Instability among middle class families and the impact of health insurance

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INSTABILITY AMONG MIDDLE CLASS FAMILIES AND THE IMPACT OF HEALTH INSURANCE

By

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DISSERTATION

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in

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ABSTRACT

INSTABILITY AMONG MIDDLE CLASS FAMILIES AND THE IMPACT OF HEALTH INSURANCE

by

Sarah Savage

University of New Hampshire, May, 2009

What it takes to be middle class in the United States has changed dramatically from the post World War II period to the 1970s and the present. At the same time the requirements for attaining the income and assets associated with a middle class position changed, many financial protections available to the middle class weakened. The new economic landscape following a period of economic restructuring has made it harder to earn a position in the middle class while the changed political landscape has possibly made it harder to maintain one’s position. This research examines the extent to which middle class families from a birth cohort that came of age during the 1990s period of economic restructuring are economically vulnerable. To assess the role of changing financial protections, I examine the extent to which losing health insurance affects members of the middle class economically, focusing on married couples to avoid confusing vulnerability caused by divorce with macroeconomic level changes. Using panel data from the US Bureau of Labor Statistics 1979 National Longitudinal Study of Youth, I examine the economic and occupational experiences of a birth cohort who were young adults during the period of economic restructuring in the 1980s and 1990s, following their trajectories through to 2006, the latest wave of data collected. To gain a clearer sense of how individuals cope with economic struggles, and to discern if
experiences vary by class position, I interviewed a small sample of individuals in the New England region.
CHAPTER 1

INTRODUCTION

There has been increased pressure on the middle class in the United States over the past decade. The economic structure and supportive policies that helped to build a growing middle class in the post World War II era have in many ways been reversed. The strong economic growth in the manufacturing sector that provided blue collar work to the less skilled has been replaced by a dual service sector, which rewards the highly skilled and penalizes the less skilled. The fruits of the economic prosperity of the post WWII period were expanded, mainly to the benefit of whites, through policies and practices in the public and private sectors, respectively, until the mid 1970s when there was pressure to scale back benefits previously available through the public sector and to cut production costs in the private sector (Harrison and Bluestone 1988). Government backed unionization meant that higher wages and fringe benefits could be negotiated, but since the 1970s, union strength has severely diminished and as a result union leverage over employers has weakened. In this political environment, the shift from a goods- to service-producing economy has increased inequality (Harrison and Bluestone 1988; Grusky 2001; Levy 1998). A worker's relationship to the means of production, once the dominant stratifying force of society, has been replaced by the level of human capital the worker has attained (Grusky 2001). The former resulted in a more equal distribution of rewards, whereas an emphasis on human capital has produced large inequalities since in
the restructured economy the earning potential is far greater with higher levels of educational attainment. At the same time that we saw growth in the high-wage service sector that rewards the better educated, rapid globalization placed downward pressure on social spending and production costs in the public and private sectors, respectively (Harrison and Bluestone 1988; Huber and Stephens 2005). It is difficult to disentangle which changes stem from economic changes or shifts in political attitudes and policies but all together the result has been a weakening of social insurance against what may come (Hacker 2006b).

Since the 1980s, Newman (1988) and others have argued that even the so-called winners of the advanced post-industrial economy are no longer guaranteed a permanent position in the middle class. As corporations are under pressure to cut production costs, even white collar occupations are not immune to downsizing. Combined with weakened protection from unemployment reflected by a decrease in unemployment insurance during the 1980s, the cost of job loss has increased and, at the same time, the strength of labor decreased (Schor and Bowles 1987; Harrison and Bluestone 1988). Scaling back financial protections became most prominent during the implementation of supply-side economics under the Reagan administration (Harrison and Bluestone 1988). Since then, the direction has been toward even greater privatization and scale backs of social provision, examples of which include the growth of Health Savings Accounts, which shift more of the cost for health insurance from the employer to the individual, and the 1996 Personal Responsibility and Work Opportunities Reconciliation Act, which reduced social welfare support for low income families. The anti-government attitudes that became prevalent in the 1980s created the policy space needed to support deregulation
efforts in favor of fewer restrictions on markets. There has long been an underlying ideological debate over whether to counterbalance a free market economy with redistributive policies or to permit the market to allocate rewards according to individual merit (Fischer et al. 1996). The New Deal was an example of the former, offering government supports to counterbalance the devastating effects of the Great Depression. There were also supportive policies enacted in the post WWII era to expand an already growing economy. But since the 1970s, the prevailing political attitudes and policy directions have been in support of smaller government.

The prevalent political attitudes following the period of economic restructuring emphasized less government and more individual effort as the means to navigating the new economic landscape, even among many who were not reaping its rewards. Franks' (2004) account of Kansans who voted against their economic interests in favor of smaller government captures this trend in political attitudes. It is this dynamic that some scholars believe is contributing to an increasingly economically vulnerable middle class (Wheary 2005; Hacker 2006b). The scaling back of many programs and the deregulation of the market had a latent effect of limiting social insurance against risk even among middle class families. For instance, when government support for unions was strong, their ability to negotiate higher wages, unemployment insurance and comprehensive benefit packages were rewards shared by non-union members of the workforce, especially in tight labor markets. Declining government support for unions had widespread implications for labor in general. At the same time, the globalization of the workforce meant American workers across multiple tiers of organizations could lose their

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1Franks' (2006) piece was written in advance of the 2008-2009 recession. The implications of the current downturn for political attitudes remain to be seen at the time this dissertation was being completed.
jobs to lower cost labor overseas. The growing risk in achieving and maintaining a middle class position became evident, reflected by shifting political attitudes among the generation coming of age in the 1980s and 1990s.

According to Katherine Newman (1993), the generation referred to as the “late baby boomers,” in many respects the younger siblings of the early baby boomers, represent the first cohort to fare worse economically than their parents, many of whom came of age in the post WWII period. Faced with massive economic restructuring, late baby boomers who grew up in middle class families would need more education and dual-earner households to achieve a standard of living like the one in which they were raised (Newman 1993; Warren 2006). Unlike their parents, it is argued, late baby boomers in the middle class can no longer take the security of their social position for granted. They have much less social insurance for navigating risk than their predecessors had. Much of the financial protection their parents’ generation enjoyed has diminished: economist Jacob Hacker (2006b) refers to a “great risk shift”, reflected by a shift of financial risk from collective to private shoulders. Whether directly through lessened unemployment insurance and stagnant wages or indirectly through the deregulation of many business practices of the private sector, protection from hard times shifted from shared to individual responsibility. According to Hacker, there is growing economic instability among American families, indicated by an increase in income volatility. He notes that over the past generation, the economic instability of families, or the rate at which family incomes rise and fall, has increased much faster than economic inequality. While the restructured economy provides contemporary middle class families with opportunities to earn a much higher income (in relative terms) than their parents’
generation, the lack of insurance against difficult times means they have better chances of falling and have further to fall than previous generations (Levy 1998). Theoretically, strong financial protections would mitigate the effects of sudden economic challenges, but in the absence of such protections, families will have a much harder time navigating unforeseen financial challenges. In the current environment, unemployment, illness, and possibly natural disasters could push a family, regardless of class position, to a lower rung. This research assesses the economic vulnerability of members of the middle class and examines the consequences of shifts in a system intended to offer financial protection — private sector health insurance — on the economic stability of members of the middle class.

The United States system of health insurance is predominantly private, where insurance is offered through employers; however there are also public components. Medicare is a universal program of health insurance for elderly persons while Medicaid is targeted toward low income families and persons with disabilities. The private-public health insurance system, originally intended to provide not only access to health care but also to financial protection from medical bills that would otherwise be financially catastrophic (Schoen et al. 2005), has been restructured to shift more risk to private shoulders at a time when growth in health insurance premiums is outpacing wage and income growth (Holahan and Cook 2005). Cost sharing through employers has shifted from employers covering nearly 100 percent of their employees’ premium costs to shrinking proportions. But with health care costs skyrocketing in the face of an aging population, increased longevity, advanced technologies, innovative pharmaceuticals, high administrative costs associated with turnover, and an obesity epidemic, employers’ ability
to cost share is becoming more and more strained. Employees are less likely to opt into their employer’s plan if the premiums are unaffordable, especially healthier individuals. The less healthy have fewer options and are more likely to participate in their employer’s plan, leading to a less healthy pool of employees over which to spread risk, which again drives up premium costs (Swartz 2006). The realization of the potential for the private sector component of the health insurance system to buckle as well as to exclude many is reflected by the on-going debate regarding health insurance reform.

For decades there has been debate about the system of health insurance in the US, with powerful interest groups supporting less government intervention while many politicians and union leaders seek reform and universal coverage (Starr 1988; Quadagno 2005). The system of health insurance is under enormous pressure from rising health care costs but the path to addressing the weakening system remains unclear. Affecting change in the public component consisting of the universal Medicare program for the elderly and disabled and the targeted Medicaid program for the low income is an issue of public policy, whereas the private component delivered mostly through employers is not. There is tension between popular political attitudes to limit government’s role and the potential impact of intervention and regulation efforts. There have been several attempts throughout the twentieth century to affect the private component of the health insurance system through regulations, generally enforced through tax benefits and stipulations for receiving federal money, and many successful attempts to repeal regulations (Day 1997). The latter trend is consistent with a risk shift described by Hacker (2006b), where more risk is displaced onto individual shoulders as a consequence of smaller government. This could be contributing to the income volatility he noted and exacerbating economic
vulnerability more generally, particularly among middle class families who are unlikely to be eligible for means tested public supports such as Medicaid.

Using data from the 1979 National Longitudinal Study collected by the US Bureau of Labor Statistics (US BLS 2006), I examine the economic vulnerability of married middle class respondents between 2000 and 2006, a period when the respondents were in their mid 30s to late 40s. Among married middle class respondents who have experienced different degrees of income mobility, I examine their sensitivity to the increasingly limited financial protection from health care costs in this country. For instance, could losing health insurance coverage for one or more family members contribute to a family slipping economically and if so, to what extent? While the quantitative analysis of the NLSY data permits observation of patterns, it did not allow me to discern with any certainty how and in what order events unfold. To better understand the processes involved and how experiences with insurance status and medical bills could lead to economic struggles, I interviewed a mixed-income sample of New England residents. Analysis of the in-depth interviews also provided insights regarding how experiences may be patterned by characteristics of respondents.

1.1. Theoretical Background

Underlying the divisive ideological debate in the United States about the appropriate balance between individual responsibility and government support is the shared belief that education, hard work, and smart investments are pathways to the American Dream, an economically secure middle class life. In other words, play by the rules and reap the rewards. While the belief is steadfast, the pathways have been
transformed dramatically, particularly since the watershed year of 1973. A combination of large-scale economic changes and dramatic policy shifts has contributed to changes in the requirements for attaining a middle class position as well as the meaning of that position.

A comparison of the requirements and meaning of a middle class position in the post WWII period relative to the period beginning in the mid 1970s to the present offers insight into the dynamics that affect class position. A paramount difference is that all skill levels were rewarded in the earlier period while only the more educated and skilled saw income rise in the later period. Each period was subject to varying levels of consumer demand and competition, both domestic and foreign. The diversity of the labor pool changed dramatically as well with members of minority groups and women often excluded from good paying jobs in the earlier period, and then incorporated more fully after the Civil Rights era. Union strength and ability to negotiate salaries, benefits, and working conditions peaked in the post WWII era and later waned. The combination of different but interrelated factors led to the current reality in which attaining a position in the middle class has grown persistently harder since the mid 1970s relative to the post WWII period (Levy 1998; Grusky 2001; Wheary 2005). According to Claude Fischer et al. (1996), societies choose their level of inequality through their use of public policy. Market forces are unwieldy but policy can help to mitigate the effects of raw forces that have no regard for how difficult it may be for some individuals to meet the requirements for full participation (1996). According to Douglas Massey (2006), the role of a democratic government should be to ensure that markets exist and are supported with proper infrastructure, that citizens share equal access to the market, that competition is
fair, and that citizens are protected against the harmful effects of market failure. An alternative view is that freer markets promote more competition resulting in downward pressure on prices while also promoting more individual responsibility. There was political support for a larger governmental role when the New Deal was passed, but some scholars argue that privileged Republican elites successfully dismantled the New Deal coalition by rallying members of the white middle and working class against civil rights, shaking up the composition of parties and potential presidential coalitions (Edsall and Edsall 1991; Quadagno 1996). Public policy scale backs and smaller government still in place today\(^2\) resulted in part from this dynamic political shift.

Public policy can provide broad access to financial and human assets such as home ownership and education, for example that would otherwise be unattainable for many. Policy can also establish levels of financial protection from unemployment, illness and other unforeseen, financially challenging events, essentially mitigating the effects of raw market forces. Although policy cannot be applied directly to the private sector, there are ways to regulate private sector activities by establishing rules, imposing penalties, or designing tax benefits to provide incentives for certain kinds of behavior, for instance. The balance of government’s role, whether through social spending or regulatory efforts, and the market has varied throughout the twentieth century, at times linked to economic circumstances or cultural shifts.

\(^2\)This dissertation was written at the time when economic bailouts of lenders and corporate giants were occurring, but the need to address the economic crisis does not imply that Americans no longer value small government.
The economic deprivation resulting from the Great Depression created a policy space amenable to the passage of the New Deal\textsuperscript{3}. The Civil Rights Era changed the composition of the workforce and entitlements in dramatic ways contributing to intense speculation and criticism of how public monies are used (Quadagno 1996). According to Jill Quadagno, there was a political backlash to social provisioning following efforts targeting minority groups, such as the Economic Opportunity Act that invested public dollars into disadvantaged urban areas consisting disproportionately of African Americans. Many white workers felt that their needs were being neglected at the expense of minority groups. A lasting implication of the emergence of political attitudes favoring smaller government was a shift in policy direction from expanding access to capital and financial protection in the post WWII period to limiting both in the period beginning in the mid 1970s. One study showing attitudinal changes in the recent period from 1990 to 1997 revealed evidence of waning support for financial protections such as Social Security, where the percent that agreed that it was an earned right for the elderly declined from 82 to 74 over the seven year period (Silverstein, Parrott, Angelelli, and Cook 2000). Specific policy changes that affected both the private and public sectors fell into one of three policy types: distributive, regulatory, and redistributive (Lowi 1969).

Distributive policies, the costs of which are spread across taxpayers and are not targeted to one specific group, tend to be the least controversial and may even go unnoticed except among those directly affected (Weissert and Weissert 2006). For instance, a federal scholarship for nurse practitioners that practice in rural underserved areas is a direct win for the nurses while also benefiting residents of rural areas. The most

\textsuperscript{3}The extent to which the current economic landscape at the time of this writing will also promote a policy space open to a larger governmental role remains to be seen.
hotly debated of the three types are redistributive policies which rely on progressive tax policies, where higher earners pay more. The funds are then redistributed to others. Social groups benefiting from targeted policies may be stigmatized because they are recipients of rewards they did not directly earn. Welfare recipients often are stigmatized, and the stigma may be reinforced by stereotyping those receiving welfare as undeserving. Regulatory policies that affect the behavior of private and public sector players are also controversial and while some benefits may be obvious wins such as protecting consumers’ health and lives, they could cost private sector players billions of dollars by having to put certain protections or quality controls in place, for example. All three policy types can impact the private sector, but the type that is most likely to directly affect the private sector is regulatory.

A regulatory measure that has been frustrating for some state decision-makers is the exemption of self-insured health plans from state oversight through the passage of the federal Employee Retirement Income Security Act (ERISA) of 1974. ERISA was passed to prevent retirement plan abuses. Congress extended the act to health plans in a way that did not mandate employer coverage but rather limited a state’s ability to realize reforms of self-insured employers and employers that offer no coverage whatsoever (Day 1997). This is an example of a regulatory policy that fits within the larger pattern of scale backs from more extensive social provision. By making self-insured employer health plans exempt from state oversight, individual employees are not guaranteed the same level of public protection. However, there have been numerous lawsuits by employees over claim denials so the practices of self-insured employer health plans are not immune from challenge. An example of a scale back of a distributive policy that had indirect effects on
the private sector includes the weakening of unemployment insurance. Reductions of unemployment insurance undercut union ability to negotiate better wages and benefits (Harrison and Bluestone 1988). While policies differ in type and how they affect the public and private sectors, whether directly or indirectly, the pattern beginning in the period of the mid-1970s was to scale back government and shift more onus to the individual. The new policy direction has effectively changed the meaning embedded within certain social positions, particularly the middle class.

Adjustments have been made by aspiring middle class families to meet the new requirements needed to achieve and maintain a middle class position. Many are working harder and longer to maintain a middle class income and lifestyle, and there is a growing realization that it is not to be taken for granted. In a study examining a weakened social contract in the US, Tom Kochan (2005) found that many young families feel that they will be unable to achieve the same standard of living as their parents. He also found that support for unions increased from 55 to 67 percent from 1980 to 1999, possibly indicative of a desire for increased financial protection. Evidence of the way middle class families are adjusting to the precarious nature of their status can be seen in child rearing: to better prepare the next generation to achieve a middle class position, middle class parents are utilizing certain child rearing techniques that may impart an advantage to their children in the changed economic and social landscapes (Lareau 2005). According to Annette Lareau, middle class parents are more likely to instill in their children the skills needed to navigate social institutions important to achieving a middle class position than their working class counterparts. While children reared in middle class families are cultivated to question authority figures and feel entitled to a certain level of quality,
instance, children raised by working class parents are more likely to defer to authority and less likely to exert pressure on the gatekeepers of social institutions (2005). Simply put, according to Lareau, middle class parents are more deliberately building cultural capital in their children than working class parents are. Many Americans are working harder and earning higher educational attainments, accepting that the minimum requirements for achieving a position in the middle class have increased. Less well known is that knowledge of social institutions can lead to access to more opportunities for financial protection. This is in contrast to the middle class from the postwar generation, who could take economic security for granted as a result of a much different economic, social and political climate.

Much can be observed by making comparisons between the post WWII generation and the one that came of age in the restructured economy. There were stronger social insurances in place in the earlier period partly as a result of the political attitudes that emerged following the Great Depression and the economic prosperity following WWII. For instance, a comparison of political views over the period ranging from 1974 to 2006 as measured by the General Social Survey⁴ (Davis and Smith 2006) reveals that 1974 is the only year in which a larger portion of respondents reported liberal views than conservative ones. Every year following 1974 the reverse is true—a larger portion of respondents reported conservative views, sometimes by a difference of ten plus percentage points. According to Jill Quadagno (1996), the change in political attitudes is explained in part by the fact that prior to the period of economic restructuring, there was

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⁴The General Social Survey is a cumulative survey administered to a nationally representative sample, conducted almost every year since 1972 by the National Opinion Research Center at the University of Chicago (Davis and Smith 2006).
more to go around, but also, in the pre-Civil Rights period, there was less controversy surrounding redistributive policies that provided social insurance. But political attitudes cannot fully explain the change in social provisioning.

In attempts to explain why the United States was a “welfare state laggard” relative to other advanced Western nations, Theda Skocpol (1995) offers multiple theories. She emphasizes how the lack of a labor party and the emergence of a two-party system that tapped into national social groups resulted in provisions favoring those represented in such groups, which happened to be women and children. Skocpol’s examination offers insight into the history of US policy formation; however it is relevant to the new policy direction in the restructured economy because it highlights the role that interest groups may play in driving policy. Despite the challenges of the changed economy, combined with scaled back social insurances, the opportunity to earn higher incomes was much greater.

The opportunity to earn what may have been considered unprecedented levels of income was not shared equally across social segments but it existed nonetheless. For instance, as education became the new stratifying force in the restructured economy (Grusky 2001), children’s access to quality education as a function of their neighborhood could determine their level of advantage or lack thereof (Furstenberg, Cook, Eccles et al. 1999). So while the earning potential grew to unprecedented levels in the restructured economy, since it was not shared equally, inequality also grew. Yet there were also new trends in making consumer goods and home loans more accessible across the economic tiers of society, which has managed to mask growing inequality and lead the majority of people to self-identify as middle class (Sullivan et al. 2000). For instance, there was a
tremendous shift in consumerism on account of the explosion of discount retailers as well as the legalization of high interest rates. Although the restructured economy presents new challenges, it also makes many consumer goods accessible to most Americans regardless of their socioeconomic position. But a downside to this is that the legalization of high interest rates may be exerting enormous pressure on American families (2000).

While more Americans in the restructured economy have access to a range of consumer goods and home loans to which they might not otherwise have had access in earlier times, they tend to carry much higher levels of debt than previous generations (Sullivan et al. 2000). This places American families in a precarious position and in part symbolizes the growing tenuousness attached to a middle class position, especially if faced with a sudden financial challenge such as a job loss or illness. Katherine Newman (1988) observed this in the late 1980s as many white collar managers experienced layoffs due to downsizing. Although many of the families Newman interviewed did not enter the ranks of the low income, many were forced to switch homes, neighborhoods and school systems in accordance with a reduced budget. This research examines the extent to which declining financial protection from health care costs may be contributing to economic instability among members of the middle class.

Health insurance in the US is delivered primarily through private sector employers, but there is also a public component for the elderly, disabled and low income members of the country. Between 1987 and 2005, an average of 65 percent of non-elderly adults had health insurance coverage through an employer (US Census 2005). But as the nature of employment patterns change with fewer individuals spending careers at the same employer and many others piecing together contingent forms of employment such
as part-time jobs and temporary/contract work – work that is much less likely to offer
fringe benefits – relying on employers to be the dominant source of health insurance is
both insufficient and unsustainable (Harrison 1994; Tillman and Indergaard 1999). In
addition, the administrative costs associated with frequent movement between jobs is a
significant driver of health care costs. Even with Medicaid and Medicare to help fill gaps
in coverage, a large portion of the population (45 million under age 65) is excluded from
any coverage whatsoever (US Census 2008). Furthermore, even as a high percentage of
non-elderly adults continue to receive health insurance through their employers, the
coverage is becoming increasingly thin, exposing the insured to unprecedented levels of
cost-sharing with rising premiums, deductibles and co-pays and limited coverage, which
could potentially move toward covering catastrophic events only (Moran 2005). The
combination of aging baby boomers, increased longevity, advanced technologies,
expensive new drugs, preventable and costly diseases, growing ranks of uninsured, and
high administrative costs sends health care costs soaring to unprecedented levels. Without
health care cost controls, employer sponsored health insurance may continue to weaken
and hurt those who have this coverage (2005). The employer-sponsored system in the US
is threatened in part because it affects the competitiveness of employers relative to
foreign businesses, many of which can rely on public provisions. These nations’
governments cover costs that the majority of employers and workers in the US are
responsible for as companies and individuals. The growth of unconstrained health care
costs may be contributing to economic instability of middle class families precisely at a
time when social insurances are much thinner than they were in previous generations.
This research explores economic instability among middle class families consisting of
adults from the generation to come of age in the restructured economy. Secondly, it examines their sensitivity to shifts in financial protection by looking at changes in their health insurance status specifically. A closer look at how the post WWII middle class compares to the more recent cohort provides information on how the interplay of economy, history and politics shape both the requirements and meaning of a middle class position.

1.1.1 The Middle Class: Then and Now

The economic, political and cultural landscape has changed dramatically from the post WWII era to the post-1970s period. In comparison, the magnitude of the changed shape and trajectory of the middle class might seem minimal. Part of this is explained by the fact that families adapted to the new economy by forming two-earner households, necessary to maintain a middle class standard of living. For instance, although similarly aged men earned lower median incomes in 2004 than 1974, after adjusting for inflation, family income was 9 percent higher in 2004 (Sawhill and Morton 2007). On the one hand, more education and work is required to achieve a middle class position, which has implications for its composition, but certain consistencies among members from the earlier generation to the more recent one still exist. For instance, members of the middle class were and continue to be a politically influential group that demand resources and often enjoy safer and more affluent neighborhoods and schools than the lower income tier of society (Kawachi 2005). However, not only have the requirements for entering the middle class changed but also the security of the position is much different on account of the interplay of economy, politics and culture unique to each period. In an effort to tease
out the shape and trajectory of middle class families from each period, I compare the events leading to the growth of a large middle class in the post WWII period to more recent trends that some scholars argue have contributed to a hollowing out of the middle class (Harrison and Bluestone 1988) and an increased tenuousness of a middle class position (Newman 1988; Hacker 2006b).

1.1.1.1 An Economically Secure Middle Class – the Post World War II Generation. The post WWII generation entered adulthood during a favorable economy accompanied by expansive policies and a period of peace—what many consider ideal circumstances. This is not to suggest that the postwar generation never experienced financial struggle, for those in their thirties and forties in the 1950s were also children of the Great Depression—hardly ideal times. But as adults the opportunities were plentiful and the policies expansionary.

The fruits of rapid economic production and expansive policies benefited many working class families and facilitated their entry into the middle class; however it should be acknowledged that these rewards were not shared equally. America’s black population and many women were excluded. For instance, the National Labor Relations Act that allowed unions to organize and bargain permitted the exclusion of blacks, who were left to establish separate racially segregated unions. The effect was the barring of blacks from skilled trade unions and job training opportunities while increasing the advantage of white workers who were able to maintain a smaller pool of skilled workers (Quadagno 1996). And beneath the surface, civil unrest was brewing, which would erupt in the 1960s and early 1970s, but the dominant sense was an appreciation for the “golden years of capitalism”, marked by a strong economy and social contract. The political attitudes of
the time were also much less opposed to bigger government, especially in comparison to
the period following the mid-1970s. Perhaps the scars of the Great Depression were fresh
even to warrant such a governmental role. The years following WWII were also unique
in that the US had an economic advantage over war-torn Europe, which helped its goods-
producing sector to flourish. The market for consumer goods was far from saturated both
domestically and abroad. Imports to the US were low and there was little pressure from
foreign competition (Harrison and Bluestone 1988). US employers and workers were
interdependent at this time, reinforcing a strong social contract.

Workers had the support of the government to organize and improve working
conditions. It was however permissible to exclude blacks from skilled trade unions
(Quadagno 1996). Unionized workers fought for better wages and fringe benefits, which,
along with strong economic growth, contributed to a relatively equal distribution of
income growth across income levels (Mishel et al. 2007). With strong bargaining power,
unemployment insurance was high and thus the “cost of job loss”, low (Schor and
Bowles 1987). US employers had a vested interest in maintaining the job satisfaction of
its workforce particularly since strong unions meant that strikes could severely threaten
productivity levels. Improving wages and offering fringe benefits was a way to build
employee loyalty at a time when US employers were dependent on the domestic
workforce. Public policy further supported high wages and fringe benefits through raising
the minimum wage to unprecedented levels and making health insurance tax exempt
(Wheary 2005). It was not uncommon for workers at this time to build a lifelong career at
a single employer, which has since been replaced with a growing trend of contingent
forms of employment (Harrison and Bluestone 1988). The US workforce, particularly
veterans returning from WWII, was further supported through the GI Bill and the creation of affordable home loans to ensure a smooth transition into civilian life. The strong economy provided a means for the average, white, working class American to earn a livable wage that could support a family, and in turn, relatively expansionary public policy provided the means for working class families to attain assets that would move them into an economically secure position in the middle class.

1.1.1.1 Assets Provide Economic Security. Michelle Miller-Adams (2002) distinguishes between different types of assets — economic, human, and social. All types of assets offer “staying power” and the potential to provide security against hard times. Postwar public policy facilitated the accumulation of human capital assets through the GI Bill and economic assets through unprecedented initiatives to encourage home ownership. For instance, while low interest long-term home loans with affordable down payments are today standard practice in the mortgage industry, such practices were uncommon until the postwar years (Wheary 2005). Despite the economic prosperity at the time, many working class families would not have been able to purchase a home without such policies in place, and home ownership is a major stepping stone into the middle class (Sherraden 1991; Oliver and Shapiro 1997). As investments that increase in value over time, assets improve the net worth and overall financial positions of individuals and families. Homes may be passed down to offspring as inheritances, providing a new family with an advantage over families having to bear the entire cost alone and for the first time. Assets also serve as buffers to help weather challenging or costly life events (Sherraden 1991; Miller-Adams 2002; Shapiro 2003). For instance, home equity loans can be used to help pay for a child’s college education, and homes

Miller-Adams (2002) also examines a fourth asset type — natural.
may be refinanced or investment accounts liquidated to provide relief from medical bills or other sudden expenses. The ability to tap assets to cover emergency expenses exemplifies the “transformative power of assets” (Shapiro 2003). The advantages of the supportive policies of the post WWII era were not distributed equally, an injustice that political leaders of the time attempted to address through inclusive policies.

Not all Americans benefited from the strong economy and progressive public policies following WWII. Blacks were excluded, as they had been from the New Deal passed decades earlier (Quadagno 1996). For instance, the New Deal permitted southern Congressmen to exclude blacks from social security and unemployment insurance through exclusionary policies targeting agricultural and domestic workers—mostly blacks. Efforts to rectify racial injustices were part of Johnson’s Economic Opportunity Act of 1964. Also referred to as Johnson’s “War on Poverty”, the Economic Opportunity Act contributed financial resources to disadvantaged, mostly urban communities in hopes of eradicating poverty. Despite many successes of Johnson’s “War on Poverty” including a plummeting poverty rate in many central cities, the efforts were unsustainable due to what some scholars refer to as a backlash toward redistributive efforts (Quadagno 1996). Redistributive policies tend to be the most controversial relative to other policy types since they require taking from those who have more resources and reallocating to those with less (Lowi 1969), but at the time of Johnson’s War on Poverty, there was the added layer of unprecedented cultural shifts, which fueled the controversy according to some scholars (Edsall and Edsall 1991; Quadagno 1996). Additionally, the growing trend of stagnant wages made it difficult for less skilled workers to justify the use of their tax dollars for programs that had no direct benefit to them (Edsall and Edsall 1991).
1.1.1.1.2 A Changing Economic and Political Context for Policy in the 1980s.

According to Jill Quadagno (1996), throughout the media and public discussion, theories of the demoralizing nature of welfare spread. It is unclear whether the backlash to redistributive efforts was fueled by the idea that welfare is a disincentive to work (Murray 1984) or racist sentiments and a reluctance to support nonwhites (see Newman 1993; Quadagno 1996). According to Edsall and Edsall (1991), not only did an upsurge of growing distaste for liberal politics occur, but the composition of the Democratic Party changed in ways that would have profound implications for the shape of public policy moving forward. The tension between tax payers and tax recipients, for instance, led to a polarization of the presidential coalition of the Democratic Party. Many white working class men resented paying for services they did not use. At the same time, the stereotype of recipients of such services grew more negative as social dysfunction associated with minority groups rose, reflected by increases in crime, welfare dependency, illegitimacy, and educational failure (1991).

Despite the increases in social dysfunction disproportionately associated with minority groups, many blacks experienced significant gains in economic and social mobility. The number of blacks doubled from 1950 to 1990, but the number employed in white collar professions increased by 920 percent (Edsall and Edsall 1991). Even though the gains were substantial, they received little attention. Instead, the social dysfunction was viewed as being the cost of liberalism, which in part led to defections of a portion of the Democratic base—members of the white working class, referred to as “Reagan Democrats” (1991). As described by Edsall and Edsall (1991), many defectors were in part driven by racism to the extent that they opposed paying for services that went to
mostly blacks and Hispanics, but alternatively this group also felt that their own needs were being neglected as they moved up from the working to middle class, having lasting effects on the composition of both parties and making clear the political consequences of policies targeting marginalized groups. These sentiments grew at a time when economic restructuring was threatening existing wealth and making financial goals harder to achieve. It is this threat, as opposed to racist sentiments, that Katherine Newman (1993) in part attributes to the growing pervasiveness of conservative political attitudes.

According to Newman (1993), in response to a growing sense that there is no longer enough to go around, conservative attitudes emerged. Figure 1 below shows the distribution of income quintiles over three distinct time periods and illustrates this dramatic shift in the distribution of resources. The postwar period witnessed relatively equal income growth across quintiles, followed by unequal, yet positive income growth that rewarded the lowest income group the least, and the richest, the most, across quintiles from 1973-2000; and finally all losses across groups in the post-2000 period, with the lowest income group experiencing the largest losses and so on.
In view of these dramatic shifts in the distribution of income growth over fifty odd years one might be inclined to ask what policies could have helped mitigate such outcomes. It is difficult to know the answer because dramatic changes to the economic landscape occurred at a similar time as the cultural upheaval that may have contributed to waning support for larger government (Quadagno 1996). Regardless of the answer, the
outcome was such that significant roadblocks for social reform were taking root and would continue to do so as the political attitude emphasizing individual responsibility became more and more prominent. This political shift occurred at a time when increasing financial protections and social insurances may have helped mitigate the consequences of economic restructuring. Instead, party fractions and more limited financial protections resulted.

1.1.1.2 A New Middle Class – the Late Baby Boomer Generation. By interviewing members of both the early and late baby boomer generations, Newman (1993) provides an illustrative comparison of changing attitudes toward a social contract. She quotes early baby boomers that came of age in the progressive 1960s era who express disappointment over their younger siblings’ complacency with the growing conservatism that took root in the mid-1970s but became firmly established under the Reagan administration, reflected by tax cuts, anti-regulatory measures, and social spending scale backs. But according to interviewees from the late baby boomer generation, their lack of progressivism is not because they do not care, but rather a pragmatic response to the weakened economy (1993). It is this observation that leads Newman (1993) to disagree with the claim that racism explains the shift in policy direction, such that in the post-civil rights era many white Americans objected to tax dollars being used to provide assistance to people of different skin color, and rather conclude that the changing attitudes and public policy shifts were due to the fact that there was simply less pie to go around. After all, the economy had changed in unprecedented ways from goods- to service-producing, and the skill level required for jobs paying livable wages in the restructured economy was much higher. The wages
available to the less skilled in the changed economy were not only lower, they were also increasingly stagnant. Figure 2 shows evidence of a breakaway in wages among the high income workers from middle and low income workers, beginning in the mid-1970s, at which point the wages of high income workers continue on an upward slope and those of low income and, albeit to a lesser degree, middle income appear to plateau or increase very little.

Figure 2. Real Hourly Wage Trends for Low-, Middle-, and High-wage Workers, 1947-2003

The effects of the slowed growth in wages on family income relative to when they steadily increased can by seen by making intergenerational comparisons. A recent study comparing men in their thirties in 2004 to similarly aged men in their fathers’ generation in 1974 showed that the younger generation was economically worse off, with inflation-adjusted median income, 12% lower for the men in their thirties in 2004 than their fathers’ generation (Sawhill and Morton 2007). However, when taking median family income into account, the 2004 income figures are 9% higher than the 1974 figures. This
is a result of the increase in two-earner households in recent decades, now necessary to achieve a middle class income (Blank 1997; Warren 2006) or for many low-wage workers, just to make ends meet (Ehrenreich 2001). Considering that it is harder to attain a position in the middle class in the post-economic restructuring era, it would seem plausible to expect a smaller middle class moving forward. In fact, a reduction in the size of the middle class from 1973 to 1996 is reflected in Figure 3. Using data from the US Census, Frank Levy (1998) employs a definition of middle class as having an income between $30,000 and $80,000, making note of the fact that there is no definitive definition of "middle class". Among families with heads between ages twenty-five to fifty-four and using 1997\(^6\) dollars, the portion of families that fall into the middle class category is smaller in 1996 than in 1973. Some of this is explained by the increase in the highest income group (over $80,000) by 1996, but clearly there were also slight increases in the lower income segments in 1996.

\(^6\)The median family income in 1997 was $44,568 (US Census Current Population Survey).
Harrison and Bluestone (1988) explain the shift in the size and shape of the middle class, pointing to a major U-turn in the economy that occurred between 1969 and 1979. Essentially, the authors approximate that sometime between 1969 and 1979, in addition to the oil crisis of 1973, the value of imports to the US practically doubled. For instance, by 1986, families and businesses were buying $45 worth of imports for every $100 of US produced goods. While just decades earlier, the US was little threatened by foreign competitors, by the 1970s, multiple countries were regularly producing and exporting the same exact goods as one another. Corporations in each country found themselves operating well below full capacity, eroding productivity levels and increasing the unit cost of production (1988). This trend is consistent with the hyper-globalization thesis that maintains that rising production costs stemming from globalization put downward pressure on resources available for social spending (Huber and Stephens...
Harrison and Bluestone (1988) argue that the US had a choice of how to respond, and that the response had implications for the future stability or vulnerability of the workforce. Fischer et al. (1996) also argue that societies choose their level of inequality through public policy.

According to Harrison and Bluestone (1988), faced with foreign competition, US corporations had an opportunity to invest in better quality and more innovative products and to use public policy to manage competition and trade. Instead, the prevalent strategy focused on lowering production costs. The authors maintain that the effect of the corporate restructuring in this country has pitted individual workers against one another (1988). Just as a split labor market was used to pit white workers against black workers, which benefited employers in need of strike breakers (Bonacich 1972), the wage concessions and loose ties to employers divided workers in the US. These divisions have contributed to a weakened labor movement. In fact, some scholars attribute the failure to pass health care reforms to the lack of a strong labor party in the US (Quadagno 2005).

As a possible response to the economic restructuring of the 1980s, many analysts like Harrison and Bluestone (1988) called for more government intervention as opposed to an unregulated market. They argued that if the structure of the US workforce continues to be characterized by part-time, contract, and temporary employment, more than ever, workers would require a safety net to ensure financial protection, through national health insurance and supportive unemployment insurance, for instance (1988). Such policies can help individuals to weather changes and forces beyond their control (Fischer et al. 1996).

The effectiveness of any policy depends on the context. A policy designed at one historical point can achieve successes for the greater good, but be ineffective during a
different time period. In order to understand how policies support the middle class, it is important to examine them within the appropriate political, social, historical, and cultural contexts.

1.1.1.3 Policies that Support the Middle Class. The supportive policies that helped working class Americans accumulate assets and attain a postsecondary education were enacted in a period of economic prosperity—the "golden years of capitalism." US employers' dependence on the domestic workforce meant that workers were in a position of leverage to affect wages and benefits, further strengthened by government backed rights to organize. This positively affected the minimum wage, unemployment insurance, fringe benefits, and job conditions all in the interest of the working class. In addition there were more regulatory measures in place to protect consumers from, for instance, usury interest rates, irresponsible lending practices and unconstrained health care costs. At a time when productivity levels were high and foreign imports and competition low, members of the domestic workforce were not expendable, nor were their bargaining achievements. The value attached to the domestic workforce prior to economic restructuring is further illustrated by policies that assisted returning WWII veterans.

As a way to smooth the transition of returning WWII veterans into civilian life, the GI Bill was passed and home loans made affordable, helping many families move into the middle class. The concern for the reintegration of veterans that drove certain policy reflects the strength of domestic labor at the time. Foreign competition was not a threat and the production process was not global—the cultivation of a lower wage workforce outside the US, not yet a reality. The job security and power of domestic

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3Certificate of Need legislation was intended to make developers accountable for building new hospitals since unnecessary development could lead to unnecessary hospitalizations to cover costs.
workers were high. The economic prosperity and the dependence on domestic labor translated into evenly distributed income growth, with the notable exception of members of minority groups (see Figure 1, 1947-1973). Individuals of all skill levels were able to find entry level work paying family-friendly wages. Policies crafted to expand the purchasing power of individuals and create financial protections affected a large electorate of the country—the white working class. This had implications for the composition of Party electorates as the working class was fundamental to the Democratic voter base (Edsall and Edsall 1991). But as the economic landscape changed, many of the policies responsible for moving working class families into the middle class no longer met the needs of the new working class.

Many less skilled individuals entering the workforce after the shift from goods- to service-producing found themselves excluded from the high-wage service sector (Ehrenreich 1998). In an examination of worker displacement using Current Population Survey (CPS) data in the period from 1985 to 1989—a period of expansion in the US economy—Diane Hertz (1991) found that despite large job growth, 4.3 million workers who had been at a given job for three or more years were displaced due to plant or business closings, the elimination of their shifts or positions, or not enough work for them to do. Koeber and Wright (2001) who studied displacement in 1998 using the Displaced Worker Supplement of the CPS found that displaced workers experienced a decline of approximately 14 percent in goods-sector employment. Work in the low wage service-sector is less likely to offer livable wages and fringe benefits than in the goods-producing sector, which presents challenges to workers who lack the skills needed to participate in higher wage service-sector jobs.
The policies needed to move this new generation of working class individuals and families into the middle class are not the same policies that may have helped the parents of this generation. The shift to a knowledge economy placed an unprecedented level of responsibility on socializing agents such as quality schools, neighborhoods, and families for the cultivation of the knowledge and skills needed to participate effectively in the changed economy.

The quality of educational institutions, intended to equalize opportunity, varies. More affluent communities tend to have higher quality facilities, lower student-teacher ratios and more qualified teachers, while those in high poverty areas may experience overcrowding, dilapidated structures and teachers less able to focus on learning than disciplining and the environment (Lippman, Burns, and McArthur 1996; Furstenberg et al. 1999). The higher degree of social capital among middle class persons in affluent communities, leading them to demand more quality from institutions, likely explains the variation (Kawachi 2005; Lareau 2005). Also, the way in which public schools are funded, typically through property taxes, plays a role in the link between the socioeconomic status of the community and quality of the school system. But the quality of the education also depends on family background and individual characteristics, out of reach of public policy (Lippman et al. 1996). For instance, the “Moving to Opportunity” demonstration project was based on the premise that students from poor communities would fare better academically in schools located in more affluent communities. One study found no difference between students’ reading and math scores that participated in the program relative to students who remained in poor communities (Sanbonmatsu et al. 2006). The strength of family background and individual characteristics are possible
reasons for the findings. It is also possible that the program may produce latent outcomes yet to be realized such as improved high school completion or college enrollment. Regardless, this attention to remedying schooling inequities reflects policy makers' realization that schooling had become critical to building and maintaining the middle class in the new economy. In the knowledge economy, which favors the more highly skilled, human capital is the new major stratifying source of society (Grusky 2001).

Quality educational institutions are rare in high poverty areas that consist disproportionately of minority groups such as African Americans and Hispanics. Efforts to diminish these inequities through the passage of the Economic Opportunity Act of 1964, while successful at first, met with severe backlash among primarily white voters, leading to two decades of neglect of inner cities (Quadagno 1996). This has placed members of minority groups residing in cities at a particular disadvantage in the emergent knowledge economy. The emphasis on education and skills in the changed economy means that entire segments of the population, particularly those who lack access to quality institutions required to prepare for a position in the middle class, are excluded from the level of economic opportunity available to those with access. Until equalizing institutions live up to their name, which requires effective policies, by default, society can expect higher levels of inequality.

An emphasis on human capital and skills seems to be indicative of a more open and meritocratic society, one in which achievement rather than ascribed characteristics determine life chances. What is becoming evident, however, is that with such varying degrees of quality education and skills enforced by gatekeepers controlling access to such capital, family background is becoming increasingly deterministic of life chances and
therefore of opportunities for attaining a position in the middle class. But even among individuals who have access to quality education and are qualified to participate fully in the knowledge economy, in the absence of effective financial protections, there is no guarantee against slipping economically (Hacker 2006b).

1.1.1.4 Policies and Politics that Undermine the Middle Class. Americans who began their careers in the 1980s and 1990s have not only been subject to a slowed economy and unprecedented changes in employment patterns (Newman 1993; Farley 1996; Levy 1998), they have also received more limited financial protections than their parents and grandparents (Hacker 2006b). Whether or not the decline in protections is ideologically driven, stems from downward pressure on social spending commensurate with global competition, or is a combination of broader demographic and social changes, it is clear that the welfare state in the US was developed to meet the needs of a different workforce than exists today (Esping-Andersen 1999).

According to Esping-Andersen (1999), the contemporary welfare state was developed when both low skilled industrial jobs among a homogenous male workforce and stable families supported by housewives prevailed. But rather than adjusting the welfare state to meet the evolving needs of a diversified workforce in a global knowledge economy, there has instead been a shrinking of programs and the size of government more generally. Program and regulatory scale backs occurring on the heals of economic restructuring may be exacerbating the challenges of becoming and remaining middle class. In the absence of basic protections from a certain level of economic risk, investments in assets such as homes, education and business ventures tend to be perceived as unsafe (Hacker 2006). Some level of individual risk is often necessary to
achieve upward economic mobility. Student loans, 30-year mortgages, small business investments, all involve risk. Among those willing to assume risk, more limited financial protections from expenses that have shifted from being manageable to burdensome could create economic instability or worse, result in downward mobility.

The scaling back of social insurances such as unemployment insurance and the increased deregulation of the market may make individuals more vulnerable to risks beyond their control—risks associated with aging, becoming ill, or losing a job. Without a minimum level of social insurance against involuntary risks, individuals may be less likely to assume voluntary types of risks through investments necessary to achieve upward mobility and to build a strong economic position (Sherraden 1991; Hacker 2006). For instance, one of the middle class interviewees in this study said that she and her spouse decided that he should stop contributing to his 401K to offset the increase in their proportion of cost-sharing for health insurance. To demonstrate the impact of declining financial protections on the economic stability of families today, Jacob Hacker (2006b) compares income volatility—a measure of the rate at which income rises and falls—over the last thirty years.

Using data from the Panel Study of Income Dynamics, Hacker (2006b) illustrates that the volatility of family incomes (controlling for family size) has risen dramatically in the past thirty years and, in fact, has increased much faster than economic inequality. This is partly explained by the changes to the economic landscape over the same period consisting of a shift in employment patterns from stable long-term jobs in goods-producing industries available to workers of varying skill levels to more short-term
occupations in a dual service economy favoring the educated. The increased income volatility is also driven in part by the weakness of the labor movement in the US.

The weak labor movement in the US has helped lay the groundwork for political attitudes and policies favoring social spending scale backs, deregulatory measures, and smaller government more generally. This pattern is not unique to the US as other advanced Western nations have also experienced social spending scale backs. Huber and Stephens (2005) describe a hyper-globalization thesis, which posits that as a nation’s integration into the global production chain increases, their flexibility toward public policy and spending decreases. A consequence is a decline in financial protections funded by collective sources. The shift in funding financial protections from public to private sources is risky because unless the resources needed to fully participate in the market economy are shared equally, some individuals will find themselves unable to shoulder financial risk on their own. For instance, if unemployment insurance were completely privatized one might expect a surge in homelessness since some members of society living paycheck to paycheck may be unable to save for such emergencies. This is also a concern in the private sector. If private sector health insurance shifted from the current practice of employers cost sharing to individuals paying the entire cost, we might expect to see the uninsured rate soar to unprecedented levels, with implications for both the physical and economic health of those affected. The changing nature of the private sector’s role in providing financial protection consists of unique events in American history.

At a time when US employers had a vested interest in the satisfaction of their workers, according to some scholars, employers served as mini-welfare states, providing
social insurance against illness and old age (Hacker 2006b). Theda Skocpol (1995) describes a theory explaining the emergence of welfare policies as occurring in response to pressure from welfare capitalists on political decision makers. This theory, however, is time sensitive. As Massey (2006) points out, the number and nature of markets changes as societies change socially, culturally, demographically, and technologically. Democratic governments can choose to react to these changes with more or less financial protection (Fischer et al. 1996; Massey 2006). Changes in the labor market are a case in point.

With the emergence of a large contingent workforce, the employee benefits structure, originally designed to pool risk and contain costs through economies of scale, weakened (Harrison 1994; Tillman and Indergaard 1999). Prior to the rise of a contingent workforce, it was in the best interest of employers to ensure the welfare of employees in exchange for their loyalty. But the lack of a true labor party combined with fractions in the labor movement between one side that sought better wages and working conditions versus another that wanted a European-like corporate welfare state undermined its overall strength (Quadagno 2005). As a result, US employers are not pressured to rely on domestic labor and therefore have less of a stake in providing for the welfare of domestic workers than their foreign counterparts. Nor is it necessarily in their best interest economically considering the pressures from global competition. The reality is that in a globally competitive environment, a weak labor movement does not have the political clout needed to negotiate a strong social contract. So if employers are no longer willing or able to serve as mini-welfare states, in the absence of government intervention, greater privatization of risk-spreading programs such as Social Security and health insurance is
inevitable. There is a distinction between changes occurring in the public and private sectors that should be noted. With regards to the possible privatization of Social Security, there would actually be a shift from using public funding sources to having individuals bear the costs alone. This is different than how shifts would play out in the private sector, where employer cost sharing protects individuals from having to bear the entire cost of health care coverage. In the latter instance, the burden is not shifting from public to individual shoulders per se, however from the perspective of the individual required to bear higher costs, the question of how the shift impacts their individual finances emerges regardless. Greater privatization may undermine economic security, once an expected benefit of a middle class position. If Hacker's (2006b) thesis is correct, many families today, including middle class families, may be more economically vulnerable than their parents and grandparents were and less likely to have the financial stamina to weather emergencies without experiencing some downward slippage. While their parents and grandparents may have enjoyed higher unemployment insurance and more comprehensive health insurance, for instance, middle class families today have fewer public forms of cushioning and weaker private sector protection and must therefore be responsible for preparing in advance for what may lie ahead.

1.1.1.5 Mobility Patterns of the Middle Class. The movement to a knowledge economy concurrent with the deindustrialization of cities and closings of manufacturing facilities is not inherently negative for an economy. What has been challenging is that the replacement opportunities available to those displaced by deindustrialization are not adequate for movement into the middle class (Ehrenreich 2001). According to Frank Levy (1998), when agricultural workers were displaced by new technology in the past,
they could hop on a bus to work in the desirable well-paying manufacturing trades in the cities. Even those with low skill levels could find jobs that paid livable wages and included fringe benefits. This changed dramatically starting in 1973, after which displaced workers of manufacturing jobs had skills transferable only to the less desirable low-wage service sector (1998). The skill bias in the post-1973 knowledge economy has affected minority groups such as African American males disproportionately since they rely more on the less skilled sector, having major consequences for black families who, according to some scholars, have become matriarchal in structure partly as a result (Wilson 1996). The growing number of females in the workplace has offset some of the lost ground of the middle class, especially in two-earner households. For instance, although the median household income grew very little in the full employment span of 1980 to 1993, per capita income went up 15% during this same period, mostly driven by a rise in two-earner households and a decline in the fertility rate (Farley 1996). But even among those lucky enough to earn a position in the middle class, there is no guarantee of staying there.

According to Katherine Newman (1988), many workers in highly skilled white collar industries saw their fortunes slip away in the 1980s due to economic restructuring and a shift to meritocratic individualism, embraced by employers to justify performance-based firings. The “late baby boomer” cohort, identified by Reynolds Farley (1996) as those born between 1956 and 1965, started their careers in the 1980s and 1990s, a period of significant economic restructuring, and were therefore the first generation that would live their lives with a lower standard of living than their parents (Newman 1993). According to Farley (1996), the World War II birth cohort was the last group able to
enter the middle class by the age of thirty with just a high school education. In contrast, members of the late baby boomer cohort needed a college education to get a family of four into the middle class by 1990 (1996). Shifting job opportunities and employment patterns are crucial to understanding changes in the structure of the middle class family, now overwhelmingly consisting of two-earner households (Warren 2006) with at least one member possessing a bachelor’s degree or higher (Fischer and Hout 2006). The emphasis on education in the restructured economy, which has never been supported with a truly equal distribution of quality education, has made it so that those with access to quality education have a better chance of achieving upward mobility or economic stability. More advantaged families may draw from economic and social assets to fund and ensure their children’s education—the most salient stratifying force of the knowledge economy (Grusky 2001). As such, family background is becoming increasingly deterministic of educational opportunities, which in turn, have implications for future economic prospects.

According to Isaacs et al. (2008), family background makes a real difference in determining whether one completes college. Whereas 54% of children with a college education who were born into the top quintile remain there, this is almost triple the proportion with a college education who were born into the bottom quintile who make it to the top (2008). The latter group is much more likely to assume student loans, which could inhibit upward mobility, even if only temporarily. In addition, the former group may attend higher quality schools and receive valuable familial assets. The importance of education in current times helps to explain why family background has become so much more salient in determining life chances. For instance, in contrast to Blau and Duncan’s
(1967) findings of a lack of intergenerational status transmission between fathers and sons, there is evidence that family background is a significant factor in mobility trajectories of children. Perhaps this is because as Alan Kerckhoff (1995) points out, institutional arrangements structure the link between educational attainment and occupational status.

According to Kerckhoff (1995), "Highly stratified educational systems (those with small proportions of a cohort at the higher levels) produce a stronger association between socioeconomic status of origin and educational attainment because the earlier definitive sorting occurs, the more it will be affected by social origin." This seems to support the idea that even in an achievement oriented stratification system, birthrights can convey advantages, particularly because of the access they might provide to valuable and even achievement-enhancing institutions. In fact, Figure 4 below indicates a much higher measure of intergenerational immobility between fathers and sons in 2000 than in the decades preceding the period of economic restructuring, when education was not nearly as salient a predictor of one’s economic prospects.
While a logical response to the growing importance of a quality education in the changed economy would be to ensure an equitable distribution of quality educational resources and institutions, this has not fully occurred (Furstenberg, Cook, Eccles et al. 1999). Of course there have been some efforts at the national policy level in the last decade to make schools more accountable for the standards they set and the quality of education they offer. The *No Child Left Behind Act* of 2002 is a case in point. However, there continues to be significant variation in indicators of school quality such as the teacher to student ratio, availability of resources, the integrity of the physical facility and teacher experience by the level of disadvantage in the school’s community (1999). Since a child’s preparedness for the new knowledge economy rests in part on the educational resources available to him or her, some children will start off with distinct disadvantages relative to their peers. While those growing up in more disadvantaged communities with lower quality educational institutions may be aptly prepared for work in the less skilled sector, in the restructured economy they will have a much harder time earning a livable wage and achieving economic stability since opportunities available to the less-skilled have shifted mostly to the low-wage benefit-poor service sector (Ehrenreich 2001).
Achieving upward mobility in the restructured economy is more difficult, requires more resources, and demands more effort overall. These may be factors of an evolving society, but until institutions adapt fully to the emerging needs for full participation in the knowledge economy and protection against its risks, the trajectory of middle class families will be less predictable than it was for previous generations.

Newman’s (1988) depiction of middle class families losing economic ground as a result of corporate downsizing in the 1980s, coupled with less generous unemployment insurance, is illustrative of the fact that the economic security of a middle class position is in jeopardy. Prior to the period of economic restructuring, workers built careers based on long-term relationships with a single employer. In fact, it was not uncommon for three generations to work for the same employer (Harrison and Bluestone 1988). The decline in job security, characteristic of the knowledge economy and global competition, has likely contributed to the greater incidences of downward mobility among middle class families as depicted by Newman’s (1988) observations in *Falling from Grace*. More recently, Jacob Hacker (2006b) has argued that American families have become increasingly economically unstable since the 1970s to the present, which he attributes to a scale back of financial protections intended to help families manage risk. The contribution of this research is to examine the extent of economic instability among middle class families specifically, and the impact of a weakened financial protection—health insurance—on instability.
1.1.2 This Study—Part I: To What Extent are Middle Class Families Economically Unstable

Given that the circumstances of the postwar middle class are very different than those of the post-1970s middle class, this research examines the extent to which middle class families from the latter period experience economic instability. Newman (1988) already identified the negative ways in which the economic restructuring of the 1980s affected middle class families. Hacker (2006b) also provided evidence indicating that many American families are highly economically unstable as indicated by income volatility between the 1970s and the present. Newman (1993) described the late baby boomer generation as the first group to fare worse than their parents economically due to entering adulthood at the peak of economic restructuring. This study uses data from the 1979 National Longitudinal Survey of Youth (NLSY79), which includes a large sample of members from the late baby boomer cohort.

Focusing on a birth cohort allows researchers to examine the interplay of economy, politics, and culture at different points in time and throughout a life course (Myers 2004). Cohort analysis helps to explain, for instance, why two families from different time periods must meet very different requirements to earn similar standards of living. American families may be experiencing more economic instability as Hacker (2006b) contends, but to what extent is this true among middle class families specifically, particularly those that started families around the time of economic restructuring? To answer this question, this research uses the NLSY79 to explore economic stability among middle class families of the economic restructuring period. Then I examine the extent to which a weakened financial protection—health insurance—may further destabilize
middle class families. A review of the changing system of health insurance reveals the growing weakness of financial protection in the system over time.

1.1.3 Health Insurance: Then and Now

Private sector health insurance in the US was designed to meet the needs of the average worker prior to the period of economic restructuring. The financial protection it once offered has not been sustainable given the changing patterns of work stemming from globalization and the knowledge economy. The rapid growth of a contingent workforce, consisting of temporary and part-time employees, has made health insurance coverage a concern since these forms of employment are least likely to offer coverage, especially comprehensive types of coverage (Parker 1996). According to Kennet Jost (1993), the percentage of contingent workers lacking benefits or job security rose from 10 percent in 1982 to 25 percent in 1992. This new flexible workforce model carries higher administrative costs than the previous model based on long-term ties to a single employer (Harrison 1994). A consistent pool of workers means less turnover and administration costs that accompany the provisioning of fringe benefits. Consistency of health benefits with a single employer means fewer gaps in coverage than among workers who move between many employers, each of whom may have different benefit structures—a trend more common today as the comprehensiveness of benefits increases with firm size (Kaiser Family Foundation 2007). Overall, the changing nature of private sector health insurance means that being uninsured is no longer an issue just among individuals outside of the labor force; it is very much an issue among employed persons in occupations that either lack health insurance or offer costly or non-comprehensive insurance. While there
have been multiple studies examining the impact of the current health insurance system on health outcomes (Marmot 1986; Evans and Stoddart 1994; Mirowsky and Ross 2003; see Quesnel-Valle 2004b), there have been no systematic studies on the impact of changes in the system on the economic stability of middle class families\(^8\).

A loss of health insurance or being underinsured exposes one to greater financial risk when seeking health care, so by definition, health insurance provides a source of economic security. A lack of coverage, or having overly thin coverage, has the potential to undermine economic security and be financially burdensome to families in need of medical care (Banthin et al. 2008). For instance, in the event of illness or injury, some uninsured and even underinsured individuals will avoid seeking health care to avoid expenses. This could lead to health-driven job interruptions or job loss and could be even more detrimental to those who lack sick leave such as the self-employed. Such persons may face the double jeopardy of losing valuable work time if sick and the loss of income, not to mention the negative consequences to their health. The lack of economic security could also block chances for upward mobility among lower income persons, especially if, as Jacob Hacker (2006b) contends, individuals are less likely to invest in their futures if they are feeling economically insecure.

This research examines two trends: first, the extent to which middle class families from the period of economic restructuring show signs of economic instability and second, the impact of weakened private sector health insurance on the economic stability of middle class families. Katherine Newman (1988) observed that a rising trend in downsizing and lay offs in white collar occupations in the 1980s showed how little

\(^8\)There have, however, been studies on the relationship between medical bills and bankruptcy (Himmelstein, Warren, Thorne et al. 2005; Dranove and Millenson 2006), which will be reviewed in later sections of this research.
protection against downward mobility middle class families had. This research builds on Newman’s earlier observation by examining the extent to which middle class families who may be experiencing economic instability may be slipping in response to a different aspect of the workforce—not only the job security on which Newman focused, but also weakened financial protection through adequate private sector health insurance. A review of the ways in which the private-public health insurance system evolved and changed in response to economic restructuring illustrates why it may have negative consequences for middle class families today in comparison to middle class families of the postwar period.

1.1.3.1 Expansion of the Health Insurance System – the Period of Economic Growth. The evolution of the institution of health insurance in the United States during the twentieth century is tied to the trajectory of health care costs, which were driven in part by supply and demand but also by public policy decisions (Starr 1982). According to Paul Starr, the sovereignty of medicine in the US was not inevitable, but rather developed as a result of a series of events. In fact, a comparison of the prestige of medicine in the US relative to other advanced Western nations and periods in history reveals that it was more highly regarded, demanded, and financially rewarded in the US. Perhaps this is partly due to the cultural importance credited to medicine resulting from specific historical events in US history.

9I do not assume that the changing system is to blame for incidences of economic instability among middle class families, but rather that it may be contributing to worsening circumstances such as slipping down the economic ladder and even below the ranks of the middle class.

10There were elements of health insurance in place as far back in history as the 1700s, but I focus on events in the twentieth century in particular as they relate to changes affecting the middle class.
Following WWII, science took center stage. After the atom bomb and benefits of penicillin were realized, science was regarded as vital to national security. In addition, malaria had been conquered, better vaccines created, and the soldier death rate per 1,000 soldiers fell dramatically in the Second World War relative to the First. The discovery of a polio cure had considerable impact on the general public’s perspective of and support for medicine (Starr 1982). Starr shares an account describing nationwide moments of silence mixed with celebration in response to news of a polio cure. The case for investing in science, and health care research in particular, had been made. In addition, because the economic prosperity in the postwar years, stemming from extremely high levels of production relative to a devastated Europe, had cemented the position of the US as a nation of affluence, Americans had the opportunity to focus on their health with a shift from infectious to chronic disease such as cancer, heart disease, and even obesity and neurosis, into which only affluent societies tend to invest resources. The high demand for health care was met by an insufficient supply (1982). As a result, public policy at the time focused on providing access to health care as opposed to managing costs. For instance, the 1946 Hill-Burton program was instituted to fund construction for community hospitals as a means of increasing access. This expansionary measure with direct consequences for health care was consistent with policy trends of the time. According to Starr, successions in policies impacting health care beginning in the postwar period mirrored the direction of social policy more generally with the objectives of first expansion, then equity, and finally cost containment.

The supportive postwar policies that raised the minimum wage and made home ownership and a postsecondary education more widely available aimed to expand
opportunities, while the subsequent “War on Poverty” in the 1960s aimed to distribute the pie more equally. The more recent trends of social spending scale backs, deregulation and focus on individual responsibility, taking root most notably during the Reagan years, include attempts to contain costs through increased competition thus lessening the need for big government. Similarly, the growth of health insurance as a fringe benefit in the period following the Second World War expanded access to health care and financial protection from medical bills, making it possible for middle and working class families to access medical services at rates approaching those of the rich whereas previously they used medical services at rates closer to the poor (Starr 1982). Despite these advances, it was recognized that access to health care as well as health insurance was not distributed evenly across the population, and subsequently, efforts were made to remedy the inequities by supplementing the private sector component of health insurance with public components.

To compensate for the fact that not all workers would have access to good jobs offering fringe benefits, in 1965 Medicare and Medicaid were established. The programs differ in that Medicare is a universal program for the elderly and Medicaid is a targeted program for the low-income, but both are public forms of health insurance subject to varying degrees of governmental control and oversight. The aim of distributing the benefits of health insurance more equally throughout society was to fill gaps in coverage, particularly those occurring when individuals are unattached to the labor market (Swartz 2006). While the goals of establishing public forms of health insurance were to provide access to many without private sector health insurance, some argue that aspects of the public component had a latent effect of perpetuating inequalities (Starr 1982). For
instance, the ways in which Medicare and Medicaid were structured led to differential access to medical care. Medicare covered less than half of elderly health expenditures; Medicaid covered one-third of the poor and neighborhood health centers only an additional five percent. While Medicare was subject to the same national requirements, Medicaid varied by state and often omitted childless couples, widows, two-parent families and single people under age 65. Some people were caught in the "Medicaid-private insurance corridor", whereby they were neither Medicaid-eligible or covered through an employer (1982). There have been numerous changes and expansions to these programs over the past several decades. For instance, the State Children’s Health Insurance Program (SCHIP), enacted in 1997, has made publicly funded insurance available to children whose families’ income falls between the federal poverty line and a state defined eligibility limit. More recently, in 2006, an amendment to Medicare increased access to pharmaceuticals—a major driver of health care costs.

Yet, the initial structure may have set inequalities in motion as did other federally funded programs such as the way in which funding for hospital construction was allotted. The allotment benefited middle income communities the most because communities were required to raise two-thirds of construction costs on their own, even though poorer communities needed more help in hospital construction. Not only were hospitals not meeting demand, there was also a growing dearth of general practitioners as a direct consequence of failures to fund medical education and training, which would have implications for high medical costs in the future as the demand for medical professionals exceeded the supply. This lack of support combined with higher economic returns of medical specialization led to a rise in medical students seeking positions in a specialty
and a fall in general practitioners (1982). Finally, critics argue that the structure of financing Medicare led to substantial health care cost increases, which has led to a proliferation of alterations to both Medicare and Medicaid over the past several decades in efforts toward cost containment (Day 1997).

The practice of Medicare and Blue Cross reimbursing hospitals on the basis of their costs encouraged higher costs. This structure was chosen in part to appease the American Medical Association (AMA), but the implications were costly and far reaching. For numerous reasons, a powerful case was made that public aid to medicine should not be subject to public control (Starr 1982). More recently however, Jill Quadagno (2005) shows that the strength of interest groups has shifted and the influence of the AMA weakened. An important source of skepticism of medicine was driven by public officials and employers who became sensitive to the health care cost crisis as early as the 1970s.

There was a significant shift in the perception of the health care cost problem and who it affected by 1970. Prior to 1965, rising health care costs were seen as a problem of the individual and family, but by 1970 public officials became sensitive to rising and unconstrained health care costs. For instance, the cost of medical services increased from 3.2 percent a year for the seven years before Medicare to 7.9 percent annually in the five years following. National health expenditures increased from $142 to $198 per capita between 1960 and 1965 to $336 by 1970. Likewise community hospital costs increased from 8 percent of hospital costs annually from 1950 to 1965 to 14 percent a year after 1965 (Starr 1982). The structure of Medicare financing is of course only one of several health care costs drivers since advanced technologies, new pharmaceuticals, longer life spans, chronic disease and growing administration costs are all salient as well. In
response to rising health care costs, there were attempts to implement Health Maintenance Organizations (HMOs) to minimize costs, but they never became highly prominent and thus affected only a small portion of costs overall. This has the potential to change however, because doctor-patient relationships have weakened and therefore, individuals might ultimately choose lower costs over choice if the relationship component is going to be missing either way. What is certain, however, is that the private sector response to rising health care costs has been to shift more of the cost share to employees. This is occurring at the same time that many employees are also experiencing stagnating wages, so the combination likely presents challenges to many middle class families.

1.1.3.2 Constraints on the Health Insurance System – the Period of Economic Restructuring. Just as the stratifying forces of advanced postindustrial nations have changed from the means of production to human capital skills (Grusky 2001), so have the determinants of accessing health insurance. While the majority of developed countries have essentially eliminated the connection between health insurance coverage and socioeconomic status through universal health insurance, in the United States, coverage depends on individuals' position in the stratification hierarchy (Fried and Gaydos 2002). Educational attainment, the most salient stratifying force in an advanced postindustrial society (Grusky 2001), impacts occupational status and income, which in turn determine the available options for health insurance, whether through the private or public sector. However even within the former there is increasing variation of how health insurance is designed and delivered. For instance, “good” jobs, which tend to include full-time white collar occupations at large firms, are more likely to be accompanied by more affordable
and comprehensive health insurance. These jobs also require more education and skills
than “bad” jobs in the low-wage, benefit-poor service sector. Thus there is a direct link
between education and the ability to procure employment more likely to offer
comprehensive health insurance coverage. In the event of too few economic resources,
one may be Medicaid-eligible. In either case, socioeconomic status is a determinant of
health insurance coverage and type. Coverage alone is not enough; the
comprehensiveness of health insurance varies by type and source, and there is increasing
concern over the growth of the financially burdened underinsured (Schoen et al. 2005;
Banthin et al. 2008).

According to Schoen et al. (2005), based on the Commonwealth Fund 2003
Biennial Health Insurance Survey, a nationally representative telephone survey of 4,052
adults age nineteen and older, 35% of respondents were uninsured or underinsured in
2003. The authors define underinsured as “being insured all year but without adequate
financial protection” (2005). In the US, the type, affordability, and comprehensiveness of
one’s health care coverage depend on one’s position, or that of one’s spouse or
parent/guardian(s), in the division of labor. A study by Schoen et al. (2000) reveals the
implications of the stratified system in the US compared to five other English-speaking
countries. Results from a random survey conducted in 1998 of approximately 1,000
adults ages 18 and over in each of five English-speaking countries including the US,
Britain, New Zealand, Canada, and Australia; reveal that the US represented an extreme
with a third of respondents reporting out-of-pocket costs of at least $500 per year and
only 7% reporting no out-of-pocket expenses (2000). If this was the case in 1998, when
the study was conducted, the direct costs to individuals would be even greater in the post-
2000 period, as health insurance coverage has become more costly and less comprehensive in the face of rising health care costs and shifting employment patterns. The authors examined differences in access to care, financial burdens of medical bills and perceived quality of care between those with above and below average incomes and found that overall, care experiences were more unequal in countries with greater reliance on private sector health insurance (US, Australia, and New Zealand) than in those with larger public components. In contrast, among respondents in Britain, which has comprehensive national health insurance and reported that only 17% of respondents purchase private insurance as a supplement, care experiences varied the least across the two income groups (2000).

The inequitable distribution of affordable and comprehensive health insurance in the US is an issue of national health and economic security. There is evidence that the growing number of uninsured is exacting heavy costs on society and undermines health and productivity levels (Davis 2003). The combination of unconstrained health care costs and downward pressure on social spending and regulation is creating a situation not unlike the profit squeeze experienced by corporations in the 1970s (Harrison and Bluestone 1988). In both instances the response has been to lower costs by decreasing compensation to employees. Stagnant wages and higher cost sharing of health insurance premiums both lead to lower paychecks. This marks an overall weakening of the financial protection once offered by private sector health insurance in the US, with individuals shouldering more risk than ever before (Hacker 2006b).
1.1.3.3 The Evolution of the System of Employer Sponsored Health Insurance.

The original intent of private sector health insurance in the United States was to provide health care access and financial protections across occupation levels, but since the system relies on insurance through employers in the US, the amount of protection offered has become highly sensitive to economic changes. This was not as problematic in the industrial system when income growth was shared across skill levels and wages rose faster than health care costs (Holahan and Cook 2006). In such an environment, an unemployed, uninsured person could more easily weather medical bills they might face. By pooling economic risk across the old and young, sick and healthy, and rich and poor; health insurance was designed “to facilitate timely access to care when needed and to protect patients from costs that would be catastrophic relative to their income” (Schoen et al. 2005). Given the range of occupations in this country with varying health hazards, a system that pools risk is in the best interest of a nation that strives to be economically productive.

The health insurance model that emerged in the US in the postwar period developed through a series of events relating to the economic conditions of the time and pressures from interest groups (Blumenthal 2006; Quadagno 2005). In an effort to pass the Social Security Act of 1935, Franklin D. Roosevelt made a conscious decision to remove a universal health insurance component. Due to the power at that time of the American Medical Association (AMA), which opposed universal health insurance, Roosevelt feared that the Social Security Act would not pass at all if universal health insurance were included (Blumenthal 2006; Quadagno 2005). In response to the gap created by the lack of universal insurance, private insurers emerged – Blue Cross and
Blue Shield and other commercial insurers, which were poised to sell to employers when the opportunities arose, and they did. In an effort to prevent inflation, federal rules in the 1940s and 1950s limited wages despite a tight labor market. To compensate for this limitation on employers' ability to compete for labor, federal rules allowed for fringe benefits to be included as part of wage packages, also giving unions leverage for contract negotiations. Following this, ultimately the IRS rendered employer sponsored insurance (ESI) as non-taxable income, which motivated employers to supplement wages with health insurance—a system still in place today (Blumenthal 2006). According to Melissa Thomasson (2000), the tax subsidy has had a significant role in shaping the health insurance system in the US because it encouraged the development of group insurance through employers to counter the risks of adverse selection and to lower administrative costs. This puts those without access to group coverage at a relative disadvantage since without the benefit of a large group over which to spread costs and risk, rates in the non-group market are unaffordable by many standards (Swartz 2006). There have been numerous failed attempts to bring about health care reform.

Roosevelt's failed attempt at health care reform was one of many in the twentieth century. In the 1910s, there was the AALL Compulsory Health Insurance Plan, and not long after Roosevelt, Truman's plan in the postwar era, followed by Nixon's National Health Insurance Partnership, then Kennedy's Health Care for All Americans in the 1970s, and finally Clinton's Health Security Plan in the 1990s (Quadagno 2005). Each attempt to pass universal health insurance in the twentieth century has failed. These failed attempts served to strengthen the private component of the health insurance model. For instance, the AALL failed attempt stimulated growth of commercial insurers, and
Nixon’s defeat led to federal support for private HMO's. Jill Quadagno (2005) links the failed attempts to a combination of anti-statist sentiments, weak labor, racial politics, state structures, policy legacies, and stakeholder mobilization. More generally, Skocpol (1995) points to the role that the US state formation, marked by considerable fragmentation, plays in inhibiting social provisions. Checks and balances built into the US government may prevent power takeovers but they also have a latent affect of inhibiting change. For instance, even “successful” reforms often end up watered-down versions of the original proposal (Hacker 2006b). While many of these factors persist, the present context is unique because of the unprecedented rise of health care costs concurrent with competitive pressures from globalization. The outpacing of wages and income growth by rises in health care costs, especially since 2000, makes a status of uninsured or underinsured increasingly financially burdensome (Banthin et al. 2008). Essentially these are signs of a weakening system, which is only expected to worsen in the absence of intervention and reforms (Moran 2005).

1.1.3.4 Employer Sponsored Health Insurance – Recent Trends. Private sector health insurance in the United States is under strain due to a combination of rising health care costs and pressures from globalization to lower production costs (Starr 2004). Globalization and the accompanying competitive pressures have forced many employers to lower costs through workforce cuts, relocating operations overseas, and adopting more efficient technologies, which have hurt less skilled manufacturing workers, many of whom have joined the growing service sector despite the relatively lower wages and lack of fringe benefits (Wilson 1996; Newman 1988; Beller and Hout 2006). Rising health care costs are yet another challenge faced by US employers, who are responding by
eliminating insurance coverage, passing along higher cost sharing to employees, purchasing bottom-line packages or devising options such as Health Savings Accounts (HSA) (Scott 2001; Starr 2004). Tying the majority of health care coverage to employment is an increasingly risky policy choice as both offers and take up rates are sensitive to not only rising health care costs, but also economic cycles, which directly drive unemployment and wage rates (Reschovsky, Strunk and Ginsburg 2006).

Declining take up rates are a cause for concern because they could threaten the ability to negotiate lower group rates, which could result in fewer offer rates, and also because a larger uninsured population is likely to result. Using data from the Community Tracking Study Household Survey, Reschovsky et al. (2006) noted a declining take up rate across low, middle and high income groups between the period of 2001 and 2003, but found the decline to be the largest among the middle income group, accounting for a 1% point change in the overall 5.8% point decline in ESI coverage for this group. A growing uninsured population is troubling not only because of the potential health consequences but also because from a system perspective, care of the uninsured is subsidized by those who purchase insurance through higher premiums (Scott 2001).

Based on 1996-1998 data from the Medical Expenditure Panel Surveys (MEPS), Hadley and Holahan (2004) estimated the value of uncompensated care of individuals uninsured at least part of the year to be $40.7 billion and among those uninsured the entire year, $26.3 billion\textsuperscript{11}. Hospitals incur the majority of uncompensated care dollars (60%), and the government is a primary source of funding for uncompensated care, covering 85% of

\textsuperscript{11}Estimates were adjusted to 2001 dollars, and projections were applied to 2004 health care costs (Hadley and Holahan 2004).
the total (2004), but this still leaves hospitals with a portion they must absorb, which affects the amounts charged to paying consumers.

While decoupling the health insurance model from employers may seem like a safer course of action to make the system more resistant to economic changes, attempts toward this end have failed repeatedly (Quadagno 2005). Instead, employers continue to react to rising health care costs through higher cost sharing, purchasing bottom-line coverage, keeping wages flat, and/or eliminating health insurance. In turn, individuals are being forced to choose between higher take home pay or protection from illness or injury. This decision is likely to be even more difficult at the family level, since it is one thing to forego insurance for oneself and yet another to do so for one’s spouse or child. In contrast, the targeted public component of the system providing Medicaid and SCHIP to low and moderate income families, respectively, and Medicare to the disabled and elderly are intended to provide access to coverage to members of the population who do not have access to “good” jobs offering health insurance.

These programs have the benefit of being countercyclical since they are unrelated to employment (Reschovsky et al. 2006). However, they are out of reach for many individuals who are above the eligibility limit but unable to afford private insurance through an employer or direct purchase, the latter of which is exceedingly costly due to the lack of a group rate and the use of actuarial risk estimates (Scott 2001; Swartz 2006). From a consumer perspective, health insurance is becoming less affordable and comprehensive as reflected by double digit premium increases as of 2001 (Strunk and Reschovsky 2002), and from a policy perspective, it became less regulated. For instance, there have been attempts to affect health care costs through regulatory measures such as
the 1974 National Planning Act that required state review and approval of new hospital construction, referred to as certificate of need (CON) legislation, in exchange for federal funds for health care. But by 1987, due to antiregulatory bias under the Reagan administration, the act was repealed. Another example is the Employment Retirement Income Security Act of 1974 (ERISA) that was intended to stop retirement-plan abuses. By extending the law to employer health plans, a state’s ability to regulate self-insured employers or employers that refuse to provide employee coverage is limited. Private sector health insurance is not subject to public control, but it can be affected through regulatory measures especially when making federal funding contingent on the following of explicit rules such as the CON legislation. But the movement toward smaller government and deregulation under the Reagan administration lifted many potential constraints on health care costs that would ultimately lead to a weakening of the financial protection once offered through private sector health insurance.

Consumers are paying higher out-of-pocket expenses driven by rising health care costs and employers are finding these rising costs especially burdensome in the globally competitive market, leading to a decline in offer rates. The financial protection offered by private sector health insurance in this country is weakening at the same time that challenges to becoming and remaining middle class are mounting. The unraveling of private sector health insurance may be contributing to economic instability of middle class families—the very group it was intended to protect.

Despite the persistence of the private-public health insurance system in the US, which depends disproportionately on employers, debates regarding this type of model have been and will certainly continue to be on-going as health care costs and the
proportion of uninsured rise (Starr 2004; Quadagno 2005). In a climate of unconstrained health care costs, an uninsured family of average financial means cannot weather the financial burden that may accompany the use of health care. In fact, even insured families facing high premiums and uncovered services are increasingly economically insecure, especially those who purchase less affordable private insurance (Banthin et al. 2008). From 2000 to 2003, health care premiums rose substantially faster than wages and income (Holahan and Cook 2006). According to one study based on 2006 data, since 2001, the premiums for family coverage increased 78% while wages rose only 19% (Kaiser Family Foundation 2007). This has placed the American workforce in a vulnerable position. When employers cut costs through downsizing, the ensuing unemployment and potential loss of health insurance in the context of rising health care costs may seriously threaten a family's economic stability.

The recent economic reality facing employers and employees alike is reflected in Figure 5, which illustrates a noticeable drop in ESI coverage starting in the year 2000. This decline is partly explained by recent economic trends including a decrease in large and mid-sized firms, more likely to provide ESI; a decline in employee take up rates, and a rise of small firms and self-employed persons less able to bear the costs of sponsoring insurance (Holahan and Cook 2006). According to Scofea (1994), the noticeable dip in the early 1990s is explained by the fact that in 1991, employees were choosing to forego health care benefits most likely due to a 150% increase in the monthly premium for individual coverage and approximately a 200% increase in the premium for family coverage compared to nearly a decade earlier. The reversal of this decline is likely due to
an increase in discounted managed care programs, although these programs are not likely to have the same effect moving forward (Swartz 2006).

Figure 5. Percentage of Persons Under 65 with Employer Sponsored Health Insurance

![Graph showing percentage of persons under 65 with employer-sponsored health insurance]


Whether or not an organization offers health insurance to employees through cost sharing varies on a number of dimensions including firm size, job quality, occupational sector, and state regulations (Swartz 2006). But even among larger firms better able to continue offering health insurance because of their eligibility for group rates, cost sharing is rising, which may discourage more and more employees from opting into their company’s health plan. This could have consequences for negotiating group rates with insurers since large risk pools, which large firms embody, are seen as a way to spread risk leading to lower rates per person (2006). In response to rising health care costs, declining ESI rates, competitive pressures from globalization, and decades of anti-regulatory bias, private sector health insurance in the US appears to be unraveling.

1.1.3.4.1 Current State of the Health Insurance System. Social spending scale backs and a preference for smaller government may have resulted partly in response to a backlash to redistributive programs that aided poorer segments at the expense of the moderate and middle income, but the consequences of these political attitudes and policy
trends have directly impacted the working and middle class. Anti-poverty programs thought to promote disincentives to work and marry among members of minority groups (Quadagno 1996) were unfounded as evidence has shown that the average welfare recipient did not fit the stereotyped profile (Blank 1997). The majority of welfare recipients consisted of white working mothers, but by making the welfare debate racially charged, efforts to support low income mothers were undermined. Some argue that nations of the European Union are only now beginning to experience the ramifications of greater heterogeneity of their populations upon opening borders in recent decades. Even Sweden, known for its generous social programs, engages in entitlement policing to ensure that non-citizens are excluded (Klausen 1995). But while the US has scaled back many programs thought to serve as disincentives to work and marry, such efforts were targeted toward low income or minority groups. It would only later be observed that a latent effect of these policy trends would include serious implications for the private sector. For instance, many argue that shifting the scales from a more interventionist government to a freer market economy has led to a weakened labor movement, which has hurt workers' ability to negotiate better wages and benefits, affecting union and non-union workers. Some analysts argue that anti-regulatory bias led to a decline in accountability of health care spending such as the repeal of the Certificate of Need legislation. While HMO’s had the potential of offering reprieve from higher health insurance premiums and overall health care costs, they were unsuccessful since they were perceived as undermining the quality of the doctor-patient relationship. This is well reflected by the shift in support by former President Clinton who made managed care the focus of the proposed 1993 Health Security Act only to later criticize such forms of care.
in response to a lack of support (Day 1997). Despite the backlashes to social spending and big government, it is not the beneficiaries of targeted public forms of insurance who are most at risk of being financially burdened by costs associated with health care, but rather moderate and middle income persons who pay for health care through private sector health insurance. In particular, families who are ineligible for the financial protection offered by Medicaid and SCHIP and possibly without access to or unable to afford insurance through an employer or private source may be especially at risk of being overexposed to costs associated with health care.

In urban areas in particular, the demographic profile of the uninsured is changing to include more moderate income persons (Pandey and Cantor 2004). According to a study on declining rates of employer sponsored insurance, the take up rates had declined the most among middle income earners (Reschovsky et al. 2006). In fact, even in good economic times when access rates increased by 1.3% points (between 1997 and 2001), take up rates declined slightly. Despite the lower take up rates, the uninsured rate of children declined because of the expansion of public forms of insurance such as Medicaid and SCHIP. This implies that some families with access to employer sponsored insurance are choosing to enroll their children in public programs, a situation referred to as “crowd out,” most likely because of the increasingly financially burdensome nature of private insurance (Strunk and Reschovsky 2002; Banthin et al. 2008). Being uninsured or underinsured is no longer limited to marginal segments of society. It is becoming a far-reaching problem with consequences for individuals’ quality of life and productivity levels, for employers who might be faced with employees missing work or facing early retirement due to poor health, for the health care system that is increasingly burdened by
costs of the uninsured, and for the economy overall, which performs better with a healthy and productive population (Davis 2003).

In 2007, 15 percent of individuals residing in the United States lacked health insurance at some point during the year (U.S. Census 2008). This is considerably higher than in other advanced industrialized nations (Schoen, Davis, How, and Schoenbaum 2006). This discrepancy is partially driven by the higher costs of health care in the US, where 16% of gross domestic product (GDP) is spent on health care—double the median of other industrialized countries (2006). According to a report on the uninsured by the Kaiser Family Foundation (2007), the current portrait of the uninsured (based on 2006 data) tend to be Americans with family incomes below 200% of the poverty level (over one-third of the poor and 30% of the near-poor defined as 100 to 199% of the poverty level). Two-thirds of the uninsured are in low income families. A large majority of the uninsured are in working families (82%), but although ESI covers most non-elderly Americans, it is rarely offered in the low wage service sector or by small businesses. This is a fundamental problem inherent to the US health insurance model. Because the system relies on employers for health insurance, a large portion of the US workforce is excluded. Public forms of insurance are intended to fill the gap but in reality, there are often obstacles to enrolling in public programs, such as eligibility issues or a lack of information and access (Kaiser Family Foundation 2007). The majority of uninsured adults are over the age of 30 (61%). As reflected in Figure 6 below, there is a noticeable upward trend of uninsured non-elderly adults beginning in 2000. The elderly have maintained extremely low uninsured rates due to high Medicare enrollment rates, while
children under 18 benefit from both Medicaid and beginning in 1997, SCHIP, which reaches children in families of more moderate incomes than Medicaid.

Figure 6. Percentage of Uninsured Persons by Age Group, 1987 to 2005

Source: U.S. Census Bureau, Housing and Household Economic Statistics Division.

Almost a quarter of individuals whose health is fair or poor are uninsured. And 80% of the uninsured are U.S. citizens (Kaiser 2007). According to Figure 7, uninsured rates are highest among blacks and Hispanics, who are disproportionately represented in the lower wage service sector that tends not to offer health insurance, but the gap appears to be narrowing in the late 2000s between these groups and whites partly due to declining rates among blacks and Hispanics and a slight rise in uninsured rates among whites. The erratic nature of the line indicating Asians and Pacific Islanders is likely to reflect immigration, whereby newer arrivals are less likely to be insured than the native born, so the uninsured rate may be reflecting the migration patterns of the population. Together, Figures 6 and 7 paint a picture of the inequities fostered by the private-public health insurance system in the US.
1.1.3.4.2 Variations in Health Insurance. Health insurance varies by comprehensiveness, affordability and quality, leading to differential experiences with health and economic outcomes even among those with health insurance. Both affordability and accessibility of private insurance vary by whether it is employer sponsored or privately purchased, by characteristics of employment, and possibly by the health of the individual (pre-existing conditions drive up premiums due to adverse selection techniques (Scott 2001; Swartz 2006). Other characteristics affecting offer rates include union membership, part or full-time status, and wage rates as reflected in Figure 8.
Figure 8. Percentage of Firms Offering Health Benefits by Firm Characteristics, 2006


Access alone does not determine coverage since affordability also varies by employment characteristics such as firm size, occupational sector and region. For instance, due to their inability to negotiate lower group rates (Swartz 2006), there is a pattern of higher percentage increases across smaller firms (Claxton et al. 2006). Whether or not rising premiums and cost sharing depress take up rates also varies by employment characteristics. A low wage service worker is less likely to be able to afford rising premiums than a worker in a white collar industry such as finance. According to a Kaiser study on employer-sponsored health benefits, take up rates are the lowest among small firms, firms located in the south, and those in the retail and service sectors (Claxton et al. 2006).

Studies comparing private versus public insurance have shown that while public insurance far surpasses being uninsured, it does pose some limitations relative to private insurance (Quesnel-Vallee 2004). For instance, among those enrolled in public forms of insurance, access to health care is partly dependent on hospital and physician
participation rates. It is argued that as long as Medicaid payment rates and physician participation rates are lower for Medicaid than private insurers, Medicaid patients will not have equal access to medical care (Rowland, Salganicoff, and Keenan 1999). State regulations also play a role in comprehensiveness and affordability of health insurance, whether through setting eligibility limits for participation in public programs or regulation of insured employee health plans (with the exception of self-insured benefit plans due to the federal preemption of state legislation through the Employee Retirement Income Security Act of 1974). Other determinants of health insurance besides those already mentioned include family structure.

Family plans are more costly than single, but perhaps this is offset to a degree in some two-earner households. Childless families are not eligible for Medicaid regardless of their income, which means that if a child, in a previously eligible family, ages out of the system, the family could suddenly lose Medicaid. In 2007, it was estimated that two-thirds of low income families were uninsured (Kaiser Family Foundation 2007). This is not explained by a lack of employment, as 82% of the uninsured reside in working families, rather, it is explained by characteristics of the employment in which low income persons tend to be overrepresented, such as the low wage, benefit-poor service sector (2007).

The low wage service sector, which has taken the place of manufacturing in terms of employing the less skilled, differs significantly from the manufacturing sector. Unlike the manufacturing jobs in the postwar period that offered livable family wages and generous fringe benefits, the low wage service sector that employs a similar segment of the American population tends to offer neither livable wages nor benefits. Low income
families may be eligible for public insurance coverage through Medicaid, but eligibility
does not equal enrollment. Barriers to enrollment include lack of information, language
differences, residential remoteness, fear of stigmatization and even the belief that health
insurance is unnecessary. Although the State Children’s Health Insurance Plan (SCHIP),
which offers affordable health care coverage to children in families whose incomes are
above the Medicaid eligibility limit but below a limit set by the state, was intended to
provide coverage for families without access to more affordable ESI plans, a gap of
uninsured still remains: approximately 46 million, according to the U.S. Census (2008).
As Schoen et al. (2005) point out, if health insurance continues to offer less and less
financial protection, the US may be headed in a direction where it becomes more and
more difficult to distinguish the insured from the uninsured. It is this decline in the
financial protection once offered by employer provided health insurance that may be
threatening the economic stability of middle class families.

1.1.4 Health Insurance and the Middle Class

Health care costs have been rising steadily to the point where premium increases
have outpaced wage growth every year between 1988 and 2006 (with the exception of
1996) (Kaiser 2007b). According to a study by the Kaiser Family Foundation, the cost of
health insurance rose 7.7% in 2006, much higher than the overall rate of inflation (3.5%)
and the average increase in earnings (3.8%) (2007b). If this trend continues, and there is
little reason to expect otherwise in the absence of intervention (Moran 2005), middle
class families that may already be economically vulnerable in the context of the
restructured economy could find themselves falling out of the middle class when medical
bills accrue. There are numerous studies indicating that families are feeling the consequences of rising health care costs based on health and economic outcomes (Quesnel-Vallee 2004b; Edin 2001; Himmelstein, Warren, Thorne and Woolhandler 2005; Teles et al. 2005; Monheit and Cooper 1994).

After surveying 1,771 bankruptcy filers in 2001, Himmelstein et al. (2005) attributed approximately half of the filings to medical bills. The authors also found that filers citing medical reasons were 42% more likely to have experienced lapses in health care coverage than those citing other reasons (2005). A similar study underscoring the relationship between health care costs and debt was conducted by Demos and The Access Project (Zeldin and Rukavina 2007). The study included a national household survey of 1,150 low and middle income households that carried credit card debt for at least three months. Of those surveyed, 29% reported that medical expenses contributed to their credit card debt and among this group, 69% had experienced a major medical expense in the past three years. Also within the group citing medical bills as a cause of credit card debt, those without health insurance had an average debt of $14,512 compared to those with insurance of $10,973 (2007). As these studies show, medical bills are directly related to economic security. While medical bills may accrue to both the uninsured and underinsured, the consequences are likely to be worse among the uninsured since some coverage is better than none when health care is needed and/or used.

There have also been studies showing indirect links between medical bills and economic outcomes\(^\text{12}\). In interviews with low income parents, Katherine Edin (2001)...

\(^{12}\) It is important to acknowledge the on-going debate regarding whether or not asset tests for public health insurance programs serve as a disincentive to save and accumulate assets among lower income populations (Gruber and Yelowitz 1999). As health insurance becomes more privatized and health care costs continue
found that medical bills not only presented financial challenges, but also hurt parents’ credit and ability to secure home and educational loans. These obstacles inhibit asset accumulation and economic improvements intrinsic to the transformative power of assets (Shapiro 2003). Even if out-of-pocket expenses do not strip a family’s economic resources to a dangerous level, the threat of unexpected and costly medical needs may create a sense of insecurity about the future. For instance, Hacker (2006) notes that regardless of medical bills, a lack of health insurance may lead to a lost sense of security, which may make individuals more risk-averse and less willing to make financial investments, such as obtaining a mortgage, starting a small business, or maximizing one’s 401K contribution, for instance. Alternatively, having access to affordable and comprehensive health insurance may serve as a shock absorber against downward mobility since unexpected illnesses may strip family assets or interrupt career trajectories (Teles et al. 2005). Or perhaps, as Monheit and Cooper (1994) describe, pre-existing illnesses can lead to a situation known as job-lock, where individuals stay at their current employer for the continuation of the fringe benefits, which are not guaranteed with new job opportunities, despite career advancement possibilities.

to rise, one might expect higher incidences of crowd out in the public insurance arena. This deserves attention by researchers, but is beyond the scope of this work.
1.1.5 This Study—Part II: What Is the Impact of Health Insurance on Middle Class Families

Just as the requirements to achieving a middle class position have changed, so too has the meaning of the position. The postwar generation could rely on some degree of economic security not only because of a strong economy, but also supportive policies that provided a virtual safety net. Middle class families of the postwar generation may not have experienced the income highs of educated workers in the post-1970s knowledge economy, but they were less likely to fall from their position than may be true of families today because of the presence of strong social provisions in the postwar period (Hacker 2006b).

Political support for unions led to job concessions that benefited union and non-union workers alike such as strong unemployment insurance and comprehensive employer sponsored health insurance supported by a tax exempt status. But as the labor movement weakened with the changed economy and new policy directions, so did the financial protections. Many middle class families may be somewhat insulated from the weakened financial protections since members of the middle class are more likely to work in the “good” jobs offering better wages and benefits. However, as health insurance is becoming less and less comprehensive and health care costs more expensive, and middle class families remain ineligible for public health insurance, more and more middle class families may find themselves in economic trouble if faced with medical bills today than was true for previous generations. The research question guiding the second half of this study attempts to answer the following: What is the impact of a loss of health insurance on the economic stability of middle class families?
CHAPTER 2

RESEARCH DESIGN

The economic security of a middle class position in the postwar era is no longer a guarantee. The economic restructuring beginning in the 1970s has redefined the requirements of a middle class position and shifts in political attitudes and policy directions have affected the economic security that once accompanied a middle class position.

This research examines levels of economic stability among married couple middle class families with heads of household who entered adulthood in the post-economic restructuring era. To understand the role of weakened financial protections, I also examine the impact of loss of health insurance on the economic stability of married couple middle class families. Using panel data from the 1979 National Longitudinal Study of Youth, I examine multiple waves of data capturing both experiences with family-level health insurance as well as economic outcomes of interest. As a supplement to the quantitative data analysis, I also conducted in-depth interviews with a small mixed-income sample of New England residents regarding their experiences with medical bills and health insurance, more generally. In addition to including questions not captured by the NLSY79, the qualitative data allowed me to observe cases that not only fit patterns identified in the survey data but also those that could represent anomalies. Finally, the
qualitative data revealed evidence of certain patterned experiences with health insurance coverage that I could not discern from the survey data.

2.1. Hypotheses

2.1.1 Panel Study

Part of the analysis in this research is exploratory in nature and meant to provide a context for the more robust statistical analysis examining loss of health insurance. The primary question guiding the exploratory portion is: To what extent are married couple middle class respondents who entered adulthood in the period of economic restructuring economically stable? The context offered by the exploratory analysis helps inform the test of the hypotheses associating a loss of health insurance with economic instability among married couple middle class respondents. The NLSY79 captures economic and health insurance related variables for a consistent cohort over a period of twenty-seven years. The panel study will be used to test the following:

Loss of health insurance among married couple middle class respondents contributes to:

1. Downward income mobility
2. Increase in bankruptcy claims
3. Loss of home ownership

2.1.2 Interview Data

I conducted interviews with a small (N=25) mixed-income sample of New England residents to put experiences with health insurance and medical bills into context. The family structure of interviewees also varied from married couple families with
children to empty nesters and single parents and persons. The interview data provided information about how and in what order actual events might unfold and about how individuals respond to these events. The survey design of the NLSY79 did not capture many questions that are important for understanding how a middle class family could slip economically in response to medical bills and/or a loss of health insurance. For instance, one would expect a loss of health insurance to be more threatening economically as health care is used, but health care usage for all family members is not captured by the NLSY79. Health limitations are captured for respondents but this is not necessarily a proxy for using health care. By speaking directly with families who experienced hardship from medical bills, I was able to put health care usage into perspective and see how experiences differ when more or less health care is used by the respondent and the respondents’ family members. This process provided a useful frame of reference for interpreting the quantitative data and recognizing limitations of the NLSY questions and findings.

2.1.3 Data

2.1.3.1 Quantitative Data. The quantitative data used in this research are from the 1979 National Longitudinal Study of Youth (NLSY79), sponsored by the US Bureau of Labor Statistics (US BLS). The BLS has collected data regarding the labor market experiences of men and women from multiple cohorts examined at different points in time (US BLS 2006). It is a nationally representative sample of 12,686 young men and women, who were 14-22 years old when first surveyed in 1979, interviewed annually through 1994, after which they were interviewed biennially (2006). I use different waves
of data for different parts of the analysis. I include all waves for descriptive purposes but only 1996 to 2006 for the exploratory analysis examining the economic stability of middle class families. Prior to 1996, many respondents in the NLSY79 cohort were not old enough to have established patterns of economic circumstances. For the purposes of testing the hypotheses laid out in this research, I am focusing on outcomes experienced by respondents in the post-2000 period. This has implications for the number of cases used in this analysis. By 2006, a total of 5,451 of the original 12,686 respondents were not surveyed for various reasons, including being deceased, a very difficult case, unable to locate, that the supplementary/military sample was dropped for fiscal reasons, incarcerated, in the military, or other (US BLS 2006). This has the potential to lead to bias in the results since survey dropouts may share important characteristics. Because a particular probability sampling method was used to recruit respondents and also because there are three distinct strata including a cross-section and two supplements (military and disadvantaged), it was necessary to weight the data accordingly.

On average, NLSY79 respondents are in their early forties by 2006. This is ideal for examining intragenerational mobility. During their thirties, individuals are often consumed with getting settled in a home and occupation (Myers 2004). By the early forties, it is fairly safe to assume that families have achieved the level of education, income and assets that will be indicative of their adult status, and it is their trajectory from this point that I am examining. But as mentioned previously, in a period of weakened social insurances, their status may fluctuate further and their vulnerability to downward mobility may be greater than for previous generations.
The NLSY79 consists of a long questionnaire that was first administered through in-person interviews from 1979 to 1986, but for budgetary reasons was administered mostly over the telephone starting in 1987. By 2004, some web-based survey tools were used (US BLS 2006). The panel study offers rich data on the economic and labor market experiences of a large sample over time, but what is missing is more in depth information on how specific processes unfold, especially with regard to struggles with rising health care costs and medical bills, regardless of insurance status. The qualitative data component of this research partly compensates for this missing piece.

2.1.3.2 Qualitative Data. To uncover the processes involved with managing the costs of health insurance and out-of-pocket medical expenses and to gain an in depth understanding of the impacts of these processes on the overall economic well-being of both individuals and families, I conducted interviews with a small mixed-income sample of northern New England residents (N=25) who have struggled with medical bills. I gained access to some individuals, most of whom struggled with low income or poor credit, through their participation in a non-profit loan program (N=12). Others self-identified as having struggled with medical bills during a larger survey conducted with a random sample of New Hampshire residents\(^\text{13}\) (N=13). Both interview groups consist of a mix of low and middle income individuals and families, but with more low income represented in the first group and middle and upper income in the latter. The low income interviewees were a useful comparison group but the focus of this study is on how middle class persons handle challenges stemming from health insurance issues and medical bills.

\(^{13}\)Thirteen of the interviewees are from a random probability sample collected by the University of New Hampshire Survey Center, during the conduction of a Granite State Poll.
The interviews with individuals who struggled, themselves or on behalf of their families, with health insurance coverage and/or medical bills provided a framework for understanding how events might unfold, which was useful for interpreting the findings from the quantitative analysis. This was important given the potential problem of circularity with my research question and its “chicken and egg” conundrum. Could a loss of health insurance really lead to downward mobility or does it accompany downward mobility that has other causes? Lastly, the qualitative data offered insight into how experiences with health insurance and medical bills may be patterned by both class position and family structure.

2.1.4 Concepts and Measures

The operationalization of all concepts used in the quantitative portion of this research includes the following:

**Net family income.** The NLSY79 asks respondents to report an annual amount of *net family income* – income from all combined sources – for each year of the survey. As is often the case with income variables, there is missing data since it is a sensitive question, but in 2006 less than 6% of responders failed to provide an estimate of *net family income*. This variable is a continuous measurement variable, and it is also used to create indicators of middle class status in this research including downward income mobility and income quintile positions.

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14 There are multiple dependent variables of interest to this research. But they all center on a conceptualization of middle class, the definition of which is central to this research. If I employ a definition that is too inclusive of lower income families I may be capturing too much activity among a segment that is not quite middle class. Conversely, if I use a definition that is too narrow, I may miss some important activity occurring among middle class families. This presents a challenge to my research, but after experimenting with several conceptualizations of a middle class position, I feel confident in the selected definition.
Middle class. There is no definitive method for operationalizing a middle class position. While some studies suggest using a rather narrow definition consisting of education, home ownership, net family worth and even health insurance (Wheary 2005), I define respondents of the NLSY79 as middle class according to income parameters. After constructing within sample quintiles and examining median net family incomes for different quintile groups, I classified the fifth quintile as “above middle class”, the fourth quintile as “upper middle class”, the third quintile as “lower middle class” and the bottom two quintiles as “below middle class”.

Downward income mobility. For one section of the analysis, downward income mobility is examined between 2000 and 2006. Using within sample quintile groups for these two years, I label movement from the fourth to the third quintile as downward mobility from the upper to lower middle class. Movement from the fourth quintile to either of the bottom two quintiles is labeled as downward mobility from the upper middle class to below the middle class, the largest move. Movement from the third quintile to either of the bottom two quintiles is labeled as downward mobility from the lower middle class to below the middle class. The shaded cells (N=617) in the box below represents respondents that experienced downward income mobility between 2000 and 2006.

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<thead>
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<th>2000</th>
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<td>below m.c.</td>
<td>lower m.c.</td>
<td>upper m.c.</td>
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<tr>
<td>below m.c.</td>
<td>1,975</td>
<td>356</td>
<td>155</td>
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<tr>
<td>lower m.c.</td>
<td>282</td>
<td>411</td>
<td>220</td>
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<tr>
<td>upper m.c.</td>
<td>124</td>
<td>211</td>
<td>398</td>
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<tr>
<td>Total</td>
<td>2,381</td>
<td>978</td>
<td>773</td>
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80
Loss of home\textsuperscript{15}. For each year of the survey, the NLSY79 includes the yes/no question: “Does respondent/spouse own/make payments on this house.” To indicate a change in home ownership status from owning to not owning, respondents were coded as “1” if they no longer owned a home between 2002 and 2006 after first indicating that they owned a home in 2000.

Bankruptcy claims. The NLSY79 asked a question in 2004 among bankruptcy claimants as to the year they filed. Respondents who indicated a year in the post-2000 period were coded as “claimed in 2000s” and assigned a value of “1”. Respondents that never filed were coded as “never claimed” and assigned a value of “0”. I chose to exclude respondents that filed during the pre-2000 period in order to learn more about the post-2000 filers that I think would be lost by including previous filers. The bankruptcy question was not asked in 2006.

Children in household. The presence of children in a household impacts household expenses. The NLSY79 asks respondents to indicate the number of children (biological, step, or adopted) living in the household for each wave of the survey. When appropriate, I generate an average number of children measure for a specified timeframe based on the children in the household variable. The result is a discrete measurement variable.

Sum of weeks unemployed. Unemployment is an important factor for both assessing economic stability and access to health insurance. The NLSY79 includes a variable of sum of weeks unemployed for each year of the survey. I summed the number

\textsuperscript{15}There is no guarantee that those coded as “lost home” actually lost their home due to hard financial times, but by requiring that they previously owned and considering that many people purchase a new home concurrent with the closing/sale of a previous home, the identified group may represent a change in ownership indicative of financial struggle. There is no indicator of foreclosure offered by the NLSY79.
of weeks unemployed to match timeframes used at different points in the analysis. The result is a continuous measurement variable.

**Income volatility.** There are different ways to measure income volatility, which is some measure of the rate at which incomes rise and fall. Borrowing from another study that examines income volatility (Yeung et al. 2002), I created an indicator of an income decline of 30% or greater to signify income volatility. The result is a dummy variable that codes individuals as “0” if they did not experience an income decline of 30% or greater between 2000 and 2006 and “1” if they did.

**Number of jobs.** A changing employment pattern since the period of economic restructuring is a shift from more full-time to part-time and contract jobs. As a result, some workers must piece together multiple jobs to make ends meet (Ehrenreich 1999). Thus holding more than one job with different job characteristics may be indicative of economic instability. The NLSY79 asks respondents to report the number of jobs held since the last interview. For some respondents, this could mean concurrent jobs whereas for others it may be indicative of consecutive jobs. I examine changes in this variable over time among married couple families by class grouping.

**Occupation.** Respondents were assigned to one of three categories based on their three-digit Census occupation codes (values 1 to 395 were coded as “professional/white collar”, 401 to 824 as “blue collar”, and 901 to 984 as “service sector”). I then dichotomized each occupational category with 0/1 values for ease of interpretation using different analytical techniques. For instance, those with a professional/white collar occupation are coded “1” while respondents are coded “0” if they work in either the blue collar or service sector.
Uncovered family member. Starting in 1989, the NLSY79 asked respondents if they, their spouse and child(ren) are covered by a health/hospitalization plan. For each year this question was asked, respondents who indicated an uncovered family member were coded as “1” and those who reported all members of the family as having coverage were coded as “0”. A dichotomous version of this variable is used in part of the analysis and is also used to create the loss of health insurance variable in a different portion of the analysis.

Loss of health insurance. I assigned respondents to a category of loss of health insurance if they met two criteria. First, all members of their family had to be covered at a selected starting point. Second, the respondent had to experience a loss of health insurance for at least one family member in selected subsequent years following the initial point when all family members were covered. Respondents who met these criteria were coded as “1”, and those with consistent coverage over the period in question were coded as “0”. I lose many cases by using such stringent definitions of loss of health insurance in one portion of my analysis but in another section where I use the uncovered family member variable across all years for which data are available, I have more cases.

Health limitations. As an indicator of possible exposure to health care usage and medical bills, I include a measure of health limitations asked of survey respondents. Based on the survey question of whether “health limits the amount of work you can do”, I coded respondents dichotomously as either having limitations during a given period or not having limitations, where limitations is equal to “1”.

Source of health insurance. When the survey that included a question about the respondent’s health/hospitalization plan, it also included a question about the source of

16The year 1989 is excluded from my analysis since it was asked differently this year.
that plan(s). Respondents were assigned to one of three categories including: employer sponsored, purchased private, and Medicaid/public. For ease of interpretation, I then dichotomized each of the three categories into 0/1 indicators of, for example, having employer sponsored insurance (a value of “1”) as opposed to either of the other types (a value of “0”).

*Educational attainment.* The NLSY79 includes a measure of *highest degree received* by 1988. This could change by later waves of the survey, but in most cases it does not. The education variable consists of five categories including “high school diploma or equivalent”, “some college”, “bachelors”, “advanced degree”, and “other”.

*Sex and Race.* Interviewers captured the sex and race of respondents in 1979, the initial wave of the survey. I dichotomized both variables where “female” has a value of “1” and being “white” has a value of “1”. In both cases, respondents are coded as “0” otherwise.

Because I operationalized the dependent variables in different ways, for instance, there is a dichotomous indicator of *downward mobility* as well as a continuous measurement variable of *net family income*, different analytical techniques will be applied to fit the needs of the relationships being investigated.

### 2.1.5 Analytical Techniques

2.1.5.1 *Descriptive Analyses.* There is no definitive method for assessing the economic stability of middle class families, however it is possible to examine symptoms of instability. By examining a number of characteristics indicative of different degrees of economic stability according to other studies (Newman 1988; Sullivan et al. 2000; Yeung
et al. 2002), I provide an economic portrait of a sample of married couple middle class families from the NLSY79. For instance, attachment to the labor market, income volatility, and bankruptcy trends are useful for assessing degrees of economic stability over time. An examination of the associational relationships among variables indicative of economic stability is also useful for understanding the economic patterns and experiences of the married couple middle class families in this study.

2.1.5.2 Income Mobility Matrices. Income mobility matrices are a useful tool for comparing the economic movement of families over time (Zaidi and Gustafsson 2007). By assigning respondents to quintile groups according to their net family income at two time points, I can compare the proportion of respondents in different quintile positions at times 1 and 2. Times 1 and 2 in this analysis are 2000 and 2006, respectively. These time points are of substantive interest since private sector health insurance was more affordable and comprehensive in the 1990s than in the post-2000 period, during which signs of the system’s unraveling have been reflected by higher cost sharing, less comprehensive coverage, and declining offer/enrollment rates (Holahan and Cook 2006).

A completed income mobility matrix contains raw numbers or proportions in each cell, but for the purposes of illustration, the example below should be interpreted as “X% of families that were in the lowest quintile in 2000 remained in the lowest quintile by 2006”. In fact, the shaded cells indicate families that experienced no movement between quintiles over time. These families could have still experienced income gains between 2000 and 2006, but their relative economic position would have stayed the same. The other example percentage should be interpreted as “Z% of families that were in the
lowest quintile in 2000 were in the highest quintile by 2006”, thus indicating upward income mobility.

<table>
<thead>
<tr>
<th>Quintile Position in 2006</th>
<th>2000</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>X%</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Z%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Income mobility matrices comparing quintile positions of middle class respondents based on their net family income in 2000 and 2006 serve as a benchmark against which to compare matrices that include only those middle class respondents who lost health insurance coverage for at least one family member by time 2 after having had full coverage at time 1. The comparison provides a sense of the unique economic experiences of families who lost coverage during a period when private sector health insurance became both thinner and financially burdensome for many (Banthin et al. 2008). This research hypothesizes that a loss of health insurance may contribute to downward mobility, particularly in the post-2000 period, recognizing that there are multiple potential causal factors of downward mobility. Using multivariate regression techniques, I can test whether or not a loss of health insurance has a statistically significant independent effect on downward mobility as well as on other indicators of financial struggle including bankruptcy claims and loss of home.

2.1.5.3 Multivariate Regression. Multivariate regression analytical techniques, specifically logistic and fixed effects regression, are used in this research to help determine causality. This technique allows for the inclusion of multiple independent variables that potentially affect the outcome variables of interest – downward mobility,
bankruptcy claims, and loss of home – while controlling for demographic characteristics. I recognize that employment and marital status directly affect changes in income and assets. I control for these factors by limiting the sample to married couple families and by including sum of weeks unemployed as an independent variable in the analyses. This research aims to determine the extent of economic stability among married couple middle class families and to assess the impact of a loss of health insurance on these families. The different nature of the dependent variables necessitates using different regression techniques. Multinomial logistic regression is appropriate for examining the impact of a loss of health insurance on the categorical indicator of downward income mobility, while standard logistic regression is useful for regressing the dichotomous dependent variables bankruptcy claims and loss of home on loss of health insurance. Fixed effects regression techniques are useful for exploiting far more of the cases and years available in the panel study with the use of a continuous measurement variable, net family income.

Fixed effects regression techniques provide a way of controlling for unmeasured characteristics of the individual, by essentially using the individual as a control. Another benefit to using fixed effects is that it is well suited for panel study data and allows for the exploitation of far more cases than is possible when employing stringent parameters, such as those used in the logistic regression portion of this analysis. For instance, in order to simulate temporal ordering in the logistic regression analysis, I examine economic outcomes during a period following specific experiences with health insurance. This method does not allow for unmeasured characteristics of individuals, only those that I include in the regression equation. Fixed effects controls for unmeasured characteristics
while also providing a method for examining lagged effects, for example, the effect of a loss of health insurance on net family income two years later.
CHAPTER 3

ANALYSIS

3.1 Panel Study Data from the 1979 National Longitudinal Survey of Youth

The birth cohort followed by the 1979 NLSY, born between 1957 and 1965, is ideal for investigating the extent of economic stability among middle class families. According to Reynolds Farley (1996), this generation consists of the “late baby boomers,” meaning that they are part of the larger baby boomer generation, but differ somewhat from the “earlier baby boomers”, who are their older siblings in many cases. The most significant difference is that the earlier baby boomers entered young adulthood during the more progressive political era and prior to the period of economic slowdown and restructuring of the late 1970s and 1980s. The younger group entered young adulthood during the period of economic restructuring and therefore mark the first birth cohort to fare worse than their parents economically (Newman 1993). For instance, they must invest more and work harder than previous generations to achieve a middle class position. The changing economic and employment patterns have heightened the requirements needed to enter the middle class and the concurrent policy shifts have weakened the economic security that once accompanied a middle class position.

The following analyses examine the extent of economic stability among married couple middle class families today and the impact of a loss of health insurance on middle class families.
To put the cohort captured by the NLSY79 into context, the following Life Course Analysis provides insight into milestones experienced from the period of young adulthood to the late thirties and forties of respondents in this sample.

3.1.1 Life Course Analysis

According to Figure 9, among all respondents who remained in the sample by 2006, the frequency of first marriages was high, close to 400 per year until the average age reached 27. At this point, some tapering off occurs and the number of first and second divorces starts to rise. The upward trend of divorces starting in the late 1990s reaffirms the importance of focusing on married couples in the subsequent analyses. The high frequency of divorce, which may be accompanied by income declines and loss of home ownership, would complicate my analysis and ability to make causal inferences about the impact of health insurance on middle class families.
Figure 9. Frequency of First Marriages, Divorces and Second Divorces by Year and Mean Age of Respondents

Figure 10, which shows the frequency of first child born mirrors the first marriage patterns in Figure 9. This is likely because newly married couples are in a position to build a family but also because this is when mothers are in their prime child-rearing age, which starts to decline after the average age of 31. The presence of children in the household increases all expenses but it also represents another possible user of health care. A sick uninsured child could present financial risks to a family.
The pattern of owning a first home is a bit different than first marriage and child trends. Rather than a high frequency in the earliest years followed by a declining trend, Figure 11 reveals that the highest peak of first home purchase occurred when the average age of respondents was the mid to late twenties. At this point many respondents had accrued several years in the job market, positioning them better for a home purchase than in their younger years. The increase in housing costs may partly explain the declining trend toward the later years. I would expect to see differences by region of the country to compensate for different standard of living costs.
An examination of life course patterns of the NLSY79 respondents reveals that by the average age of 27, a large portion of respondents had settled down. At this point, most had been married at least once, had at least one child and owned a home. These are the rewards many people hope to achieve in their adult life. Members of this cohort show signs of being settled by their early thirties. By limiting the analysis to married couples only, I can examine changing patterns of economic stability among families in the late 1990s to 2006—a period when they are already settled. Any incidences of economic instability then are likely to be structural in nature as opposed to a function of life stage.
3.1.2 Assessment of Economic Stability among Married Couple Middle Class Respondents

In the context of the post-economic restructuring period, the work and educational requirements for achieving a middle class position are greater than they were in the postwar period. The simultaneous scale back in social spending and emphasis on smaller government more generally, which weakened social insurance, has meant that middle class families today also enjoy less economic security than the postwar generation. The dual challenge of heightened requirements and weakened financial protections may, as some scholars argue (Hacker 2006b), be creating more economic instability among families today. This section will examine the extent of economic stability among married couple middle class families, drawing on data from the NLSY79. Respondents included in the analysis came of age during the period of economic restructuring.

According to the data in Table 1, lower and middle income respondents consistently married from 1996 to 2006 (N=2,947) are similar by sex and age, but those above middle income show a variation in sex, with fewer female respondents represented. There appears to be a linear relationship between race and income position, where a larger percentage of lower income respondents are nonwhite, followed by middle income and the smallest percentage represented by above middle income. An inverse linear relationship appears to exist for educational attainment where the smallest percentage of respondents with a bachelor’s degree is represented by the lower income respondents and so on. Across financial indicators, members defined as middle class or above are much better off but this is part of how I operationalized class positions—using income parameters. There is a large degree of variation in the extent of financial struggles across the three groups. For instance, the mean percentage income change for the lowest income
group is negative and in the double-digits, whereas it is just less than one percent for the middle group and approximately 10 percent for the highest income group. This may be reflective of lower wages in service sector jobs more likely to be held by lower income persons as well as stagnant wages facing middle income persons. In fact, nearly a fifth of the lower income married respondents reportedly worked in service sector occupations in 2006, reflected at the bottom of Table 1.

Table 1. Descriptive Statistics* of Respondents Married from 1996 to 2006 by Class Position

<table>
<thead>
<tr>
<th>Descriptive Variables (2006 unless otherwise indicated)</th>
<th>Below middle (N=587)</th>
<th>Middle class (N=1450)</th>
<th>Above middle (N=762)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (female)</td>
<td>51.5%</td>
<td>51.9%</td>
<td>45.7%</td>
</tr>
<tr>
<td>Mean age</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>Race (non-white)</td>
<td>13.5%</td>
<td>7.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Bachelor's degree, 1988</td>
<td>5.4%</td>
<td>12.8%</td>
<td>25.8%</td>
</tr>
<tr>
<td>Mean number of children in household</td>
<td>1.5</td>
<td>1.7</td>
<td>1.8</td>
</tr>
<tr>
<td>Median net family income</td>
<td>$35,000</td>
<td>$77,195</td>
<td>$149,175</td>
</tr>
<tr>
<td>Median percent income change, 04-06 (2006 $)</td>
<td>-12.2%</td>
<td>.74%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Percent with 30% or greater income decline, 04-06 (2006 $)</td>
<td>32.8%</td>
<td>6.6%</td>
<td>5.8%</td>
</tr>
<tr>
<td>Ever declared bankruptcy (asked in 2004)</td>
<td>22.6%</td>
<td>10.7%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Median savings, 2004</td>
<td>$1,800</td>
<td>$5,000</td>
<td>$15,000</td>
</tr>
<tr>
<td>Median net family worth, 2004</td>
<td>$40,000</td>
<td>$145,320</td>
<td>$364,302</td>
</tr>
<tr>
<td>Home ownership:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own home, 2006</td>
<td>78.3%</td>
<td>93.5%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Lost home in 04-06</td>
<td>7.8</td>
<td>2.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Health insurance (all family members covered)</td>
<td>63.7%</td>
<td>88.2%</td>
<td>94.5%</td>
</tr>
<tr>
<td>Two or more jobs since last interview</td>
<td>23.9%</td>
<td>24.0%</td>
<td>22.6%</td>
</tr>
<tr>
<td>Hours worked</td>
<td>1,573</td>
<td>1,922</td>
<td>2,062</td>
</tr>
<tr>
<td>New employer since last interview</td>
<td>21.1%</td>
<td>18.0%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Mean number of weeks unemployed</td>
<td>1.7</td>
<td>.65</td>
<td>.20</td>
</tr>
<tr>
<td>Occupational sector:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blue collar</td>
<td>32.1%</td>
<td>24.9%</td>
<td>11.3%</td>
</tr>
<tr>
<td>Service sector</td>
<td>18.6</td>
<td>8.9</td>
<td>4.2</td>
</tr>
<tr>
<td>Professional/white collar</td>
<td>49.3</td>
<td>66.2</td>
<td>84.5</td>
</tr>
</tbody>
</table>

*Sampling weights for 2006 have been applied.

While percent income change varies to a large degree across the middle and upper income groups, these groups are more similar along the indicator of income volatility, operationalized as an income decline of 30 percent or greater. A third of the lower
income respondents reported an income decline of 30 percent or greater between 2004 and 2006, whereas closer to 6 percent of both higher income groups shared this experience. However, the large degree of variation in the percentages of respondents who ever declared bankruptcy by income group, such that the mean percent of lower income was double that for middle income and the mean percent for the middle income was double that of upper income, might suggest that middle income respondents, while less likely to claim than their lower income counterparts, are more likely to resort to claiming bankruptcy to manage financial struggles than their upper income counterparts. This could be an indicator that they are exposed to less economic security than their upper income counterparts. Additionally, a higher mean percentage of married middle income respondents owned a home in 2006 than the lower income respondents. Home equity is another means of managing financial struggles. Other interesting differences and similarities across income groups relates to job characteristics.

Respondents defined as middle and above middle class work more hours on average and are more likely to hold positions in the professional/white collar sector than those defined as lower income. This might explain the higher percentage of health insurance coverage for married middle and above middle income respondents. Higher wages and fringe benefits are characteristics of “good” jobs such as white collar occupations. Some similarities are that nearly a quarter of members of all three groups reportedly worked two or more jobs since the last interview. This could include transitioning to new jobs as well as working multiple jobs simultaneously. Also, close to 20% of members of all three groups reported a new employer since the last interview. A new employer could represent a career advancement opportunity or the end of
unemployment. In either case, the contingent nature of employment today is a factor. Even with much different education levels and economic circumstances, the requirements of the changed economy are felt by members of all three groups.

More direct measures of the relative degrees of economic stability include income changes and losses. Figures 12 and 13 below show recent trends in percent median income change and percent experiencing income declines of 30 percent or greater. Figure 12 reveals larger median income increases among middle class respondents who have not been consistently married for the indicated ten-year period. The absolute income levels are likely to be greater among the married couple respondents since they are more likely to be comprised of dual-earner households, but the percentage increases are greater among the group that has not been consistently married. There is also the possibility that some spouses fluctuate between being in the labor market and staying home for child-rearing purposes, which could exert downward pressure on income changes. There is a bit more consistency of percent income changes among the consistently married respondents, whereas the group that includes a mix of marital statuses shows a clear declining pattern. This could reflect marital dissolutions, which could potentially divide income in half, for instance. For this reason, I focus on consistently married respondents in later parts of the analysis. Figure 13 examines income losses of 30 percent or greater by class status.
Immediately it is apparent that lower income married couple respondents have had more experience with large income losses than their middle and above middle income counterparts (see Figure 13). A larger degree of variation is also present among lower and upper income married couple respondents than among middle income. Approximately 5 percent of married couple middle class respondents experienced income losses of 30 percent or greater for each of the years reflected in Figure 13. What is not reflected in Figure 13 is movement into and out of the middle class each year; rather it only shows respondents who were in a middle class position for each given year. Therefore it is possible that changes in the composition of the middle class could help explain why the level experiencing large income losses appears to remain rather steady over the ten-year period. A later section using income mobility matrices to examine movement across income quintiles provides insight into compositional changes of income groups over time.
A final indicator of economic stability that reveals interesting differences by income grouping is bankruptcy claims (see Figure 14). The largest proportion of bankruptcy claimants in a given year occurred among the lowest income group (12-14%). For the most part, it is respondents in the lower and middle income groups that represent the highest proportion of bankruptcy claimants in a given year, but across all three groups there is considerable variation and no clear pattern or consistency. As Sullivan et al. (2000) emphasize, bankruptcy is not just a problem among lower income groups. It can be used to salvage assets and avoid slipping down the economic ladder and is therefore a useful strategy among middle and upper income groups to help maintain their positions. It may slow the fall from one position to another, and limit the depth of the fall. Furthermore, recent studies have shown that there is a rising incidence of bankruptcy claims, particularly Chapter 7, among baby boomers (Golmant 2007). Reasons for this might include a combination of factors affecting this cohort such as earning unprecedented levels of income but also reaching an earnings peak during the height of
economic restructuring (2007). Additionally, the laws for claiming bankruptcy changed such that it became easier and more affordable (Sullivan, Warren and Westbrook 2006). There is an argument that amendments to the bankruptcy code in 2005 that made it easier to claim bankruptcy led to a declining stigma associated with filing that helps explain the rise in bankruptcy rates. But an alternative view held by Sullivan et al. based on a study of claimants in 1981, 1991, and 2001 is that growing financial struggles better explain the rise in bankruptcy rates than does a possible decline in the stigma associated with filing.

Figure 14. Percent of Respondents, Married 1996 to 2006, Who Claimed Bankruptcy, by Class Status and Year

The declining experience of economic stability of middle class Americans has been observed since the 1980s and mostly attributed to economic restructuring such as firm downsizing (Newman 1988). The data presented above support the idea that the sample captured by the NLSY79 includes middle class Americans who are not immune

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to falling and struggling financially. The next section aims to understand the causes, particularly ones that do not stem directly from economic restructuring such as declining financial protections. To place the economic experiences of the married respondents belonging to the three income groups into context, the next section examines associations among factors that might be contributing to their respective trajectories.

3.1.3 Establishing Association and Significance among Key Factors

Building on the simple descriptive analysis offered in Table 1, the next section explores whether and how the variables of interest in this study are related. Table 2 presents pairwise correlation coefficients among economic, occupational, and demographic characteristics of respondents who were consistently married from 1996 to 2006. Although the trajectories of the different income groupings are of interest, I included all three groups in the correlation matrix. This method provides a clean look at the direction and strength of association among variables used in this study.

Overall, the correlation coefficients in Table 2 are in the expected direction. For instance, unemployment is positively and significantly (at the p<.10 level) associated with income declines of 30 percent or greater. In contrast, number of hours worked is negatively associated with large income declines. Number of jobs is negatively associated with income change. A possible explanation for the direction of this relationship is that an individual working or piecing together multiple jobs may be in lower wage work or changing jobs frequently and therefore foregoing advancement opportunities such as raises. Regarding health insurance specifically, the changing nature of the weakening system is reflected.
As indicated in the first area boxed in red under the income decline column header in Table 2, having an uncovered family member is positively and significantly (p<.10) associated with large income declines. Also boxed in red under the health insurance column header are coefficients relating occupational sector to having an uncovered family member. The coefficients are positively and significantly correlated to blue collar and service sector jobs and negatively correlated with professional white collar work. Consistent with this pattern is the fact that the education variable indicative of a bachelor’s degree or higher, also boxed in red, is negatively associated with losing health insurance. This is likely because higher education is more strongly associated with work in the professional/white collar sector (.221 at the p<.10 level) where “good” jobs carrying benefits are more prevalent.

The correlation coefficients in Table 2 reveal patterns consistent with what one would expect in the context of the restructured economy. Working more is a necessary requirement to not only succeeding but also to prevent slipping as indicated by the inverse relationship of number of hours worked and large income declines. There is also preliminary evidence for the proposition that a loss of health insurance, even for a single family member, could expose a family to economic risk and lead to downward income mobility, as reflected by the positive association between having an uncovered family member and large income declines. The correlations are useful for examining direction and strength of relationships of variables of interest but in order to tease out differences by income groups, the next section will employ income mobility matrices.
Table 2. Pairwise Correlations among Economic, Occupational, and Demographic Characteristics of Respondents, Married 1996 to 2006

<table>
<thead>
<tr>
<th></th>
<th>Percent income change, 04-06</th>
<th>Income decline of 30% or greater, 04-06</th>
<th>Sum of weeks unemployed, 2006</th>
<th>Health ins: uncovered family member, 2006</th>
<th>Health limits amount of work, 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent income change, 04-06 (2006 dollars)</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income decline of 30% or greater, 04-06</td>
<td>-0.205*</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sum of weeks unemployed, 2006</td>
<td>-0.021</td>
<td>0.130*</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health ins: uncovered family member, 2006</td>
<td>0.009</td>
<td>0.109*</td>
<td>0.072*</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>Health limits amount of work, 2006</td>
<td>0.039*</td>
<td>0.068*</td>
<td>0.008</td>
<td>0.156*</td>
<td>1.000</td>
</tr>
<tr>
<td>Number of jobs, 2006</td>
<td>-0.038*</td>
<td>-0.016</td>
<td>0.057*</td>
<td>0.005</td>
<td>-0.228*</td>
</tr>
<tr>
<td>Number of hours worked, 2006</td>
<td>-0.009</td>
<td>-0.121*</td>
<td>-0.231*</td>
<td>-0.098*</td>
<td>-0.312*</td>
</tr>
<tr>
<td>Children in household, 2006</td>
<td>0.019</td>
<td>-0.006</td>
<td>-0.009</td>
<td>-0.117*</td>
<td>-0.073*</td>
</tr>
<tr>
<td>Bachelor's degree or higher, 1988</td>
<td>0.010</td>
<td>-0.023</td>
<td>-0.062*</td>
<td>-0.127*</td>
<td>-0.074*</td>
</tr>
<tr>
<td>Race: non-white</td>
<td>-0.012</td>
<td>0.033</td>
<td>0.100*</td>
<td>0.078*</td>
<td>0.032*</td>
</tr>
<tr>
<td>Sex: female</td>
<td>-0.044*</td>
<td>0.032</td>
<td>0.015</td>
<td>0.049*</td>
<td>0.086*</td>
</tr>
<tr>
<td>Own home, 2006</td>
<td>0.007</td>
<td>-0.091*</td>
<td>-0.050*</td>
<td>-0.138*</td>
<td>-0.087*</td>
</tr>
<tr>
<td>Occupation: blue collar, 2006</td>
<td>0.013</td>
<td>-0.017</td>
<td>0.025</td>
<td>0.089*</td>
<td>0.003</td>
</tr>
<tr>
<td>Occupation: service sector, 2006</td>
<td>-0.005</td>
<td>0.012</td>
<td>-0.001</td>
<td>0.099*</td>
<td>0.069*</td>
</tr>
<tr>
<td>Occupation: professional/white collar, 2006</td>
<td>-0.008</td>
<td>0.008</td>
<td>-0.022</td>
<td>-0.144*</td>
<td>-0.048*</td>
</tr>
</tbody>
</table>

*Significant at the p<.10 level.
3.1.4 Income Mobility Matrices

Income mobility matrices are a useful visual tool for examining mobility trends and understanding the changing trajectories and compositions of different income groups. There are multiple ways in which to examine mobility such as occupational versus income, intergenerational versus intragenerational mobility, and relative versus absolute. In this research, I examine relative intragenerational income mobility because it is most relevant to my hypotheses. For instance, through the NLSY79 I have access to a single cohort but spanning several years of their life course.

Using the net family income variables in 2000 and 2006 to create within-sample quintile categories, respondents were assigned to quintiles based on their income. The matrix (Table 3A) is essentially a cross-tabulation of the aggregated positions of respondents in 2000 compared to 2006. The area below the shaded cells in the income mobility matrix represents downward income mobility. For instance, a combined total of 28% of respondents in the fourth quintile in 2000 moved down one or more quintiles by 2006. According to Table 3A, respondents belonging to the top two quintiles were least likely to move. However, when limiting the observations to respondents who lacked health insurance for at least one family member in 2002 and 2004, this pattern changes (see Table 3B).

With one exception, all of the percentages below the shaded area—indicative of downward income mobility—are larger among respondents who lacked health insurance coverage for at least one family member (Table 3B) than among all married couple respondents (Table 3A). The combined percentage of downward mobility among those
who lacked health insurance is 146 percentage points higher than among all married couple respondents.

Table 3A. Comparison of Within-sample Quintile Positions among Married Couple Respondents (N=2,702)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2006 quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>37.3</td>
<td>28.2</td>
</tr>
<tr>
<td>2</td>
<td>11.3</td>
<td>40.5</td>
</tr>
<tr>
<td>3</td>
<td>3.8</td>
<td>17.2</td>
</tr>
<tr>
<td>4</td>
<td>1.9</td>
<td>5.4</td>
</tr>
<tr>
<td>5</td>
<td>1.4</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Pearson chi2(16) = 1.9e+03 Pr = 0.000.

Table 3B. Comparison of Within-sample Quintile Positions among Married Couple Respondents, Who Lacked Health Insurance in 2002 and 2004 (N=213)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2006 quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>49.2</td>
<td>39.7</td>
</tr>
<tr>
<td>2</td>
<td>26.9</td>
<td>50.8</td>
</tr>
<tr>
<td>3</td>
<td>20.8</td>
<td>31.3</td>
</tr>
<tr>
<td>4</td>
<td>4.2</td>
<td>20.8</td>
</tr>
<tr>
<td>5</td>
<td>18.2</td>
<td>18.2</td>
</tr>
</tbody>
</table>

Pearson chi2(16) = 60.9372 Pr = 0.000.

The movement across income groupings reflected in the income mobility matrices suggests that there is a relationship between the trajectory and composition of an income group and economic security such as that offered by health insurance. What cannot be discerned from this analysis is the temporal ordering of income changes and potential causal factors such as changes in health insurance status. There are likely to be numerous factors affecting the composition of an income group such as employment and education changes. The potential for spuriousness is the main reason I limit much of the analysis to married couple respondents, so that income changes resulting from marriage and marital dissolution are minimized. In an attempt to disentangle the number of factors that may contribute to income mobility, I employ statistical controls in the next section featuring regression techniques.
3.1.5 Regression of Downward Mobility and Financial Struggles on Loss of Health Insurance

Different regression techniques are used in this analysis based on the nature of the dependent variable in question. There are three hypothesized dependent variables, categorized in ways that demand different approaches. Multinomial logistic regression, useful with un-ordered categorical variables, will be used for the downward income mobility variable consisting of four categories. Standard logistic regression techniques are used for the dichotomous loss of home and bankruptcy dependent variables. The tables in the next section present results from regressing each of the hypothesized dependent variables on key independent and control variables. I limit the sample used in the regression models to include respondents married from 2000 to 2006 who were middle class in 2000.

The following linear models represent the hypothesized relationships among the key variables in this section of the analysis:

\[
\text{Downward income mobility} = \beta_{int} + \beta_{unemp} + \beta_{occ} + \beta_{sex/race/educ} + \beta_{loss of health insurance} + \epsilon
\]

\[
\text{Bankruptcy} = \beta_{int} + \beta_{unemp} + \beta_{occ} + \beta_{sex/race/educ} + \beta_{loss of health insurance} + \epsilon
\]

\[
\text{Loss of home} = \beta_{int} + \beta_{unemp} + \beta_{occ} + \beta_{sex/race/educ} + \beta_{loss of health insurance} + \epsilon
\]

The models differ only in the dependent variable, but this is because similar independent variables are likely to have some unique contribution on the three hypothesized effects. For instance, occupation and employment are directly linked to income, which in turn is related to assets.

I start by regressing the dependent variables on the hypothesized independent variable, loss of health insurance (2002 and 2004) as well as other health related variables including health limitations (2000 to 2006) and source of health insurance (ESI
in 2000) while controlling for demographic characteristics such as sex (female), race (non-white) and education. I exclude age since the NLSY79 consists of a birth cohort. This partial model, which excludes other potentially predictive independent variables such as occupation and unemployment, reveals the strength and direction of a loss of health insurance without the inclusion of potentially confounding factors. This serves as a good point of comparison for the full model that does include occupation and unemployment variables, sum of weeks unemployed (2000 to 2006) and occupation (professional/white collar in 2000). If loss of health insurance did not affect the dependent variables in the partial model, then it was expected that the relationship would be even weaker in the full model and probably not worth examining. By employing a phased approach, I can see how the coefficients change as the model changes, but also, I can compare the relative strength of the hypothesized causal variables and try to discern whether or not a loss of health insurance exerts a real effect on the dependent variables or if it is masking a spurious relationship.

In attempts to avoid spuriousness, I manipulated the timing of the variables in the logistic regression models to include only occurrences of the causal variables on the right side of the equation in years preceding experiences with the dependent variables on the left side of the equation. This is a simplistic way of establishing temporal ordering and there are limitations to this method such as 1) being locked into timing assumptions and 2) not exploiting all of the cases and time-series potential of the panel study. The N’s are significantly reduced with the use of these methods, in some cases by a fraction of the entire sample (N=7091).

3.1.5.1 Logistic Regression Analyses. Table 4A shows output from conducting a
multinomial logistic regression of *downward income mobility* in a two-phased approach. The partial model includes the hypothesized independent variable, *loss of health insurance* as well as other health insurance-related variables and demographic characteristics. Each of the three categories representing varying degrees of downward income mobility are relative to members of a group that either experienced no movement or upward movement—the base outcome. Thus, relative to members of the group that experienced no movement or upward movement, *loss of health insurance* is positively and strongly associated with downward movement and significantly so for the groups that moved from upper middle to below middle class and from lower middle to below middle class (p<.10). *Health limitations*, which may serve as a proxy for use of health care at least among respondents, does not seem to have an effect on the dependent variable.

Across mobility types in the partial model, there is some variation in the direction of the demographic characteristics with the exception of *education*, which is negatively associated with downward mobility as one might expect. When *sum of weeks unemployed* and *occupation* are introduced into the full model, the coefficients for *loss of health insurance* remain strong and positive but are only significant for the group that moved from the upper to below middle class (at the p<.05 level). While the coefficients are weak, *sum of weeks unemployed* is in the expected direction (positive) and significant across mobility types. The direction of influence of the demographic variables changed little in the full model. Again *education* has a negative influence on downward mobility across mobility types. Overall, the fact that the *loss of health insurance* variable exhibits a strong and positive influence on downward mobility in the full model that included

---

18 The decision to allow for a larger alpha for assessing statistical significance is because there are multiple factors that may contribute to the dependent variables and therefore, I hope to avoid making a Type I error by allowing for a larger probability that the null hypothesis is false.
unemployment and occupation variables supports part of the hypothesis being tested in this research. The other dependent variables of interest are asset-related and include bankruptcy and loss of home.

In the partial models regressing bankruptcy (Table 4B) and loss of home (Table 4C), on loss of health insurance and related factors, the coefficients are strong, positive and significant (at the p>.05 level with one exception at the .10 level). Introducing unemployment and occupation variables in the full model has very little impact on the strength of influence of loss of health insurance on the respective dependent variables. This is likely due to the fact that unlike downward mobility, which was operationalized based on income changes, experiences with bankruptcy and home ownership can occur independent of income changes and are thus less sensitive to employment. For instance, it is possible to take on debt regardless of income changes. Other studies have demonstrated links between medical bills and bankruptcy (Himmelstein et al. 2005), so it is little surprise that my findings provide further support. The relationship between loss of health insurance and asset depletion (if health care is used) is more straightforward than the relationship with income changes. The latter may include a more complex dynamic of time out of work or foregoing health care, hurting one’s ability to earn income, which is not possible to tease out of the survey data. For this reason, my research also consists of interviews, which help uncover the processes involved and reveal how events unfold. But before proceeding to the qualitative portion of this research, some additional patterns observed using the panel study data will be discussed and different analytical techniques applied.

A pattern worth noting while looking at the logistic regression of bankruptcy and
loss of home on the hypothesized independent variable is that in each of the models, partial and full, the regression of the dependent variables on education produces strong negative coefficients—statistically significant in the model regressing bankruptcy (at the p>.05 level). This relates to Annette Lareau’s (2003) thesis that the more educated are adept at navigating social institutions because of the resources available to them, such as access to information and knowledge on how to manage, in this case, difficult financial burdens. That is, those with postsecondary education may be better able to stave off financial consequences of the risk shift noted by Hacker (2006b).19

Although the logistic regression analyses are not ideal since they are based on my own time assumptions and they do not exploit all the cases in the panel study, the hypotheses being tested are supported. A loss of health insurance demonstrates a positive influence on downward mobility (significant among the group that moved from upper to below middle class), bankruptcy, and loss of home. Each of the models is statistically significant (p<.05). To better exploit the data and to take advantage of the time-series nature of the panel study, I employ fixed effects techniques in the final section of the analysis.

19Determining the role that postsecondary education plays in buffering against financial risk would be an interesting follow-up study.
Table 4A. Multinomial Logistic Regression Models of Downward Mobility from 2000 to 2006 Among Married Couple Respondents on Loss of Health Insurance (Standard errors appear in parentheses. No movement or upward movement is the base outcome.)

<table>
<thead>
<tr>
<th></th>
<th>Partial Model (N=1691)</th>
<th>Full Model (N=1440)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Upper to lower</td>
<td>Upper to below</td>
</tr>
<tr>
<td>Lost health ins., 2002 and 2004</td>
<td>.460 (.346)</td>
<td>1.056* (.563)</td>
</tr>
<tr>
<td>Health limitations, 2000-2006</td>
<td>-.094 (.406)</td>
<td>.023 (.670)</td>
</tr>
<tr>
<td>Source (ESI), 2000</td>
<td>-.619 (.460)</td>
<td>-.926 (.764)</td>
</tr>
<tr>
<td>Weeks unemployed, 2000-2006</td>
<td>-.619 (.460)</td>
<td>-.926 (.764)</td>
</tr>
<tr>
<td>Occupation (prof/white collar), 2000</td>
<td>.158 (.228)</td>
<td>.971** (.475)</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>.472 (.313)</td>
<td>.480 (.579)</td>
</tr>
<tr>
<td>Race (non-white)</td>
<td>-.261** (.101)</td>
<td>-.122 (.165)</td>
</tr>
<tr>
<td>Education level, 1988</td>
<td>-1.707 (.476)</td>
<td>-3.696 (.751)</td>
</tr>
<tr>
<td>Intercept</td>
<td>-.038** (.012)</td>
<td>.080 (.271)</td>
</tr>
</tbody>
</table>

*p<.10; **p<.05.
Table 4B. Logistic Regression Models of Bankruptcy Claims from 2001 to 2004 Among Married Couple Respondents on Loss of Health Insurance (standard errors appear in parentheses)

<table>
<thead>
<tr>
<th></th>
<th>Partial Model (N=2398)</th>
<th>Full Model (N=2096)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost health ins., 2000</td>
<td>.921** (.427)</td>
<td>.928** (.418)</td>
</tr>
<tr>
<td>Health limitations, 2000-2004</td>
<td>1.119** (.344)</td>
<td>1.119** (.344)</td>
</tr>
<tr>
<td>Source (ESI), 1998</td>
<td>-.367 (.469)</td>
<td>-.360 (.527)</td>
</tr>
<tr>
<td>Weeks unemployed, 2000-2004</td>
<td>.005 (.111)</td>
<td>-.771** (.305)</td>
</tr>
<tr>
<td>Occupation (prof/white collar), 1998</td>
<td>-.207 (.274)</td>
<td>.182 (.294)</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>1.148** (.277)</td>
<td>1.044** (.294)</td>
</tr>
<tr>
<td>Race (non-white)</td>
<td>-.399** (.135)</td>
<td>-.333** (.150)</td>
</tr>
<tr>
<td>Education level, 1988</td>
<td>-2.920 (.572)</td>
<td>-2.697 (.657)</td>
</tr>
</tbody>
</table>

*p<.10; **p<.05

Table 4C. Logistic Regression Models of Loss of Home Among Married Couple Respondents on Loss of Health Insurance (standard errors appear in parentheses)

<table>
<thead>
<tr>
<th></th>
<th>Partial Model (N=2246)</th>
<th>Full Model (N=1915)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost health ins., 2002 and 2004</td>
<td>1.137** (.469)</td>
<td>1.20** (.510)</td>
</tr>
<tr>
<td>Health limitations, 2002-2006</td>
<td>1.329** (.483)</td>
<td>1.057* (.559)</td>
</tr>
<tr>
<td>Source (ESI), 2000</td>
<td>-.471 (.735)</td>
<td>.006 (1.035)</td>
</tr>
<tr>
<td>Weeks unemployed, 2002-2006</td>
<td>-.026 (.027)</td>
<td>-.881* (.534)</td>
</tr>
<tr>
<td>Occupation (prof/white collar), 2000</td>
<td>-.380 (.435)</td>
<td>-.180 (.520)</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>.160 (.444)</td>
<td>-.143 (.493)</td>
</tr>
<tr>
<td>Race (non-white)</td>
<td>-.245 (.209)</td>
<td>-.241 (.244)</td>
</tr>
<tr>
<td>Education level, 1988</td>
<td>-3.898 (.921)</td>
<td>-3.843 (1.197)</td>
</tr>
</tbody>
</table>

*p<.10; **p<.05

3.1.5.2 Fixed Effects Regression. Unlike traditional OLS regression techniques, which are useful for looking at variation across cases, fixed effects regression is useful for looking at variation within cases. Since an attribute of panel studies is that data are collected on the same cases year after year, fixed effects regression is well suited for examining variation within cases. The previous logistic regression was applied in such a way as to examine variation across cases, whereas the following fixed effects regression examines variation within cases by including multiple waves/years of observations for
every case in the model. This offers a way to control for unobserved characteristics and omitted variable bias. Because the fixed effects analysis also includes every wave of data for each case included in the model, far more cases are exploited than was possible in the logistic regression models that employed stringent time parameters in an effort to emulate temporal ordering of events.

After reshaping the dataset from wide to long, a feature of time-series data where each respondent is unique by case id and some time variable, in this case year, and limiting the sample to married respondents, I ran a baseline fixed effects regression of net family income on multiple independent and control variables, the key of which is uncovered family member. In the previous logistic regression analyses the variable uncovered family member was used to create the loss of health insurance variable as described in the Concepts and Measures section. Since I am no longer bound to time constraints with the fixed effects analysis, all years during which health insurance was captured (1990-2006) are included. For example, for each year that a value exists for uncovered family member and net family income, regression coefficients are produced. The uncovered family member variable is the key independent variable. The baseline approach including all years is offered only for comparison purposes to an approach that includes a lagged version of the independent variable uncovered family member. In the absence of a time lag, as in the baseline model, I cannot minimize the potential for reverse causality. Manipulating the uncovered family member variable to contain a time lag essentially produces coefficients of the dependent variable, net family income, on the past occurrence of the independent variable, uncovered family member. By lagging the uncovered family member variable, I am able to see if there is a cause and effect
relationship between coverage and income. Using the fixed effects analysis I do not, however, limit the cases to respondents identified as middle class, so the findings are broader than those in the logistic regression analysis. A two-year lag was chosen partly for convenience (the NLSY79 shifted from collecting data annually to biannually) but substantively because two years seems to represent enough time for the effects of a loss of health insurance to unfold. For instance, in the elapsed time, events could occur that might lead to the accrual of medical bills or job interruptions. In contrast, if the time lag were too long, the consequences of a loss of health insurance may have been remedied so the results could mask a financial struggle. The value of comparing the baseline model to the lagged approach is to show the impact of introducing a two-year lag into the model.

The baseline model in the first column of data in Table 8 reveals a negative coefficient when regressing net family income on uncovered family member along with the other independent and control variables. While the direction of the coefficients included in the baseline model are as expected, indicating that the presence of an uncovered family member may lead to a depression in earnings, the coefficient for uncovered family member is not significant. According to the baseline model, unemployment is strongly inversely related to net family income in a statistically significant fashion (p<.05). The variable number of children in the household is positively and significantly related to net family income most likely because it overlaps with marriage, which tends to exert a positive influence on income. Because fixed effects are used, the control variables of sex, race, and education drop out since they do not vary over time. I did not expect the baseline model to produce a statistically significant regression coefficient for uncovered family member since it may take time for the
financial impacts of a gap in health insurance to take effect. However it is encouraging to see that it is in the expected direction. The second column of data in Table 5 reveal the coefficients produced when regressing net family income on a two-year lagged version of the uncovered family member variable. Not only is the coefficient for the lagged version of uncovered family member in the expected direction and much stronger than in the baseline model, it is also statistically significant (p<.05). Consistent with the results from the logistic regression analyses, the results from the fixed effects regression provide support for the hypothesis test that posits a loss of health insurance can lead to income declines, and ultimately downward mobility.

Table 5. Fixed Effects Regression of Net Family Income on Key Independent Variables

<table>
<thead>
<tr>
<th></th>
<th>Baseline model</th>
<th>Two-year lag on coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncovered family member</td>
<td>-1600 (2047)</td>
<td>-5694** (2709)</td>
</tr>
<tr>
<td>Health limitations</td>
<td>-2795 (4024)</td>
<td>-644 (5382)</td>
</tr>
<tr>
<td>Unemployment</td>
<td>-422** (121)</td>
<td>-459** (163)</td>
</tr>
<tr>
<td>Occupation (prof/white collar)</td>
<td>-361 (1102)</td>
<td>460 (1552)</td>
</tr>
<tr>
<td>Number of children in HH</td>
<td>1790** (762)</td>
<td>731 (1055)</td>
</tr>
<tr>
<td>_cons</td>
<td>90370 (2526)</td>
<td>91669 (3339)</td>
</tr>
<tr>
<td>Observations</td>
<td>18,096</td>
<td>13,147</td>
</tr>
<tr>
<td>Groups</td>
<td>4,229</td>
<td>4,061</td>
</tr>
<tr>
<td></td>
<td>F(11,13856)=140.87</td>
<td></td>
</tr>
<tr>
<td></td>
<td>corr(u_i, Xb)=-0.0086.</td>
<td></td>
</tr>
<tr>
<td>F test that all u_i=0</td>
<td>F(4060, 9077)=2.79.</td>
<td></td>
</tr>
<tr>
<td>Prob&gt;F=0.0000.</td>
<td>Prob&gt;F=0.0000.</td>
<td></td>
</tr>
</tbody>
</table>

Dropped variables: sex, race, and education along with several survey year indicators.

The findings based on the panel study data rule in favor of the hypothesis tests guiding this research such that a loss of health insurance is 1) negatively related to net family income and may result in downward mobility, 2) positively related to subsequent bankruptcy claims and 3) positively related to subsequent home loss. However, there are still questions remaining about how these events unfold and if the assumptions I have made are accurate. As mentioned previously, the relationship between losing coverage and spending down assets or incurring debt is more straightforward than how income
changes might ensue. This latter piece requires further investigation to ascertain whether or not the findings from the quantitative section are valid. Additionally, there is a question unrelated to the hypothesis tests worthy of investigation: are experiences with losing coverage and managing medical bills patterned by class or other factors? Annette Lareau's (2003) findings that child-rearing and the preparation of children to navigate social institutions are patterned by class position would suggest that such patterns may exist in the case of managing the complexities of health insurance. Semi-structured interviews offer an opportunity to examine these questions and gather illustrative stories.

3.2 Interview Data with Twenty-five New England Residents

The final section of this research reports findings from interviews with a small sample of 25 New England residents to 1) validate the causal inferences made in the quantitative analysis with regards to economic experiences and declining financial protection from health care costs and 2) determine if the experiences are patterned in any way.

3.2.1 The Interviewees

The interviewees included in this analysis consist of a mixed-income sample of New England residents. Approximately half the sample is lower income, recruited through a nonprofit program that offers loan assistance. The other half consisting of mostly middle to upper income individuals was recruited through a Granite State Poll.\(^{20}\)

\(^{20}\)The Granite State Poll consists of a random probability sample collected by the University of New Hampshire Survey Center. A random digit dialing method is used to contact participants over the telephone.
(GSP) conducted twice a year by the University of New Hampshire Survey Center. It is this latter group that is the most relevant to my research but I do draw on both groups for comparison purposes when appropriate. The GSP group consists of a small sample of individuals who were asked a screening question of whether they had problems paying medical bills in the last five years. This screening question and the other follow up questions were based on a Kaiser (2005) Health Costs Survey. The follow up questions include: been contacted by a collection agency, used up all or most of savings, been unable to pay for basic necessities, borrowed money and other. Respondents were also asked if they would be willing to speak with a researcher about their experiences with medical bills. It is from this pool of respondents that I selected interviewees. Including all of these respondents who answered affirmatively to the screening question about having struggled with medical bills (N=114), Figure 15 shows the distribution of the types of struggles this group faced.
While the group that claimed bankruptcy in response to medical bills was small (N=4), at least three of these individuals reported a household income of $30,000 to $59,999 and at least three reported having at least some college or more (two reported that they were college graduates). This is consistent with the observation that bankruptcy is a middle class problem to a large degree, or stated alternatively, a strategy to keep from sliding down the economic ladder (Sullivan et al. 2000) and may be indicative of the weakened economic security of a middle class position. The group of GSP respondents willing to be interviewed consisted of insured, uninsured and underinsured individuals. Table 6 offers basic descriptive characteristics of the interviewees with whom I spoke.
As Table 6 indicates, the majority of interviewees were insured. Among those with employer sponsored coverage, many considered themselves underinsured and claimed to be struggling to pay medical bills and in some cases, having difficulty making ends meet. In fact, in most cases, respondents used the term “underinsured” to describe themselves without prompting. Among the five uninsured interviewees, all but one had education and income levels that reflect a middle class position. Four respondents from the GSP sample faced the potential of becoming downwardly mobile and one respondent claimed that her household income had dropped substantially over the last decade due to medical bills stemming from job interruptions and gaps in health insurance coverage. Another three claimed that due to medical bills, their economic situations would have been far worse if not for savings and/or family inheritance to protect against difficult times. These eight respondents were either uninsured or underinsured. I conducted the interviews during the fall of 2007, a period preceding the economic crisis of 2008 and 2009. If these eight respondents were economically vulnerable when we spoke, their situations are unlikely to

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21 Individuals were coded as “underinsured” if they have insurance and met at least one of the following criteria: were on a long-term payment plan with a hospital, put off needed health care or medications, or cannot afford uncovered portions of health care.
have improved much. In fact, all thirteen respondents recruited from the GSP were asked
to rate their level of concern regarding both their family’s health care coverage and
economic security. The scale ranged from 1 to 5 (1 being not concerned at all and 5 being
highly concerned). According to the scale, uninsured respondents were the least
optimistic about the future both economically and with regard to their health insurance.
Individuals coded as underinsured were not far behind in their outlook for the future, with
the insured group being the least concerned. The sample sizes are extremely small for
each group, but there are still some interesting patterns worth noting. For instance, the
reasons for concern among the two insured respondents were hypothetical. One
respondent said that her only concern was that her status is dependent on her husband’s
continuous employment, and similarly the other insured respondent’s concern stemmed
from the fear of lay offs by his employer. This corresponds to Newman’s (1988)
observation in the 1980s that the loss of financial protection, even among employees of
white collar occupations, threatened them with downward mobility. What makes this
scenario different from Newman’s (1988) observations is that in today’s globally
competitive context, lay offs and downsizing, while still feared, have become rather
expected or commonplace. These two respondents capture that expectation well by
revealing that they do not take their current employment situations for granted. They fear
that their situations could worsen, indicative of their economic insecurity. While
Newman (1988) attributed growing economic insecurity to job insecurity, I attribute a
portion of economic insecurity to the weakened financial protection of health insurance.
The unfolding of the processes of managing and responding to medical bills and gaps in
health insurance, which I could not discern from the panel data, makes the interviews
useful to this research. For instance, while other studies have shown links between medical debt and bankruptcy rates (Himmelstein et al. 2005), the link between loss of health insurance and income changes is less straightforward. One could imagine many possible scenarios of how foregoing health care due to costs could have a rippling effect in a person’s life, affecting their ability to work, particularly among the self-employed, which could depress earnings. But rather than brainstorm possible scenarios, speaking to individuals about how events unfolded in their lives is much more effective and provides a degree of validity to the findings from the quantitative portion of this research.

3.2.2 Experiences with Medical Bills and Being Underinsured

When reviewing the data collected from interviews, three scenarios emerge that are relevant to the patterns observed in the quantitative data and useful for understanding the trajectory of families from a point of economic stability to instability and the role that medical bills and gaps in health insurance may play. There are different ways and orders in which the processes may unfold, and it is therefore important to consider cases that on the surface may appear to support my hypotheses, but upon closer look do not; in addition, there may be cases where the real impact of medical bills and health insurance gaps are masked. The scenarios of interest include middle income respondents who experienced 1) economic losses related to health insurance 2) loss of health insurance; no economic losses and 3) unrelated losses of earnings and health insurance.

3.2.2.1 Economic Losses Related to Health Insurance. The group that experienced economic losses stemming from being either uninsured or underinsured is most relevant to the hypotheses guiding this research. One case that shows the interplay of health
insurance gaps, health care usage, job interruptions, loss of home and income losses is that of Fred\textsuperscript{22}, a respondent whose uninsured spouse developed a brain tumor. Fred was a self-employed home owner with some college education and a family income of at least $100,000 at one point. Both he and his spouse experienced job interruptions, which depressed their overall household income. His spouse was unable to work. Fred spent much time trying to find a comprehensive and affordable plan to cover his spouse (ultimately they could only afford a catastrophic plan that kicks in after a $10,000 deductible) and spent much time at hospitals trying to find a solution to the mounting medical bills. Fred feared losing his home in the future, and although he was in his late sixties, retirement was not within reach. When asked to rate his health insurance, Fred replied:

\begin{quote}
We can't afford a $10K deductible, it's probably poor. It's almost impossible to get affordable health insurance if you're self-employed. The catastrophic is the best a real estate agent can do. I'd like to retire to be honest with you. If we can pay off the second mortgage on the house...we took a large second mortgage to pay medical bills—that was the purpose of it...basically we didn't have another choice.
\end{quote}

Another individual who experienced job interruptions and a decline in earnings due to health issues, Tom, also had a gap in health insurance coverage because he was self-employed and business was slow. Tom reported that he suffered from pains in his hip and probably needed surgery, but that he was fearful of surgery because “once they [the doctors] start, they don’t stop until it’s finished.” It was the cost of the surgery rather than the actual physical procedure that he feared. What became evident through our discussion is that Tom's ailment did in fact affect his ability to work. As a self-employed person with no sick time to fall back on, his avoidance of needed surgery contributed to earnings

\textsuperscript{22}Pseudonyms are used in all instances to protect interview participants.
loss, despite the fact that the lack of health insurance was by choice. He described instances of picking and choosing which jobs to take based on distance since long car rides would result in such pain that he would be forced to recover at home the following day. Prior to suffering from a hip problem, Tom claimed that he would frequently work for clients even if they were two hours away. A less direct relationship between being underinsured and potentially facing economic losses was shared by a respondent, Jay, who was lower middle class and frustrated by mounting medical bills incurred by care of an ill family member.

During the interview, Jay became emotional about his family’s circumstances. He hypothetically asked how anyone is expected to afford a vehicle to get to work and to somehow pay all the medical bills. Jay’s ultimate goal was to purchase the home in which his family lived, but he realized this would be challenging when basic necessities are the priority.

*How am I supposed to better my household situation if I have a $2400 bill every so often, and worse part is they didn’t fix [my son]. That is something that happened here. It is a very big impact on whether you can upgrade your house. Towns nowadays won’t allow a mobile home in a town...can’t just go out and buy a piece of property. And medical costs are so exorbitant you can’t get caught up!*

Some respondents had family members with unique medical histories that were the catalyst of their struggles with medical bills. Others were challenged by constraints of the institution.

Jill, a respondent who suffered from a chronic illness throughout her life, said that she and her spouse had exhausted their ability to use their home to manage their debt. Under the age of 65, she qualified for disability and was receiving Medicare but found herself in the “donut hole” of the system where prescription medications are no longer covered. Her major frustration with Medicare is that once deemed eligible, she was told
she would have to enroll immediately or pay penalties if she postponed enrollment.

Having refinanced their home twice already, Jill and her husband could not get a lower interest rate and may sell their home as a last resort. Several respondents reported spending down their savings to pay uncovered medical bills, whether insured or underinsured.

Like Jill, several individuals who could no longer work applied for disability. The process of applying for disability is not only time consuming, as individuals it requires a great deal, including many health care appointments to be considered eligible; it is also costly, particularly for the uninsured. Ultimately they may collect Social Security and receive Medicare coverage, but in the meantime, they may struggle financially due to the inability to work and lack of financial protection through gaps in health insurance. One individual said that she felt that she had been let go by several employers when they learned she had a chronic health issue. This led to a loss of insurance and earnings, further exacerbated by her inability to work due to health issues. It is clear that the financial burden of being insured or underinsured depends on health care usage.

Middle income respondents reported being fearful because of their health difficulties. Fear of not being able to retire. Fear of losing a family home. Fear of falling over the edge. Fear did not come up in interviews with the lower income respondents, perhaps because they are more likely to look up than down. One respondent who had been in prison, claimed bankruptcy, and was covered by Medicaid when we spoke said that he hoped he would make more money soon and find health insurance through an employer because of the stigma attached to Medicaid.
3.2.2.2 Loss of Health Insurance; No Economic Losses. There were few instances of cases where individuals experienced a gap in health insurance and were able to sustain the same level of earnings and/or net worth. One could argue that the strategy used to maintain a certain standard of living could have consequences for the future standard of living—the opportunity cost of using resources today that could accrue value tomorrow. One respondent, Bethany, said that she and her family were recently uninsured, but it was by choice. In response to the high cost sharing offered through Bethany’s spouse’s employer, she and her spouse decided to forego the health insurance through the spouse’s employer and essentially take their chances. When asked how she felt about this decision, she offered the following:

This is the first time in my life I haven’t had health insurance and at first it made me really nervous because it’s for big things – big illnesses and accidents. Knock on wood we’ve only had two ER visits. On the one hand I can say ‘Wow, look at all the money we’ve saved by not having to pay premiums’, but on the other I know we’ve just dodged a bullet; at any point we can have that accident and we’re not covered and that makes me nervous.

Bethany and her spouse were able to rely on family money to fund their children’s education. Inheritances played a part in maintaining the family’s net worth and managing medical expenses. Even with an inheritance as a buffer, the overall net worth of this family is being depleted. The reason this case was classified as “loss of health insurance; no economic losses” was that Bethany reported that despite gaps in health insurance, there were no gaps in health care usage. She said that her relationship with the doctor’s office was great and that she brought her children there no less frequently than when she had insurance. Despite fear of a big illness or accident, Bethany seemed unafraid of the gap in her family’s health insurance. This could be due to the buffering effect of family
money to fall back on, making this family less vulnerable to changes in financial protection than middle class families without such a resource.

The inclusion of cases in the quantitative analysis that are like Bethany’s, where a loss of insurance is not associated with an economic loss, may lead to more conservative estimates of the impact of a loss of health insurance on income measures. By examining downward income mobility by different degrees of falling (from upper middle class to below middle class versus from lower middle class to below middle class), I have grouped together cases most likely to exhibit similar patterns.

3.2.2.3 Unrelated Losses of Earnings and Health Insurance. There were a few respondents with whom I spoke that experienced a combination of challenges that explain their current financial struggles, the least influential of which included gaps in health care coverage. One individual, Pamela, had recently experienced a divorce, leading to a major drop in her household income. Additionally, Pamela had inherited half the debt incurred in the marriage and was suddenly responsible for paying large bills, many of which she claimed she had not incurred. It was part of the divorce agreement that she was responsible for half. Ultimately she claimed bankruptcy to manage this debt. After the divorce, she tried to pay for a COBRA plan but she was unable to afford it. She described medical bills as contributing somewhat to the overall debt problem and bankruptcy claim but that they were minimal in the big picture. If Pamela’s circumstances were a case in the quantitative study, her loss of health insurance would have been followed by bankruptcy and a dramatic loss of earnings. This case suggests that spurious relationships may exist in my quantitative analysis, but the fact remains that regardless of the exact events leading to economic losses, if a status of uninsured or underinsured follows, an
individual may lose financial protection from medical bills at a time when they need it most and a cumulative process of a downward economic spiral may occur, from which it is extremely difficult to escape. This is a unique aspect of the US system of health insurance—a conditional trait of the health insurance system. For instance, financial protection from medical bills is conditional not only on employment status but also employment type, and if one gets it through a spouse, it is conditional on marital longevity, and in the event of job loss or marital dissolution, the financial protection could be eliminated.

The experiences with cumulative economic misfortunes among respondents that were once members of middle class families reflect the consequences of weakened financial protections. It is more difficult to attain a middle class position in the post-economic restructuring era and divorce may present additional challenges, but in the absence of strong financial protections, members of the middle class may find themselves slipping in response to life course events.

3.2.3 Patterns of Experiences with Health Insurance and Medical Bills

Studies suggest that there are class-based differences in how different groups navigate social institutions (Dietch and Huffman 2001; Lareau 2003). Some important and applicable distinctions that Lareau (2003) makes regarding class-based differences in childrearing is that middle class parents raise their children to possess a sense of entitlement when interacting with social institutions whereas working class parents tend to instill a fear of punitive consequences when dealing with those same institutions. It is a distinction that rests on questioning versus deferring to authority figures and gatekeepers.
Deitch and Huffman (2001) argue these class-based differences are embedded in structural contexts that must be considered to fully understand the distinctions being made.

Deitch and Huffman (2001) describe the experiences of low income women forced into the workforce in response to the 1996 welfare reform and the impact that this pathway into the workforce, which was beyond their control, had on their ability to negotiate good wages and benefits if in fact they were lucky enough to avoid the low-wage service sector that tends not to offer any benefits at all. In large part, these women were not in positions where they could job shop for good wages and benefits. It is this point that is applicable to my research.

Borrowing from Lareau’s (2003) framework that associates a sense of entitlement with preparedness to navigate social institutions, I observed more examples of questioning authority (in this case, hospital personnel and private insurers) and seeking innovative solutions in response to medical bills and health insurance among middle income respondents than among their lower income counterparts. One middle class respondent, Phil, described his efforts to find a solution to deal with mounting medical bills by meeting with hospital personnel and contacting state agencies, and while these efforts were frustrating, they exemplify a willingness to navigate through different aspects of what many consider to be a complex institution.

Except for hospitals there really hasn’t been any help...I went to the state and tried for programs but we didn’t qualify: happily I signed up for VA. I think there’s a lot of people like us who don’t have health insurance, just hoping not to get sick.

Extremely concerned about the potential of not being able to afford his mortgage due to medical bills, Phil was committed to finding a solution. He described spending many
afternoons along with his wife in meetings with hospital administration staff to discuss payment plan options. Two other respondents, Marsha and Wendy, invested significant amounts of time to qualify and enroll for programs to manage their uninsured and underinsured status.

Marsha applied for Medicaid as a good faith effort even though she knew she would be denied in order to qualify for a program that eliminates some medical bills off one’s account. Wendy, who is middle class occupationally (a post-doctoral researcher) as opposed to financially, spent hours in waiting rooms, going through repetitious appointments to qualify to be a patient at a health clinic. Wendy had previously experienced the benefits of national health care in an overseas country, which perhaps made her feel more entitled to health care and more willing to make the effort to get it.

Our community up here has a community health service...it’s pro bono by doctors—a once a week health clinic, and I suffer from migraines and need meds. I started going there and it’s free to me because I fit within the income bracket. They were able to get me on a prescription med plan—some pharmaceutical companies will give free prescriptions to people who qualify—so I’ve been getting my prescriptions for free through this group. It requires a lot of time—screening visits and then doctors wanted to try me on different meds; many visits and long waits—15 hours of sitting in waiting rooms.

Another case that reflects the sense of entitlement shared by middle class individuals is Annette, who claimed that when she insisted, her doctor fought with her insurance company over the phone to get her medication covered. Eventually the insurance company agreed to pay. By comparison, the lower income respondents were either enrolled in Medicaid and therefore not as concerned with their coverage, which many referred to as “good” or “comprehensive”, or were more likely to be struggling with consequences of high medical bills such as poor credit, experiences with bankruptcy or foregoing needed care. Tanya, lower income and uninsured, could not afford to get health
insurance on her own after a divorce. She claimed that no matter what she felt like, she refused to go to a doctor because she could not afford to be in debt again. Part of the explanation for the class-based differences may be related to access to information and programs. The middle income respondent who applied for the program to wipe off certain portions of medical debt worked in the health care field in an environment that provided access to information and programs that she may not have otherwise been privy to had she worked in a different profession. Another respondent was able to gain coverage through the Veterans Association by virtue of his military experience when private insurance became unaffordable. This case suggests that improving access to existing information and programs may help improve access to management strategies. This is consistent with the finding from the quantitative portion of the analysis that higher educational attainment may serve as a buffer against the economic consequences of losing health insurance. In both instances, human capital is being leveraged to protect against slipping economically. It is not always successful, as the experiences of some interviewees in this study show, but in some instances information gathering can help keep economic instability at bay. But for how long worries many of the interviewees.

The interviews conducted for this research provided a window into how events might lead to some of the results observed with the quantitative data. While the pathways leading from economic stability to shaky ground and the role played by medical bills and loss of coverage may be complex and multifaceted, medical bills do play a part, at the very least by exacerbating economic securities with roots unrelated to coverage status. Additionally, the interviews provided insight into how experiences with health insurance and health care systems do appear patterned by class position. While higher levels of
human capital tend to be associated with a middle class position, it is clear that access to information may empower individuals to protect themselves from unmanageable health care costs—whether uninsured or underinsured. This could have direct policy implications since it provides support for efforts to increase the transparency of health care costs.
CHAPTER 4

CONCLUSION

Families in the post-economic restructuring era must invest more and work more to attain middle class positions than families from the postwar era did. Doing so is necessary but not sufficient to maintain a middle class position. The slowed economic growth and changed employment patterns that characterize the restructured economy were accompanied by a political shift toward a far less interventionist government. Social spending scale backs and deregulation of the private sector that took root during the Reagan administration occurred at a time when job and economic security that were taken for granted among middle class families of the post WWII era were fading. This has changed the meaning of a middle class position. Newman (1988) highlighted the growing tenuousness of a middle class position in her observations of downsizing of white collar occupations in the 1980s. Members of the educated workforce found themselves in vulnerable positions as job security became replaced with weak ties to employers (1988). Hacker (2006b) points to scaled back social insurances, which he claims is contributing to unprecedented levels of economic instability among American families. This research builds on both of these works to determine if the combination of the heightened requirements for a middle class position and weakened economic security of the position are creating a vulnerable middle class. I examined the extent of economic instability among married couple middle class respondents from the NLSY79 dataset and
I assessed the impact of losing health insurance on the economic stability of married middle class respondents. The NLSY79 offers an ideal cohort that came of age during the period of economic restructuring.

Those who became young adults in the era of economic restructuring, referred to as "late baby boomers" (Farley 1996) have faced a different economic reality than members of the postwar generation. The structure of the economy and globalization are significant forces of change but the response from a political and public-policy perspective also play a role (Fischer et al. 1996). As part of a larger shift among advanced western nations, the policy response has been to scale back social spending and the size of government more generally (Huber and Stephens 2005). With respect to health insurance, weakened financial protections have contributed to an uninsured population approaching 50 million people (US Census 2008). An evaluation of the current state of the health insurance system against its original goals of providing access to health care and financial protection from medical bills (Schoen et al. 2005) may lead one to conclude that the system is failing because uninsured and underinsured individuals are not protected adequately from medical bills. (Himmelstein et al. 2005; Schoen et al. 2005; Schoen et al. 2008; Banthin et al. 2008) The implications are reflected in this study, which shows that a loss of health insurance is positively related to downward income mobility, bankruptcy claims, and loss of home and it exerts a negative effect on net family income. For instance, as reflected by the income mobility matrices (Tables 3A and 3B), the total percentage that moved down one or more income quintiles was 146 percentage points higher among those who lacked health insurance than among all married couple respondents. The multinomial logistic regression of downward mobility
on loss of health insurance produced a coefficient of 1.24 (p<.05) among those experiencing movement from upper middle to below middle class relative to those who experienced no movement or upward movement, even when occupation and unemployment variables were introduced into the model. The hypotheses supported most strongly with the quantitative data were regarding bankruptcy and loss of home.

Regardless of whether partial or full models (including occupation and unemployment variables) were examined, the coefficients produced from regressing bankruptcy (greater than .9) and separately, loss of home (greater than 1.0), were strong, positive and significant (p<.05). Lastly, the use of fixed effects regression techniques offered a way to examine within case variation and to employ a lagged version of the independent variable to simulate temporal ordering of a loss of health insurance occurring prior to the outcome of net family income. Regressing net family income on the lagged version of losing health insurance, the fixed effects regression produced a strong and negative coefficient (-5694; p<.05). This indicates that a loss of health insurance at Time 1 contributes to depressed income at Time 2 (indicated as two years later). The quantitative data provide support for the hypotheses but in order to understand if the causal inferences are accurate, interviews were conducted.

By interviewing individuals who experienced a loss of health insurance for themselves or a family member or were insured but financially burdened by the costs associated with their coverage and out of pocket expenses, I was able to determine if the assumptions I was making about the results of the quantitative analysis were valid. For instance, listening to individuals explain how and in what order events unfolded in some instances confirmed my assumptions, in others refuted them. Based on the information
shared during the interviews, it is clear that in many instances my assumptions are correct
(that a loss of health insurance can lead to downward income mobility and other financial
struggles), but there are also likely to be anomalies such as when multiple economic
struggles occur simultaneously making it impossible to disentangle cause from effect. It
is impossible to know the degree to which my quantitative findings consist of such cases,
but by limiting the analysis to married couples, I hope to have minimized the potential for
spurious results. In addition to corroborating the quantitative analysis, the interview data
also gave voice to those at risk of falling in the face of the weakening system of health
insurance in this country.

The unraveling of private sector health insurance is helping to drive health care
costs since more uninsured individuals lead to more costs passed to those who can pay.
As recently as the late 1990s some employer sponsored health insurance plans covered
100% of medical bills. This has shifted to a norm of 80/20 or 75/25, leaving even insured
individuals open to the financial burden of medical bills. If insured persons struggle with
medical bills, often referred to as the “underinsured” (Schoen et al. 2005), then uninsured
persons are likely to fare worse. It is increasingly common for employers to pass along
higher cost sharing to employees, scaling back or eliminating health insurance, shifting to
self-insured plans that are exempt from state regulation under ERISA, or privatizing their
plans through Health Savings Accounts. The system is becoming more complex and
fragmented, which will only continue to produce more gaps in coverage, especially if
individuals with pre-existing conditions or risky family health histories are penalized.
Large firms that can negotiate lower premiums through group insurance are becoming an
exception to the unraveling of the system, whereas smaller firms, the self-employed and
small businesses typically only have access to costly non-group rates (Swartz 2006). In the face of rising health care costs and global competition, if all else remains the same with the system of health insurance and unconstrained health care costs in this country, we can expect to see more and more incidences of “falling from grace” as Katherine Newman (1988) observed in the 1980s.

While the US differs from more generous welfare states such as the Scandinavian countries, one explanation put forth to account for the lag in the enactment of federal social protections in this country (starting in 1935 with the Social Security Act) is that US employers once served as mini-welfare states (Hacker 2006b). While this may be the case, the dependence on employers to provide comprehensive benefits to employees is no longer sustainable in a global economy (Swartz 2006). Health insurance was offered by employers in part to protect against the hazards of industrial work. At that time US employers relied on a domestic labor force and used fringe benefits to attract and keep a loyal workforce. This is no longer the case as employers are no longer bound to a domestic workforce. As many global competitors in more generous welfare states are not required to provide insurance to employees, the incentive to provide comprehensive health care to the US workforce has diminished. As this research illustrates, even in the absence of medical bills, there are signs of economic instability among married couple middle class respondents. Declining financial protection from out-of-pocket medical expenses and the full cost of medical bills if uninsured only exacerbates economic insecurities experienced by the middle class today.

While workers can make adjustments required to meet the demands of the restructured economy—higher education, dual earner households, social capital for
navigating institutions, it is more difficult to deal with ongoing economic risk. Some argue that individuals and families should be responsible for themselves and therefore build up savings to weather emergencies. But in the restructured economy, human capital is the dominant stratifying force and unless opportunities for building human capital are distributed equally, we have to expect a large degree of inequality. This means some individuals will be better prepared to weather economic risk than others.

Economic insecurity does not happen in a vacuum. The current economic crisis of 2008-2009 exemplifies this well. For instance, high interest rates and irresponsible lending practices, which may have more directly impacted lower income segments of society, have had direct consequences for middle and upper income segments as all home values have been impacted. With regard to protection from health care costs, the more individuals who participate in the system, the more risk is pooled and costs reduced. Of course there are other health care cost drivers including increased longevity, advanced technology, innovative pharmaceuticals, high administrative costs, and increased prevalence of chronic diseases such as diabetes; but these may be easier to control through policy, as outlined in the final section of this research. By not adequately preparing enough members of society to work in “good” jobs with benefits, private sector health insurance is floundering—the degree of protection offered is only as strong as the pool over which it can spread risk. In turn, by not offering adequate financial protection to all segments of society, economic insecurity can spread even to segments that could once take their economic security for granted—the middle class.
4.1 Limitations

By using a nationally representative panel study, I was able to look at relationships among loss of health insurance variables and indicators of downward mobility over time and nationwide. Based on the multiple analytical techniques I used to examine the relationship between loss of health insurance and indicators of downward mobility and financial struggle, I am confident in the causal inferences I made in this research. However, additional survey items that would have been beneficial and relevant to my hypotheses include health care usage by the respondent and the respondent’s family members. Also, a loss of home does not necessarily mean that the respondent experienced a foreclosure or faced a financial struggle. There could be instances of foreclosure, but there could also be instances of buying and selling property by choice. Additional limitations with the NLSY79 panel study are regarding missing data and attrition.

Different respondents of the NLSY79 fall out each year, with the number of non-responders estimated to be 5,451 by 2006 (leaving an N of 7,235). Reasons for non-response include break-off, deceased, not fielded – very difficult case, institutionalized, and dropped for budgetary reasons. The cause for concern is whether or not there is bias among the responders retained in the sample. Is there a pattern of certain characteristics shared by non-responders and responders alike? The largest groups of non-responders include those that were coded as "refused/break-off" and those dropped for budgetary reasons (the supplemental military and poor white male and poor white female groups). The potential for bias must be considered as a potential limitation of the quantitative component of this research. Additionally, even among responders, there are some survey
questions with missing data. The way I chose to handle missing data when creating variables of change over several years, such as those used in the logistic regression analysis, was to allow for at least one year to contain missing data.

Given the small number of semi-structured interviews (N=25) I conducted, there are also limitations to the qualitative component, which is not comprehensive enough to be representative of the process of managing medical bills among members of the middle class. The sample was limited to the New England region where the cost of living is higher than in many other parts of the country. This could exacerbate the struggle with medical bills, which makes the region less representative of areas with lower costs of living.
CHAPTER 5

IMPLICATIONS

5.1 Policy Directions

As Jill Quadagno (2005) describes, there have been multiple failed attempts at health care reform throughout the twentieth century. According to Quadagno, the resistance to reform can be explained by a number of factors, some with more influence than others at different points in time. A combination of anti-statist sentiments, weak labor, racial politics, state structures and policy legacies, and stakeholder mobilization have formed a barrier to reform (2005). There is also the possibility that, while theoretically providing a balance of power, the fragmentation of the US government inhibits large-scale reform (Skocpol 1995). The failures of the past may or may not be indicative of the future. But we are living in volatile economic and political times—with a new presidential administration in place that has access to a much different policy space than its predecessors.

The concern for health care costs and support of universal health insurance cuts across party lines, even if it is a larger issue for Democrats (see Figure 16). This combined with the fact that members of the middle class are vulnerable to slipping economically when lacking health insurance offers unprecedented policy space for reform. Studies have shown that members of the middle class are most likely to protest
and demand resources, which partly explains the affluence of suburban communities and schools (Kawachi 2005). However, it is widely agreed that it will be challenging.

Figure 16. Opinions Among Self-identified Republic and Democratic Voters Regarding Health Insurance Issues and Reform

![Bar chart showing opinions on health insurance issues.

Source: Blendon et al. 2008.

5.2 Balance of Private Sector Insurance and Reform

In contrast to the political attitudes and policy directions that emerged most notably during the Reagan administration and that had dramatic implications for party coalitions and the size and role of government, the current policy arena may allow for regulatory measures and government intervention. There is a health care cost crisis affecting both the insured and uninsured. Cost sharing is at unprecedented high levels even among those with access to health insurance through an employer, let alone the expenses incurred by individuals with no access to coverage. Hospitals absorb some of the costs of the uninsured, which only results in passing along higher costs to paying
customers, therefore contributing to the health care cost crisis. While regulatory types of policies are controversial, they are more politically palatable than redistributive ones (Lowi 1969) and may also satisfy Americans who are craving economic security and protection from economic risk. As proposed by the current administration, regulating private insurers to prevent denial of coverage based on pre-existing conditions, to compensate for areas with little competition to drive down costs, to prevent insurers from monopolistic practices and making health plans more transparent by disclosing the percent of premiums dedicated to care versus administrative costs are all likely to dramatically change the face of health insurance and the degree of financial protection it offers.


Hello, could I speak with ________________? This is Sarah Savage and I’m a researcher at the University of NH. I’m doing some research on medical bills and how they affect people’s lives.

Either: This summer you answered some questions that were part of the Granite State poll and as part of that survey, you said that you would be willing to discuss your experience with medical bills with a researcher at UNH. I’m that researcher and would love to talk with you now or set up a time to interview you. Or we could meet in person if that would make you more comfortable. Some people like to know who they are talking with.

First I want to say how grateful I am that you are willing to talk with me. I am trying to learn how the current health insurance system and medical bills are affecting people financially especially with rising health care costs and changes in the way insurance is offered. A really great way for me to understand this is by talking with people like yourself. So thank you. Before I ask you any questions I just need to let you know your rights as an interview participant (everything you say will be kept anonymous – your name and any other identifying characteristics that you share will be kept separate from my notes and will not be used in my research; this is completely voluntary and you do not have to answer anything you do not want and if you wish to stop at anytime please let me know. I am happy to answer any questions you have about this research and there is an additional person at the University of New Hampshire by the name of Julie Simpson who reviews all research proposals dealing with interviews that I would be happy to put you in contact with if you have any questions about this research you feel that I did not answer). Do you agree to participate in this interview?

1. Can you tell me what you do for a living? Have you had that job for a long time?
2. And now, how many people live in your household? What is their relationship to you?
3. Does everyone in your household have health insurance? (If uninsured, find out why and what led to being uninsured)
4. What is the source of your health insurance (ask for all household members)?
   a. Employer (through my employer or my spouse’s)
   b. Other private plan
   c. Medicaid/Healthy Kids
   d. Government
   e. Military
   f. Other
5. In general, would you say your health insurance is – Excellent, Very good, Good, Fair, Poor? Why do you feel that way? Can you provide examples?
6. (Skip if currently uninsured) Within the past 5 years has any member of your household been uninsured? What led to losing insurance?

7. When you (or the uninsured household member) were without health insurance, did you ever:
   a. Put off health care completely
   b. Put off health care until absolutely necessary
   c. Go the emergency room when need health care
   d. Get health care when needed it and have medical bills and pay out-of-pocket
   e. Other

8. (If answered “put off health care”) What were the consequences of putting off health care? For example, did doing so ever make it difficult to work? Did you ever lose wages because of it?

9. Have you or a member of your household ever struggled to afford your health insurance in terms of premiums, co-pays, deductibles or uncovered services? Has it become more or less affordable over time? Why do you think?

10. How much do you pay in premiums, etc.?

11. (Already have for GSP sample) Has paying out-of-pocket (whether as a result of being uninsured or underinsured) ever made it so that you or your family were really struggling financially? For instance, have any of the following ever happened:
   a. Have you ever been contacted by a collection agency about health bills?
   b. Used credit card to pay for medical expenses
   c. Used savings
   d. Found that you and your family members put off buying necessities (groceries, clothes)
   e. Borrowed money to pay health bills, or other bills because you had to pay health bills?
   f. Had trouble paying your rent or mortgage?
   g. Declared bankruptcy
   h. Experienced foreclosure/eviction or the threat of foreclosure/eviction?
   i. Other

12. Have medical bills ever made it difficult to save money for the future (401K or other retirement savings, saving for a home or car, saving for education, etc.)?

13. Have medical bills ever made it difficult to get a loan? Do you have an example of a loan you applied for but were denied as a result of medical debt?

14. Has the fear of becoming sick or losing health insurance ever affected how you save money (might invest money differently; might take more financial risks if were not so concerned with possible medical bills)?

15. Have health insurance benefits ever impacted your job choices?
   a. Stayed in current job to keep benefits (despite other/better career possibilities)
   b. Left current job because benefits were weak
   c. Other
16. Do you think your economic situation would be different if you were not faced with either medical bills or insurance costs? How so? What would you do differently with your money?
17. During the last few years, has your financial situation been getting better, worse or has it stayed the same? (Source of question: GSS see Newman’s table)
18. In general, would you say your health is – Excellent, Very good, Good, Fair, Poor?
19. Do you use health care services for preventative or just when problems arise? Does this differ for you and your children/spouse?
20. How often do you use health care services?
   a. Annually
   b. A few times per year
   c. Monthly
   d. It varies year to year
   e. Other (describe)
21. On a scale of 1 to 5 (1 being not concerned at all and 5 being highly concerned), how concerned are you about your family’s health care coverage?
22. On a scale of 1 to 5, how concerned are you about your family’s economic security right now? How about 6 months from now?
23. Overall, how would you like to see health insurance offered in this country?
   a. Continue with current system (private-public; employers and Medicaid/Medicare)
   b. Health insurance for all paid for by taxes
   c. Strengthen private by making it more affordable for employers and self-employed individuals with governmental support/backing
   d. Health Savings Accounts
   e. Other________________________________________
   f. Have no idea
24. Those are all the health insurance and medical bill questions, now I just want to ask you a few questions about your background: (Already have for GSP sample)
   Which describes your highest education level (also ask for spouse/partner):
   a. High school equivalent or less
   b. Technical school/some college
   c. Bachelors
   d. Graduate/professional
   e. Other
25. (Already have for GSP sample) Which of the following includes your household income:
   a. Less than $30,000
   b. $30,000 to $44,999
   c. $60,000 to $74,999
   d. $45,000 to $59,999
   e. $75,000 to $99,999
   f. $100,000 or more
   g. NA
26. Do you have savings? How much $___________________
27. (Have for GSP) Do you own or rent a home? Own/rent
28. Is there anything else you would like to share about your experiences with medical bills or health insurance? Any opinions or examples that you think are important to tell me?
A.1b. Consent Form to Conduct Interviews with GSP Respondents

**Consent Form for Interviews:**

The purpose of this research is to examine the extent to which your experiences with health insurance and medical bills have impacted your life from an economic standpoint. I am asking you to agree to be interviewed to help me learn more about the ways in which changes in health insurance and the presence of medical bills may impact people financially. Your name will be kept confidential, and your responses will remain anonymous. The interview will last about 30-40 minutes. You do not have to answer any or all of the questions, although I would greatly appreciate learning about your experiences and opinions. Your participation is completely voluntary. At the completion of this project, interview notes, which will not have any identifying information on them, will be kept in a locked file cabinet, accessible only by the Project Director, Sarah Savage.

If you have any questions regarding this study, please contact Sarah Savage at 603-866-1207 or ssavage@unh.edu. If you have any questions about your rights as a research subject you may contact Julie Simpson in the UNH Office of Sponsored Research at 603-862-2003 or julie.simpson@unh.edu to discuss them.

Please indicate below that you agree to participate in this study.

Thank you very much for your help.

I have read the statement above, and I agree to participate in this study. 

I do not wish to participate. 

---

Print first and last name  

Date

Signature  

Date
A.1c. Institutional Review Board Letters of Approval
02-Oct-2007

Savage, Sarah
Carsey Institute, Huddleston G05B
93 Henry Law Avenue, Unit 153
Dover, NH 03820

IRB #: 4076
Study: Health Insurance Status and the Middle Class
Approval Date: 01-Oct-2007

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved the protocol for your study as Exempt as described in Title 45, Code of Federal Regulations (CFR), Part 46, Subsection 101(b). Approval is granted to conduct your study as described in your protocol.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the attached document, Responsibilities of Directors of Research Studies Involving Human Subjects. (This document is also available at http://www.unh.edu/osr/compliance/irb.html.) Please read this document carefully before commencing your work involving human subjects.

Upon completion of your study, please complete the enclosed pink Exempt Study Final Report form and return it to this office along with a report of your findings.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,

Julie F. Simpson
Manager

cc: File
Duncan, Cynthia
United States of America

University of New Hampshire

Research Conduct and Compliance Services, Office of Sponsored Research
Service Building, 51 College Road, Durham, NH 03824-3585
Fax: 603-862-3564

15-May-2007

Savage, Sarah
Carsey Institute, Huddleston
93 Henry Law Avenue, Unit 153
Dover, NH 03820

IRB #: 4004
Study: Evaluation of Bonnie CLAC
Approval Date: 07-May-2007

The Institutional Review Board for the Protection of Human Subjects in Research (IRB) has reviewed and approved the protocol for your study as Expedited as described in Title 45, Code of Federal Regulations (CFR), Part 46, Subsection 110.

Approval is granted to conduct your study as described in your protocol for one year from the approval date above. At the end of the approval period, you will be asked to submit a report with regard to the involvement of human subjects in this study. If your study is still active, you may request an extension of IRB approval.

Researchers who conduct studies involving human subjects have responsibilities as outlined in the attached document, Responsibilities of Directors of Research Studies Involving Human Subjects. (This document is also available at http://www.unh.edu/osr/compliance/irb.html.) Please read this document carefully before commencing your work involving human subjects.

If you have questions or concerns about your study or this approval, please feel free to contact me at 603-862-2003 or Julie.simpson@unh.edu. Please refer to the IRB # above in all correspondence related to this study. The IRB wishes you success with your research.

For the IRB,

Julie F. Simpson
Manager

cc: File
Ward, Sally