directly* their own insurance policy. Self-employed parents typically purchase these policies. Data from the current CPS suggests that as many as 20 million family members (8 percent of people with insurance) obtain coverage through a non-group policy. Insurers have different rules for selling insurance in non-group settings. These rules are called medical underwriting. Applicants usually provide extensive medical history on each family member, and if desired, undergo a physical exam. Based on this evaluation,

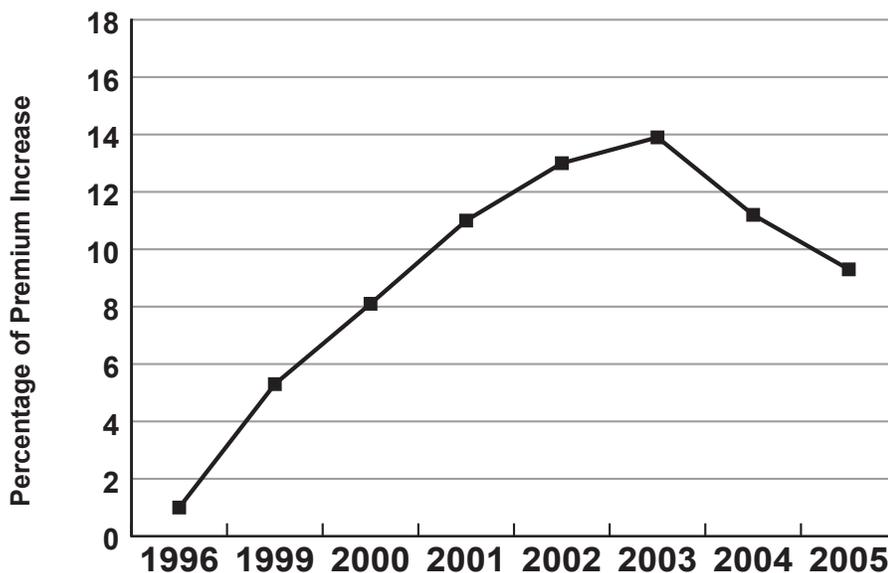
an insurer decides whether to sell a policy, and determines the terms for coverage. Families purchasing individual plans do not receive the same federal tax preference for the cost of insurance, as is the case with EHSI. The term “individual” can be confusing. Individual non-group insurance can be sold either to a family unit or to an individual (sometimes this person may be a worker in a small business). It should not be confused with ‘self-only’ or ‘single’ coverage (coverage for an individual employee) within ESHI.

### III. The Impact of Employer-Sponsored Health Insurance on Family Self-Sufficiency

ESHI is the dominant source of coverage for families. Employers do facilitate coverage for families. Although there are obvious advantages to delivering insurance through a parent’s place of employment that ultimately benefit families, such as distributing risk across a larger number of persons, tax advantages, and economies of scale to reduce administrative costs, it has several drawbacks. Many of these drawbacks – but not all — are attributable to the “third-party payer” problem inherent in ESHI discussed above. This section presents several of the more pronounced disadvantages:

A. *Families have little influence over employers’ decisions to contain high insurance costs.* Health insurance is expensive for families. Job-based insurance premiums rose 7.7 percent in 2006 — less than the 9.2 percent recorded for 2005, as well as the recent peak of 13.9 percent in 2003 (Illustration 3), according to the 2006 Annual Employer Health Benefits Survey released by the Kaiser Family Foundation and Health Research and Educational Trust (HRET).<sup>19</sup> The insurance industry attributes about 43 percent of the increase to higher utilization of services, fueled by unhealthy behaviors, as well as an aging population, increased consumer demand, innovative and intensive medical treatments, and defensive medicine.<sup>20</sup>

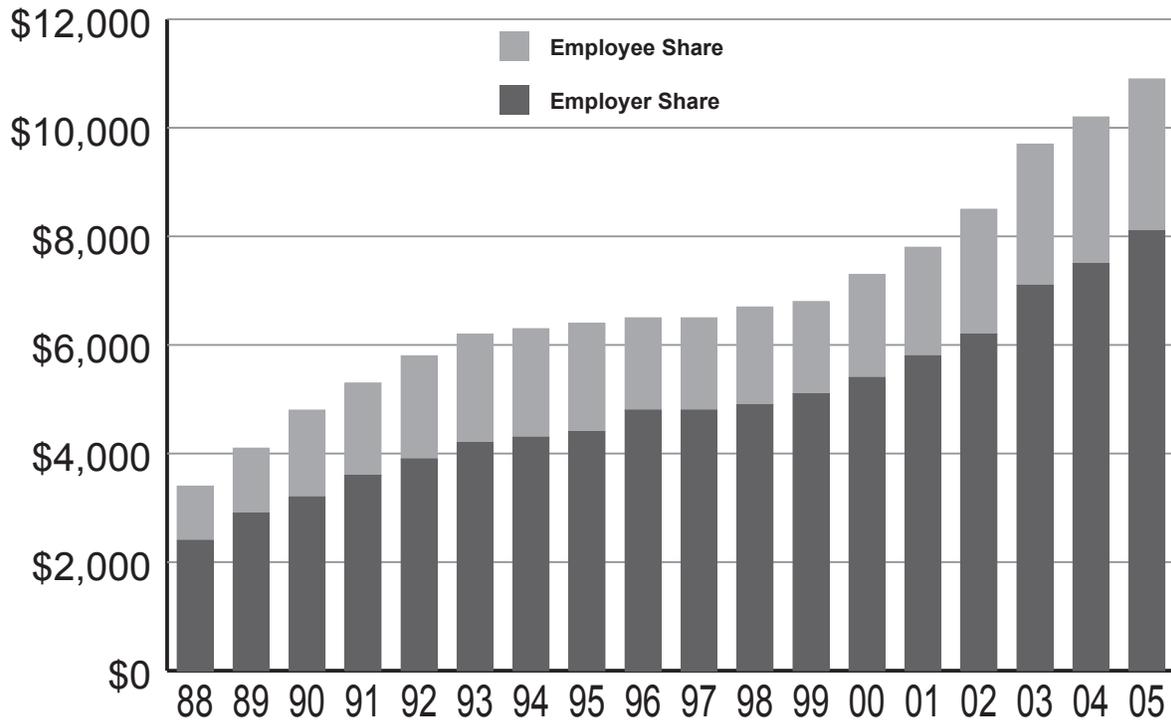
**Illustration 3 - Percentage Increases in Employer Health Insurance Premiums**



Sources: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of annual Inflation.

As a result, the employer may cut back on benefits and/or develop cost-sharing strategies such as increased premiums, reduced benefits, or higher co-pays and deductibles and pass those increases along to the employee. The trend since the late-80s has been to shift cost increases to the employees' share of premiums (Illustration 4).<sup>21</sup>

**Illustration 4 – Employer-Provided Health Insurance Premiums for Family Plans (1988–2005, adjusted for inflation)**



Sources: Kaiser Family Foundation/Health Research and Education Trust  
 Note: The following years were interpolated: 1989–1992; 1994–1995; 1997–1998

Although the average annual premium for a family of four is \$11,500, an employed parent pays an average share of \$3,000.

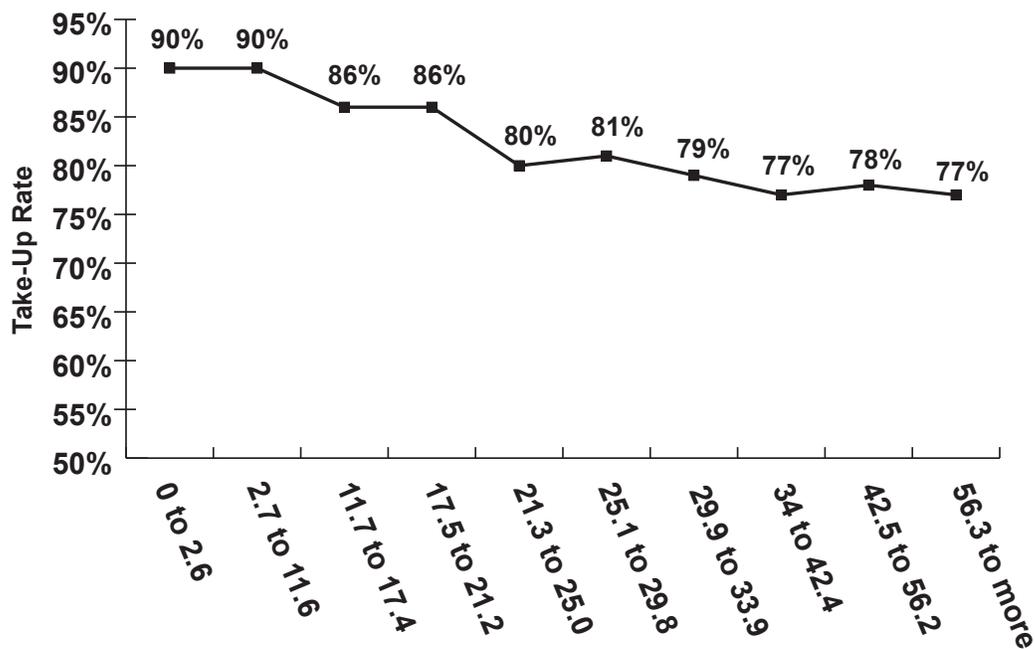
**B. High cost of EHSI reduces family discretionary income.** A portrayal of widespread financial insecurity or worse, bankruptcy, resulting from medical debt among American families is an exaggeration. But the high cost of health insurance does significantly erode discretionary dollars in a family budget that could go for other needs. Family-based premium growth for ESHI has been more than twice the rise in family wages (3.8 percent) and overall inflation (3.5 percent). Family premiums are 87 percent higher now than six years ago. If we couple the cost of premiums with the cost of out-of-pocket medical spending (i.e. expenditures not cover by insurance), it is easy to understand why health care creates a strain on the middle-class family budgets, especially over time. A recent analysis of the effect of health spending found that 11 percent of all families had direct out-of-pocket costs at or higher the 10 percent. A decade ago, 8

percent of families were spending 10 percent of their income on out-of-pocket expenses. Another 4 percent of families whose income is below 200 percent of the federal poverty level spent between 5 and 10 percent of total family income on out-of-pocket expenses.<sup>22</sup>

**C. Rising costs of ESHI impacts families directly affect access to coverage.** In some cases, whole family coverage could be affected and in other situations the employer’s decisions coverage of spouse and dependents are put at risk.

- **Fewer families accepting the employer offer of insurance.** When growth in health premiums outpaces the rise in real income, families find it financially difficult to take up the employer’s offer of health insurance. There have been a number of studies on the lower rates of “uptake.” Some studies examining the mean “take-up” rate (i.e. the percent of employed parents accepting the employers’ offer of health insurance) found significant drops among employed parents as the employee’s contributions to insurance premiums rose because it was too costly (Illustration 5).<sup>23</sup> Illustration 5 (below) shows that as the employed parent or spouse’s contribution reached 50 percent (typical for cost sharing in small businesses), the take-up of for family coverage fell 13 percent, from 90 percent to 77 percent. The Congressional Budget Office estimates that a one percent increase in premiums results in 300,000 people losing insurance. Another authoritative study estimated that the trend in premium growth has created a gap in purchasing ability that has added about one million persons to the ranks of the uninsured annually.<sup>24</sup>

**Illustration 5 – Firm Health Insurance Take-Up Rate by Percentage Contribution For Family Coverage**



Source: Pooled data from 2005 & 2006 Kaiser/HRET Annual Employee Health Benefits Survey found at <http://www.kff.org/>

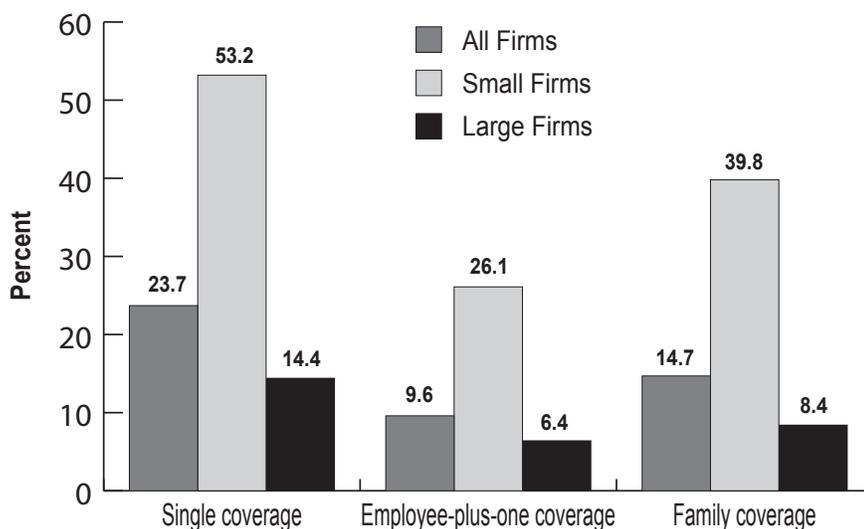
- ***Employers decide whether to cover spouse and dependents.*** As will be discussed in the next section, the IRS code permits employers to contribute to health insurance of not only the employed parent, but also the spouse and dependents. Employers' decisions about dependent care may result in reducing coverage of family members or refusing to offer insurance at all. With regard to spousal coverage, the good news is that married women are more likely to be insured than single women. Married mothers are twice as likely as single mothers to be insured and rely on job-based coverage.<sup>25</sup> A single mothers likely source of insurance is Medicaid. However, the coverage for the segment of the U.S. population with ESHI dropped from 64.4 percent in 1994 to 62.0 percent in 2005.<sup>26</sup> Most of the decline of employment-based insurance between 1987 and 2005 is attributable to dependent coverage.<sup>27</sup> Small businesses (employing between two and 50 workers), in particular, and, indeed, very small businesses (two to 20 workers) have problems offering health insurance to their employees. The smaller the business, the less likely the employer will be able to offer insurance to employees.<sup>28</sup> Businesses with few employees face challenges in pooling employees into groups large enough to cover the present and future costs of the medical claims for the business. This challenge has implications for spouse and dependent coverage since three-quarters of U.S. businesses are small employers providing most of the jobs for families, and thus, the opportunity for coverage. The lack of small businesses who offer family coverage surely underlies the number of uninsured children. Nearly 70 percent of the nine million uninsured children (under age 19) have at least one parent that works full-time<sup>29</sup> – presumably in a small business.

***D. ESHI favors single coverage over family coverage.*** ESHI has not been especially friendly toward family coverage – at least in the past decade. Studies observe that employers generally compensate *single* coverage more generously than the variations on family coverage. (For cost reasons employers can offer 'employee-plus-one' dependent and conventional family coverage as two cost variations of a plan based on family size. These variations generically can be referred to as 'non-single, family coverage'.)

An analysis of the most recent Medical Expenditure Panel Survey (MEPS) shows that it is common for employers – large and small — to make larger contributions to the premiums of their employees with single coverage than to employees who elect non-single, family coverage (Illustration 6, below).<sup>30</sup> Across all firms, for instance, nearly 24 percent of employers paid the full premium for employees with single coverage compared to about 10 percent of workers with employee-plus-one coverage and about 15 percent of workers with family coverage.

Furthermore, when both employer and employees shared the cost of the worker's health insurance (a common situation), employees with single coverage paid an average 18 percent of the total premium while employees with non-single, family coverage paid about 24 percent of the premium.

## Illustration 6 – Percentage of enrolled employees making no contribution toward health insurance premium, by firm size, private sector, 2004



Note: Small firms have fewer than 50 employees, large firms have 50 or more employees.

Source: Center for Financing, Access, and Cost Trends. AHRQ. Insurance Component of the Medical Expenditure Panel Survey. 2004

*E. Availability of health insurance affects family, personalized care-taking (typically by the mother).* Moreover, ESHI is inflexible to the exigencies of family budgets, especially for middle class families with children. Supervision of the young and care for elderly parents place special burdens on families to generate supplemental income. Part-time work is the best answer for many families. This is the sole source of income for many married women and young mothers. Businesses large and small rarely provide health insurance to part-time workers. One study found that only 28 percent of firms with more than 100 employees and only 5 percent of firms with less than 100 employees offered health benefits.<sup>31</sup> Buchmueller and Valletta found that the husbands' insurance status determined whether mothers worked more or fewer hours. In families where husbands do not have ESHI, wives substantially increase their hours to full time to qualify for the insurance benefit through their employer.<sup>32</sup> In families where the husband has ESHI, wives spend fewer hours on a job outside the home, spending more time as caregivers.

*F. ESHI is tied to job, not the breadwinner.* Family self-sufficiency attaches to family economics and well-being through job mobility. Employer-sponsored health care is frequently the fringe benefit that employed family members most seek for the security of their family. A quirk in the ESHI system is the potential for disruption in coverage. Working parents can lose insurance through job loss, change in employment, or by

an employer's decision to discontinue insurance. Lack of control over health care choices can, and often does, stymie careers in a phenomenon called "job lock." Some working parents with a chronic illness in the family have reduced career mobility by approximately 40 percent because they rely on their employer for health care coverage.<sup>33</sup>

- ***Effect on career and job mobility.*** Portability was not an issue in the pre-managed care world. For decades health insurer reimbursed providers on a fee-for-service basis. Medical professionals simply submitted the bill to the insurer for payment. Regardless of the job, if the employer provided insurance, the working parent could expect fewer disruptions in coverage. However, in today's world of managed care, the carrier "provides" health care through prepaid plans that have contractual relations with a comprehensive set of professionals and health care facilities. A worker changes jobs an average of eight times in a lifetime. This feature of health insurance ideally allows families to retain the same health plan with the same doctors at roughly the same price when transitioning between jobs, whether within or outside an industry and across state lines. The plan is personal and travels with the employees wherever they go. Not surprisingly, more than two out of three voters support congressional action to make genuine portability a reality.<sup>34</sup>
- ***Laws governing EHSI adversely affect portability.*** Federal tax law, furthermore, penalizes the one area in the U.S. health care system that approaches genuine portability. Parents insured through the non-group market (totaling about 20 million<sup>35</sup>), resulting from self-employment or employer refusal to offer insurance, present a peculiar contrast with conventional group coverage through ESHI. These non-group plans are much more personal and portable. But these families trade portability for higher cost insurance. In most cases, they purchase insurance with "after tax" income, making the coverage even more costly. Indeed, the cost of insurance for a middle class family with four children (with an annual income up to \$60,000) may be twice as much in the non-group market as the same plan offered through an employer. Moreover, if employers took advantage of the personal nature of individual policies and purchased them for employees, lawyers believe that the federal Employee Retirement and Income Security Act (ERISA) *could* prevent them from purchasing these non-group policies with pre-tax dollars.<sup>36</sup>

***G. Constrained choices.*** Choice is another area where the health care system can have an impact on families. It is connected to job lock and portability. The Kaiser Family Foundation survey on employer health benefits reports that nearly nine out of 10 firms offer only one plan.<sup>37</sup> Larger companies, however, are more likely to offer more than one plan.

- ***Choice of health plan.*** Although choice in health care is not new, the demand today is much more multifaceted than it was a decade ago. With the emergence of managed care, the concerns about choice were expressed both at the time of enrollment and the point of service. Health carriers responded with products to address that consumer demand. However, employers are the focus today rather than health carriers. Employees are increasingly wanting options different from managed care.

- ***Choice in variety among health plans should in health savings accounts.*** With the continued movement to empower consumers, choice relates now to a *variety* among plans, rather than just the different kinds of managed care plans. The key element in this approach to health care is the elimination of the third-payer effect in health care decisions. One new health care plan option outside of managed care plans is health savings accounts (HSAs), popularized in the *Medicare Prescription Drug, Improvement and Modernization Act of 2004*. HSAs combine a lower-cost, high-deductible insurance policy for catastrophic ailments attached to a personalized, medical savings account to pay for medical expenses out-of-pocket. HSAs allow an employed parent to contribute up to \$5,650 per year into the account.<sup>38</sup> The contribution to the account and interest that accrues are free of federal personal income and payroll taxes. Plus, they attach to the employed parent, thus allowing considerable portability. HSAs offer a mechanism for small employers to cover medical bills. Premiums for the required high deductible insurance are much lower than the low-deductible policies. The premiums are not excluded from taxes. However, if the employer implements one of the tax advantaged arrangements now permitted by the IRS (so called health reimbursement accounts or health flexible spending accounts), the premiums of the high deductible policy, too, can be excluded from federal taxes. Market analysts are surprised by the popularity in HSAs in just over three years. Eight million Americans (3 percent of the insured) see as the plan of choice, according to a current report in the Kaiser Daily Reports.<sup>39</sup> (This figure probably includes enrollees in other tax-advantaged arrangements, discussed below.) HSAs are most popular among middle-age and up, rather than the younger generations, according an executive in the health insurance industry.
- ***Choice requires useable and understandable information about plans and services.*** In addition, choice incorporates several other dimensions that make informed decisions possible. Critics of choice allege that most families cannot navigate the complexities of health care to make sound decisions. Consequently, choice requires a transparent system regarding prices and quality for the layperson. Health care is the only market where families have little knowledge about the costs of medical goods and services. Transparency is wildly popular in the general public.<sup>40</sup> Zogby conducted a poll for the National Council for Affordable Health Care in which 84 percent of the respondents agreed with the statement that “hospitals, doctors, and pharmacies should publish their prices for all goods and services.”<sup>41</sup>

There are two sides to a truly transparent system. On the one hand, providers and insurers need to make available relevant information in plain English. Great West Health Care<sup>42</sup> commissioned a survey of 1,000 individuals (ages 18-64) with ESHI. It found that 68 percent did not know the treatment costs until after their medical bill arrived, and 11 percent never knew. The health care plans and providers need to be more responsive in making their prices available in a timely manner. On the other hand, parents must improve their health literacy. Health literacy is quite low among adults with fewer than one in six being proficient in understanding appropriate and inappropriate uses of medical resources.<sup>43</sup> Changes in the health care system must be made so that families understand their fiscal responsibility in seeking the benefits

of high-quality health care. If the parents and spouses reflect the perceptions of the respondents in consumer attitude surveys, they discern the price of a new car with remarkable accuracy, but they underestimate the cost of a four-day hospital stay by several thousand dollars. They prudently guess the price of a Bose music system (\$530) within just dollars of the actual cost (\$500), yet they underestimate a routine physician visit by more than 50 percent and overestimate an emergency room visit by 70 percent.

It is not surprising when the Employee Benefit Research Institute cites from its survey of employee confidence (2002) that only 27 percent of individuals are “extremely” or “very” confident in their ability to select the best health plan.<sup>44</sup> The vast majority of employees in the survey are at best “somewhat confident” and at worse “not confident at all.” They prefer to have the employer make those decisions even though employers possess no special knowledge in selecting appropriate plans – and certainly not for picking a plan suitable for a particular family situation. We have already remarked on the negative economic effect of our third-party payer system. As a further consequence this system shields families from knowledge about the true cost of health care and removes them from their responsibility to make choices.

- ***Choice entails personal responsibility.*** Another dimension to choice includes personal responsibility. The primary policy-holder has the ultimate duty to ensure that members in the insured family household have necessary information to act responsibly. In this regard, parents have the right to be involved with the health decisions of their children and to have access to their medical records. Privacy rules should not obstruct the primary policy holder from exercising his or her responsibility as the ultimate caretaker. There should be rewards for making proper choices that promote health. Conversely, enrolling families should not be asked to assume the financial burden of participating in risky behaviors that are reasonably under the control of individuals.
- ***Choice protects conscience.*** Finally, choice means being able to select physicians and plans based on those benefits deemed most appropriate for a specific family. Conversely, it means not being channeled into selecting a plan where a common set of benefits cover services that are objectionable on moral, religious, or other ethical grounds. Later we will present a subscriber’s right of conscience.

***H. Whole family coverage.*** A final impact of the health care system on families is that lack of insurance has its own adverse economic and health impacts on the family that are communal in nature, as detailed in the Institute of Medicine report *Health Insurance Is a Family Matter*. The report states that “having one or more uninsured individuals in a family can have an impact, even if some or all of the remaining members of the family have health insurance.”<sup>45</sup> National policy targeting affordable health plans should address *whole* family coverage. Ideally this means that all the members in the family household are insured, within the same plan, and have a medical home comprised of the same medical team.

## IV. Assessing Proposals for Family-Friendly Coverage

Affordable health insurance is a more pressing public need for families than grand designs of universal coverage. Creating opportunity to seek coverage is noble, but proponents of CUI generally have a larger social agenda in mind than simply creating structures and subsidies to insure people. A governing assumption of CUI – and a distinguishing factor from FRC’s approach — is that broadening the social redistributive element inherent to insurance under supervision of the government will have no effect on personal responsibility and consumption. Health care is so radically different, so complex, compared to other commodities that only the government can regulate its distribution; because only the government understands its complexity. Their egalitarian vision is to achieve a comprehensive, benefit package that fits all families (“one-size fits all”). Lavish benefit packages make insurance pricier and widen the gap between the cost of premiums and the actual value to the family. A consequence of group insurance can be a significant private cross-subsidy in any given year from relatively healthy families to those with greater health risks or poorer health habits.<sup>46</sup> Furthermore, government-controlled systems fall error to problems associated with third-party payers. Once established, government programs create dependencies that detract from the self-sufficiency of families. The challenge is to assess new proposals that surely will promise to fix these issues of affordability and rising costs of family coverage. This section amplifies the preceding discussion and lays out a framework consisting of several criteria that can be deployed to analyze the strengths of various proposals.

**A. *Affordability and accessibility.*** Although these goals of health insurance are independent concepts, they are closely related, as we have seen. The family issues involved with affordability and accessibility can be better understood by separating them topically to correspond to the two major components of ESHI. One major component is the federal tax treatment of employer contributions toward health benefits for their employees. The second major component is an insurance methodology that *requires risk-sharing through groups.*

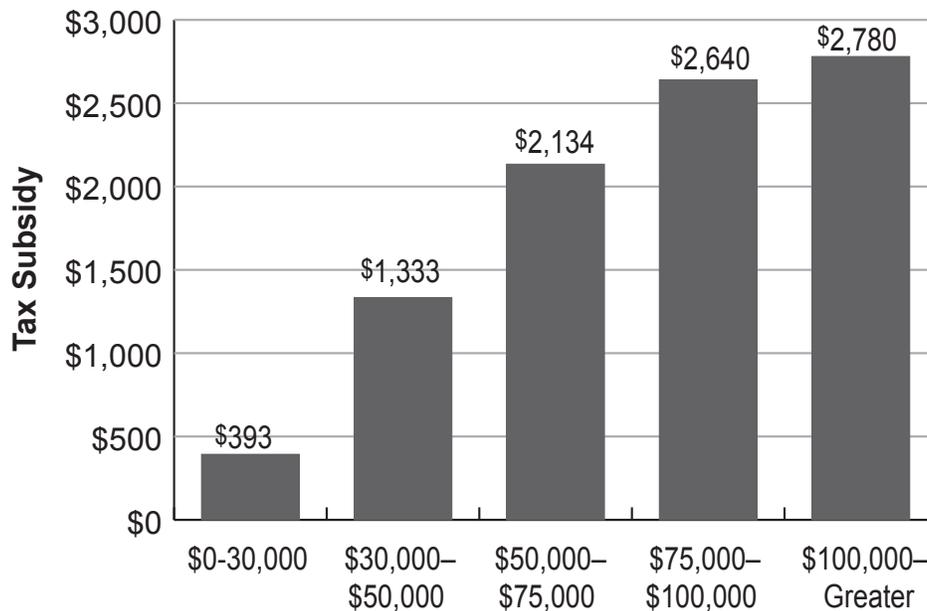
- ***The employer tax exclusion for employee health benefits.*** IRS Code §105 states that employers who fund employee health insurance can exclude from taxable income the value of the benefit and accompanying share of the payroll tax (FICA), including the contributions for a “spouse and dependents.” The exclusion for employer health benefits is the largest annual tax expenditure<sup>47</sup> in the federal budget, surpassing the deduction for home mortgage (\$79.9 billion) – which is a distant second, followed by capital gains on home sales (\$43.9 billion), child tax credit (\$42.1), and contributions to personal retirement savings. The U.S. Department of Treasury estimates the size of the tax budget for ESHI at \$132 billion.<sup>48</sup> But this is probably an underestimate because it does not account for the tax exclusions through federal tax expenditures associated with other tax-advantaged arrangements for health care expenditures, such as health Flexible Savings Arrangements (hFSAs) or Health Reimbursement Arrangements (HRAs); nor does it account for the effect of the federal exclusion on state income tax policies. A recent study estimates the annual federal and state impact at \$208 billion (exclude expenditures for the other tax-advantaged

arrangements).

Health FSAs in cafeteria plans and HRAs are additional employer-sponsored health arrangements that permit the employees to exclude from federal income and payroll taxes the costs of their share of the premium, as well as out-of-pocket medical expenditures. FRC has developed background papers on these two arrangements. Working parents may be able to take advantage of some of these workplace strategies to save a third or more on their family's health bill. But they provide no relief to families detached from employers.

The average tax subsidy for employer-sponsored family-coverage is \$3,825 or about 35.6 percent of the premiums. This statistic conceals the inequitable distribution favoring upper-income families rather than low-income and middle-income families (Illustration 7).

**Illustration 7 – Average Federal Tax Health Care Expenditure (2004)**



Source: Data from John Sheils, "The Cost of Tax-Exempt Health Benefits in 2004," Health Affairs

*A Pro-family critique of the employer tax exclusion.* The tax exclusion is not without its critics. Despite the obvious recognition that the tax code gives to marriage and family, FRC endorses the views of leading economists who see several drawbacks to the tax subsidy in its current form. First, it favors families in employer groups over families who are uninsured or who purchase family coverage directly through the non-group market. Even within the employer-group market, it tends to favor workers in larger companies rather than smaller firms. Second, a larger share of the expenditures goes to families at higher incomes than lower incomes (Illustration 6, above). Third, the tax subsidy promotes higher consumption and consequently increases the price of health insurance. Thus, the subsidy calls into question our basic sense of fairness, as well as

promotes inefficiencies in the market, driving up the cost for all.

*A 'family-defined responsibility unit' critique of the employer tax exclusion.* The exclusion has also been a target for proponents of domestic partners policies, who allege that the IRS code discriminates against them. Their central argument is that households with married couples and households with domestic partners are a difference without a distinction. Under the tax code, income in the form of direct or indirect payments (i.e. benefits) will be treated like taxable wages, unless specifically excluded under §105.

Section 105 was added to the IRS code in 1954 during a time when the government was clarifying its tax treatment of employee benefits that emerged during the WWII era of price and wage controls. Expansion of pre-tax benefits and coverage was a natural development of that period and contributed greatly to the growth of modern health insurance. Section 105 (b) simply recognized the importance of marriage and family in the life of an employee. It did not discriminate on the basis of sexual orientation—as courts, too, have acknowledged. Neither same-sex, nor unmarried heterosexual partners, can exclude the partner's health benefits from taxable income. Thus, a change to this section of the code would be nothing more than devaluing marriage.

The real inequitable tax treatment under §105 (b) is its preference for employer groups over non-groups. Tax preference should not be based on where you work. A tax policy change to make relief more universally beneficial to families in employer groups and non-groups would remove the unfairness — unless one is trying to push an anti-marriage social agenda rather than health care reform. Some have proposed capping the exclusion. But even if a capped exclusion helped to contain costs it would not remove the inequities between the tax treatment of groups and non-groups. The type of tax policy envisioned here would be more along the lines of HSAs or an increased standard deduction for health care expenses (i.e. premiums and out-of-pocket) as recently proposed by President Bush, or a restructuring of the tax code to redirect the federal tax exclusion in the form of tax credits. Cost-containment would be achieved by the level of deductions set for families and individuals.

- *Insurance methodology that requires risk-sharing through groups.* The second major component of health insurance involved with affordability and accessibility are employer groups themselves. On the one hand, employees of businesses, particularly of certain sizes, provide convenient opportunities for insurers to assign risk pooling groups. Through the economies of scale afforded by the group, employers are able to pay lower premiums. On the other hand, insurers employ risk-sharing methodologies to groups. As noted earlier, risk sharing involves cross-subsidization within the group to pay for the medical claims of the group. It is critical that these private transfers are based on criteria fair to all families and promote personal responsibility within the group. Of course, compassion dictates that families help one another with costs that are beyond their control, such as unknown genetic diseases. But compassion is reciprocal such that all parties need to avoid risky behaviors that result in conditions that unduly drive up premiums.

Application of these criteria will identify legislation that promotes appropriate

underwriting. It will encourage competition rather than price controls. In this connection, the sale of insurance plans across state lines – which current laws prohibit — will promote competition and expand the range of affordable products. Furthermore, there is now a need for non-regulatory group purchasing mechanisms in the non-group market. A statewide, health insurance exchange (HIE),<sup>49</sup> as it is sometimes called, is such a mechanism. Something like the statewide HIE would benefit families in the small-group market affecting very small businesses with fewer than 20 employees. Employers at very small firms could designate the HIE as their company plan, allowing their employees to purchase coverage with “before-tax” dollars, which might increase their purchasing power by as much as a third. In the event that tax policy is reformed, the HIE would become even *more* critical in making coverage more affordable for employers of all sizes. These clearinghouses bring together large volumes of buyers and sellers where economies of scale emerge to leverage lower prices.

**B. Portability.** In general, employer-sponsored plans are not portable. Although there are some statutory mechanisms that make transitioning through the system less onerous, federal law discourages portable health plans. It penalizes the non-group market. There are three criteria that can help assess the genuineness of the portability advanced in health proposals.

- ***Ideal portability means portable benefits.*** A portable plan means keeping the same health plan, rather than portable access to a plan with a new set of benefits. A decade ago Congress passed the *Health Insurance Portability and Accountability Act* (HIPAA) to address problems in the insurance system. The reference to portability in the title is a misnomer. It addresses only the obstacles affecting *continuity* of coverage<sup>50</sup> by limiting exclusions for preexisting conditions; prohibiting denial of coverage based on the health status of employees and their dependents; and guaranteeing renewable and available insurance. Prior to the passage of HIPAA in 1996, insurers along with employers set the conditions for coverage that affected transitions in family life, such as marriage, birth or adoption, loss or change in health coverage, and starting or changing jobs. HIPAA gave portable access to a new set of benefits, but it did not make the same benefits portable.
- ***Ideal portability is long-term portability.*** COBRA<sup>51</sup> continuation health coverage is a familiar acronym to families displaced from work. For some families with significant medical needs this costly route to maintain insurance may be the only option available. The federal law guarantees the option of short-term portability of the same insurance policy up to 18 months. The plan stays with the worker and the cost remains at the group rate, but the worker pays 102 percent of the premium, covering the employee and employer share, plus an administrative charge. To make matters worse, the family budget takes the full hit because the premium is paid for with “after-tax” dollars. Portability should continue for an indefinite duration and not be temporary.
- ***Ideal portability is complete.*** Health savings accounts combine a personal savings

account to pay for medical expenditures with “pre-tax” dollars and a high-deductible insurance policy (meeting qualified standards) to provide catastrophic protection. The personal savings account travels with the working parent regardless of job or location. However, the high-deductible insurance plan is not portable. The employee can purchase continued coverage under an inexpensive, qualified high deductible policy and continue to make contributions into and disbursements from the account with “pre-tax” dollars.

**C. *Transparency in Health Care.*** The third criterion of a family-health care system gives family members access to information on the prices and quality of the medical services it provides. Achieving the optimal mix between the highest quality at the lowest price in health care is commonly referred to as “value-driven” health care.

Would a transparent market, where price and quality information are readily available in understandable terms, mean that families would become sensitive to prices, as in other markets? This question is critical because reforming health care insurance so that it promotes family self-sufficiency means that families not only *can* but *will* choose a plan best suited for their family and purchase their health care directly. Transparency in health care means that families can improve decisions about their health, lower their medical costs, and reduce medical errors, resulting from non-compliance with treatment regimens. In a recent poll 79 percent of the respondents said that if they had that information, they “would be likely to shop for the best price.”<sup>52</sup> However, the social science has yet to show significant correlations between behaviors related to health care utilization and price sensitivity.<sup>53</sup> The key to getting families to pay attention to prices may well be to make better, more actionable information and savings incentives available to families to help them with their marketplace and treatment decisions, and to reward them for prudent choices to avoid unnecessary care.

**D. *Right of Conscience.*** In general, a right of conscience evolves from a protection for providers, to health plans and medical students, and should now expand to subscribers. It protects physicians and other health providers from being compelled to provide a treatment or to participate in activities related to those interventions that are objectionable to their religious or moral beliefs. Conscience clauses typically focus on *life-taking* activities (e.g., abortion and emergency contraception) and sterilization, but increasingly there are concerns regarding select family-formation services, such as in vitro fertilization. Federal and state conscience laws have existed for more than a generation in response to *Roe v. Wade*.<sup>54</sup> These laws preserve access to a wider selection of medical professional services and medicines by protecting practitioners and new entrants who would otherwise be forced from practicing medicine. They protect the special professional relationships needed to provide quality care. Without them there would be fewer entrants into the various medical fields, as well as a reduction of current, experienced professionals.

- ***The conscience of physicians protected.*** The evolution of the U.S. health care system also includes a natural progression in protecting the right of conscience of various

agents with respect to different services. The early conscience laws in the mid-1970s affected physicians and hospitals being asked to perform abortions or sterilizations. The facilities protected under this law are public and private, as well as secular and religious institutions. Nearly all states followed with their version of the conscience clause by 1978.<sup>55</sup>

- ***The corporate conscience of health plans and medical students protected.*** The onslaught of managed care in the mid-1990s produced a renewed interest in conscience clauses to address the way managed care restricts an enrollee's choice through its network providers. The contemporary delivery systems, such as managed care, blur a market once composed predominantly of individual physicians and hospitals by integrating financial and service delivery functions. Protections were expanded beyond medical personnel and facilities to include health care plans and payers. Additionally, these new laws widened the protection beyond performance of a life-taking act to referrals and payments for treatment. Conscience provisions were added to Medicaid law<sup>56</sup> and Medicare law<sup>57</sup>. Similarly, the regulations for the Federal Employee's Health Benefits Plan, which involve nearly 250 insurance plans nationwide, protect the moral and religious sensitivities of participating providers by preventing them from being "required to discuss treatment options that they would not ordinarily discuss in their customary course of practice."<sup>58</sup> To protect enrollees, these laws require providers, facilities and plans make public those services that will not be performed. Meanwhile medical schools were required to assess medical training programs so that students and residents would not be forced to participate in morally or religiously objectionable treatments.
- ***A subscriber's right of conscience.*** The economic impetus behind risk-sharing in group insurance pools may coerce some into paying for services that they find objectionable on religious or moral grounds. Insurers that cover controversial services may offend plan members on moral grounds. A transparent health care system should not be opaque on matters of subscriber conscience. This criterion helps make translucent proposed changes to the system that might have an impact on personal values. These subscribers may have few acceptable plans from which to select. Therefore, short of assurances that the market will provide family-driven health plans void of coverage that triggers conscience issues, a *subscriber's right of conscience* is emerging as a necessary step to ensure that members are not pushed into groups or risk pools where the coverage violates their conscience.
- ***A comprehensive law protecting conscience.*** Some recent efforts to enact a permanent law that would protect all health care entities have been unsuccessful. Instead Congress incorporated a similar protection into an annual spending law, withholding federal funds from any federal agency and program or state and local governments that subject "any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."<sup>59</sup> The duration of this provision, however, lasts only as long as

the appropriation law is effective, which is usually 12 months. New health care laws should make the appropriation language permanent and extend to subscribers.

## **V. The Future of Family-Based Coverage**

Personal responsibility is the foundation for family-based health insurance. This principle makes families self-sufficient. As a governing assumption, it distinguishes FRC approach for other policy-orientations that would attach significance to expressions of equality or freedom within the health care system.

Health insurance has become so costly that contributions need to be treated more as an investment in the well-being of families. National policies that attach significance to the effect of personal responsibility in health care decisions and target affordability will do more for families than utopian hopes of CUI. These approaches give too much power to the government to make decisions about the best interests for families. New laws should promote policies of personal ownership of health plans rather than the drawbacks perpetuated through third party payment approaches such as government-controlled, public insurance and ESHI.

Ideally, an equitable federal tax subsidy is key to health reform that has affordability as its goal. It would respect families as a whole. The FRC supports this sweeping change and opposes any sweeping changes that give government more control over family coverage. Moreover, the subsidy should target relief to those with the greatest medical need.

For low-income families a dollar-for-dollar refundable tax credit could be deployed to expand coverage, allowing parents to purchase private health insurance for their children. The credit would cover most, if not all, of the cost of health insurance. Parents would pay the difference, if any. A refundable credit means that families would receive the full benefit of the credit, no matter how minimal their income tax obligation.

If changing the tax subsidy is not feasible at the present time, then parallel structures of tax subsidies need to be put into place that will extend the opportunities to purchase health care to all families regardless of place of employment. Individuals who do not have employer-sponsored health care should have access to a standard deduction for health care equal to the economic value of the treatment within the ESHI.

Furthermore, employers should make every effort to utilize the tax benefits accompanying health FSAs and HRAs on behalf of their employees. Health savings accounts, despite their limitations, appear to be the best mechanism at the current time for policy holders to realize ownership.

Employer groups will always be attractive for insurers because of the economies of scale. A reformed tax code would not change that basic reality. Although FRC has serious concerns about conferring preferential tax treatment to employer groups only, FRC recognizes a role for the employer to help organize groups for the purpose of

lowering the costs of insurance. Employer groups, however, will leave many families without the opportunity to purchase affordable insurance even with the increased purchasing power afforded through a tax subsidy. This is true irrespective of tax policy reform. Thus, establishing HIEs at the state level would in many cases be the least intrusive to assure state oversight for very small business groups, self-employed and even some uninsured.

Moreover, families should not be hindered by state lines when purchasing insurance. They should be free to purchase a plan in another state if it the lowest priced product suitable to the family's need.

One thing is certain: changing current tax policy is the way most conducive to promoting family-level ownership when accompanied with transparent information on price and quality. It solves the drawbacks of ESHI. Tax policy can preserve genuine portability and choice. It can assign responsibility to families to control their own costs and to purchase services according to their own conscience.

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