

Employer-Sponsored, Personal, And Portable Health Insurance

Three existing insurance models offer many advantages to employers as well as employees.

by **John C. Goodman**

ABSTRACT: Personal and portable health insurance is an idea whose time has come. Despite its stated intent, however, the Health Insurance Portability and Accountability Act (HIPAA) strongly discourages individually owned, portable insurance. Federal tax laws do the same. Some examples of portable benefits exist, such as the TIAA-CREF system. This paper considers three reform models for moving toward personal, portable coverage: the National Center for Policy Analysis–Texas Blue Cross Blue Shield proposal, the Massachusetts health care plan, and a health reimbursement arrangement (HRA) approach. Congress could make the transition smoother by clarifying when and if individually owned insurance can be purchased with pretax dollars. [*Health Affairs* 25, no. 6 (2006): 1556–1566; 10.1377/hlthaff.25.6.1556]

ONE OF THE STRANGE FEATURES OF THE U.S. health care system is that the health plan most of us have is not a plan that we chose; rather, it was selected by our employer. Even if we like our health plan, we could easily lose coverage because of the loss of a job, a change in employment, or a decision by our employer.

Most employer health insurance contracts last only twelve months. At the end of the year, the employer may choose a different health plan or cease providing health insurance altogether. Strangely, the only people with private health insurance guaranteed to last longer than one year are people who purchase insurance on their own.

A switch of health plans might mean changing doctors as well, if the two plans do not have overlapping networks or if cost-sharing arrangements penalize the patient's previous choice of doctors. If an employee (or family member) has a health problem, that could interrupt the continuity of care. In addition, different plans have different benefit packages. So some services, such as mental health, might be covered by one plan but not the next.

These disruptions affect some families more than others. For people who are healthy, they amount to minor inconveniences; for others, the problems can be severe. One study of chronically ill workers found that relying on one's employer for

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health coverage reduced job mobility 40 percent.¹ Older workers, who are more likely than younger workers to have health problems, are also disproportionately affected. Further, as more employers cut back on postretirement health care benefits, many baby-boomer early retirees will have to shop for individual insurance and pay for it with after-tax dollars. The same fate will confront many younger spouses of retirees who enroll in Medicare.

To address these problems, President George W. Bush called for portable health insurance in his 2006 State of the Union address. Polls show that the idea is popular.² But is it something we can realistically expect to achieve?

This paper proposes answers to five questions: (1) What exactly do we mean by *portable health insurance*? (2) What are the legal obstacles to achieving it? (3) Can private health insurance survive without portability? (4) What models could be followed to implement portability? (5) What are the expected gains and losses from moving to portable health insurance?

What Does ‘Portability’ Mean?

The word *portability* is used loosely in many different contexts. Here is a brief summary.

■ **Role of the employer.** In principle, portable insurance can be obtained either outside or through the workplace. The National Health Service (NHS) in the United Kingdom and Medicare in Canada provide health insurance that is independent of job status, although in both countries, employers may provide alternative (U.K.) or supplemental (Canada) benefits that are not portable. In the United States, Medicare, Medicaid, and Department of Veterans Affairs (VA) health plans all travel with workers from job to job.

Portable insurance may also be purchased outside the workplace in the private market. Switzerland has built its entire health care system around mandatory, individually purchased health insurance. Although the Swiss have moved in the direction of managed competition in recent years, the country has a history of people choosing a plan and remaining in it for many years.³

Advocates of personal and portable health insurance (on both the left and the right) often see it as an alternative to employer-sponsored insurance.⁴ However, it is easy to imagine portable health insurance obtained through the workplace, with employers paying some or all of the premiums.

■ **Intra-industry portability.** Perhaps the best-known example of intra-industry portable employee benefits is the TIAA-CREF retirement system for employees of academic, research, medical, and cultural institutions. The benefit is administered much like a large 401(k) plan by an independent entity. Employees make contributions (usually matched by the employer), and the account is fully portable as employees move from job to job.⁵ Industrywide bargaining, for both pensions and health insurance, results in multi-employer benefit plans (called Taft-Hartley plans) used by the United Mine Workers and union members in the construction, enter-

tainment, garment, and other industries.⁶ However, both groups of constituents benefit from special provisions of federal law that do not apply to other workers.

In general, when workers leave these industries, they either lose the benefit altogether or lose the right to make future contributions. For example, when a mine worker leaves the industry, he or she eventually loses mine workers' health insurance coverage. When a college professor accepts a nonuniversity position, the professor continues to own his or her TIAA-CREF account and can continue to make investment decisions. But this person can make no additional contributions.

■ **Inter-industry portability.** Certain employee benefits potentially travel from one job to any other job, but the conditions are restrictive. The best-known example is the 401(k) account. Upon the cessation of employment, workers have the right to roll any vested 401(k) funds over into the next employer's plan or into their personal individual retirement accounts (IRAs). But an employee cannot make contributions at the second job unless the new employer offers a 401(k) benefit, and the limits on contributions to IRAs are much lower than the limits for 401(k) plans.

Another portable benefit that is becoming increasingly important is the health savings account (HSA). Employees have the right to choose the financial institution that handles their account, and they can retain that relationship or switch to a new one after a job change. They cannot continue to make contributions, however, unless the new employer offers a qualified HSA-related plan or unless they obtain such coverage on their own.

■ **Full versus limited portability.** In some cases, part of an employee benefit is portable. For example, only the vested portion of a 401(k) plan travels with a worker who switches jobs. The unvested portion must be forfeited. In an HSA plan, the HSA itself is portable, but not the third-party insurance that accompanies it.

■ **Portable benefits versus portable access to benefits.** Because of concern over the many problems that lack of portability creates, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996. The legislation placed restrictions on employers and created obligations for state governments to ensure what most would regard as simple fairness: Anyone who has been paying into the insurance system should not be denied access to it simply because of a change in employment status.

HIPAA did not create true portability of health insurance benefits, however. What it created is a guarantee of access to a new set of benefits, which might not be the same as the benefits under the original health plan. If you leave an employer's health plan (for any reason), HIPAA ensures that any new employer cannot deny you access to its health plan because of your health status. Or if you cease working altogether, the state in which you reside must make sure that you are not denied access to health insurance because of health status (say, by admitting you to a risk pool). But the new plan benefits might be skimpier than those of the original plan. You might not be able to see the same doctor or get services from the same facilities. In fact, the new plan might not even cover the malady for which

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you needed health insurance in the first place.

■ **Short-term versus long-term portability.** In an earlier attempt to address the problems of portability, Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. Generally, COBRA allows workers to continue their health coverage, after leaving a job, for up to eighteen months, in most cases by paying 102 percent of the plan's cost. Clearly, COBRA is not a long-term solution. But even in the short term there are some disadvantages to this approach, for both employers and employees. Ex-employees find that they must make their COBRA premium payments with after-tax dollars, whereas most (or all) of the payments were made with pretax dollars when they were employed. For this reason (in addition to the fact that unemployed people have less income), those who continue COBRA coverage tend to be those with above-average costs—and this is true as well for those who have the opportunity to switch to individual coverage with the same insurer (group-to-individual conversions).

Employers tend to not like COBRA because those who continue coverage tend to generate above-average health care costs, although they pay average premiums. Thus, the employers lose money for the benefit of people who are no longer producing for the firm.

Legal Restrictions On Portability

Despite the important steps Congress has taken to address portability, the thrust of federal law is to encourage health insurance that is not portable and discourage insurance that is.⁷

■ **Role of the tax law.** In the main, insurance obtained through an employer is not portable, whereas insurance purchased by individuals is. Strangely, the tax law heavily subsidizes the former while giving very little tax relief to the latter. Employer-paid premiums avoid federal, state, and local income taxes, as well as the (FICA) payroll tax.⁸ By contrast, people who buy their own insurance get no tax relief unless their premiums exceed 7.5 percent of their adjusted gross income.⁹

■ **Role of HIPAA.** If health insurance portability is desirable and if the tax law favors employer purchase, why don't employers purchase individually owned (and therefore portable) insurance for their employees? The answer: Federal law makes this impossible, or at least impractical. Although there is some disagreement on the point, lawyers generally interpret the Employee Retirement Income Security Act (ERISA) of 1974 as amended by HIPAA to say that employers can purchase only group insurance with untaxed dollars.¹⁰

Also, partly in response to HIPAA, many states outlaw “list billing,” the practice of using employer funds to pay premiums for employee-owned insurance. In other

states, laws say that if an insurer accepts a check from an employer, the insurance will be regulated under the more restrictive rules for group insurance, rather than as individual insurance.¹¹ Under a strict interpretation of HIPAA, employees (and their employers) should not be able to purchase individual insurance through Section 125 plans if there is medical underwriting.¹² However, enforcement is left to the states, and there appears to be no consistency in state regulation. An ironic (and perhaps unintended) consequence of HIPAA is that the legislation that was supposed to create portability actually makes genuine portability more difficult to obtain.

■ **Is there an HRA exception?** Some employers believe that they can accomplish what HIPAA would otherwise forbid. The vehicle is the health reimbursement arrangement (HRA), an account through which employers can reimburse employees with untaxed dollars for health care expenses, including health insurance premiums. I return to this below.

Can We Live In A World Without Portability?

Most employees view health insurance as a fringe benefit. When they enter the job market, they primarily search for employment opportunities that reward them for their skills and abilities. But a minority of workers approach the job market very differently. These are people with a family member (often a spouse or child) who has very high health care costs. When these workers compare job opportunities, they are primarily comparing health plans. For them, health insurance is the main attraction, rather than the job or the pay. And the passage of HIPAA makes it easier for them to enroll in the employer-sponsored plan of their choice.

Clearly, it is not in employers' financial self-interest to attract workers whose primary motivation is to get their medical bills paid. So, to protect themselves from such potential hires, employers are increasingly altering their health plans to attract the healthy and avoid the sick. Having small copayments for routine office visits and higher deductibles for hospitalization is one technique. Having long waiting periods before employees become eligible for the company's health plan is another.

These reactions by employers are rational responses to a labor market that increasingly is looking like a game of musical chairs. But what is good for the employer is not necessarily good for society as a whole. An efficient labor market is one in which employers compete for labor and workers seek employment without regard for anyone's health status.

How Can We Get From Here To There?

Through the years there have been many proposals to abolish the existing system and start all over. National health insurance is one idea; the Swiss system of individual mandates is another. The more interesting question is this: Is there a way to make the transition from the current system (in which employers play a

major role) to a system of personal and portable insurance (in which employers continue to play a major role)? Three models are worth considering (Exhibit 1).

■ **The National Center for Policy Analysis (NCPA)–Texas Blue Cross Blue Shield (BCBS) Plan.** This proposal was presented to the Texas Blue Ribbon Task Force on the Uninsured, under then-governor George W. Bush.¹³ Its implementation, however, would require an amendment to HIPAA.

Initially, the employer would choose an insurance plan for all employees, much as small employers choose group insurance today, and the expected premiums would resemble group rates. However, the insurance purchased would be individual, not group insurance. Practices that insurers follow in the group market today probably would still apply, including the requirement that (1) employers pay a substantial part of the premium, (2) a substantial percentage of eligible employees elect to take up coverage, and (3) any new employees elect coverage on a certain date, not of their choosing.¹⁴ In return, the group could avoid the administrative cost of individual underwriting (although this would not be a legislative requirement).

A typical transition period would involve a three-year contract. After three years, employees could switch to another plan if they were dissatisfied. However, a person’s entry into another plan would not be guaranteed. During the three-year

**EXHIBIT 1
Models For Implementing Personal And Portable Health Insurance**

	NCPA–BCBS	Massachusetts	Health reimbursement arrangement (HRA)
Legislation needed	Federal ^a	State	None
Scope of the plan	State	State	National
Type of insurance	Modified individual market ^b	Managed competition (Connector)	Individual market
Duration of insurance	Indefinite ^c	Annual	Tenure with initial employer ^d
Incentives for employers	Defined-contribution finance	Mandates	Defined-contribution finance
Why pretax dollars can be used	Employer pays premiums	Connector is employer-sponsored	HRA regulations
Protections for high-cost employees	HIPAA regulations	HIPAA plus state minimum benefits	HIPAA regulations plus state laws
Opportunity to change plans	Individual market plus HIPAA regulations apply	Annual open season plus community rating	Individual market plus HIPAA regulations apply

SOURCE: Author’s analysis.

NOTES: NCPA is National Center for Policy Analysis; BCBS is Texas Blue Cross Blue Shield. See text for details on all three models.

^a Requires an amendment to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

^b Insurance pools will be separate from the individual market and subject to additional restrictions.

^c Upon leaving the initial employer, subsequent coverage requires after-tax premium payments by the individual or before-tax payments by a participating new employer.

^d Only the original employer can make premium payments through an employee’s HRA. Subsequent coverage requires after-tax premium payments by the individual or pretax payments by a new employer through a new HRA.

period, new employees who do not have their own portable insurance plan would be required to join the employer's selected plan to qualify for an employer contribution. Eventually, however, we would expect labor-market mobility to create a workplace environment with employees in many different health plans.

The system would be voluntary. No employer would have to make the switch from traditional insurance; as a practical matter, this option would not be interesting unless many employers decided to exercise it. Small employers would likely find the new system attractive, however, for several reasons. First, instead of being experience-rated every twelve months (as is common in the small-group market), they would be rated only once—at the point of entry. Second, they would be able to move from a defined-benefit system with uncertain future costs to a defined-contribution system in which costs are more predictable. In fact, they would be required to become defined-contribution employers—making a fixed sum of money available to pay premiums for every employee.¹⁵ As a result, the employer's role would be largely financial, much as it is with employer-sponsored 401(k) plans today. Finally, employers would be able to maximize the impact of their fringe-benefit dollars, providing each employee with the full tax advantage of premium payments to the plans they prefer.

■ **The Massachusetts health plan.** At the instigation of Gov. Mitt Romney, Massachusetts has adopted a new plan whose goal is to insure the uninsured.¹⁶ Portable insurance is a by-product.

The Massachusetts plan is the first state plan to integrate spending subsidies and tax subsidies by using free-care money (which encourages people to be uninsured) to subsidize the purchase of private health insurance and using the extra taxes (or fines) paid by people who are uninsured to provide the safety-net care they may obtain.¹⁷ Thus, from day one, it will eliminate some perverse incentives that all other reform plans have left in place.

Although the Massachusetts plan is said to have an individual mandate, this is a misnomer. What is really proposed is a play-or-pay plan for individuals. They must either buy insurance or get it through an employer or Medicaid, or pay a fine to the state. The state, in return, will use its funds to either subsidize private insurance or subsidize free safety-net care, depending on the choices individuals make.¹⁸

Employers under this plan are not required to provide insurance. But they are required to set up a structure that allows their employees to purchase insurance with pretax dollars.¹⁹ The vehicle is a managed competition-style insurance exchange (much like the system available to federal employees) called the Commonwealth Health Insurance Connector. When the law is fully implemented, health plans will compete at annual open enrollment periods, and individuals up to 300 percent of the federal poverty level will receive subsidies (depending on their income) to make insurance more affordable.

The resulting insurance will be portable for twelve months (until the next open

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season), and as individuals move from job to job, each of their employers can make their own contributions to the premium payments. Beyond twelve months, individuals will have portable access to the system (that is, the Connector).

An advantage of this approach over the NCPA-BCBS plan is that no change in federal law is needed. A disadvantage is that a long-term relationship with a health plan is not assured.

■ **Health reimbursement arrangements.** As noted above, Treasury regulations appear to allow employers to use HRAs to pay premiums with pretax dollars for individually owned insurance. Some large companies are considering using the accounts to help early retirees purchase their own coverage and retired Medicare enrollees purchase supplemental coverage.

There are also other possibilities. We could imagine an employer using HRAs to enable active employees to purchase their own insurance. Or the employer might negotiate with a single insurer for individual insurance (but at group rates) for all of its employees. These options are subject to restrictions under both federal and state laws, however. Treasury regulations appear to forbid the use of HRAs to purchase insurance that is medically underwritten.²⁰ Oregon, for example, explicitly prohibits the use of HRAs to purchase individual insurance.

HRAs are notional accounts created by specific employers. The account itself is not portable, although insurance purchased with the account can be. Thus, employees who leave the employer (other than people getting postretirement benefits) eventually will be able to continue their insurance only if they pay their own premiums out of pocket with after-tax dollars or become an employee of some other firm that also uses HRAs to pay premiums in this way. The HRA approach, therefore, is not a satisfactory way to create genuine portability unless a large number of employers decide to participate.

Weighed against this disadvantage is the fact that an HRA-based system requires no legislation. Thus, one could imagine portability emerging as a purely market-based phenomenon, with large companies perhaps leading the way. Privately created insurance exchanges (like the Massachusetts plan) and other arrangements are all conceivable as the market evolves through time. We could even see a health insurance version of TIAA-CREF emerge.

What Are The Costs And Benefits Of The Transition?

Each of the models discussed above builds on the current system, rather than attempting a complete overhaul. Under the current system, employers offer health insurance because they can purchase it with pretax dollars (whereas employees on their own cannot do so), and there are often lower administrative costs with

group purchase.

The three models assume that the current tax regime remains in place, making entry into the system through an employer attractive to workers. They also allow employers and employees to benefit from the economies of group purchasing in the transition. Administrative costs to employers will be further lowered if their role becomes purely financial—much like the administration of 401(k) accounts. On the supply side, costs to insurers will be lowered if multiyear contracts eliminate the need for annual repricing.

On the down side, some employers might view the current lack of portability as a good thing, since it discourages job hopping and helps them retain employees. However, what is good for the employer in this instance is bad for the employee. Competition for workers could induce employers to offer portable health benefits, even if they were not otherwise inclined to do so.

Also, there will be some offsetting increases in administrative costs if, say, an employer of fifty people has to send premium payments to fifty different health insurers. These administrative costs, however, are comparable to managing the different portfolio choices of employees in 401(k) plans. A more serious issue is that some employees who now escape the effects of state regulation will be converting to the kind of insurance that is subject to state regulation (and its potentially higher costs). Whether the costs outweigh the benefits may vary from state to state.

In all cases, there is the question of what happens to people with chronic illnesses and high expected health costs. Were employers to help employees purchase individual health insurance with their own money (through Section 125 plans) or make defined contributions to HRA plans for that purpose, the employees would face medical underwriting in most states. As a result, high-cost employees would face considerably higher premiums or perhaps be denied coverage altogether except through a risk pool.

The Massachusetts health plan solves these problems through required community rating, but it does so at the price of creating distortions that may affect the quality of care patients receive.²¹ The NCPA-BCBS plan gives employers incentives to enroll all employees (the sick as well as the healthy) into a single initial plan. For high-cost patients to subsequently switch plans, the receiving plan would have to receive a side payment from the original plan to compensate for the higher expected costs. Such arrangements might benefit both the plans and the patients if some plans specialize (and become more efficient) in the treatment of certain conditions. Large employers using HRAs might be able to arrive at more creative solutions through private contracts with health insurers.

Under all three models, every employee who is guaranteed reasonable access to insurance under today's HIPAA rules would continue to have it guaranteed in the new system. However, the state could meet this requirement creatively through subsidies and risk pools, which would also offer portable insurance.

PERSONAL AND PORTABLE HEALTH INSURANCE is an idea whose time has come. The advantages to employees are obvious. There are also advantages to employers. With defined-benefit contributions, employers could get out of the health insurance business and specialize instead on those activities where they have a comparative advantage. Employers could compete for labor based on the work skills of potential hires, unburdened by worries about undisclosed, costly illnesses. People could seek employment based on their talents and job opportunities, rather than on the basis of health insurance benefits.

The difficulty is in implementation. Apparently, much can be done without a change in federal law, as demonstrated by the reform in Massachusetts and the opportunities afforded by HRAs. Congress could make the transition much smoother, however, by clarifying when and if employers and employees can purchase individually owned insurance with pretax dollars.

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NOTES

1. K.T. Stroupe, E.D. Kinney, and T.J. Kniesner, "Chronic Illness and Health Insurance-related Job Lock," *Journal of Policy Analysis and Management* 20, no. 3 (2001): 525-544.
2. In a 2002 poll of female swing voters conducted for the National Center for Policy Analysis, pollster Bill McInturff found that portable health insurance was not only extremely popular, it ranked right below equal pay for equal work.
3. R.E. Herzlinger and R. Parsa-Parsi, "Consumer-driven Health Care: Lessons from Switzerland," *Journal of the American Medical Association* 292, no. 10 (2004): 1213-1220.
4. See, for example, the Physicians for a National Health Program proposal outlined in D.U. Himmelstein and S. Woolhandler, "A National Health Program for the United States: A Physicians' Proposal," *New England Journal of Medicine* 320, no. 2 (1989): 102-108; and proposals for mandated individual coverage in M.V. Pauly et al., *Responsible National Health Insurance* (Washington: AEI Press, 1992); and in S.M. Butler and E. Haislmaier, *A National Health System for America* (Washington: Heritage Foundation, 1989).
5. TIAA-CREF offers defined-contribution retirement annuity contracts. See TIAA-CREF, "What Types of Plans Do Employers Offer?" http://www.tiaa-cref.org/finance/what_types_plans_employers_offer.html (accessed 28 April 2006).
6. Multi-employer "Taft-Hartley" plans are collectively bargained by a labor union and multiple employers. According to the Pension Benefit Guarantee Corporation, 9.4 million people are covered by 1,600 multi-employer defined-benefit pension plans. Taft-Hartley plans can also provide portable health coverage. See American Federation of State, County, and Municipal Employees, "All for One and One for All: Taft-Hartley Health Insurance Plans," 2000, <http://www.afscme.org/publications/9727.cfm> (accessed 11 August 2006).
7. Some defend the current system by arguing that employer-sponsored group insurance uniquely pools the employees, making it easier for high-cost employees to obtain insurance at an affordable premium. Yet if this is the underlying goal, it might make more sense to reduce subsidies to group insurance and increase the subsidies for individually owned, risk-pool insurance whose enrollees actually have been denied coverage because of health problems.
8. An employee in the 25 percent federal income tax bracket facing a 5 percent state and local tax bracket and a combined (FICA) payroll tax of 15.3 percent receives a subsidy of about 45 percent.
9. There is an exception for the self-employed, who are allowed to fully deduct their health insurance premiums but who get no relief from the (FICA) payroll tax.

10. HIPAA prohibits employers from discriminating against employees either in price or in availability of coverage on the basis of health status. In most states, this restriction is incorporated into regulations governing the small-group market, but not the individual market. Therefore, only group insurance satisfies HIPAA in these states.
11. See the discussion in Council for Affordable Health Insurance, "One Solution for the Small Group Market," April 2006, http://www.cahi.org/cahi_contents/resources/pdf/n133ListBilling.pdf (accessed 11 August 2006).
12. The Massachusetts health plan is an exception to this rule because the insurance is guaranteed issue and community rated.
13. Texas Blue Ribbon Task Force on the Uninsured, *Report to the 77th Legislature*, February 2001, p. 44, http://www.senate.state.tx.us/75r/senate/commit/archive/BR/Blue_Ribbon.pdf (accessed 25 August 2006).
14. Insurers impose such rules to avoid being selected against—that is, insuring sick employees only at the time they appear to be sick.
15. Adjustments would be made for age and perhaps health status as well.
16. See E.F. Haislmaier and N. Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs* 25, no. 6 (2006): 1580–1590.
17. This is a design originally proposed in J.C. Goodman and G.L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington: Cato Institute, 1992); and subsequently elaborated on in J.C. Goodman, "Solving the Problem of the Uninsured," *Thoracic Surgery Clinics* 15, no. 4 (2005): 503–512.
18. Individuals relying on free care, however, are not guaranteed it. If they have resources, they will probably be asked to pay for the care—a characteristic of the current system.
19. Specifically, employers must set up Section 125 plans, through which employees' pretax dollars can be used to pay premiums.
20. See Internal Revenue Service, "Part I—Rulings and Decisions under the Internal Revenue Code of 1986: Section 105—Amounts Received under Accident and Health Plans; and Part III—Administrative, Procedural, and Miscellaneous: Health Reimbursement Arrangements, Notice 2002-45," *Internal Revenue Bulletin* no. 2002-28 (Washington: U.S. Government Printing Office, 2002).
21. See J.C. Goodman, G.L. Musgrave, and D.M. Herrick, "Is Managed Competition the Answer?" in *Lives at Risk: Single-Payer National Health Insurance around the World* (Lanham, Md.: Rowman and Littlefield, 2004), 201–213.