Individual vs. family health plans: implications for access to health care and welfare

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NBER Center for Aging and Health Pilot Proposal
April 2024

Adverse health shocks are one of the largest sources of risk to families, often leading to high out-of-pocket healthcare costs and disparities in access to health care. Health insurance can help protect against this risk, but access to insurance can vary widely across households. For example, most individuals aged 65 and over qualify for Medicare, while options for younger individuals can depend on whether their employer offers coverage, whether they have low enough resources to qualify for Medicaid, or whether their geographic location has a robust ACA exchange. One oft-overlooked channel through which many individuals gain access to health coverage is through their families, in which a family member is enrolled in a health insurance plan that covers spouses and dependent children.

In this project, we[1] seek to understand the economics of family coverage of health insurance plans through two specific aims. The first aim is a simple descriptive analysis that documents the prevalence and features of family policies using both publicly available data and administrative health claims data that we already have access to. We will ask: What fraction of the population across the life course is covered by individual and family plans? How do prices and cost-sharing structures vary between the two types of policies? We will use data from the Kaiser Family Foundation (KFF) Employer Health Benefits Survey, the Medical Expenditure Panel Survey (MEPS), and IBM/Truven Marketscan data for this analysis.

Documenting these patterns across the life course is important because access to insurance through family coverage is likely to be highly disparate by age since family plans are predominantly found in plans offered through employers while Medicare plans (both traditional Medicare and Medicare Advantage) do not offer family plans. Cost-sharing structures, and more specifically deductible structures, are also important to document because family plans often have deductibles that are multiple times the magnitude of individual plans, and prior work by our team (Hong and Mommaerts, forthcoming) shows that large deductibles can have detrimental effects on households. Preliminary analyses of high-deductible plans in the KFF data suggest that the majority of family plans have “aggregate” deductibles that are much larger than the deductibles of single plans (see Table 1 below).

The second aim is to understand the underlying mechanisms through which family plans provide better or worse access to health care and quantify the welfare implications of such plans. To do this, we will develop a model of family health risk, insurance demand, and medical consumption that highlights the role of correlated health shocks between family members (Sinaiko et al., 2017), liquidity constraints (Ericson and Sydnor, 2023), adverse selection (Nguyen, 2022), and moral hazard (Brot-Goldberg et al., 2017) for individual and family welfare. We will use this model to simulate the effects of introducing family plans to populations that do not have access to these plans, including the Medicare population and families on the ACA exchanges.

Despite the existence (and likely prevalence) of family plans, there is scant research on them. Sinaiko et al. (2017) document the correlation of health shocks between family members, but stop short of analyzing the consequences for individual versus family plans. Solomon (2024) studies family bundling in long-term care insurance, and Nguyen (2022) studies family bundling in health insurance in Vietnam but focuses on adverse selection concerns. Our contribution to this nascent

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literature is to provide the first documentation of the prevalence and features of family plans in the US, and uncover a broad swath of mechanisms for which family plans provide better or worse access to coverage.

The findings of this project will have practical policy relevance for the design and regulation of health insurance. The Commonwealth Fund 2023 Health Care Affordability Survey (Collins et al., 2023) found that 29 percent of people with employer coverage and 40 percent of people enrolled in Medicare and Medicaid have delayed or forgone care due to unaffordability. As a result, more than half of them reported worsened health within the family. Given the prevalence of family plans in employer-sponsored health insurance and the lack of family plans in Medicare, it is important to understand the implications of introducing (or banning) family plans in Medicare, especially its health consequences for people at older ages.

Our team is well-suited to conduct this project because it builds on our prior work that examined deductible structures within individual health insurance plans (Hong and Mommaerts, 2023). This project will use some of the same data sources and build on the modeling techniques developed in the previous paper to shed light on optimal design of *family* plans.

Table 1: Average single and family plan structures in high-deductible health plans, 2023

		Premium ($)		
	Deductible ($)	Employee Contr.	Employer Contr.	Obs.
Single plan	2,887	1,189	6,707	765
Family plan – aggregate ded.	5,389	5,891	16,674	569
Family plan – per-individual ded.	3,841	6,170	15,950	195

Note: data from Kaiser Family Foundation Employer Health Benefits Survey, 2023. Sample is high-deductible health plans among employers' primary plans.

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