CALIFORNIA BUDGET PROJECT

budget brief

MAY 2007

HOW MUCH IS TOO MUCH?:
A FRAMEWORK FOR EVALUATING HEALTH CARE AFFORDABILITY

The Governor and legislative leaders have proposed to substantially expand health coverage for uninsured Californians. These proposals would require individuals to purchase or share in the cost of coverage.[1] However, these proposals may not go far enough to make health coverage affordable for California families.

An understanding of who lacks coverage and how much Californians – whether or not they have coverage – can afford to spend on coverage will be central to the success of the current debate. In order to succeed, reform proposals must:

- Make realistic assessments about how much families can afford to pay for health care;
- Ensure that families can afford to *use*, and not simply buy, coverage;
- Provide adequate assistance to families who cannot afford the cost of coverage;
- Take into account the cost of essential services – such as dental and vision care – that are not included in the basic benefits package; and
- Ensure that increases in health care costs do not erode these protections.

Who Are the Uninsured by Income Level?

Most uninsured Californians have low or modest incomes, but some higher income families also lack coverage. Nearly two-thirds (63.1 percent) of non-elderly uninsured Californians have incomes below twice the poverty line – $20,976 for an individual and $32,484 for a family of three in 2006 (Table 1 and Figure 1). In contrast, one in five (21.2 percent) have incomes between 200 percent and 399 percent of the poverty line and 7.7 percent have incomes between 400 percent and 599 percent of the poverty line.

Nearly all uninsured Californians are in working families. Two-thirds of the uninsured under age 65 are in families with a full-time employee (Figure 2). An additional 18.4 percent are in families with either a self-employed or part-time worker.

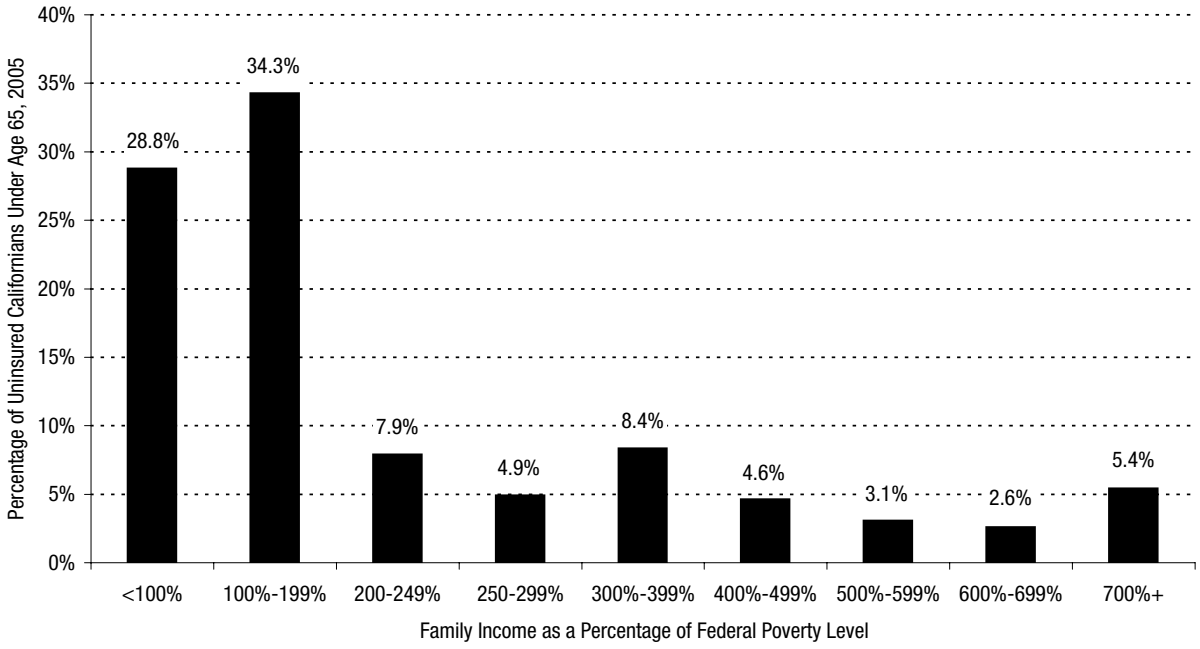
Many of the uninsured do not have coverage because they cannot afford to purchase it. Nearly half (47.7 percent) of workers who declined job-based coverage in 2005 did so because the coverage was too expensive. In contrast, only 13.2 percent of these workers did not think they needed it.[2] While some moderate or high-income uninsured may choose not to purchase health coverage, many with pre-existing conditions or histories of high medical costs do not carry coverage either because insurers will not offer them coverage or because they cannot afford the high cost of coverage.

Table 1: Poverty Line by Family Size, 2006

Family Size	Poverty Line
1	$10,488
2	$13,896
3	$16,242
4	$20,444
5	$24,059
6	$26,938
7	$30,172
8	$33,171

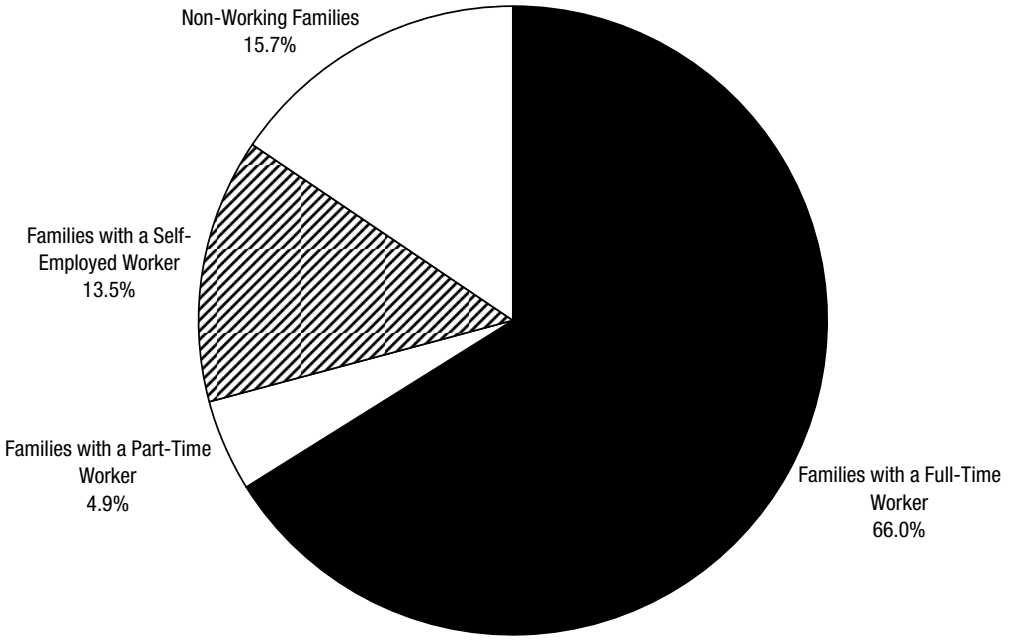
Note: Figures for families of three or fewer assume one adult; figures for other families assume two adults.
Source: US Census Bureau

Figure 1: Most Uninsured Californians Have Incomes Below Twice the Poverty Line, But Many Have Higher Incomes



Source: CBP analysis of California Health Interview Survey data

Figure 2: Most of the Uninsured Are in Working Families



Note: Includes uninsured Californians under age 65.
Source: 2005 California Health Interview Survey

What Does Affordability Mean?

Affordability is inherently subjective. However, policies aiming to make health care "affordable" should protect families from financial stress, taking into consideration other basic necessities such as food, housing, and child care; encourage the appropriate use of health care services, including preventive services; and protect families from catastrophic health costs. While there is no perfect way to define affordability, policymakers should base reform proposals on a reasonable assessment of what families can afford to pay for health care; provide sufficient premium subsidies to make health care affordable for those lacking the means to purchase coverage on their own; and place limits on copayments, deductibles, and other out-of-pocket costs.

A recent national study defines health insurance as "unaffordable" for families with incomes below 300 percent of the poverty line.[3] The authors base this threshold on how much families would have to pay to purchase nongroup coverage, recognizing that even at this income level, families may not be able to afford to purchase coverage. The authors also examine broader definitions of affordability, including having income at or above 400 percent of the poverty line. Given California's high cost of living, health care would be considered affordable only at higher income levels.

How Much Do Families Currently Spend on Health Care?

How much families *currently* spend on health care can help policymakers understand how much families can *afford* to spend. Since families face a wide range of health care costs, it is useful to look at both typical families and those with high costs due, for example, to chronic conditions. A recent study examines how much families spend on health care nationally, but similar information does not exist for California.[4]

Premiums

Nationally, low-income families with health coverage spend a much larger share of their incomes on premiums than do high-income families.[5] In contrast, most policymakers and policy experts believe it is appropriate for low-income families to spend a *smaller* share of their incomes on health care, since they must spend a large share of their incomes on other necessities, such as food and shelter. Families with incomes between 100 percent and 199 percent of the poverty line who have job-based coverage typically spend 10.4 percent of their incomes on premiums – equivalent to $2,600 per year for a family of three with an income of $25,000 – compared to 3.0 percent for families with incomes at or above 300 percent of the poverty line (Table 2).

Spending on premiums differs by type of family and type of coverage. Consumers with job-based individual coverage typically spend about half as much as a share of their incomes as do families with job-based coverage. Families who buy nongroup coverage directly from insurers spend about twice as much as a share of their incomes as do families with job-based coverage, since families with nongroup coverage pay the full cost of coverage themselves. In addition, families with nongroup coverage must use after-tax dollars to buy their coverage, while workers are not taxed on dollars used to buy job-based coverage, and employers can deduct the cost of coverage purchased for employees.

Total Health Costs, Including Out-of-Pocket Costs

Copayments, deductibles, and other out-of-pocket payments increase families' health care costs substantially. Nationally, families with job-based coverage typically spend between 4.0 percent and 14.7 percent of their incomes on total health costs, with lower income families paying a larger share of their incomes than higher income families pay (Table 3). Families with incomes between 100 percent and 199 percent of the poverty line who have job-based coverage typically spend 14.7 percent of their incomes on health costs – equivalent to $3,675 per year for a family of three with an income of $25,000 – compared to 4.6 percent for families with incomes at or above 300 percent of the poverty line. Individuals with job-based coverage typically spend much less than families, measured as a share of income. In addition, families and individuals with nongroup coverage spend substantially more as a share of their incomes than do those with job-based coverage.

Some families face very high out-of-pocket costs, which drives up their total health care costs. For example, families with job-based coverage and very high out-of-pocket costs spend at least seven times the share that the typical family with job-based coverage spends on these costs.[6] These families spend at least

Table 2: Median Premium Payments as a Percentage of Income, US				
	Single, Job-Based Coverage	Single, Nongroup Coverage	Family, Job-Based Coverage	Family, Nongroup Coverage
100% - 199% FPL	5.2%	20.9%	10.4%	21.8%
200% - 299% FPL	3.2%	12.1%	6.5%	13.8%
300% - 399% FPL	2.4%	8.9%	4.7%	9.9%
400% FPL and Higher	1.3%	5.3%	2.6%	5.4%
300% FPL and Higher	1.5%	6.4%	3.0%	6.0%
All Income Groups	2.0%	11.5%	3.6%	9.6%

Note: FPL = Federal poverty line. Figures for job-based coverage include only workers' premium payments. Premiums are for 2005.
Source: The Urban Institute

Table 3: Median Premium and Out-of-Pocket Medical Costs as a Percentage of Income, US				
	Single, Job-Based Coverage	Single, Nongroup Coverage	Family, Job-Based Coverage	Family, Nongroup Coverage
100% - 199% FPL	7.9%	29.4%	14.7%	35.0%
200% - 299% FPL	4.5%	16.2%	9.2%	21.0%
300% - 399% FPL	3.2%	11.5%	6.9%	13.5%
400% FPL and Higher	2.0%	6.6%	4.0%	7.3%
300% FPL and Higher	2.3%	8.2%	4.6%	8.5%
All Income Groups	3.1%	16.9%	5.5%	14.7%

Note: FPL = Federal poverty line. Figures for job-based coverage do not include employers' premium contributions. Premiums and out-of-pocket costs are for 2005.
Source: The Urban Institute

9.8 percent of their incomes on copayments, deductibles, and other out-of-pocket costs, which for a family earning $55,000 is equivalent to $5,390 per year. Moreover, families with nongroup coverage face higher out-of-pocket costs than do those with job-based coverage.

Premium Costs Are High Relative to Income and Rise with Age

Buying health coverage is an expensive proposition. In 2006, job-based health coverage cost an average of $4,550 for individuals and $11,860 for family coverage.[7] Premium costs represent more than one-fifth (21.7 percent) of an individual's income at twice the poverty line – $20,976 – and more than one-third (36.5 percent) of the income of a family of three earning twice the poverty line (Table 4). Health coverage would consume a substantial portion of the income of higher income families. For example, the average job-based premium would cost 14.6 percent of the income of a family of three earning $81,210 – five times the poverty line.

Moreover, the cost of health coverage increases substantially with age. For example, a consumer in her early 20s with an income at 300 percent of the poverty line would spend 7.4 percent of her income to buy comprehensive health coverage with $25 copayments directly from a health plan (Table 5).[8] The same plan would cost a consumer in his late 50s with the same income more than twice as much, or 16.3 percent of his income. Family premiums also increase with parents' age.

High-Deductible Plans Are Not the Answer for Most Uninsured

Policymakers may be tempted to steer uninsured Californians into high-deductible health plans in order to lower the cost of coverage. While the premiums for these policies cost less, they can result in higher *total* health costs since families must pay 100 percent of health care costs up to the deductible. Thus, high-deductible coverage does not generally help families meet their routine health needs – such as preventive care – and only pays for health services if families face very high costs.

Families with high-deductible plans are more likely to delay seeing a doctor, filling prescriptions, or taking preventive tests because they have to pay for the entire cost of services until the deductible is reached.[9] More than two in five adults with these policies (44 percent) failed to seek needed medical care, such as seeing a doctor or filling a prescription, due to cost, much higher than the rate for adults with deductibles of less than $500 (Figure

Table 4: Health Insurance Premiums Are Substantial as a Share of Income, Even for Those with Moderately High Incomes								
		Income as a Percentage of Poverty Line, 2006						California Median Income, 2005
		100%	200%	300%	400%	500%	600%	
Individual	Income	$10,488	$20,976	$31,464	$41,952	$52,440	$62,928	$23,568
	Average Premium as a Percentage of Income	43.4%	21.7%	14.5%	10.8%	8.7%	7.2%	19.3%
Family of 3	Income	$16,242	$32,484	$48,726	$64,968	$81,210	$97,452	$63,027
	Average Premium as a Percentage of Income	73.0%	36.5%	24.3%	18.3%	14.6%	12.2%	18.8%
Family of 4	Income	$20,444	$40,888	$61,332	$81,776	$102,220	$122,664	$67,000
	Average Premium as a Percentage of Income	58.0%	29.0%	19.3%	14.5%	11.6%	9.7%	17.7%

Note: Average premiums for individuals and families are for job-based coverage and include both employee and employer share. Premium and poverty data are for 2006; median income data are for 2005. Family of three includes one adult and family of four includes two adults.
Source: California HealthCare Foundation, CBP analysis of Current Population Survey data, and US Census Bureau

Table 5: Premiums Rise Substantially with Age				
	Single Individuals		Families of Four	
Age	Monthly Premium	Annual Premiums as a Percentage of 300% of Poverty Line for Single Individual	Monthly Premium	Annual Premiums as a Percentage of 300% of Poverty Line for Family of Four
19-24	$194	7.4%	$665	13.0%
25-29	$219	8.4%	$763	14.9%
30-34	$244	9.3%	$864	16.9%
35-39	$262	10.0%	$864	16.9%
40-44	$294	11.2%	$877	17.2%
45-49	$323	12.3%	$877	17.2%
50-54	$373	14.2%	$970	19.0%
55-59	$427	16.3%	$970	19.0%
60-64	$473	18.0%	$1,096	21.4%

Note: Family premiums and poverty lines are for two adults and two children.
Source: Premiums are for Kaiser Permanente's nongroup $25 copayment plan in Sacramento

3). In addition, adults with high-deductible coverage were four times as likely to delay or skip preventive screening tests, such as mammograms or colonoscopies. One in five adults (20 percent) with high-deductible policies delayed or did not receive such tests, compared to 5 percent of adults with deductibles of less than $500. These findings are consistent with other research on high-deductible plans and the RAND Health Insurance Experiment of the 1970s, which found that higher out-of-pocket costs caused consumers to seek less health care, including fewer preventive services.[10]

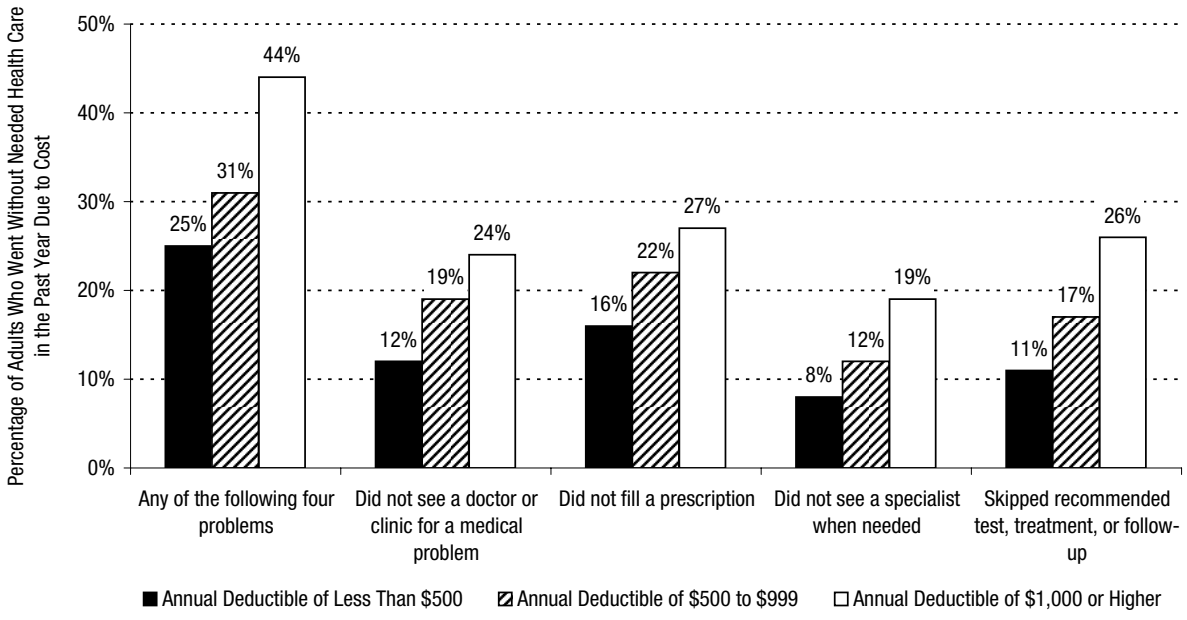
How Have Other Programs Determined Affordability Levels?

Existing health programs can provide policymakers with guidance for setting affordability levels. The programs outlined below impose considerably lower costs on individuals and families than the subsidies proposed by the Governor – which would require families with incomes up to 250 percent of the poverty line to pay between 3 percent and 6 percent of their incomes on premiums alone.[11]

- **The Healthy Families Program** provides coverage to children with incomes at or below 250 percent of the poverty line and who are not eligible for Medi-Cal. Families pay monthly premiums of between $4 and $15 per child (Table 6). Families also pay $5 per visit, and a family's total copayments cannot exceed $250 per year. The cost for a family of three earning $35,000 equals 1.7 percent of their income if the family incurs the maximum $250 in copayments.[12]

- **The California Access for Infants and Mothers (AIM) Program** provides comprehensive health care during

Figure 3: Adults with High-Deductible Plans Were More Likely to Avoid Needed Health Care Because of Cost, 2005



Note: Includes adults age 19 to 64 insured all year with job-based or individually purchased health coverage.
Source: The Commonwealth Fund

pregnancy and for 60 days following delivery to mothers with incomes at or below 300 percent of the poverty line. AIM requires participants to pay 1.5 percent of their income – for a total cost of $515 to $772 for a family of three – and does not charge any copayments, deductibles, or other out-of-pocket costs.[13] Children born to mothers covered by AIM receive coverage through the Healthy Families Program.

- **San Francisco's recently passed Health Access Program (HAP)** will cover all uninsured San Franciscans.[14] The county proposes to subsidize coverage for uninsured adults with incomes less than five times the poverty line ($51,050 for an individual or $85,850 for a family of three).[15] Individuals with incomes at or above the poverty line will pay fees of up to $150 per month, or between 2.8 percent and 5.8 percent of a couple's income.[16] These amounts reflect, in part, sliding scale fees the uninsured currently pay for health services. HAP participants may also incur copayments for certain services.

- **Massachusetts' Commonwealth Care** is a part of that state's health reform package enacted last year and will provide subsidized coverage to adults with incomes at or below 300 percent of the poverty line. Individuals with incomes above 150 percent of the poverty line will pay monthly fees of between $35 and $105 – 3.5 percent and 6.7 percent of a couple's income – for the coverage, not including copayments.[17] After relatively few adults enrolled in coverage that required monthly premiums, Massachusetts lowered or eliminated premium payments for many individuals. Families face additional premiums for children enrolled in a separate public program. Total copayments cannot exceed between $200 and $750 per year, depending on family income. These premiums are based in part on the state's current system of providing limited health services at no charge to individuals with incomes below 200 percent of the poverty line.

Policy Considerations

Details matter when policymakers consider how much Californians can afford to pay for health care. Policymakers should establish a "yardstick" against which affordability is measured, what other costs to consider in determining how much families can afford to pay, and how to protect families from health care inflation. Policymakers should consider the following:

- **Income is a broad measure of a family's resources.** Income is a broad and appropriate measure of the resources

Table 6: Annual Fees or Premiums for Various Health Programs				
Family Income as a Percentage of Poverty Line	Healthy Families Program (2 Children)	Access for Infants and Mothers Program (Family of 3)	San Francisco Health Access Program (Two Adults)*	Massachusetts Commonwealth Care (Two Adults)
0-100%	n/a	n/a	$0	$0
101-150%	$168	n/a	$480	$0
151-200%	$216	n/a	$480	$840
201-250%	$360	$515 to $643	$1,200	$1,680
251-300%	n/a	$643 to $772	$1,200	$2,520
301-400%	n/a	n/a	$2,400	n/a
401-500%	n/a	n/a	$3,600	n/a

* For individuals who do not work for employers who pay a fee to support the program.
Source: Managed Risk Medical Insurance Board, San Francisco Department of Public Health and Office of Labor Standards and Enforcement, and Massachusetts Commonwealth Health Insurance Connector Authority

families have to meet their needs. For this reason, many programs use family income to determine who receives services. Wages, on the other hand, do not capture earnings for self-employed or contract workers and do not adequately reflect the resources of a family with two parents who have very different earnings. In addition, by definition an individual's wages do not reflect family size. For example, an individual earning $40,000 may be able to pay for his or her basic costs, but a family of four with the same level of earnings would likely struggle to make ends meet. Wages also do not capture investment income for higher income families or transfer payments for low-income families.

- **Families' other costs affect what they can afford to contribute toward health care.** While income is an appropriate starting point for measuring affordability, it may not fully capture a family's ability to meet its needs. Families' costs can differ dramatically, such as the cost of housing and the need of families with young children for child care. Rents vary substantially throughout California, even among nearby counties. For example, the 2007 Fair Market Rent (FMR) for a two-bedroom apartment in Riverside and San Bernardino Counties is $974, more than one-third (34.4 percent) lower than in Orange County ($1,485). In addition, child care for two young children can add $12,000 in yearly costs that families with older or no children do not face.[18]

- **Health care inflation can erode standards on how much consumers can afford to pay.** The growth in health costs could gradually erode the standards that policymakers put in place regarding how much consumers can afford to pay. Forecasts suggest that health care costs will likely continue to outpace overall inflation. Since the poverty line increases every year at the same pace as overall inflation, health costs will tend to grow faster than the poverty line. As a result, standards on how much families can afford that are based on the poverty line will lose ground to rising health care costs over time. For example, a person in her early 20s earning three times the poverty line might spend 7.4 percent of her income on premiums. However, a person of the same age and income relative to the poverty line might spend more than 10 percent of his income to purchase the same coverage in five years.

Recommendations

Success of any health care reform or expansion depends on whether families will be able to afford the health coverage. In order to ensure that health coverage is affordable, policymakers should:

- **Make realistic assessments about what families can afford to pay for health care, including premiums and out-of-pocket costs.** Reform proposals should include a realistic assessment of what families at different income levels can afford to pay for health costs, including both premiums and out-of-pocket costs such as deductibles and copayments. Policymakers should include additional protections for families with high health costs, including those with chronic conditions and older Californians. In addition, because coverage for single consumers is less expensive than family coverage, policymakers should set different standards for what families and individuals can afford to spend.

- **Ensure that families can afford to *use*, and not simply buy, coverage.** Reform proposals should ensure that Californians can afford to buy health coverage that provides them ready access to health services. Coverage that does not pay for many services, such as high-deductible plans, does not respond to families' everyday health needs. High-deductible

coverage exposes families to financial risk and discourages families from accessing necessary health care.

- **Provide broad subsidies for families who are unable to purchase health coverage without support.** Subsidies should be sufficient to allow families to afford health coverage and other necessities. This could be accomplished by providing subsidies to families up to a certain income level. Providing subsidies to Californians below three times the poverty line would include three-quarters (75.9 percent) of the uninsured. Nearly nine in 10 uninsured Californians (88.9 percent) have incomes below five times the poverty line.

  Policymakers should exempt Californians with very low incomes from premium contributions and scale contributions for other families based on their income. Since most Californians have job-based coverage, policymakers may be tempted to use what families spend on job-based coverage to set premium subsidy levels, assuming that most families can afford to pay what they currently spend. For example, they could ask families at the highest income level who would receive subsidies to pay the same share of their income that the typical family across all income groups currently pays (3.6 percent).

  However, data on what families spend on health care likely overstate what they can afford. Public opinion research indicates that consumers believe they are spending too much on health care, and one-quarter (25 percent) have problems paying medical bills.[19] As a result, families often spend more than they can afford on health care by cutting back on other necessities, borrowing, or going into bankruptcy. Over half of all bankruptcies are related to medical costs.[20] Also, low- and middle-income families tend to spend more each year than their incomes, according to national data, indicating that they cannot necessarily afford what they currently spend.[21] Finally, national data on health spending likely overstate what California families spend on health care because the cost of living is higher in California. Thus, many California families would not be able to afford to spend the same share of income on health care as do families in the US as a whole.

- **Determine what families can afford to pay based on families' incomes and the costs of other necessities.** Whenever possible, measures of affordability should be based on family income, not wages. If employers are used to collect premiums for workers who receive coverage through a purchasing pool, an intermediary should determine how much workers contribute based on total family income and inform the employers how much they should deduct from workers' paychecks. Using an intermediary would streamline the determination of how much workers can afford to contribute toward premiums and would prevent employers from knowing about a spouse's earnings and other family income information. However, careful consideration is needed to avoid requiring workers to disclose confidential information to their employers.

  Policymakers should consider adjustments to family income that reflect major differences in the costs that families face. Adjusting for particularly high costs would enable policymakers to direct public dollars to those most in need. These adjustments should include regional differences in housing costs, the cost of child care, and other extraordinary costs, such as health-related costs not included in the coverage plan.

  One way to address these differences would be to subtract non-health expenditures from a family's income before determining how much the family must contribute toward health care premiums.[22] For example, a family earning $50,000 who pays $12,000 per year on child care would have an adjusted income of $38,000 for the purpose of determining how much the family must contribute toward health care. In contrast, health-related costs should be subtracted from a family's required contribution to health care. For example, if a family is determined to be able to pay $2,000 in annual health costs per year and incurs $1,000 in dental or other costs which are not included in the coverage plan, the family should only be required to pay $1,000 toward premiums and other costs associated with the coverage plan.

  If policymakers do not include income adjustments, families facing high costs may not be able to afford required premium contributions. For example, families in the greater Boston area have enrolled at lower rates than expected in Massachusetts's Commonwealth Care, which provides premium subsidies to families with incomes up to three times the poverty line. Advocates believe that many families in the Boston area cannot afford the required premium contributions, which are not adjusted to reflect Boston's higher cost of living.[23]

- **Adjust standards on how much families can afford as health care costs rise.** Policymakers should ensure that rising health care costs do not erode the standards on how much consumers can afford to pay. For example, policymakers could automatically adjust the income levels that determine which families receive subsidized premiums at the same rate as health care costs, or require a periodic review of these income levels.[24]

Conclusion

Proposals to expand health coverage should reflect the fact that many California families struggle to make ends meet. Otherwise, expanding health care could come at the cost of families not being able to pay for other basic necessities such as food and shelter. Policymakers should make realistic assessments about what families can afford to pay for health care; ensure that families can afford to *use*, and not simply buy, coverage; and provide adequate assistance to families who cannot afford the cost of coverage. Taking these steps will help ensure that California families receive health coverage and meet other basic needs.

David Carroll prepared this Budget Brief. The California Budget Project (CBP) was founded in 1994 to provide Californians with a source of timely, objective, and accessible expertise on state fiscal and economic policy issues. The CBP engages in independent fiscal and policy analysis and public education with the goal of improving public policies affecting the economic and social well-being of low- and middle-income Californians. General operating support for the CBP is provided by foundation grants, individual donations, and subscriptions. Please visit the CBP's website at www.cbp.org.

ENDNOTES

1 The Governor's proposal requires all Californians to carry coverage. Senator Perata's proposal requires state taxpayers to buy coverage for themselves and their dependents. Assembly Speaker Núñez's proposal requires certain workers to share in the cost of coverage.

2 CBP analysis of California Health Interview Survey data.

3 Lisa Dubay, John Holahan, and Allison Cook, "The Uninsured And The Affordability Of Health Insurance Coverage," *Health Affairs – Web Exclusive* (November 30, 2006).

4 John Holahan, Jack Hadley, and Linda Blumberg, *Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts* (The Urban Institute: August 2006).

5 Many low-income families go without coverage because they typically have to spend a high share of their incomes on premiums to buy coverage.

6 John Holahan, Jack Hadley, and Linda Blumberg, *Setting a Standard of Affordability for Health Insurance Coverage in Massachusetts* (The Urban Institute: August 2006). Figure is for families with job-based coverage whose out-of-pocket costs are higher than those of 95 percent of similar families.

7 California HealthCare Foundation and The Center for Studying Health System Change, *California Employer Health Benefits Survey* (November 2006). Figures include both employer and worker premium contributions.

8 Premiums are for Kaiser Permanente's nongroup $25 copayment plan in Sacramento. These premiums are for consumers whom Kaiser Permanente chooses to cover after screening for health and pre-existing conditions. Premiums for consumers whom insurers are required to cover, such as workers with job-based coverage who leave employment, could be substantially higher.

9 Sara R. Collins, et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (The Commonwealth Fund: September 2006). These data include adults who do not have Health Savings Accounts. They also include adults with job-based coverage, the cost of which is generally shared between employers and workers, and those with health care policies purchased through the nongroup market.

10 See, for example, Jonathan Gruber, Ph.D., *The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond* (The Henry J. Kaiser Family Foundation: October 2006) and Melinda Beeuwkes Buntin, et al., "Consumer-Directed Health Care: Early Evidence About Effects On Cost And Quality," *Health Affairs – Web Exclusive* (October 24, 2006).

11 Under the Governor's proposal, families with incomes below the poverty line would not pay premiums.

12 Assumes two children enrolled in Healthy Families.

13 Based on 2007 federal poverty guidelines.

14 The HAP is expected to be implemented beginning July 1, 2007.

15 Based on 2007 federal poverty guidelines.

16 Individuals who work for an employer that contributes to the program will pay less.

17 Based on 2007 federal poverty guidelines.

18 California Budget Project, *Making Ends Meet: How Much Does It Cost to Raise a Family in California?* (Revised November 2005).

19 See ABC News/Kaiser Family Foundation/USA Today, *Health Care in America 2006 Survey* (October 2006).

20 David U Himmelstein, et al., "Illness And Injury As Contributors To Bankruptcy," *Health Affairs – Web Exclusive* (January - June 2005).

21 US Bureau of Labor Statistics, *Consumer Expenditures in 2005* (February 2007).

22 Regional differences in housing costs could be based on the amount by which a county's rents exceed the state average as measured by Fair Market Rents.

23 Commonwealth Care, *Board Update* (April 3, 2007). Approximately one-third (34 percent) of enrollees in free coverage were from the greater Boston area, as compared to approximately one-quarter (23 percent) of enrollees who must pay subsidies.

24 See Kaiser Family Foundation, *Effect of Tying Eligibility for Health Insurance Subsidies to the Federal Poverty Level* (February 2007), downloaded from http://kff.org/insurance/snapshot/chcm021507oth.cfm on May 1, 2007.