



**HEALTH SAVINGS ACCOUNTS:
WHY THEY WON'T CURE WHAT AILS U.S. HEALTH CARE**

Sara R. Collins, Ph.D.
Assistant Vice President
The Commonwealth Fund
One East 75th Street
New York, NY 10021
src@cmwf.org
www.cmwf.org

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Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on health savings accounts (HSAs). The Committee is to be commended for focusing attention on the manifold problems currently confronting the U.S. health care system: steady growth in the number of uninsured Americans, rising health care costs and premiums, wide variation in the quality and cost of care, and inefficiencies in the delivery and administration of care.

Some maintain that HSAs, coupled with high-deductible health plans (HDHPs), are an important part of the solution for the cost, quality, and insurance problems that plague the U.S. health care system. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, driving down growth in health care costs and improving the quality of care as providers compete for patients. And the tax incentives of HSAs will lure previously uninsured people into the individual market, reducing the numbers of families without health insurance.

But while it is comforting to believe that such a simple idea could help solve our health care problems, nearly all evidence gathered to date about HSAs and HDHPs points to the contrary. Indeed, there is evidence that encouraging people to join such health plans might act as salt on a wound, exacerbating some of the very maladies that undermine our health care system's ability to perform at its highest level.

Higher Patient Cost-Sharing Is the Wrong Prescription

- Americans already pay far more out-of-pocket for their health care than citizens in any other industrialized country.
- Real per capita out-of-pocket spending has been steadily rising since the late 1990s. Combined with sluggish growth in real incomes, families are spending increasingly more of their incomes on medical costs.
- There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need.
- Rising out-of-pocket costs reduce people's ability to save for the future.

Early Experience with HSA-Eligible HDHPs Reveals Low Enrollment, Low Satisfaction, High Out-of-Pocket Costs, and Cost-Related Access Problems

- Few people are currently enrolled in HSA-eligible HDHPs; those who are enrolled are much less satisfied with many aspects of their health care than adults in more comprehensive plans.
- People in these plans allocate substantial amounts of income to their health care, especially those who have poorer health or lower incomes.
- People in HDHPs are far more likely to delay, avoid, or skip health care because of cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- People in these plans are more cost-conscious consumers of health care: they are more likely to ask for lower-priced drugs and more likely to discuss with their doctors different treatment options and the cost of care.
- Few Americans in any health plan have the information they need to make decisions. Just 12 to 16 percent of insured adults have information from their health plan on the quality or cost of care provided by their doctors and hospitals.

Patients' Use of Information Alone Is Not Likely to Dramatically Reduce Health Care Costs or Improve Quality

- It is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of health care system will be driven by patients' choice of provider. Patients are in the weakest position to demand greater quality and efficiency.
- Most health care costs are incurred by very sick patients, often under emergency conditions. Shopping for the best physician or hospital is impractical in such circumstances.
- Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.

HSAs Will Not Solve Our Uninsured Problem

- Economists Sherry Glied and Dahlia Remler estimate that under current law, fewer than 1 million currently uninsured people are expected to gain coverage as a result of HSAs. This is primarily because 71 percent of uninsured Americans are in a 10-percent-or-lower income tax bracket and would thus benefit little from the tax savings associated with HSAs.

New Proposals to Expand HSAs May Fragment Group Insurance Markets, Increasing the Number of Uninsured

- Additional tax incentives proposed by the Administration's 2007 fiscal year budget aim to equalize the tax treatment of HSAs in the individual market to those in the employer market, with premium tax deductibility and tax credits. Economist Jonathan Gruber estimates that the Administration's proposals would actually increase the number of uninsured Americans by 600,000. While 3.8 million previously uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small employers, would drop coverage. Some 8.9 million people would lose their employer-based health insurance.

What Needs to Be Done

We as a nation should focus on more promising strategies for expanding coverage, improving affordability, and lowering costs. These strategies include:

- Expanding group insurance coverage, with costs shared among individuals, employers, and government. This could be done by expanding employer-based coverage, eliminating Medicare's two-year waiting period for coverage of the disabled, letting older adults "buy in" to Medicare, and building on Medicaid and the State Children's Health Insurance Program (SCHIP) to cover low-income parents, young adults, and single adults.
- Ensuring affordable coverage for families by placing limits on family premium and out-of-pocket costs as a percentage of income (e.g., 5% of income for low-income families).
- Greater transparency with regard to provider quality and the total costs of care.
- Pay-for-performance incentives to reward health care providers that deliver high quality and high efficiency.
- Development of "value networks" of high performing providers under Medicare, Medicaid, and private insurance.
- High cost care management and disease management.
- Improved access to primary care and preventive services.
- Investment in health information technology.

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Thank you, Mr. Chairman, for this invitation to testify on health savings accounts (HSAs). The Committee is to be commended for focusing attention on the manifold problems currently confronting the U.S. health care system and our collective need to find solutions to solve them.

National health care spending is climbing by more than 7 percent per year and is expected to continue to outpace growth in the economy by a substantial margin.¹ The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$10,880 last year, more than the average yearly earnings of a full-time worker earning the minimum wage (Figure 1).² Many employers, particularly small companies, are coping with rising premiums by passing along more of their costs to employees or eliminating coverage altogether (Figures 2 and 3).³

Consequently, the number of people without health insurance in the United States is climbing steadily: in 2004, nearly 46 million people were uninsured, an increase of 6 million over 2000 (Figure 4).⁴ An additional 16 million people could be considered “underinsured” as a result of their high out-of-pocket costs relative to income.⁵ Americans, meanwhile, experience significant variation in the quality and cost of their health care, depending on where they live and where they go for care. Adding to these problems are inefficiencies in the delivery and administration of care.

Some maintain that HSAs, coupled with high-deductible health plans (HDHPs), are an important part of the solution for the cost, quality, and insurance problems that

¹Stephen. Heffler, et al., “U.S. Health Spending Projections for 2004-2014,” *Health Affairs* Web Exclusive 23 Feb 2005; C. Smith, et al., “National Health Spending in 2004,” *Health Affairs* (Jan/Feb 2006): 186-196.

²Jon Gabel et al., “Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode,” *Health Affairs* 24 (September/October 2005): 1273–1280.

³Ibid.

⁴C. DeNavas-Walt, B.D. Proctor, C.H.Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports (Washington, D.C.: U.S. Census Bureau) August 2005.

⁵C. Schoen, M.M. Doty, S.R. Collins and A.L. Holmgren, “Insured But Not Protected: How Many Adults Are Underinsured?” *Health Affairs* Web Exclusive, June 14, 2005, W5-289–W5-302.

plague the U.S. health care system.⁶ Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care. As patients shop around for the cheapest, and best, providers, the market for health care services will ultimately look more like the market for other goods and services, driving down growth in health care costs and improving the quality of care as providers compete for patients. And the tax incentives of HSAs will lure previously uninsured people into the individual market, reducing the numbers of families without health insurance.

While it might be comforting to believe that such a simple idea could solve our collective health care problems, nearly all evidence gathered to date about HSAs and HDHPs points to the contrary. Indeed, there is evidence that encouraging people to join such health plans might act as salt on a wound, exacerbating some of the very maladies that undermine our health care system's ability to perform at its highest level.

Higher Patient Cost-Sharing Is the Wrong Prescription

Increasing patient cost-sharing is a misguided solution for reining in U.S. health care costs. The claim that Americans spend too much on health care because they are protected from the real cost simply is not borne out by evidence. Americans already pay far more out-of-pocket for their health care than citizens do in any other industrialized country (Figure 5).⁷ Furthermore, real per capita out-of-pocket spending has been steadily rising since the late 1990s (Figure 6).⁸ Higher spending on health care, combined with sluggish growth in real incomes, also means that families are spending increasingly more of their earnings on medical costs. A Commonwealth Fund report by Mark Merlis found that the percentage of households spending 10 percent or more of their income on out-of-pocket costs rose from 8 percent during the years 1996–97 to 11 percent in 2001–02 (Figure 7).⁹ Including premiums, 18 percent of all families spent more than 10 percent of income on health care.

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-

⁶ R. Herzlinger, *Consumer-Driven Health Care: Implications for Providers, Payers and Policy Makers*, Jossey-Bass, 2004.

⁷ B.K. Frogner and G.F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Forthcoming.

⁸ C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (January/February 2006).

⁹ M. Merlis, D. Gould and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund) February 2006.

essential health care.¹⁰ Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs, and it increased the risk of adverse health events (Figure 8).¹¹ In addition, a review by Rice and Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.¹² Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, found that insured people with out-of-pocket costs high relative to income were nearly as likely to report not accessing needed health care because of costs as were people without any coverage at all.¹³

Early Experience with HSA-Eligible HDHPs: Low Enrollment, Low Satisfaction, High Out-of-Pocket Costs, and Cost-Related Access Problems

Given that American families are already spending large shares of their income on health care, it should not be surprising that enrollment in HSA-eligible HDHPs remains low. These health plans currently comprise a very small share of the insurance market. The Employee Benefit Research Institute (EBRI) and Commonwealth Fund Consumerism in Health Care Survey (2005), a national online survey of adults ages 21 to 64, found that as of October 2005, just 1 percent of the adult population had a HDHP and an HSA or health reimbursement arrangement (HRA) (Figure 9).¹⁴ An additional 9 percent had an HSA-eligible HDHP but had not yet opted to open an account. Other studies have found similarly slow take-up. The General Accountability Office (GAO) found that as of March 2005, only 7,500 federal employees, retirees, and dependents out of 9 million covered lives had opted to enroll in the HDHP/HSA product offered by the Federal Employee

¹⁰ J.P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, November/December 2004.

¹¹ R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421-429.

¹² T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review* 16 (December 2004): 415-452.

¹³ C. Schoen, M.M. Doty, S.R. Collins and A.L. Holmgren, "Insured but Not Protected: How Many Adults are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289-W5-302.

¹⁴ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005. The EBRI/Commonwealth Fund Consumerism in Health Care Survey was a national online survey conducted in Fall 2005 of 1200 adults ages 21-64 and an oversample of those in HSA-Eligible HDHPs with and without savings accounts that can be rolled over year to year (both HSAs and Health Reimbursement Arrangements or HRAs). There were 1061 people in comprehensive plans, 463 in HSA-eligible HDHPs without a savings account, and 185 in HDHPs with either an HSA or an HRA.

Health Benefits Program (FEHBP) (Figure 10).¹⁵ A recent study by America's Health Insurance Plans estimates that there are currently about 3.2 million people enrolled in HSA-eligible HDHPs, though the study did not indicate how many people had opened an account.¹⁶ The U.S. Treasury Department estimates that under current law only 14 million people will ever enroll in HSA-eligible HDHPs—still a relatively small share of the overall market.¹⁷

Reflecting the fact that people in higher income tax brackets have the greatest tax benefits associated with HSAs, HDHPs have disproportionately attracted people who have higher incomes. In addition, higher deductibles have also attracted those who are in better health. The GAO study of enrollment in FEHBP's HDHP/HSA product found that 43 percent of those enrolled in the HDHP/HSA plans had incomes of \$75,000 or more, compared with 23 percent of those in all FEHBP plans (Figure 11).¹⁸ Rates of enrollment in the plans were higher among federal employees under age 54 than among those ages 55 to 64 (Figure 12). In the EBRI/Commonwealth Fund Survey, people with HSA/HDHPs were slightly more likely to be in excellent or very good health than those with more comprehensive insurance.¹⁹

Yet, unlike federal employees, most workers who were enrolled in HSA-eligible HDHPs in the EBRI/Commonwealth Survey did not have a choice of plans: less than half of those enrolled in the plans had a choice (Figure 13).²⁰ Among those in the plans who did have a choice, lower premiums and the ability to open a savings account were the primary reasons for selecting the plan. Those in comprehensive plans chose them for low out-of-pocket costs.

¹⁵ Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006; OPM, <http://www.opm.gov/insure/handbook/FEHBhandbook.pdf>.

¹⁶ America's Health Insurance Plans, *January 2006 Census Shows 3.2 Million People Covered by HSA Plans*, March 9, 2006; C.L. Peterson, *Data on Enrollment, Premiums and Cost-Sharing in HSA-Qualified Health Plans*, Congressional Research Service, CRS Report for Congress, May 13, 2006; E. Park, *Informing the Debate About Health Savings Accounts: An Examination of Some Misunderstood Issues*, Center on Budget and Policy Priorities, June 13, 2006.

¹⁷ U.S. Department of the Treasury, *Fact Sheet: Dramatic Growth of Health Savings Accounts (HSAs)*.

¹⁸ Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006; OPM, <http://www.opm.gov/insure/handbook/FEHBhandbook.pdf>.

¹⁹ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005; General Accounting Office, 2006.

²⁰ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005.

Low satisfaction with plans. Few Americans who are currently enrolled in HDHP/HSA plans are satisfied with them. The EBRI/Commonwealth Fund survey found that people with HDHPs, both with and without accounts, were far more likely than people in more comprehensive plans to report dissatisfaction with quality of care, out-of-pocket costs, and overall satisfaction with their plans (Figures 14-15).²¹ More than half of those in the plans were not satisfied with their out-of-pocket costs. Moreover, one-third of those in the plans would change plans if they had the opportunity to do so, and only one-third or less would recommend the plan to a friend or co-worker (Figures 16-17).

High out-of-pocket costs. The high rates of dissatisfaction with the costs of HSA-eligible HDHPs likely stem from the substantial amount of income people in these plans allocate to their health care, particularly those individuals with health problems or in lower-income households. The Kaiser/HRET Employer Health Benefits Survey 2005 found that employer costs of HSA/HDHP products are lower relative to other plans offered, but the costs to their employees are higher relative to other plans (Figure 18).²² The EBRI/Commonwealth Fund survey found that two-thirds of adults who are enrolled in a HDHP with an HSA or HRA and who have incomes of less than \$50,000 spent 5 percent or more of their income on out-of-pocket costs and premiums—twice the rate of those with similar incomes in more comprehensive plans (Figure 19). People with health problems in HSA-eligible HDHPs, both with and without accounts, were also vulnerable to spending large shares of their income on out-of-pocket costs and premiums: more than half (53%) of those in HDHPs without accounts and 38 percent of those in HDHPs with an account spent 5 percent or more of their income on out-of-pocket costs.²³ People with health problems in comprehensive plans were much better protected by comparison: 17 percent spent 5 percent or more of their income on out-of-pocket costs.

The majority of those in HDHPs have deductibles substantially above the level required for HSA eligibility. According to the EBRI/Commonwealth Fund survey, nearly three of five adults (59%) who had individual HDHPs with accounts had deductibles of \$2,000 or more.²⁴ Among those with family coverage in HDHPs with accounts, two-

²¹ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005.

²² G. Claxton, et al., “What High Deductible Plans Look Like: Findings from a National Survey of Employers, 2005,” *Health Affairs* Web Exclusive, September 14, 2005.

²³ Health problem was defined as reporting fair or poor health or one of eight chronic health conditions: arthritis; asthma, emphysema or lung disease; cancer; depression; diabetes; heart attack or other heart disease; high cholesterol; hypertension, high blood pressure or stroke.

²⁴ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund) December 2005

thirds (67%) reported a deductible of \$3,000 or more; 24 percent had a deductible of at least \$5,000.

Cost-related access problems. The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay, avoid, or skip health care. The EBRI/Commonwealth Fund survey found that one-third of those in HDHPs with and without accounts had delayed or avoided getting health care when they were sick because of cost, nearly twice the rate of those in more comprehensive plans (Figure 20). People with health problems or incomes under \$50,000 reported particularly high rates of avoiding care. Nearly half of adults in HDHP/HSAs with incomes of less than \$50,000 reported delaying or avoiding care; this was nearly twice the rate of people in the same income group in more comprehensive plans. People enrolled in HSA-eligible HDHPs without accounts were more likely to skip doses of their medications, in order to make them last longer, or to not fill their prescriptions at all. The rates of skipped medication were highest among people with health problems (Figures 21 and 22).

Risk of medical debt. When people with high-deductible health plans access health care, they are at risk of accumulating medical debt. Karen Davis and colleagues examined data from the Commonwealth Fund Biennial Health Insurance Survey (2003) and found that adults with deductibles of more than \$500 were more likely than those in lower-deductible plans to report that they had problems paying medical bills or that they were paying off medical debt over time (Figure 23).²⁵ Medical bill problems included not being able to pay bills, being contacted by a collection agency about medical bills, or having to change your way of life in order to pay bills.

Other research has found that rising out-of-pocket costs are reducing people's ability to save for retirement. The 2005 EBRI Health Confidence Survey found that 29 percent of insured adults under age 65 reported that they financed increased health care spending by using up all or most of their savings, while 45 percent had decreased contributions to other savings (Figure 24).²⁶

Information Currently Available to Enable Patients to Make Informed Choices Is Inadequate

The theory most central to the consumerism in health care movement is that prudent choices in the use of health care will drive the health services market to look more like

²⁵ K. Davis, M.M. Doty and A. Ho., *How High is Too High? Implications of High Deductible Health Plans* (New York: The Commonwealth Fund) April 2005.

²⁶ R. Helman and P. Fronstin, "2005 Health Confidence Survey: Cost and Quality Not Linked," EBRI Notes (Washington, DC: EBRI), November 2005, Vol 26, No 11.

markets for other goods and services, lowering costs and improving quality as providers compete for patients. But patients' ability to make informed choices is dependent on the extent to which they have access to useful information.

The EBRI/Commonwealth Fund survey finds that Americans, regardless of the health plan they are in, continue to encounter a yawning gap between the cost and quality information they need to make decisions and what is actually available. Just 14 to 16 percent of insured adults—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their health plan on the quality of care provided by their doctors and hospitals (Figure 25).²⁷ Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals.

There is evidence that people in HSA-eligible HDHPs are more cost-conscious consumers of health care than those in more comprehensive plans. The EBRI/Commonwealth Fund survey finds that three of five of those enrolled in HDHPs, both with and without accounts, said that they had checked whether their health plan would cover their costs prior to receiving care, and about one-third checked the price of a doctor's visit or other health service (Figure 26). People in HDHPs also appeared to be somewhat more willing than those in comprehensive plans to discuss the cost of their care with their doctors or ask them to recommend a less costly prescription drug.

Patients' Use of Information Alone Is Not Likely to Reduce Health Care Costs Dramatically or Improve Quality

It is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of health care will be driven by patient choice of provider. Patients are in the weakest position to demand greater quality and efficiency. Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance.²⁸ Most health care costs are incurred by very sick patients—those with heart attacks, strokes, cancer, mental illness, fractures, and injuries—often under emergency conditions. Ten percent of the sickest patients account for about 70 percent of all health care spending (Figure 27).²⁹ Shopping for the best physician or hospital is impractical in such circumstances. Moreover, to the

²⁷ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

²⁸ See also S.R. Collins and K. Davis, *Transparency in Health Care: The Time Has Come*, Invited Testimony, Energy and Commerce Committee, Subcommittee on Health, U.S. House of Representatives, Hearing on "What's the Cost?: Proposals to Provide Consumers with Better Information About Healthcare Service Costs," March 15, 2006.

²⁹ A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53–III64.

extent that consumer-driven plans encourage people to skimp on preventive care or chronic disease management, they could fuel growth in health care costs over time.

Patients are also unaccustomed to seeking information on price or quality, or trusting the information that is available. The EBRI/Commonwealth Fund survey found that the most trusted source of information on the quality of providers is the patient's own physician (Figure 28).³⁰ The least trusted sources of information are health plans and government agencies—with only one of 20 trusting those sources of information. Yet health plans and government agencies are far more likely to be able to assemble the required information.

Still, studies regularly find that public information on quality is not used by patients. New York and Pennsylvania were pioneers in publishing information on cardiac surgery mortality by name of surgeon and hospital, yet few patients in these states avail themselves of this information.³¹ The data were valuable because hospital CEOs investigated the reasons for poor performance and took necessary action—not because patients voted with their feet.³²

Provider response to public information is, in fact, one of the strongest arguments for public reporting. The National Committee for Quality Assurance has found that those managed care plans that report their quality data publicly are more likely to improve.³³ Hospitals that report such information take steps to improve the care they deliver.³⁴ And a recent study found that the top-performing medical groups were those that reported quality data publicly, either voluntarily or because of local reporting requirements.³⁵

³⁰ P. Fronstin and S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (EBRI/Commonwealth Fund), December 2005.

³¹ M.N. Marshall, P.G. Shekelle, S. Leatherman and R.H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *JAMA* 283, no. 14 (April 2000): 1866 - 1874.

³² M.N. Marshall, P.G. Shekelle, S. Leatherman and R.H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *JAMA* 283, no. 14 (April 2000): 1866 - 1874.

³³ National Committee for Quality Assurance, *The State of Health Care Quality, 2005* (Washington, D.C.: NCQA, 2005).

³⁴ J.H. Hibbard, J. Stockard and M. Tusler, "Hospital Performance Reports: Impact on Quality, Market Share, and Reputation: Evidence from a Controlled Experiment," *Health Affairs*, July/August 2005 24(4):1150-60; J.H. Hibbard, J. Stockard and M. Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs*, March/April 2003 22(2):84-94.

³⁵ S.M. Shortell, J. Schmittiel, M.C. Wang et al., "An Empirical Assessment of High-Performing Medical Groups: Results from a National Study," *Medical Care Research and Review* 62, no. 4 (August 2005): 407-434.

HSAs Will Not Solve Our Uninsured Problem

The combination of HSAs and HDHPs will not significantly reduce the nation's growing number of people who are uninsured. The Commonwealth Fund Biennial Health Insurance Survey of 2005 found that more than one-quarter (28%) of U.S. adults ages 19 to 64, or 48 million people, were either uninsured at the time of the survey or had experienced a time without coverage in the previous 12 months (Figure 29).³⁶ Lack of insurance coverage continues to be highest among families with incomes under \$20,000, with more than half (53%) uninsured for at least part of 2005. But uninsured rates are climbing rapidly among adults in moderate-income families—those with incomes between \$20,000 and \$40,000 (under 200 percent of poverty for a family of four)—rising from 28 percent in 2001 to 41 percent in 2005. Young adults ages 19 to 29, meanwhile, are the fastest growing age group among the uninsured, a reflection of two factors: their loss of dependent coverage on their 19th birthday, or more importantly in terms of sheer numbers, their reclassification as adults at 19 by Medicaid and the State Children's Health Insurance Program (SCHIP).³⁷ Nearly 70 percent of uninsured young adults are in families with incomes under 200 percent of poverty (Figure 30).

Because HSAs allow people to use pre-tax dollars to pay for out-of-pocket expenses not covered by health insurance, they are expected to draw previously uninsured people into the individual insurance market. People without insurance coverage have always had the option of purchasing a HDHP in order to lower their premium expense. Indeed, the majority of people in the EBRI/Commonwealth Fund Consumerism in Health Care Survey who had purchased an HSA-eligible HDHP, but not opened an account, had done so because of the lower premium.

The marginal effect of HSAs on the overall number of uninsured Americans depends on the degree to which uninsured individuals realize enough tax savings on out-of-pocket spending to make insurance affordable relative to their income. This will depend on expected out-of-pocket expenditures and marginal income tax rates, as well as savings from Medicare and Social Security taxes for employer-based plans. Research by Sherry Glied and Dahlia Remler found that 71 percent of uninsured Americans are in a 10-percent-or-lower income tax bracket. Indeed, more than half (55%) of people without coverage have no income tax liability at all (Figure 31).³⁸

³⁶ S.R. Collins, K.Davis, M.M. Doty, J.L. Kriss, A.L. Holmgren, *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund) April 2006.

³⁷ S.R. Collins, C.Schoen, J.L. Kriss, M.M. Doty, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies can Help* (New York: The Commonwealth Fund) updated May 2006.

³⁸ S.A. Glied and D.K. Remler, *The Effect of Health Savings Accounts on Health Insurance Coverage* (New York: The Commonwealth Fund) April 2005.

Using data from the Medical Expenditure Panel Survey, Glied and Remler calculated expected tax savings as a share of premiums, finding that savings associated with HSAs ranged from zero percent for those in the zero-percent tax bracket, to 6 percent for middle-income people in employer plans. Assuming a range of take-up rates in response to such savings, the authors estimated that the tax savings associated with HSAs would help cover fewer than 1 million previously uninsured people—even under their most generous assumptions of price sensitivity and not taking into account the effect of existing medical savings accounts, such as flexible spending accounts. In short, the major beneficiaries of the protective tax status of HSAs will be healthier, higher-income, *insured* taxpayers, who can afford to fund their accounts and afford the financial risk posed by higher-deductible health insurance plans.

New Proposals to Expand HSAs May Fragment Group Insurance Markets, Increasing the Number of Uninsured

In its most recent 2007 fiscal year budget, the Administration proposed additional tax incentives for people to purchase HSA-eligible HDHPs in the individual market. The proposals, which aim to equalize the tax treatment of HSAs in the individual market to those in the employer market, would allow a tax deduction for premiums associated with HSA-eligible HDHPs in the non-group market, along with a tax credit of 15.3 percent to offset the premium cost. Or, low income individuals and families could opt for a tax credit of \$500 per child and \$1,000 per adult, and up to \$3,000 per family premium.³⁹ The proposal also includes a 15.3 percent tax credit to be applied to HSA contributions, which are already tax-exempt.

Jonathan Gruber, an MIT economist, estimates that the Administration's proposals would actually increase the number of uninsured Americans by 600,000.⁴⁰ While 3.8 million previously uninsured people would become newly insured through HSA-eligible HDHPs in the individual market, many employers, especially small employers, would respond to the equal tax treatment of some policies in the individual market by dropping coverage. Consequently, Gruber estimates that 8.9 million people would lose their employer-based health insurance. While some people who lose their coverage would buy insurance in the individual market, about 4.4 million would become uninsured.

³⁹ These tax credits would be phased out at incomes between \$15,000 and \$30,000 for individuals and between \$25,000 and \$60,000 for families.

⁴⁰ J. Gruber, *The Cost and Coverage Impact of the President's Health Insurance Budget Proposals*, Center on Budget and Policy Priorities, February 15, 2006.

What Needs to Be Done?

Armed with the right information, patients can contribute in a small way to better care by exercising and eating well, by getting regular preventive care, by becoming educated about the risks and benefits of elective procedures, and by sharing their medical history with all their providers to reduce duplication of tests. But placing greater financial burdens on the sickest and poorest patients is not the right prescription for what ails the health care system. Nor is it the right prescription for people when they are ailing. High-deductible health plans increase the risk that patients will fail to get care early on, before a health condition becomes serious, and fail to get medications that could control their risk factors and chronic conditions.

Health care costs are high because of the fragmented way we organize and deliver health care, and because we provide the wrong financial incentives to hospitals and doctors. If we want to transform the health care system, we will need to make fundamental changes in current payment methods. Medicare's physician group practice demonstration (Figure 32) is a step in the right direction and should yield valuable insight into whether gains in efficiency and quality can be achieved simultaneously. Some state Medicaid programs, particularly Rhode Island's RItE care (Figure 33), have had excellent results in both slowing the rate of increase in premiums and improving quality.⁴¹ A Fund-supported evaluation of the PacifiCare pay-for-performance initiative in California also found promising results.⁴² Yet, these programs are just the beginning, and Medicare, Medicaid, and private payers need to do much more to change financial incentives for providers so that they systematically reward high quality and efficiency.

To achieve transparency in quality and costs in our health system, Medicare needs to take a leadership role in making total cost and quality information by provider and by patient condition publicly available. Medicare should also forge public-private partnerships to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs.

Conflicting quality metrics used by different parties, however, have the potential to add to administrative burden on providers. The Institute of Medicine has called for creation of a National Quality Coordination Board located within the U.S. Department of Health and Human Services to set priorities, oversee the development of appropriate quality and efficiency measures, ensure the collection of timely and accurate information

⁴¹ S. Silow-Carroll, *Building Quality into RItE Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations*, The Commonwealth Fund, January 2003.

⁴² M.B. Rosenthal, R.G. Frank, Z. Li et al., "Early Experience with Pay-for-Performance: From Concept to Practice," *Journal of the American Medical Association*, October 12, 2005, 294 (14): 1788-93.

on these measures at the individual provider level, and encourage their incorporation in pay-for-performance payment systems operated by Medicare, Medicaid, and private insurers.⁴³

Investment in health information technology is essential to ensure the right information is available at the right time to patients, providers, and payers. While many have called for such change, the current state of affairs is inadequate. Only about one of four physicians has electronic health records, demonstrating that the benefits of modern information technology (IT) are far from being realized.⁴⁴ Some private insurers have begun to build rewards for IT into their payment systems. Medicare and Medicaid should consider doing the same, at least on an initial basis, to encourage the adoption and utilization of IT.

But we will never achieve a high performing health care system when millions of Americans are without adequate health insurance coverage. The Commonwealth Fund Biennial Health Insurance Survey (2005) finds alarming evidence that adults without health insurance who have chronic conditions are far more likely to skip medications or not fill prescriptions for controlling their conditions. They are also far more likely than their insured counterparts to have gone to the emergency room or to have spent the night in the hospital (Figure 34).⁴⁵ Uninsured adults are also far more likely to report inefficiencies in their care, such as receiving duplicate tests (Figure 35).

Health care needs to be made more affordable—not less affordable—for patients. We need to cover the nation’s 46 million uninsured, building on group forms of coverage that we know pool risk and provide affordable, meaningful protection to people.

The individual market is not a solution for our uninsured problem. The administrative costs of individual coverage comprise 25-40 percent of each premium dollar compared to 10 percent of group coverage.⁴⁶ This means premium dollars buy fewer benefits in the non-group market than they do in employer group markets. Research has shown that few plans in the individual market, even with low deductibles

⁴³ Institute of Medicine, *Performance Measurement: Accelerating Improvement*, National Academies Press, Washington, DC: December 2005.

⁴⁴ A-M. Audet, M. Doty, J. Peugh, J. Shamasdin, K. Zapert and S. Schoenbaum, “Information Technologies: When Will They Make It Into Physicians’ Black Bags?” *Medscape General Medicine*, December 7, 2004

⁴⁵ S.R. Collins, K.Davis, M.M. Doty, J.L. Kriss, A.L. Holmgren, *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund) April 2006.

⁴⁶ J. Gabel, et al., *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund), May 2002.

and higher premiums, provide maternity benefits without a special rider.⁴⁷ A report by the Commonwealth Fund found that of adults who had considered purchasing individual insurance coverage, 35 percent said that it was very difficult or impossible to find a plan that met their needs.⁴⁸

In addition, to remain competitive and to be responsible to their shareholders, insurers in the non-group market necessarily estimate risk and set premiums sufficiently high to cover risk. Unless we can tolerate our sick and old neighbors, friends, and family members being charged far more than the healthy and the young, or being left out of the market altogether, it is imperative that we pool risk.⁴⁹ New forms of pooling are needed to allow people who lose, or have never had access to, employer-based coverage an affordable place to buy meaningful coverage. Particularly promising are strategies that expand employer-based coverage, eliminate the two-year waiting period for coverage of the disabled under Medicare, let older adults “buy in” to Medicare, and build on Medicaid and the State Children’s Health Insurance Program to cover low-income parents, young adults, and single adults.⁵⁰

In many cases, patient cost-sharing is far too high and deters access to needed care. Approximately 16 million adults in the U.S. are underinsured and report difficulty obtaining needed care as well as heavy financial burdens.⁵¹ Rather than insisting on minimum deductibles of \$2,100 per family, our nation’s health policy should be geared toward setting maximum limits on family cost-sharing, for example, 5 percent of income for those in the lower tax brackets and 10 percent of income for those in higher brackets. Guaranteeing affordability of care for all Americans will help ensure that patients receive appropriate preventive care, detect serious conditions in early stages, and control chronic conditions that would otherwise undermine health and functioning and lead to higher costs later in life.

⁴⁷ S. R. Collins, S.B.Berkson, D.A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund) December 2002; J. Gabel, et al., *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (New York: The Commonwealth Fund), May 2002.

⁴⁸ L.Duchon and C. Schoen, *Experiences of Working Age Adults in the Individual Insurance Market: Findings from the Commonwealth Fund 2001 Health Insurance Survey* (New York: The Commonwealth Fund) December 2001.

⁴⁹ S.R. Collins, C. Schoen, M. M. Doty, A. L. Holmgren, S, K. How, *Paying More for Less: Older Adults in the Individual Insurance Market* (New York: The Commonwealth Fund), June 2005.

⁵⁰ K. Davis and C. Schoen, “Creating Consensus on Coverage Choices,” *Health Affairs* Web Exclusive, April 23, 2003.

⁵¹ C. Schoen, M.M. Doty, S.R. Collins and A.L. Holmgren, “Insured But Not Protected: How Many Adults Are Underinsured?” *Health Affairs* Web Exclusive, June 14, 2005, W5-289–W5-302.

FIGURES

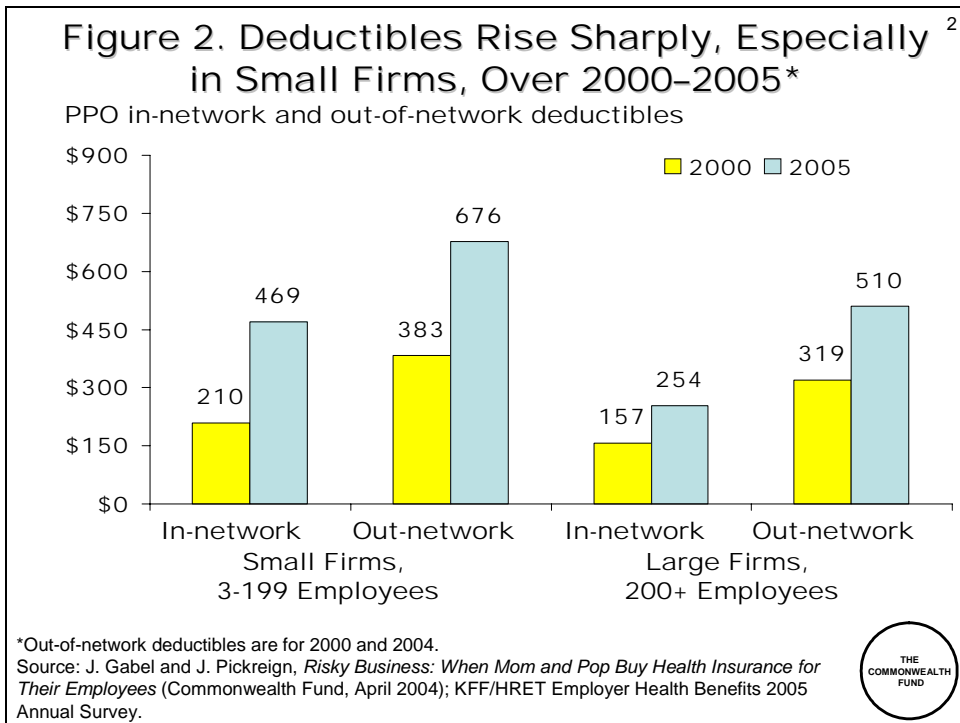
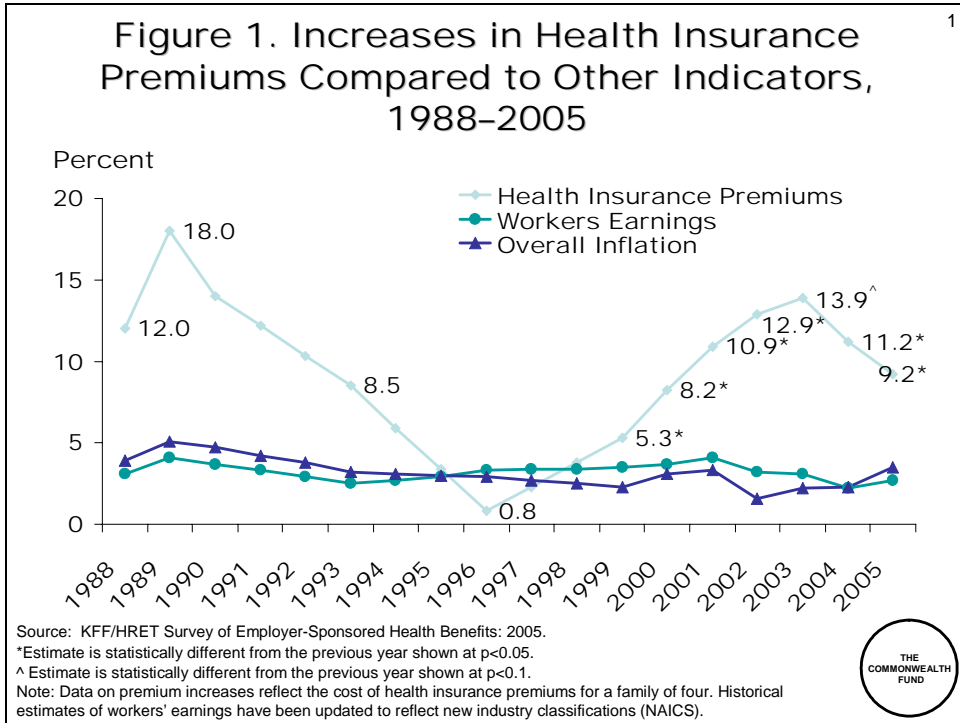
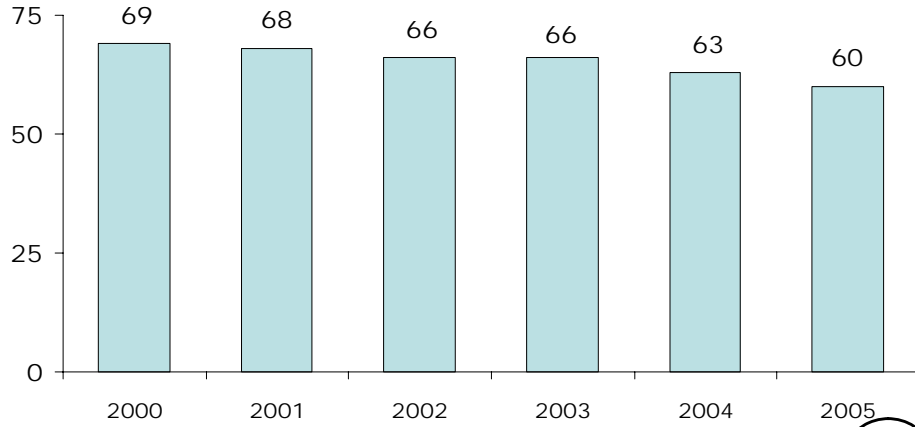


Figure 3. Percent of Firms Offering Health Benefits Declined Over 2000–2005

3

Percent of firms offering health benefits

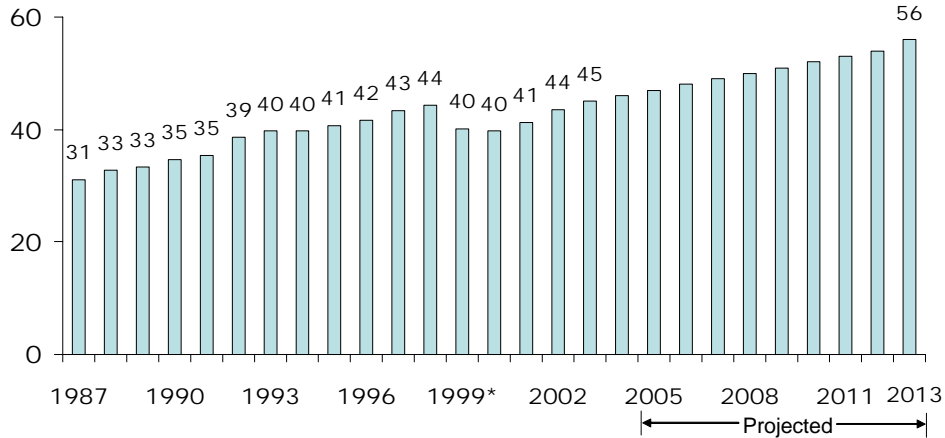


Source: KFF/HRET Employer Health Benefits 2005 Annual Survey.

Figure 4. 46 Million Uninsured in 2004; Increasing Steadily Since 2000

4

Number of uninsured, in millions



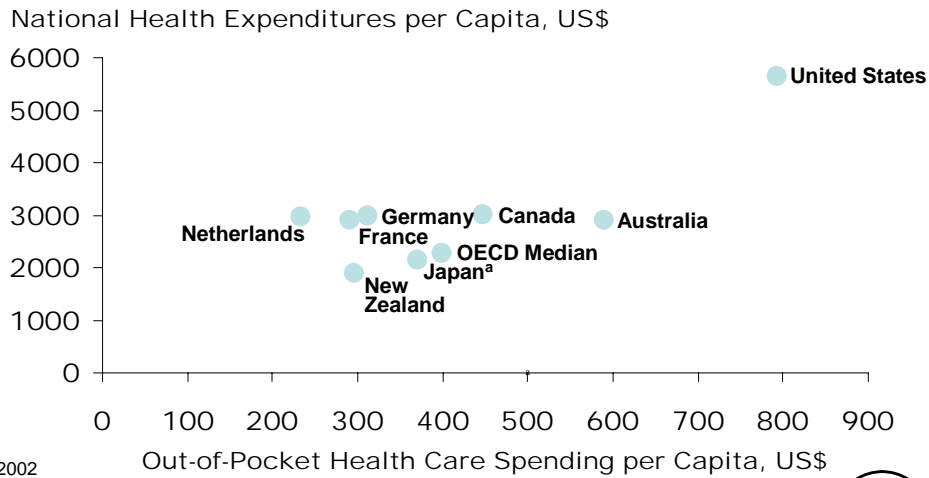
*1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.

Note: Projected estimates for 2004–2013 are for nonelderly uninsured based on T. Gilmer and R. Kronick, "It's the Premiums, Stupid: Projections of the Uninsured Through 2013," *Health Affairs* Web Exclusive, April 5, 2005.

Source: U.S. Census Bureau, March CPS Surveys 1988 to 2005.



Figure 5. Greater Out-of-Pocket Costs are Not Associated with Lower Health Spending in Cross-National Comparisons



^a2002

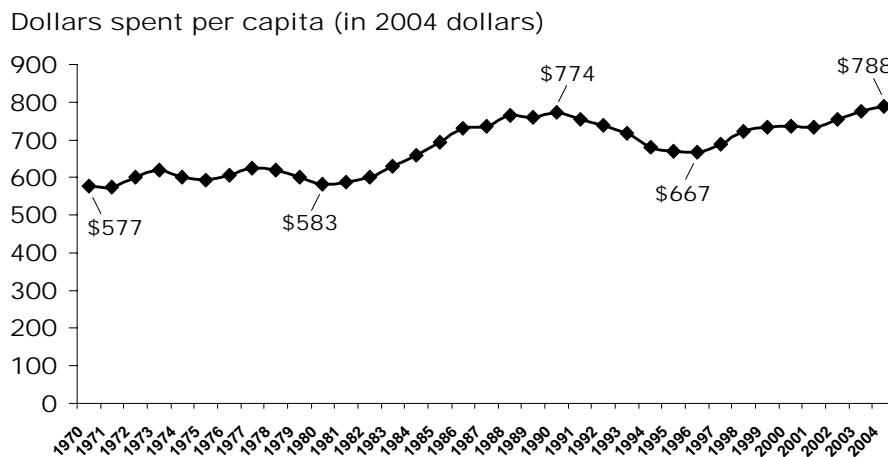
*Allan Hubbard, Director of the National Economic Council, February 14, 2006.

Note: Adjusted for Differences in the Cost of Living, 2003.

Source: Bianca K. Frogner and Gerard F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Forthcoming.



Figure 6. Americans Are Spending More Out-of-Pocket for Health Care

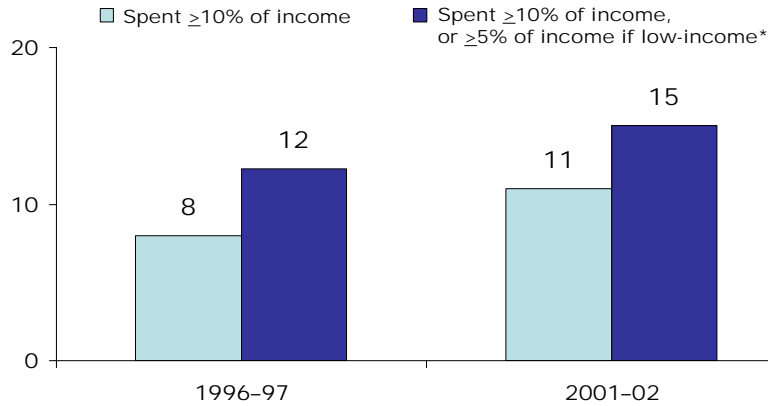


Source: C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (January/February 2006); Centers for Medicare and Medicaid Services, National Health Expenditures Data; <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>



Figure 7. Nearly One of Six Families Spent 10% or More of Income (or 5% or More if Low-Income) on Out-of-Pocket Medical Costs, 2001-02

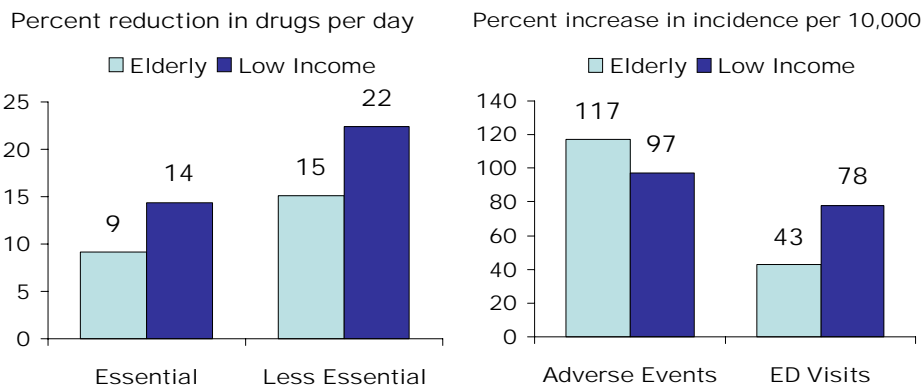
Percent of families with high out-of-pocket medical costs relative to income, *not* including premiums



*Low-income includes families with incomes <200% of the federal poverty level.
 Source: M. Merlis, D. Gould and B. Mahato, *Rising Out-of-Pocket Spending for Medical Care: A Growing Strain on Family Budgets* (New York: The Commonwealth Fund) February 2006.



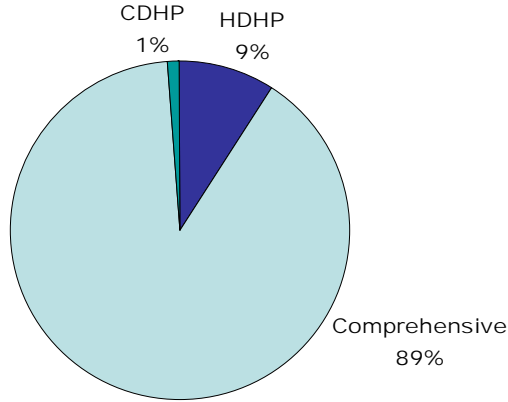
Figure 8. Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events



Source: R. Tamblyn et al., "Adverse Events Associated With Prescription Drug Cost-Sharing Among Poor and Elderly Person," *JAMA* 285, no. 4 (2001): 421-429.



Figure 9. Few Insured People Are Currently Covered by High Deductible Health Plans (HDHP) or Consumer Directed Health Plans (CDHP) with a Savings Account ⁹

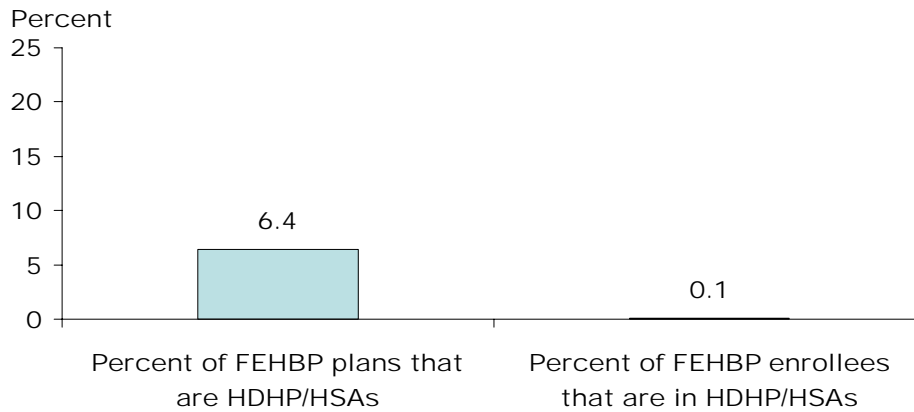


Note: Comprehensive = plan w/ no deductible or <\$1000 (ind), <\$2000 (fam); HDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), no account; CDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), w/ account.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 10. FEHBP HDHP/HSAs Plans Enroll 7,500 out of 9 Million Covered Lives ¹⁰



Note: As of March 2005.

Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006; OPM, <http://www.opm.gov/insure/handbook/FEHBhandbook.pdf>



Figure 11. Enrollees Who Chose HDHPs From the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes ¹¹

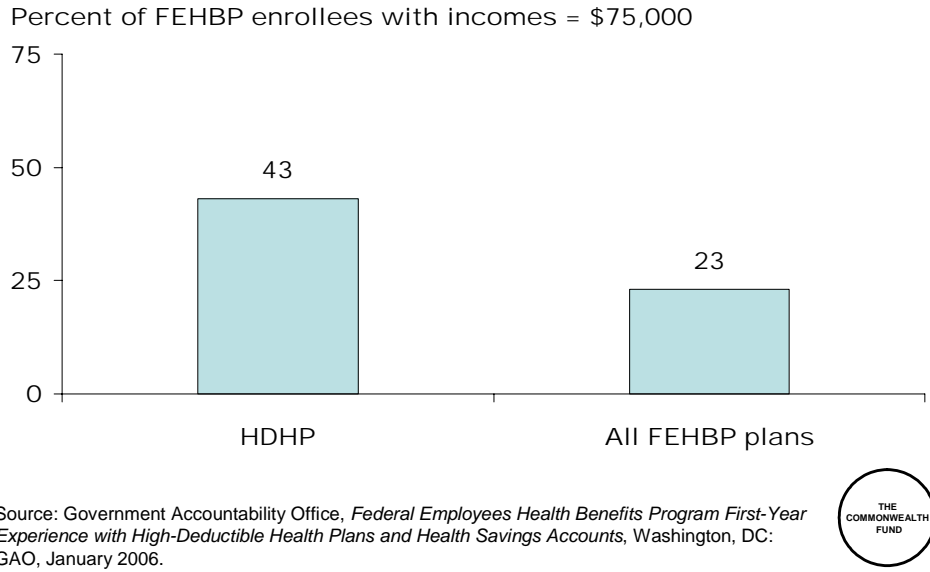


Figure 12. Age Distribution of HDHP and Other FEHBP Enrollees ¹²

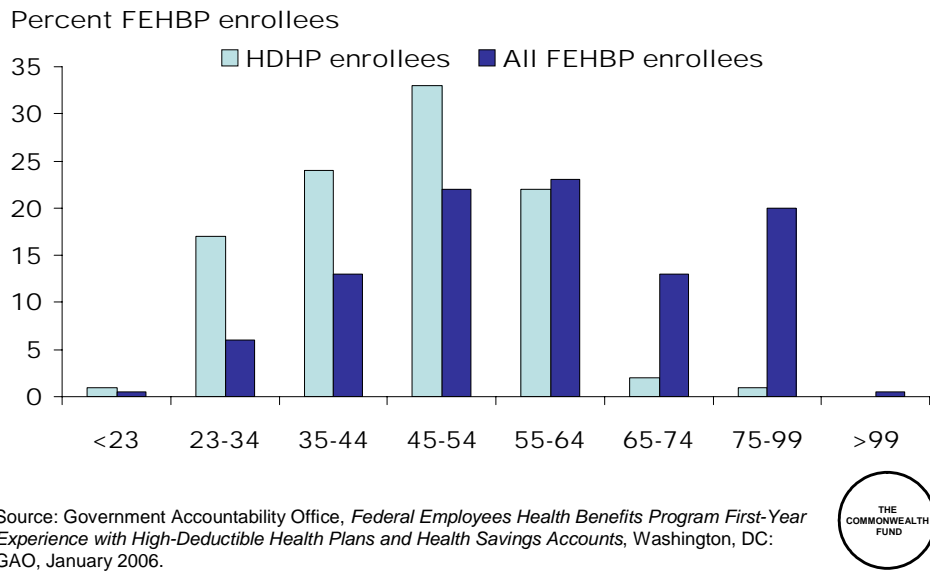
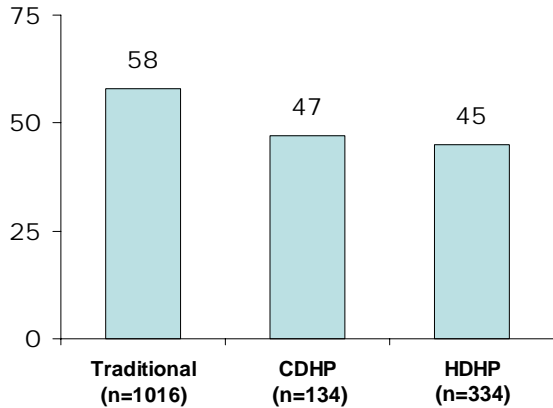


Figure 13. Less than Half of Those Enrolled in Employer-Based High Deductible Health Plans Had a Choice

13

Percent of adults with employer-based coverage who were offered a choice of health plans



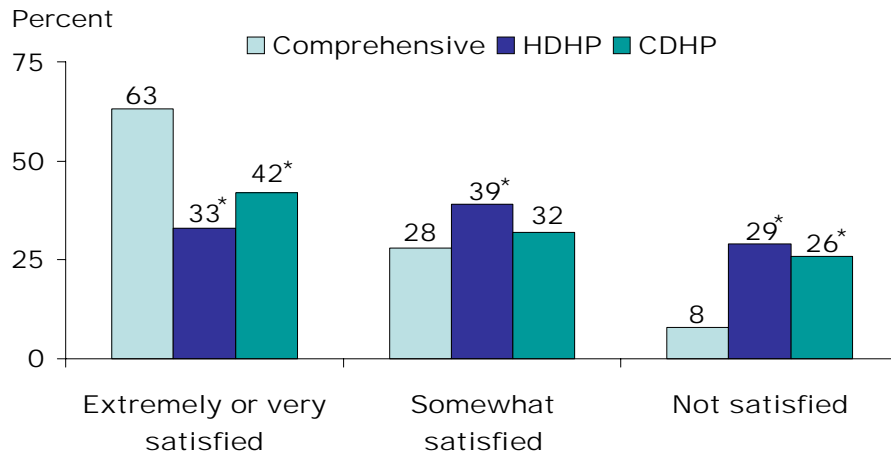
- CDHP and HDHP owners are less likely to have a choice of plans from their employer
- When they have a choice, the savings account is the leading reason for choosing CDHP, while premium cost is the most frequent reason for choosing HDHP. Traditional plans are chosen for low out-of-pocket costs.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 14. Enrollees of HDHP/CDHPs Are Less Satisfied with Their Coverage

14

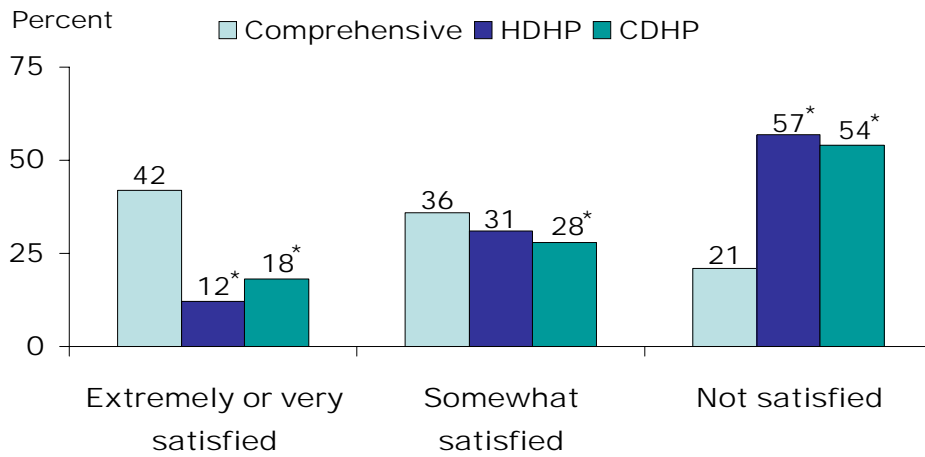


*Difference between HDHP/CDHP and Comprehensive is statistically significant at p = 0.05 or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



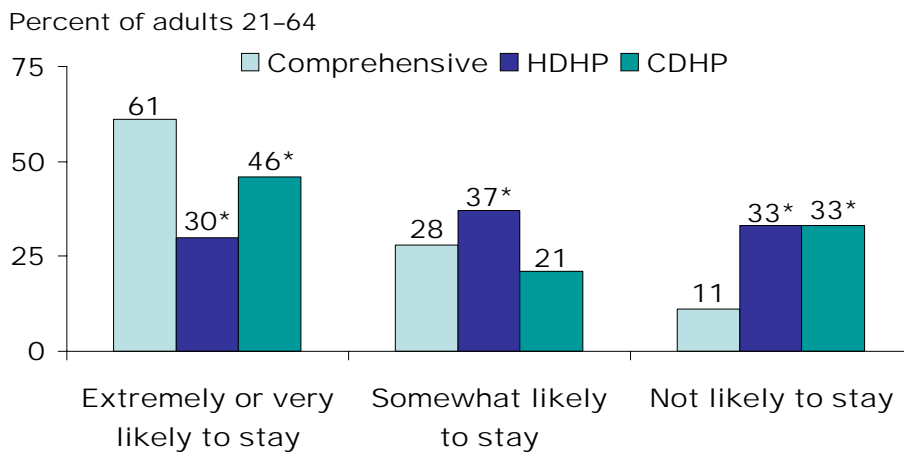
Figure 15. Enrollees of HDHP/CDHPs Are Less Satisfied with Out-of-Pocket Costs 15



*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.
 Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 16. Enrollees of HDHP/CDHPs Are Less Likely To Stay With Their Current Health Plan If They Had the Opportunity to Change 16

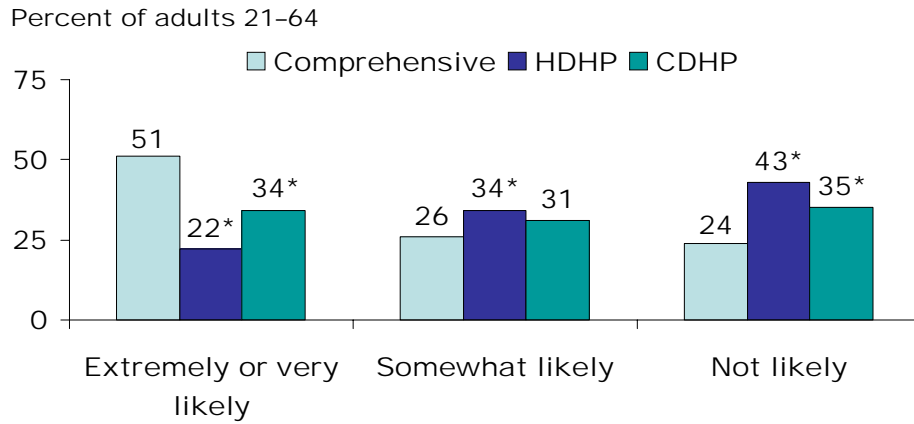


*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.
 Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 17. Enrollees of HDHP/CDHPs Are Less Likely to Recommend their Plan To a Friend or Co-Worker

17

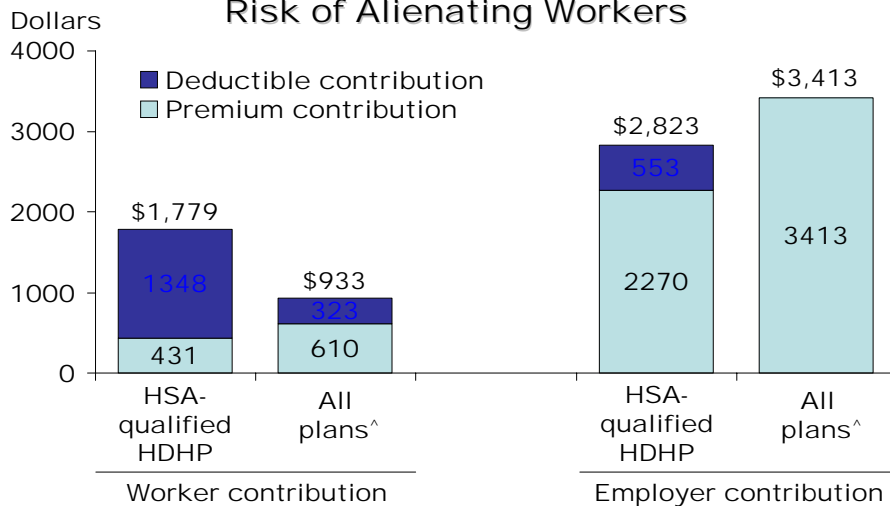


*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.
 Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 18. Workers are Less Satisfied When Their Costs Go Up – Employer Costs Go Down but at the Risk of Alienating Workers

18

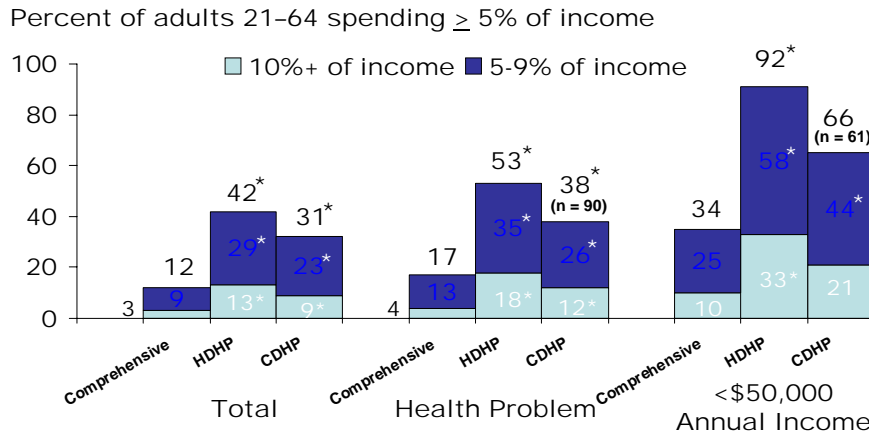


^ "All plans" refers to all conventional HMOs, PPOs, and POS plans in the survey, not just HDHP/HRA or HSA-qualified HDHPs. Source: Calculated based on: G. Claxton et al., "What High Deductible Health Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs* Web Exclusive, September, 14, 2005; J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs*, September/October 2004.



Figure 19. Enrollees of HDHP/CDHPs Spend Higher Percent of Income on Out-of-Pocket Medical Expenses and Premiums

19

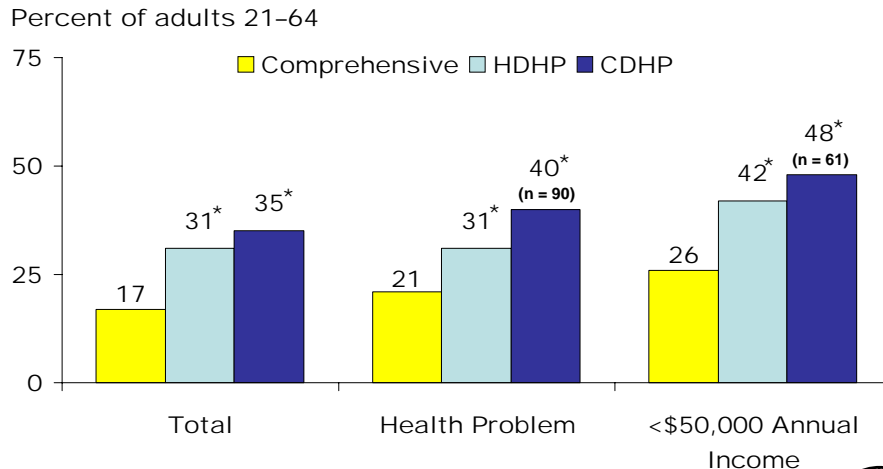


*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.
 Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 20. Enrollees of HDHP/CDHPs Are More Likely to Delay or Avoid Getting Health Care When Sick Due to Cost

20

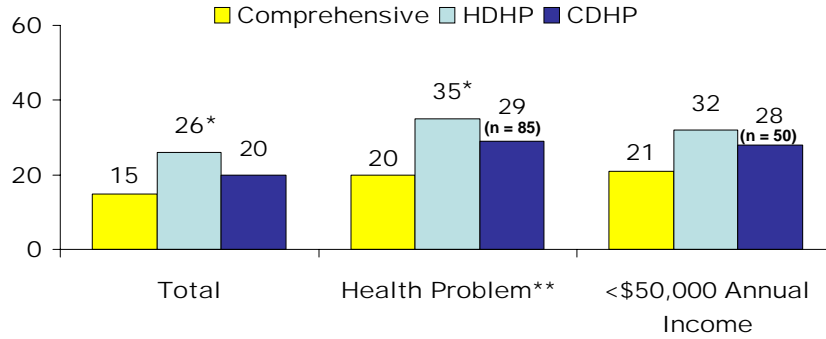


*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.
 Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 21. Enrollees of HDHP/CDHPs Are More Likely To Skip Doses to Make Medications Last ²¹

Percent of adults 21-64 with prescriptions in last twelve months



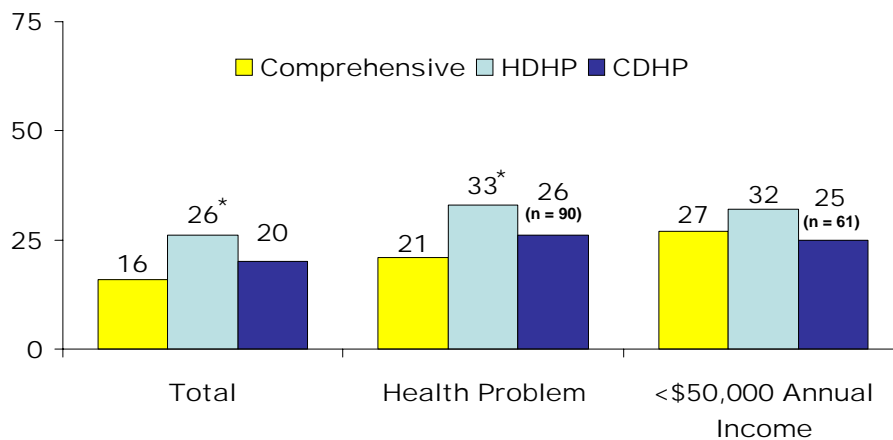
**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 22. Enrollees of HDHP/CDHPs Are More Likely to Not Fill a Prescription Due to Cost ²²

Percent of adults 21-64



*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.

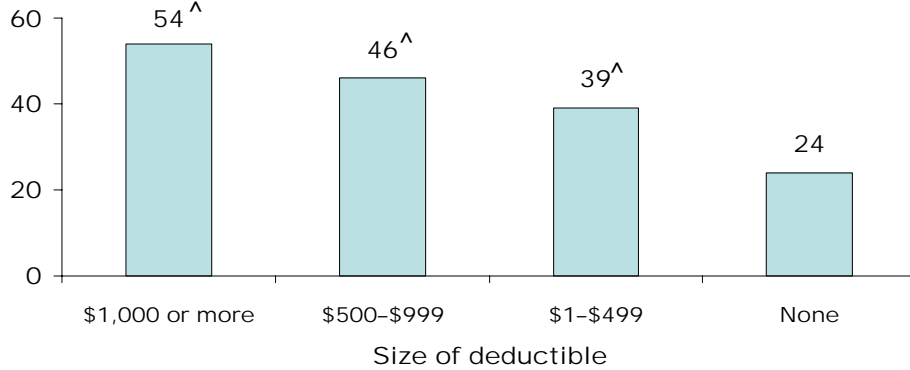
Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 23. People with Higher Deductibles More Likely to Have Medical Debt or Problems Paying Medical Bills in Past Year, by Size of Deductible

23

Percent of adults ages 19-64 with any medical bill problem or outstanding debt*



Note: Adjusted percentages based on logistic regression models; controlling for health status and income.

*Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

[^]Significant difference at $p < .05$ or better; referent category = no deductible.

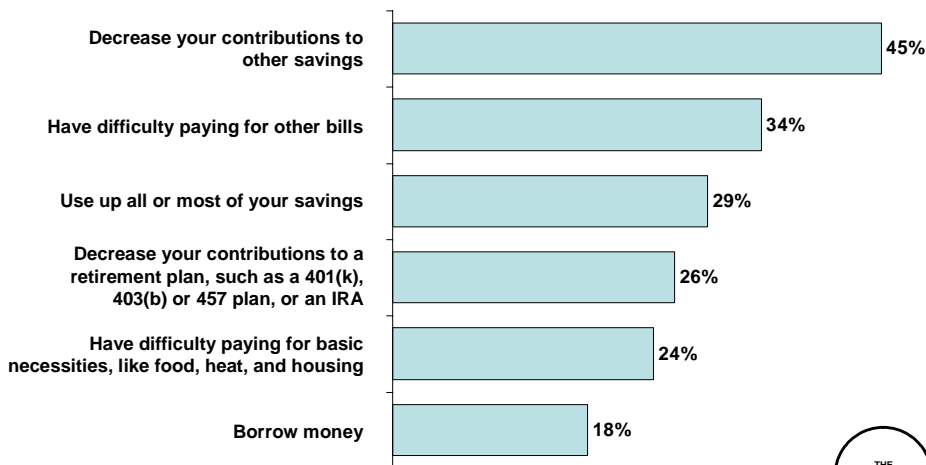
Source: The Commonwealth Fund Biennial Health Insurance Survey (2003).



Figure 24. Increased Health Care Costs Have Reduced Savings

24

Has increased spending on health care expenses in the past year caused you to do any of the following? Among those with health insurance coverage who had increases in health care costs in the last year (n=731) (percentage saying yes)



Source: EBRI Health Confidence Survey, 2005.



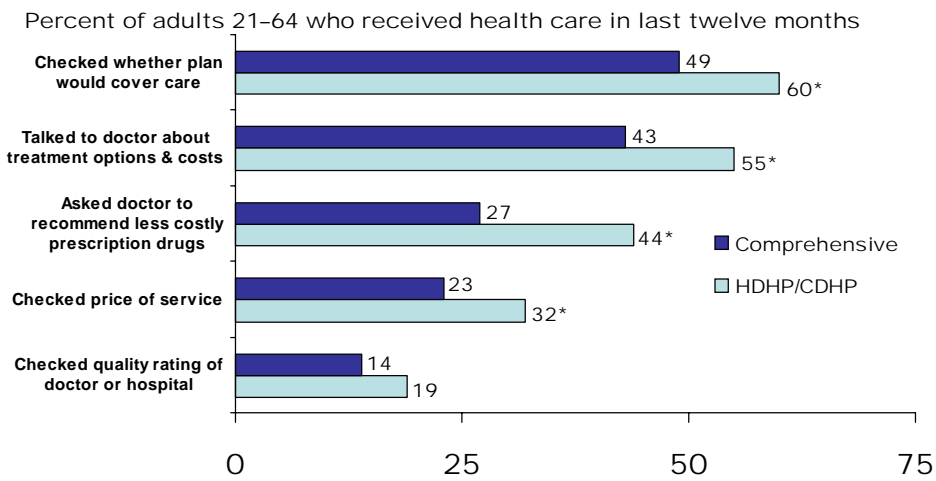
Figure 25. Most Insured Do Not Have Quality and Cost Information to Make Informed Choices 25

	Comprehensive	HDHP/CDHP
Health plan provides information on quality of care provided by:		
Doctors	14%	16%
Hospitals	14	15
Health plan provides information on cost of care provided by:		
Doctors	16	12
Hospitals	15	12
Of those whose plans provide info on quality, how many tried to use it for:		
Doctors	42	54
Hospitals	25	45
Of those whose plans provide info on cost, how many tried to use it for:		
Doctors	15	36 (n = 76)
Hospitals	14	32 (n = 76)

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 26. Cost Conscious Decision-Making, by Insurance Source 26



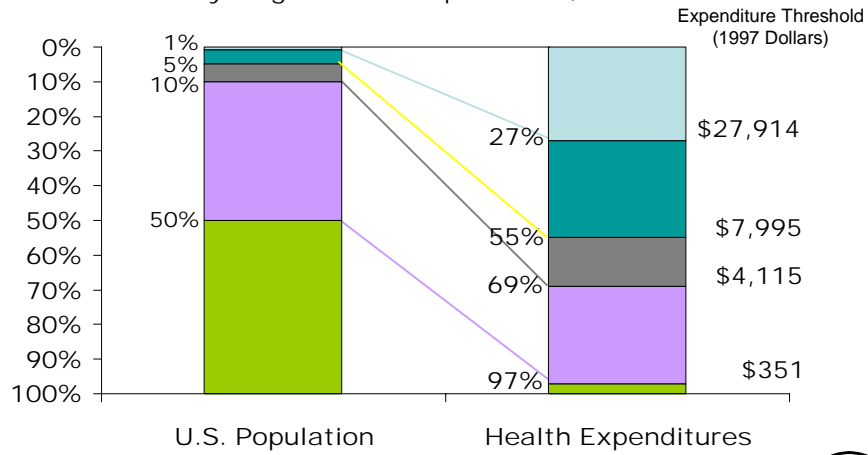
*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



Figure 27. HSAs Won't Solve the Cost Problem: Most Costs Are Concentrated in the Very Sick ²⁷

Distribution of Health Expenditures for the U.S. Population, By Magnitude of Expenditure, 1997

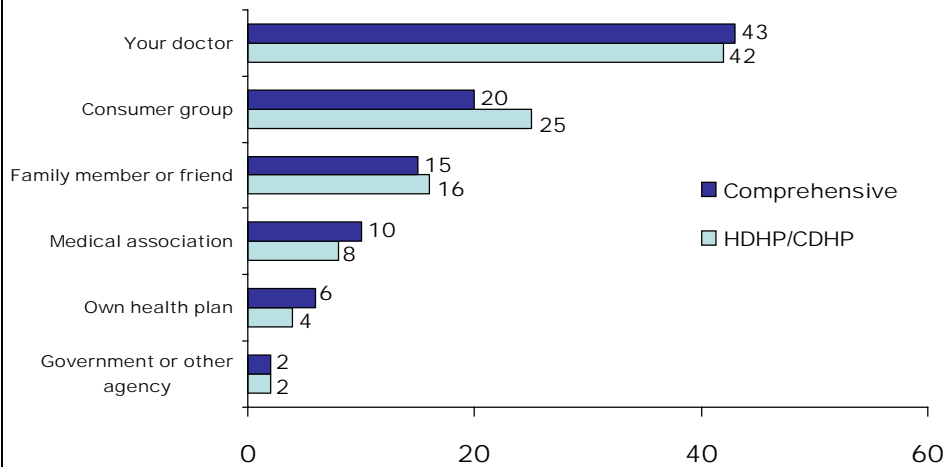


Source: A.C. Monheit, "Persistence in Health Expenditures in the Short Run: Prevalence and Consequences," *Medical Care* 41, supplement 7 (2003): III53-III64.



Figure 28. Most Trusted Sources for Information on Health Care Providers, by Insurance Source ²⁸

Percent of adults 21-64

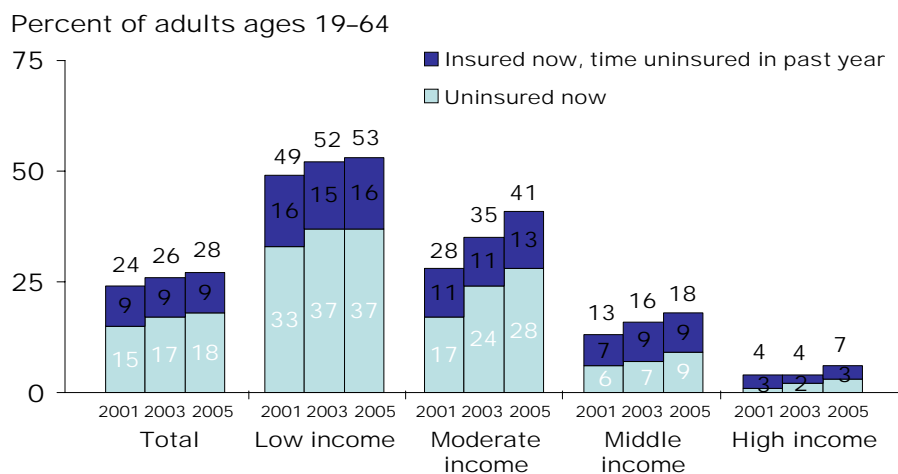


*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p = 0.05$ or better.

Source: P. Fronstin, S.R. Collins, *Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, EBRI Issue Brief, December 2005.



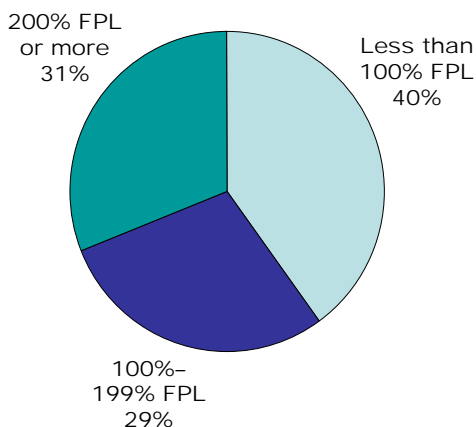
Figure 29. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001-2005 ²⁹



Note: Income refers to annual income. In 2001 and 2003, low income is <\$20,000, moderate income is \$20,000-\$34,999, middle income is \$35,000-\$59,999, and high income is \$60,000 or more. In 2005, low income is <\$20,000, moderate income is \$20,000-\$39,999, middle income is \$40,000-\$59,999, and high income is \$60,000 or more.
 Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem, Findings from The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, April 2006.



Figure 30. Distribution of Uninsured Young Adults 19-29 by Poverty Status, 2004 ³⁰

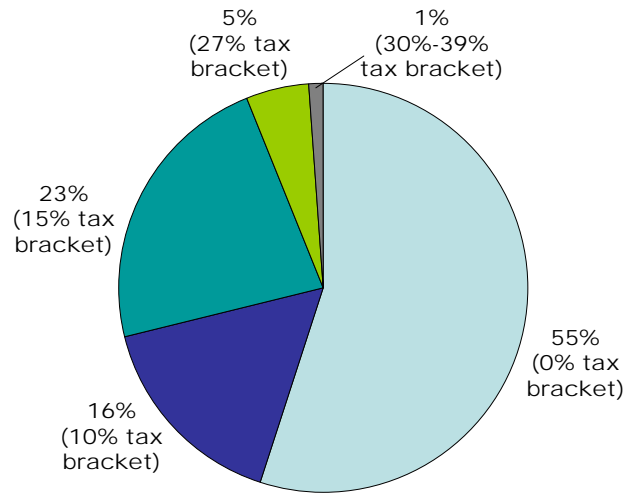


Source: S.R. Collins, C. Schoen, J.L. Kriss, M.M. Doty, B. Mahato, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, The Commonwealth Fund, updated May 2006.



Figure 31. HSAs Won't Solve the Uninsured Problem: Income Tax Distribution of Uninsured

31

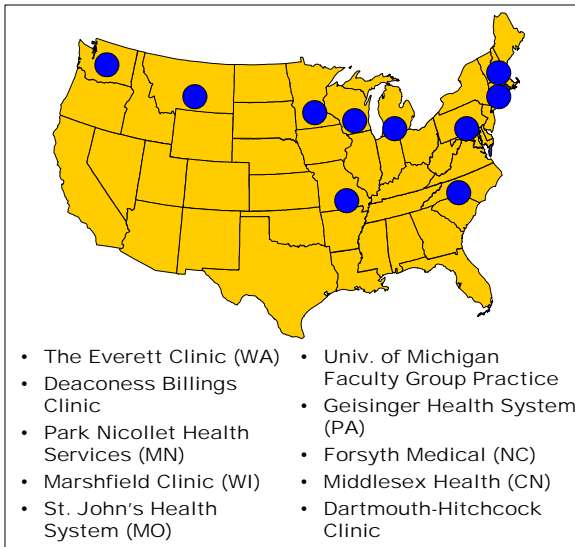


Source: S.A. Glied, *The Effect of Health Savings Accounts on Health Insurance Coverage*, The Commonwealth Fund, April 2005.



Figure 32. Medicare Physician Group Practice Demonstration

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- 10 physician group practices
- 3-year project, began April 2005
- Bonus pool based on savings relative to local area
- Practices expected to save 2%, keep up to 80% of additional savings
- Actual bonuses depend on savings and quality targets

Source: "Medicare Physician Group Practice Demonstration," www.cms.gov, January 31, 2005.



Figure 33. Building Quality Into Rite Care
Higher Quality and Improved Cost Trends

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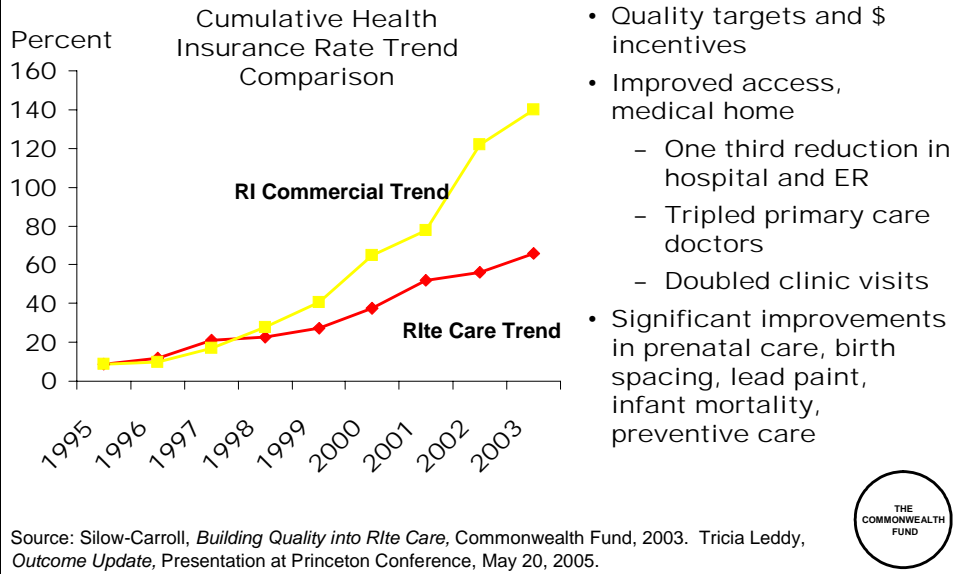
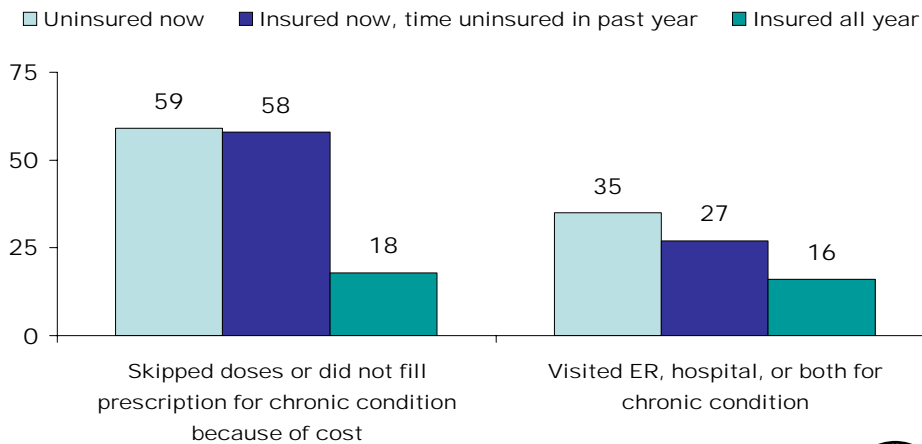


Figure 34. Lacking Health Insurance for Any Period Undermines Quality and Efficiency

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Percent of adults ages 19-64 with at least one chronic condition*



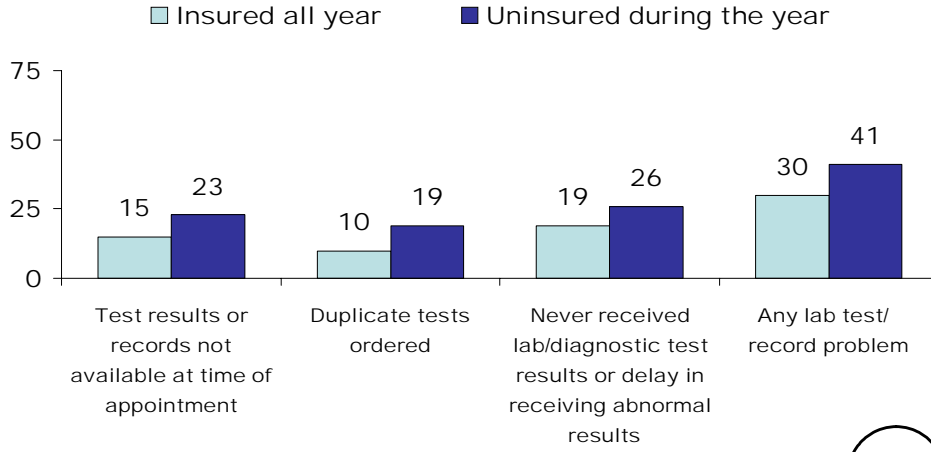
* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem, Findings from The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, April 2006.



Figure 35. Adults Without Insurance Have More Problems With Lab Tests and Records

Percent of adults ages 19-64 reporting the following problems in past two years:



Source: S.R. Collins et al., *Gaps in Health Insurance Coverage: An All-American Problem, Findings from The Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, April 2006.

