HEALTH SAVINGS ACCOUNTS AND HIGH-DEDUCTIBLE HEALTH PLANS: WHY THEY WON'T CURE WHAT AILS U.S. HEALTH CARE

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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 confronting the U.S. health care system: steady growth in the number of uninsured Americans, rising health care costs and insurance premiums, wide variation in the quality and cost of care, and inefficiencies in care delivery and administration.

Some maintain that HSAs, coupled with high-deductible health plans (HDHPs), are an important part of the solution to our health system's cost, quality, and insurance problems. Asking families to pay more out-of-pocket, the reasoning goes, will create more prudent consumers of health care, driving down cost growth and improving the quality of care as providers compete for patients. And the tax incentives associated with 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 will exacerbate some of the very maladies that undermine our health care system's ability to perform at its highest level.

Many Americans Are Already Burdened by High Health Care Costs

- Americans already pay far more out-of-pocket for their health care than residents of other industrialized countries, and real per capita out-of-pocket spending has been steadily rising since the late 1990s.
- The Commonwealth Fund Biennial Health Insurance Survey found that in 2005, 60 percent of working-age adults with private insurance with annual household incomes of under $40,000 spent 5 percent or more of their income on out-of-pocket expenses and premiums, and 40 percent spent 10 percent or more.

- There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The Commonwealth Fund Biennial Survey found that 44 percent of privately insured adults with deductibles of $1,000 or more avoided getting necessary health care or prescriptions because of the cost, compared with 25 percent of adults with deductibles under $500.
- There is also evidence that rising cost exposure leads people to accumulate medical debt, take on credit card debt, and reduce their savings. The Commonwealth Fund survey found that 40 percent of privately insured adults with deductibles of $1,000 or more had problems paying medical bills or had accumulated medical debt, compared with 23 percent of adults with deductibles under $500.

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

- The EBRI/Commonwealth Fund Consumerism in Health Care Survey found in 2005 that people enrolled in HSA-eligible HDHPs were 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.
- Adults in HDHPs are far more likely to delay or avoid getting needed care, or to skip medications, because of the cost. Problems are particularly pronounced among those with poorer health or lower incomes.
- 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 about 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 patient financial incentives, even if better information is available, will lead to dramatic improvements in quality and efficiency.
- Most health care costs are incurred by people who are very ill, often in emergencies. Ten percent of the sickest patients account for about 70 percent of all health care spending.

- Payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high quality and efficiency.

HSAs Will Not Solve Our Uninsured Problem

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

The Individual Insurance Market Is Not an Efficient or Equitable Solution to the Uninsured Problem

- The Commonwealth Fund Biennial Health Insurance Survey found that nearly 90 percent of adults who sought coverage in the individual insurance market in the last three years never ended up buying a plan.
- One-third (34%) of those who sought individual market insurance said they found it very difficult or impossible to find a plan with the coverage they needed.
- Nearly three of five (58%) adults who sought individual market insurance found it very difficult or impossible to find a plan they could afford. The problem was particularly acute among people with health problems or low incomes.
- About one-fifth (21%) of adults who had ever sought coverage in the individual market were turned down by an insurance carrier, charged a higher price, or had a specific health problem excluded from their coverage.
- The individual market is also inefficient: the administrative costs of individual coverage consume an estimated 25 to 40 percent of each premium dollar, compared with 10 percent for group coverage.

What Needs to Be Done

We as a nation should focus on more promising strategies for expanding coverage, improving affordability, and improving quality and efficiency. 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 greater numbers of low-income families, 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.
- Better management of high-cost care and chronic health conditions.
- Improved access to primary care and preventive services.
- Investment in health information technology to facilitate the transfer of information among patients, providers, and payers.

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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.

National health care spending is climbing by more than 7 percent per year and is expected to continue to outpace economic growth 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 in the form of higher deductibles and other cost-sharing, or by eliminating coverage altogether (Figures 2 and 3).[3]

Consequently, the number of Americans without health insurance is climbing steadily: in 2005, nearly 47 million people were uninsured, an increase of 7 million over 2000 (Figure 4).[4] An additional 16 million 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. A recent report by the Commonwealth Fund Commission on a High Performance Health System found that across 37 indicators of health system performance, the United States scored an average of 66 out of possible 100

[1] C. Borger et al., "U.S. Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs* Web Exclusive (Feb. 22, 2006):W61-W73; C. Smith et al., "National Health Spending in 2004," *Health Affairs* (Jan/Feb 2006): 186-196.

[2] J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24 (Sept./Oct. 2005): 1273–1280.

[3] Ibid.

[4] C. 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) Aug. 2005.

[5] 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.

on a scale based on the best possible care achievable within the country.[6] The study found that the U.S. ranks 15th out of 19 developed nations in deaths that could have been prevented with timely medical 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.[7] 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 number 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 exacerbate some of the very maladies that undermine our health care system's ability to perform at its highest level.

Many Americans Are Already Burdened by High Health Care Costs

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 the citizens of other industrialized countries (Figure 5).[8] Furthermore, real per capita out-of-pocket spending has been steadily rising since the late 1990s (Figure 6).[9]

The Commonwealth Fund Biennial Health Insurance Survey of 2005, a survey of more than 4,000 adults, found that 31 percent of privately insured adults ages 19 to 64 spent $1,000 or more out-of-pocket, excluding premiums, for their own personal medical

[6] C. Schoen, K. Davis, S. K.H. How, S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive Sept. 20, 2006, W457-475; The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on U.S. Health System Performance* (New York: The Commonwealth Fund) Sept. 2006.

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

[8] B. K. Frogner and G.F. Anderson, "Multinational Comparisons of Health Systems Data, 2005," The Commonwealth Fund, Apr. 2006.

[9] C. Smith et al., "National Health Spending in 2004: Recent Slowdown Led by Prescription Drug Spending," *Health Affairs* 25, no. 1 (Jan./Feb. 2006).

care, prescription drugs, and dental and vision care over a 12-month period (Figure 7).[10] Adults with coverage through the individual insurance market were more likely to have high personal out-of-pocket costs than those with coverage though an employer. The survey found that two of five (41%) adults insured through the individual market spent $1,000 or more out-of-pocket on their personal health care over 12 months, compared with 30 percent of adults with employer coverage.

Adults with HDHPs—whether through the individual market or through employer-based coverage—have higher out-of-pocket costs than adults with lower-deductible plans. The Commonwealth Fund Biennial Health Insurance Survey found that more than half (55%) of adults with deductibles of $1,000 or more per year spent $1,000 or more out-of-pocket, excluding premiums, for their own personal medical care, prescription drugs, and dental and vision care over 12 months (Figure 8).[11] In contrast, slightly more than one-quarter (27%) of adults with deductibles under $500 spent that much.

Higher spending on health care, combined with sluggish growth in real income, also means that families are spending increasingly more of their earnings on medical costs. In the Commonwealth Fund Biennial Survey, two of five (40%) adults were in households that spent 5 percent or more of their annual income on premiums and family members' out-of-pocket spending for medical care, prescription drugs, and dental and vision care (Figure 9).[12] One-quarter were in households where at least 10 percent of family income went toward premium payments and health care costs. Those with individual market insurance were more likely to report cost burdens. Nearly two-thirds (65%) of adults with individual market insurance spent 5 percent or more of their household income on premiums and out-of-pocket costs, and more than two of five (43%) spent 10 percent or more. In contrast, one-quarter (24%) of adults with employer-based coverage spent 10 percent or more of their family income on premiums and out-of-pocket expenses.

Privately insured adults with high deductibles also are more likely to spend a large share of their household income on health care costs and premiums than are those with lower deductibles. More than two-thirds (67%) of adults with deductibles of $1,000 or more spent 5 percent or more of their family income on premiums and family

[10] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006). See appendix to this testimony for survey methodology.

[11] Ibid.

[12] Ibid.

members' out-of-pocket expenses, and more than two of five (43%) spent 10 percent or more (Figure 10). Smaller shares of adults in households with per-person deductibles under $500 spent as much: 36 percent spent 5 percent or more of household income on premiums and out-of-pocket costs, and 22 percent spent 10 percent or more.

The costs of health care and health insurance impose the greatest burden on families with low or moderate incomes. The Commonwealth Fund survey found that over half (57%) of privately insured adults with annual household incomes of less than $20,000 spent 5 percent or more of their income on premiums and family members' out-of-pocket costs, and 42 percent spent 10 percent or more (Figure 11).[13] Middle- and moderate-income families are also greatly burdened by health care costs. Three of five (61%) adults with annual household incomes of $20,000 to $39,999 spent 5 percent or more of income on family out-of-pocket health care costs and premiums, while 40 percent spent 10 percent or more. Of those adults with incomes between $40,000 and $59,999, over one-third (37%) spent 5 percent or more on health care and insurance premiums, and 21 percent spent 10 percent or more. Even many families with higher incomes spend a considerable share of income on health care costs—30 percent of those with incomes of $60,000 or more spent 5 percent or more of their income on family out-of-pocket health care costs and premiums.

Higher Out-of-Pocket Spending Leads People to Avoid Necessary Care

There is considerable evidence that high out-of-pocket costs lead patients to decide against getting the health care they need. The Commonwealth Fund Biennial Health Insurance Survey found that adults with high deductibles are more likely to have problems getting necessary health care than those with lower deductibles. Forty-four percent of adults with deductibles of $1,000 or more reported one of four cost-related access problems: because of cost did not fill a prescription, did not see a specialist when needed, skipped a recommended test, treatment, or follow-up, or had a medical problem but did not see a doctor (Figure 12). In contrast, 25 percent of adults with deductibles under $500 cited similar cost-related access problems.

Other studies confirm these findings. The RAND Health Insurance Experiment, for example, found that greater cost-sharing reduced the use of both essential and less-essential health care.[14] A recent study by John Hsu and colleagues of Medicare beneficiaries found that people whose drug benefits were capped had lower drug utilization than those whose benefits were not capped; the consequences were poorer

[13] Ibid.

[14] J. P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21(6):107-113, Nov./Dec. 2004.

adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels. Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.[15]

Similarly, a study by Robyn Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to the emergency room (Figure 13).[16] A review by Thomas Rice and K.Y. Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.[17] Finally, research by Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, revealed 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.[18]

Adults with High Deductibles Have More Problems Paying Medical Bills

When people who lack adequate financial protection become ill and seek diagnosis and treatment, they may find themselves with medical bills they are unable to pay right away. In the Commonwealth Fund Biennial Health Insurance Survey, one-quarter (26%) of all privately insured adults either had a problem paying a medical bill in the past 12 months or were paying off accrued medical debt.[19] People with annual deductibles of $1,000 or higher were particularly affected by bills and debt: more than two of five (41%) reported bill problems or accrued debt (Figure 14). In contrast, 23 percent of adults with deductibles under $500 reported similar problems.

Confronted with medical bills and debt, many people are forced to make tradeoffs between spending and saving priorities. In the Commonwealth Fund survey, among

[15] J. Hsu et al., "Unintended Consequences of Caps on Medicare Drug Benefits," *New England Journal of Medicine* 354, 22 (June 1, 2006):2349-2386.

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

[17] 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 (Dec. 2004): 415–452.

[18] 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.

[19] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund) Sept. 2006. 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. Those who said they were contacted by a collection agency because of a billing mistake—and not because they were unable to pay a bill—were excluded from the total.

privately insured adults, 6 percent said that, because of medical bills, they were unable to pay for basic necessities like food, heat, or rent; 10 percent used all their savings to pay bills; 4 percent took out a mortgage against their home or other loan; and 10 percent took on credit card debt.[20] Adults covered through the individual insurance market, or those who had deductibles of $1,000 or more, were much more likely to say they had accumulated debt on credit cards because of medical bills. Nearly one-quarter (22%) of adults with deductibles of $1,000 or more and 15 percent of those with coverage purchased in the individual market reported that they had taken on credit card debt to pay their 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 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 15).[21]

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 EBRI/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 16).[22] 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 Health Benefits Program

[20] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Sept. 2006.

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

[22] 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) Dec. 2005. The EBRI/Commonwealth Fund Consumerism in Health Care Survey was a national online survey conducted in Fall 2005 of 1,200 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 1,061 people in comprehensive plans, 463 in HSA-eligible HDHPs without a savings account, and 185 in HDHPs with either an HSA or an HRA. See appendix to this testimony for survey methodology.

(FEHBP) (Figure 17).[23] A recent study by America's Health Insurance Plans, an industry trade group, 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.[24] 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.[25]

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. 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 18).[26] Another recent GAO analysis of consumer-directed health plans found that 51 percent of tax filers who reported contributing to an HSA in 2004 had adjusted gross incomes of $75,000 or more, compared with 18 percent of all tax filers under 65.[27] In addition, higher deductibles have also attracted those who are younger and in better health. Rates of enrollment in the FEHBP HSA/HDHP plans were higher among federal employees under age 54 than among those ages 55 to 64 (Figure 19). 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.[28]

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 options (Figure 20).[29] 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. Workers in comprehensive plans chose them for their low out-of-pocket costs.

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

[24] 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.

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

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

[27] General Accountability Office, *Consumer-Directed Health Plans: Early Experience with Health Savings Accounts and Eligible Health Plans*, Report to the Ranking Minority Member, Committee on Finance, U.S. Senate, Aug. 2006.

[28] P. Fronstin and S. R. Collins, Dec. 2005; General Accounting Office, 2006.

[29] P. Fronstin and S.R. Collins, Dec. 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 21 and 22).[30] More than half of those in the plans were not satisfied with their out-of-pocket costs. Moreover, one-third of those in the HDHP/HSAs 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 23 and 24).

High out-of-pocket costs. The Kaiser Family Foundation/Health Research and Educational Trust (HRET) 2005 Survey of Employer Sponsored Health Benefits, a national survey of 2,013 employers, 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 25).[31] According to the survey, employers who offered HSA-eligible plans in 2005 reduced their annual premium contributions for an employee's single coverage on average from $3,413 to $2,270.[32] The average employee premium contribution in HSA-eligible plans was $431 compared with $610 for all plans. But the average deductible in HSA-eligible HDHPs was $1,901, versus $323 in PPO plans. Moreover, employers contributed an average of $553 to employees' HSAs, an amount representing just 30 percent of the deductible. This average contribution includes the 37 percent of workers whose employers contributed nothing. Thus, workers' potential contributions to HSA-eligible HDHPs, including deductibles minus the employer HSA contribution, was $1,779, compared with $933 for all plans.

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 single-coverage HDHPs with accounts had deductibles of $2,000 or more.[33] Among those with family coverage in HDHPs with accounts, two-thirds (67%) reported a deductible of $3,000 or more; 24 percent had a deductible of at least $5,000.

Although it is legal for employers to exclude preventive services from the deductible of HSA-eligible plans, the KFF/HRET Survey found that in 2005 just 30

[30] Ibid.

[31] G. Claxton et al., "What High Deductible Plans Look Like: Findings from a National Survey of Employers, 2005," *Health Affairs* Web Exclusive, Sept. 14, 2005.

[32] Ibid.

[33] P. Fronstin and S.R. Collins, Dec. 2005.

percent of workers covered by an HSA-eligible plan had some preventive services covered within the deductible.[34]

When measured as a share of income, out-of-pocket costs associated with HSA-eligible HDHPs disproportionately burden the most vulnerable—those individuals with low incomes and/or health problems. The EBRI/Commonwealth Fund survey found that two-thirds of adults who are enrolled in a HDHP with an account 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 26). 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.[35] 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.

Cost-related access problems. The early experience with HSA-eligible HDHPs reveals that their high deductibles are leading many enrollees to delay or avoid getting needed care, or to skip their medications. 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 27). 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 medications were highest among people with health problems (Figures 28 and 29).

Available Information to Help Patients 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 markets for other goods and services, lowering costs and improving quality as providers

[34] G. Claxton et al., Sept. 14, 2005.

[35] 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.

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 information needed to make decisions based on cost and quality and the information that 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 plan on the quality of care provided by their doctors and hospitals (Figure 30).[36] 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 31). 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 Dramatically Improve Quality and Efficiency

Despite evidence that people in HSA-eligible HDHPs are more sensitive to costs when making medical decisions, it is simply not realistic to expect that even with better information the nation can achieve dramatic improvements in quality and efficiency through patient demand incentives. Most health care costs are incurred by people who are very ill, often in emergencies. Ten percent of the sickest patients account for about 70 percent of all health care spending (Figure 32).[37] Most patients or their families are not able to shop around for the best and lowest-cost physician or hospital during a personal health care crisis. Moreover, to the extent that consumer-driven plans encourage people to skimp on preventive care or chronic disease management, over time they could fuel growth in health care costs.

Payers, federal and state governments, accrediting organizations, and professional societies are far more strongly positioned than patients to demand higher quality and

[36] P. Fronstin and S. R. Collins, Dec. 2005.

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

efficiency from providers.[38] New York and Pennsylvania, for example, pioneered the publication of cardiac surgery mortality by surgeon and hospital name. Very few patients, however, used the information to choose providers.[39] Instead, the data helped improve the quality of cardiac surgery in those states because hospital CEOs investigated poor performance and acted on the findings to improve care in their institutions. Other research on managed care plans, hospitals, and medical groups has found similar evidence of provider-driven improvement in quality of care through the public reporting of information on quality.[40]

HSAs Will Not Solve Our Uninsured Problem

The combination of HSAs and HDHPs will not significantly reduce the nation's growing number of people without health insurance. 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 33).[41] 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 age 19 by Medicaid and the State Children's Health Insurance Program (SCHIP).[42] Nearly 70 percent of uninsured young adults are in families with incomes under 200 percent of poverty (Figure 34).

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[38] 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.

[39] 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 (Apr. 2000): 1866 - 1874.

[40] National Committee for Quality Assurance, *The State of Health Care Quality, 2005* (Washington, D.C.: NCQA, 2005); 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/Aug. 2005 24(4):1150-60; J. H. Hibbard, J. Stockard and M. Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs*, March/Apr. 2003 22(2):84-94; S.M. Shortell, J. Schmittdiel, 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 (Aug. 2005): 407-434.

[41] 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) Apr. 2006.

[42] 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.

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 respondents to the EBRI/Commonwealth Fund Consumerism in Health Care Survey who had purchased an HSA-eligible HDHP, but had not opened an account, did 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 35).[43]

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.

Such plans could also reduce the availability of affordable health insurance for lower-wage or less-healthy employees, particularly those in small firms. In the employer group insurance market, the average deductible for a single person in a PPO plan, according to the Kaiser Family Foundation/HRET 2005 Survey of Employer-Sponsored Benefits, was $323, far lower than the average for HSA-eligible HDHPs of $1,901.[44] When an employer offers an HSA/HDHP as a choice among other plans, the HSA/HDHP

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

[44] G. Claxton et al., Sept. 14, 2005.

is most likely to be attractive to healthier, higher-income employees. This is because these employees have higher marginal tax rates and thus derive the greatest benefit from the tax benefit. They also have higher saving rates and less need for health care; consequently, they will be less likely to draw down their accounts to pay for health services and so will be able to accumulate balances over time.[45]

When an employer offers a product that is most attractive to healthier employees, a significant shift of those employees into the new product can leave an increasingly less healthy pool of employees in non-HSA/HDHP health plans.[46] This can have the effect of increasing premiums in those plans, making them less affordable for employees in worse health, and with lower incomes. As Sherry Glied and Dahlia Remler point out, the worst-case scenario is an escalating premium spiral that might ultimately lead to the disappearance of more-generous health plans.[47]

Many small employers only offer one health benefit plan—only one-quarter of privately insured workers in firms with fewer than 20 employees have a choice of health plan, compared with 70 percent of those in companies of 500 or more employees.[48] If small employers fully replace more generous health plans with HSA/HDHPs, this will disadvantage lower-income, less healthy employees, since these workers benefit less than higher-income employees from the tax benefits of HSAs and are less able to contribute to, or accumulate, balances in HSAs.[49] This increases the risk that lower-income employees, facing tradeoffs from other living expenses, might drop coverage if the plans' total costs, including out-of-pocket expenditures, are higher than those of more-comprehensive plans they were offered in the past.

The Individual Insurance Market Is Not a Solution to the Uninsured Problem

Incentives designed to encourage people to buy coverage on the individual market are also unlikely to reduce health care costs, or decrease the number of uninsured. The administrative costs of individual coverage comprise an estimated 25 to 40 percent of each premium dollar, compared with 10 percent for group coverage.[50] This means that premium dollars buy fewer benefits in the non-group market than they do in employer

[45] S. A. Glied and D. K. Remler, Apr. 2005.
[46] Ibid.
[47] Ibid.
[48] S.R. Collins, J.L. Kriss, K. Davis, M.M. Doty, and A.L. Holmgren, Sept. 2006.
[49] S.A. Glied and D.K. Remler, Apr. 2005.
[50] 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.

group markets. Research has shown that few plans in the individual market, even with low deductibles and higher premiums, provide maternity benefits without a special rider.[51]

In addition, to remain competitive and to be responsible to their shareholders, insurers in the individual insurance market necessarily estimate risk and set premiums sufficiently high to cover risk. This means that in many states, people who are older, who are in poorer health, or have a chronic health problem like diabetes or heart disease will either be charged a higher premium than younger and healthier people, have their condition excluded from their coverage, or be turned down for coverage altogether.[52]

The Commonwealth Fund Biennial Health Insurance Survey of 2005 examined the experience of Americans in the individual insurance market over the past three years. An estimated 58 million privately insured adults ages 19 to 64 reported either that they had coverage purchased through the individual market or had considered buying, or tried to buy, a plan.[53] Of these, nearly 90 percent never bought a plan (Figure 36).

The survey asked adults who had been in the individual insurance market in the last three years about particular challenges they encountered in attempts to purchase a health plan on their own. These included ease of finding a plan with suitable or affordable coverage or being turned down for a preexisting condition. One-third (34%) of those in the individual market said they found it very difficult or impossible to find a plan with the coverage they needed (Figure 36). This problem was particularly pronounced among people with health problems: 48 percent of those with health problems (fair or poor health status, any one of four chronic conditions, or a disability) found it very difficult or impossible to find a plan with the coverage they needed.

Even greater proportions of people surveyed had difficulty finding an affordable plan. Nearly three of five (58%) adults who had ever shopped for coverage in the individual market found it very difficult or impossible to find a plan they could afford. This problem was especially evident among those with health problems and low incomes. More than 70 percent of people with health problems or incomes under 200 percent of the federal poverty level found it very difficult or impossible to find an affordable plan.

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[51] S. R. Collins, S.B. Berkson and D.A. Downey, *Health Insurance Tax Credits: Will They Work for Women?* (New York: The Commonwealth Fund) Dec. 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.

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

[53] S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, Sept. 2006.

Even people who were able to find plans that met their needs were not always able to obtain coverage. About one-fifth (21%) of adults in the Commonwealth Fund survey who had ever sought coverage in the individual market were turned down by an insurance carrier, charged a higher price, or had a specific health problem excluded from their coverage. People with health problems were the most likely to report such an experience: one-third had been turned down, charged a higher price, or had a health problem excluded from their coverage.

Some states like Massachusetts, New Jersey, and New York have strong individual market regulations that require community rating (everyone is charged the same premium regardless of age or health status) or impose age-rating bands which limit the degree to which premiums charged to older people can exceed those charged to younger people.[54] But in states that have less regulated individual markets, such as Iowa, Kansas, Kentucky, and Washington, there is no community rating, and carriers can reject applicants based on medical underwriting criteria. In these four states, researchers Nancy Turnbull and Nancy Kane have found that as many as 30 to 40 percent of applicants in the case of some insurance carriers are rejected for coverage.[55] In Kansas and Kentucky, carriers can impose permanent exclusions for preexisting conditions. Turnbull and Kane found that in Kentucky there is a 14-to-17-fold difference in premiums for the same insurance product based on health and age. While a 25-year-old Kentucky man could buy a $2,500 deductible plan for just $624 a year, a 63-year-old man would be charged $2,736 for the same product. If the 63-year-old had health problems and was eligible for coverage in the Kentucky's high-risk pool, the lowest annual premium for a $1,800 deductible plan was $10,800.

Still, while individual market regulations have improved access for older and less-healthy people, they also have made coverage more expensive for younger and healthier people. In addition, most states that have regulated their individual insurance markets have also experienced a reduction in the number of insurance carriers, leaving healthier consumers with fewer choices and distributing risk across fewer insurers.[56]

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[54] N. Turnbull and N. Kane, *Insuring the Health or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market, Findings from a Study of Seven States* (New York: The Commonwealth Fund) Feb. 2005.

[55] Ibid.

[56] N. Turnbull and N. Kane, Feb. 2005; A.M. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Politics, Policy & Law*, Feb. 2000 25(1):133–73; M.A. Hall, "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy & Law*, Feb. 2000 25(1):71–99.

What Needs to Be Done?

With good information, patients can contribute in a small way to improving their own health, the quality of care and lowering the costs of 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 high-deductible health plans increase the risk that patients will fail to get care before a health condition becomes serious or to take medications that might control chronic conditions. It is important that modifications be made to the HSA legislation to reduce potentially harmful effects on these vulnerable populations. These might include:

- Permit employers to lower deductibles for lower-wage workers and qualify for HSAs;
- Exempt primary care as well as preventive services from the deductible; exempt prescription drugs essential for management of chronic conditions;
- Guarantee choice of a comprehensive health plan to workers covered under employer plans;
- Permit greater flexibility in benefit design (e.g. actuarially equivalent benefits);
- Set an income ceiling on eligibility for HSAs to reduce the tax subsidy for high income individuals.

Health care costs are high in part because we provide the wrong financial incentives to hospitals and doctors. Improving quality and efficiency in health care will require making fundamental changes in current provider payment methods. While Medicare and some state Medicaid programs have initiated demonstration programs and other measures aimed at improving efficiency and quality, both public and private payers need to do much more to change financial incentives in order to systematically reward providers for delivering high-quality and efficient care.[57] A recent study by The Institute of Medicine endorses pay-for-performance in the Medicare program, recommending that bonuses be awarded to physicians, hospitals and other providers on the basis of their

[57] 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," Mar. 15, 2006.; 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*, Oct. 12, 2005, 294 (14): 1788–93; S. Silow-Carroll, *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations*, The Commonwealth Fund, Jan. 2003.

performance in clinical care, patient centered care, and efficiency.[58] Transparency in the quality and costs of care is essential to this effort, and Medicare needs to take a leadership role in making publicly available, by provider and by patient condition, information on total costs and quality.[59] Medicare should also forge public–private partnerships designed to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs. 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 oversee the development of quality and efficiency measures and to ensure the collection of data on these measures at the individual provider level.

Finally, investment in health information technology is essential to facilitate the efficient transfer of information among patients, providers, and payers. Yet today, only about one of four physicians has electronic health records.[60]

A high performing health care system will always be beyond our grasp, however, if we continue to leave millions of Americans 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 (Figure 37).[61] 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. Uninsured adults are also more likely to report inefficiencies in their care, such as receiving duplicate tests (Figure 38). We need to cover the nation's nearly 47 million uninsured people, building on group forms of coverage that we know pool risk and provide affordable, meaningful protection to families.

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. 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

[58] Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare*, Washington DC: National Academies Press, 2006; Audio Interview: Pay for Performance – Recommendations of the Institute of Medicine, with Dr. Elliott S. Fisher and Dr. Karen Davis, *New England Journal of Medicine* 2006;355(13):e14.

[59] S. R. Collins and K. Davis, Mar. 15, 2006.

[60] A-M. Audet, M. M. Doty, J. Peugh, J. Shamasdin, K. Zapert, and S. C. Schoenbaum, "Information Technologies: When Will They Make It Into Physicians' Black Bags?" *Medscape General Medicine*, Dec. 7, 2004.

[61] S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, Apr. 2006.

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 lower-income parents, young adults, and single adults.[62] In addition, new reforms in some states—such as Maine, Massachusetts, and Vermont—are providing models that may inform and shape national policy strategies.

Finally, we must ensure that health care coverage is affordable for people across the income spectrum and that patient incentives are designed to encourage, rather than discourage, the use of preventive services, primary care, and appropriate chronic disease management. Instead of asking families to pay a minimum deductible of $2,100, policy makers should focus on setting maximum limits on family cost-sharing, such as 5 percent of income for those in the lower tax brackets and 10 percent of income for those in higher brackets. Years of research on patient health care use has produced a considerable body of evidence that patients respond to marginal increases in costs by not getting the health care they need. Guaranteeing affordable care for all Americans will help ensure that patients receive appropriate preventive care, have serious conditions diagnosed in their early stages, and have the financial means to control chronic conditions that will inevitably degrade their health, productivity, and standard of living—and ultimately lead to higher costs later in life.

[62] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive, Apr. 23, 2003.

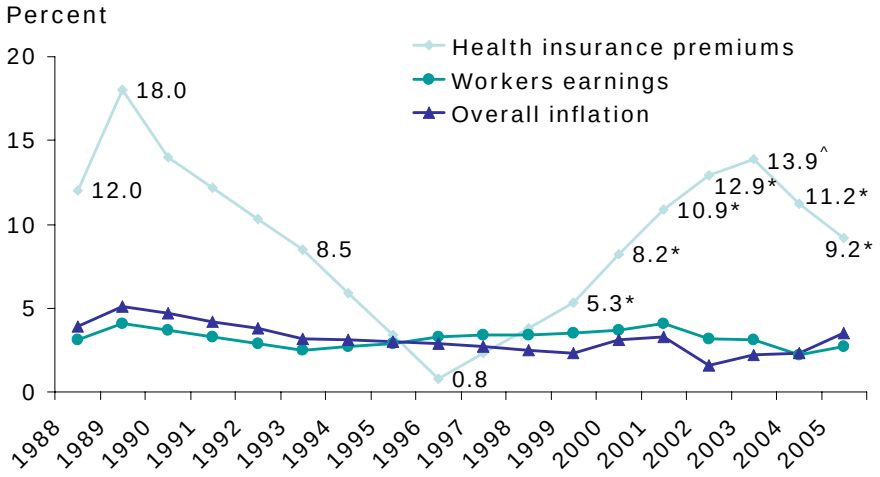
APPENDIX. SURVEY METHODOLOGY

The Commonwealth Fund Biennial Health Insurance Survey was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. There were 1,878 respondents ages 19 to 64 who were insured all year with private insurance. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental United States. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 212 million adults age 19 and older, including 108 million adults ages 19 to 64 who were insured all year with private insurance. The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The 47 percent response rate was calculated consistent with standards of the American Association for Public Opinion Research.

The EBRI/Commonwealth Fund Consumerism in Health Care Survey was conducted by Harris Interactive between September 28, 2005 and October 19, 2005 through an 18 minute Internet survey of adults ages 21-64. The base sample was randomly drawn from Harris Poll Online, Harris Interactive's online sample of 4 million Internet users who have agreed to participate in research surveys. Harris stratified the sample by gender, age, and region before drawing the random sample. The base sample consisted of 1,204 adults and was then weighted by gender, age, education, and region to reflect the proportions in the population aged 21-64 with private health insurance coverage. Harris then drew an over-sample of adults who had HSA-eligible high deductible health plans ($1,000 for an individual and $2,000 for a family) without accounts that they could roll over at the end of the year. Harris also drew an over-sample of adults with HSA-eligible high deductible health plans who also had an account they could roll over at the end of the year. By definition, these accounts were either HSAs or health reimbursement arrangements (HRAs). The over-samples were not weighted. The final sample consisted of 1,061 adults with comprehensive health plans (deductibles under $1,000 for an individual and $2,000 for a family); 463 adults with HSA-eligible health plans and no accounts (HDHP); and 187 adults with HSA-eligible health plans with accounts (CDHP).

FIGURES

Figure 1. Increases in Health Insurance Premiums Compared with Other Indicators, 1988–2005



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 2005.
* Estimate is statistically different from the previous year shown at p<0.05.
^ Estimate is statistically different from the previous year shown at p<0.1.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).

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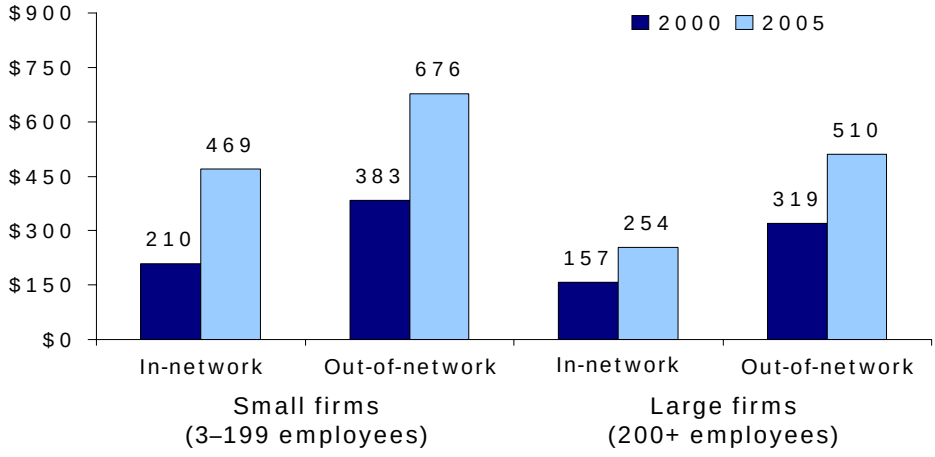
Figure 2. Deductibles Rise Sharply, Especially in Small Firms, Over 2000–2005*

PPO in-network and out-of-network deductibles



* Out-of-network deductibles are for 2000 and 2004.
Source: J. Gabel and J. Pickreign, *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (Commonwealth Fund, Apr. 2004); KFF/HRET Employer Health Benefits 2005 Annual Survey.

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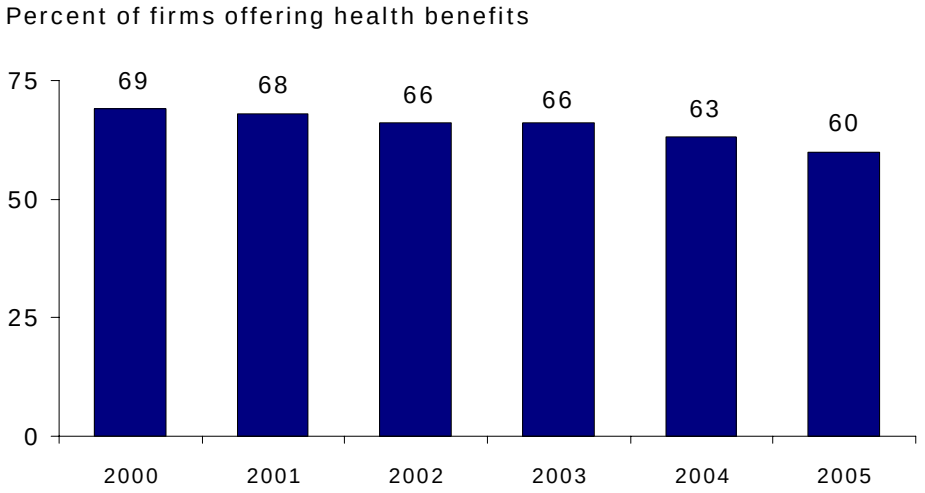
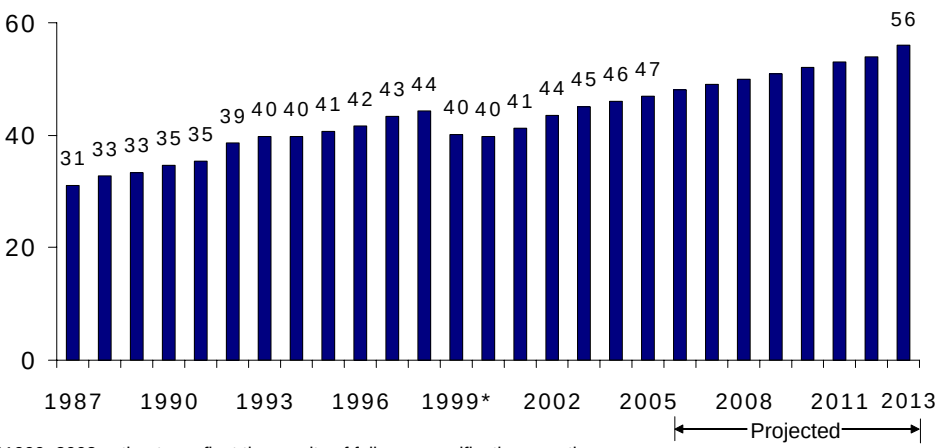
Figure 3. Percent of Firms Offering Health Benefits Declined Over 2000–2005



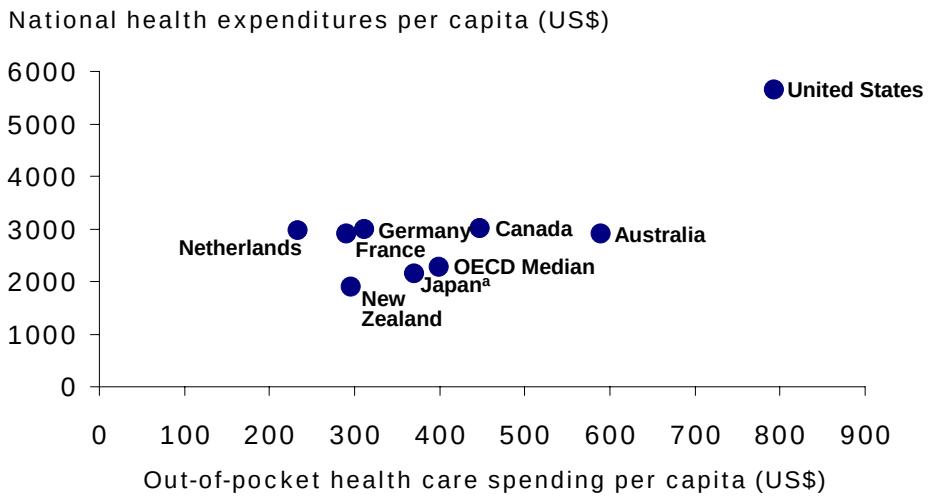
Source: KFF/HRET Employer Health Benefits 2005 Annual Survey.

Figure 4. 47 Million Uninsured in 2005; Increasing Steadily Since 2000



*1999–2003 estimates reflect the results of follow-up verification questions and implementation of Census 2000-based population controls.
Note: Projected estimates for 2006–2013 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, Apr. 5, 2005.
Source: U.S. Census Bureau, March CPS Surveys 1988 to 2005.

Figure 5. Americans Spend More Out-of-Pocket on Health Care Expenses



[a] 2002
Note: Adjusted for differences in the cost of living, 2003.
Source: B.K. Frogner and G.F. Anderson, *Multinational Comparisons of Health Systems Data, 2005,* The Commonwealth Fund, April 2006.

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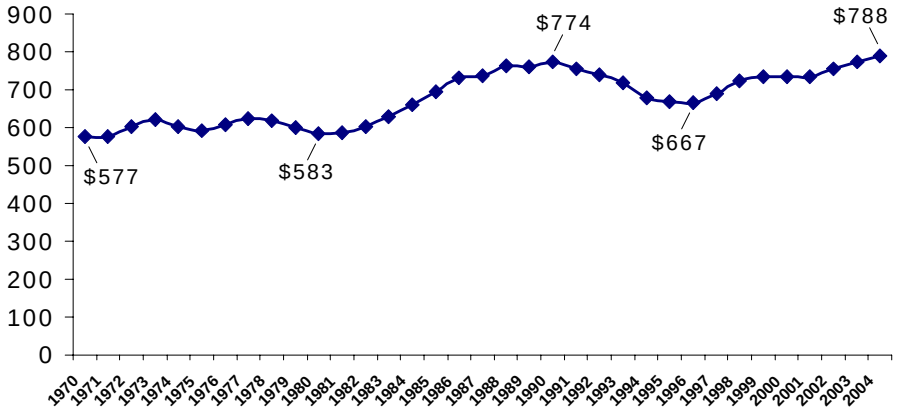
Figure 6. Americans Are Spending More Out-of-Pocket for Health Care



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

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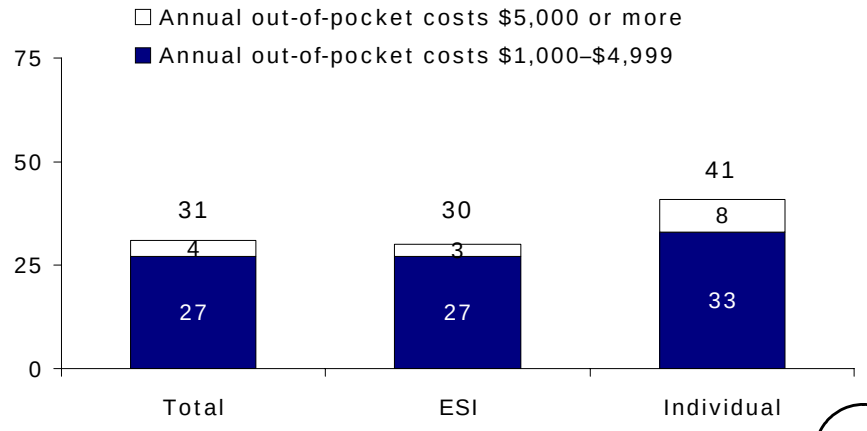
Figure 7. Adults with Individual Coverage Are More Likely to Spend $5,000 or More Annually on Personal Out-of-Pocket Expenses

Percent of adults ages 19–64 insured all year with private insurance



ESI = employer-sponsored insurance.

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

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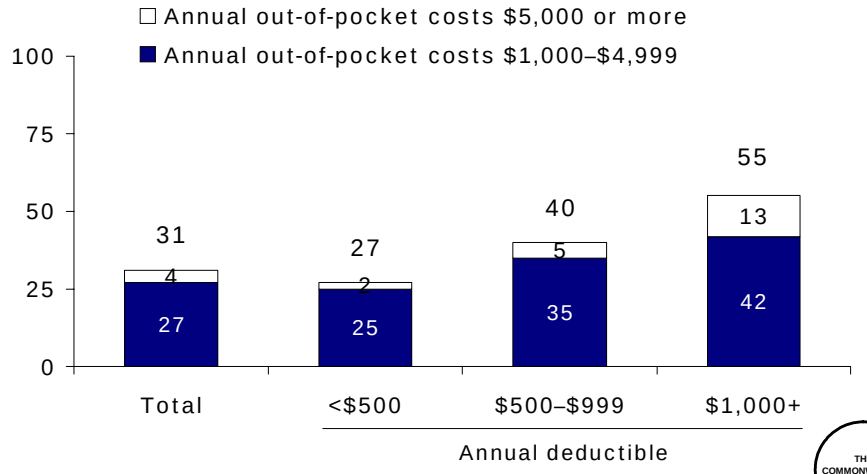
Figure 8. Adults with Higher Deductibles Are More Likely to Spend $1,000 or More on Personal Out-of-Pocket Expenses

Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

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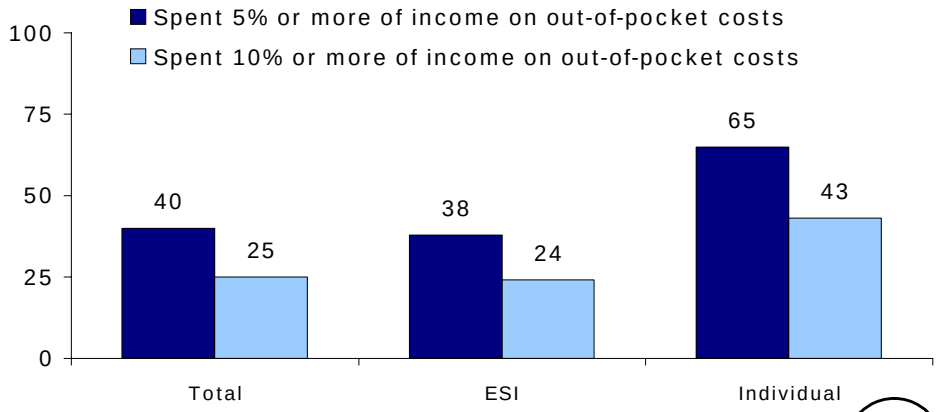
Figure 9. One-Quarter of Adults Spent 10 Percent or More of Their Household Income Annually on Family Out-of-Pocket Expenses and Premiums

Percent of adults ages 19–64 insured all year with private insurance



ESI = employer-sponsored insurance.

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

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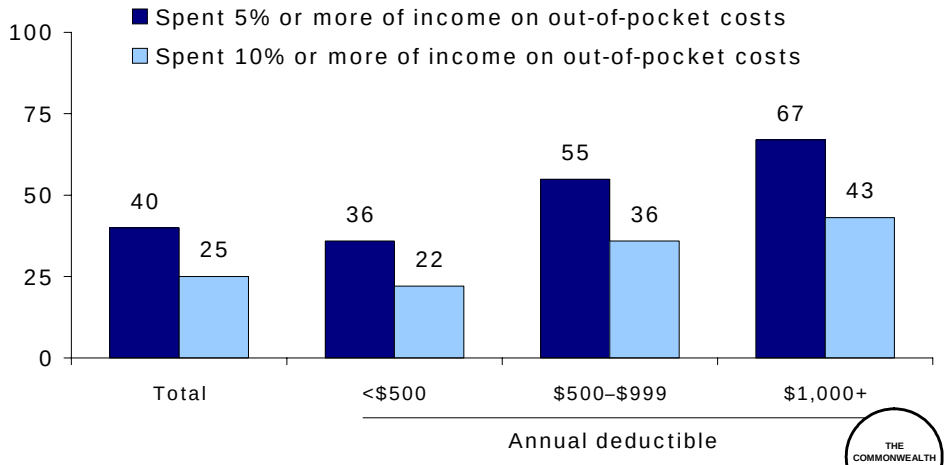
Figure 10. Adults with Higher Deductibles Are More Likely to Spend a Greater Share of Household Income on Family Out-of-Pocket Expenses and Premiums

Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

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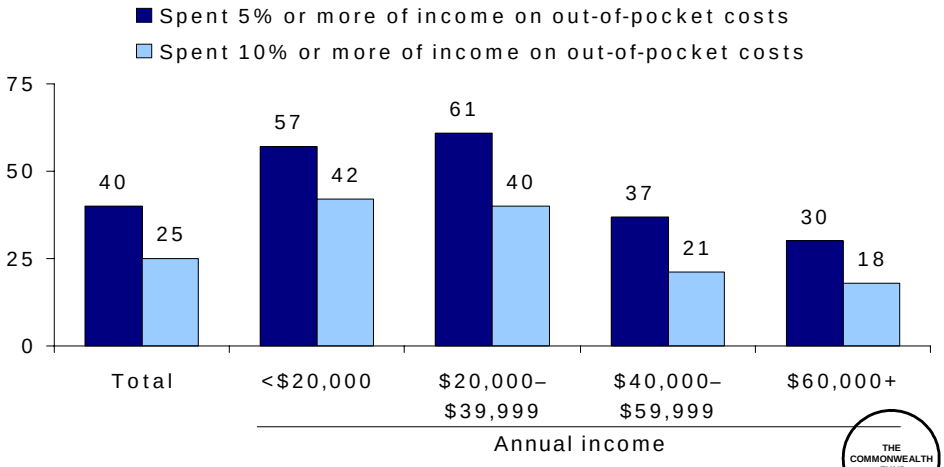
Figure 11. Low-Income Households at Most Risk for Spending Greater Shares of Income on Family Out-of-Pocket Expenses and Premiums

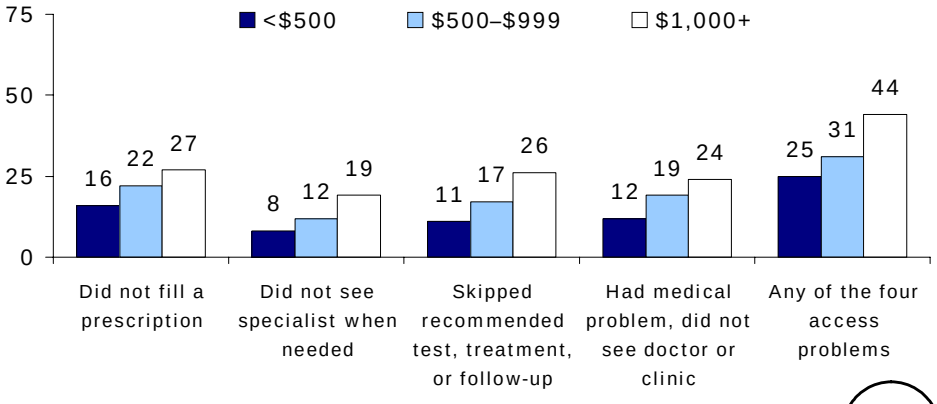
Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

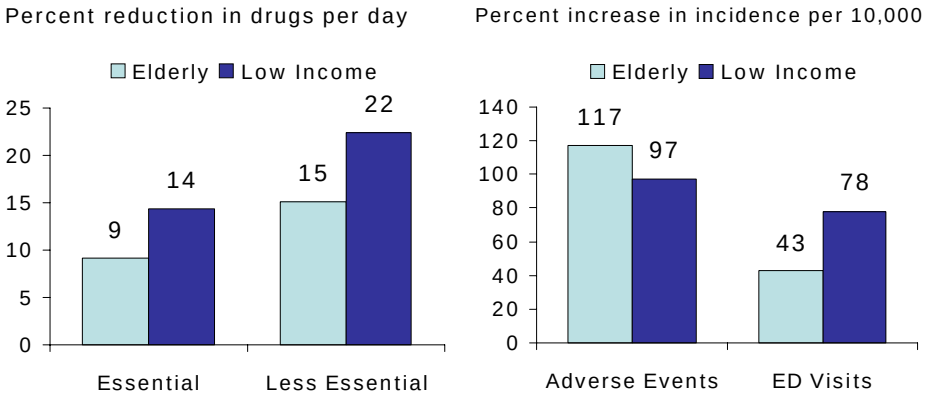
Figure 12. Adults with High Deductibles Are More Likely to Avoid Needed Health Care Because of Cost

Percent of adults ages 19–64 insured all year with private insurance



Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 13. 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 Persons," *JAMA,* Jan. 24/31, 2001 285(4):421–29.

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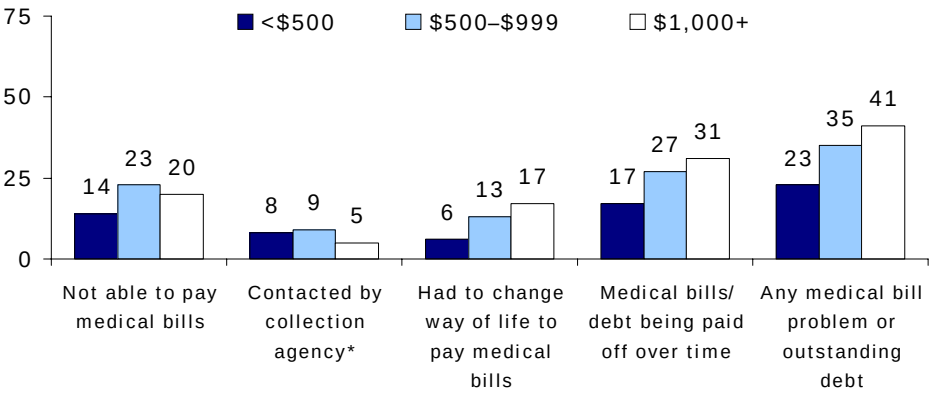
Figure 14. Adults with High Deductibles Have Problems Paying Medical Bills or Are Paying Off Medical Debt



* Includes only those individuals who had a bill sent to a collection agency when they were unable to pay it.

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

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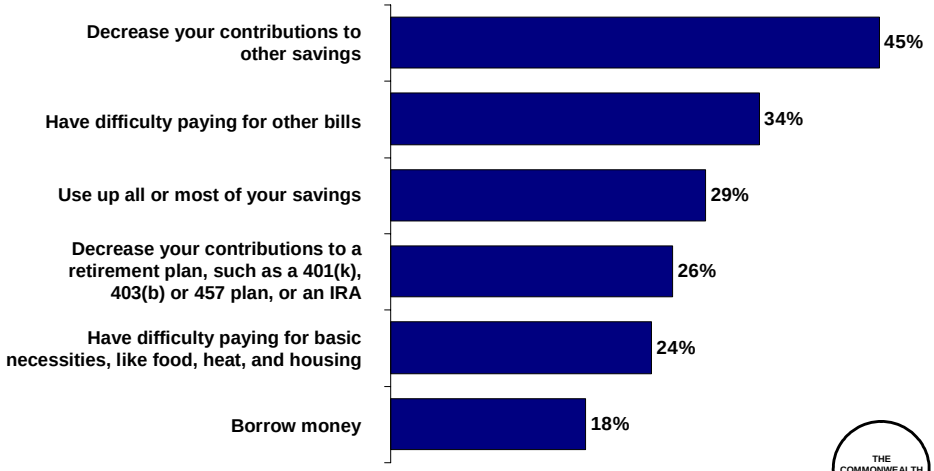
Figure 15. Increased Health Care Costs Have Reduced Savings

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)



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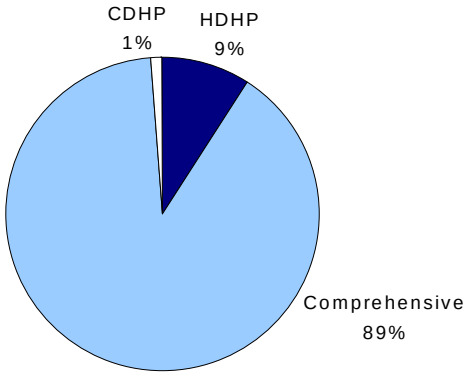
Source: EBRI Health Confidence Survey, 2005.

Figure 16. Few Insured People Are Currently Covered by High-Deductible Health Plans (HDHP) or Consumer-Directed Health Plans (CDHP) with a Savings Account



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, Dec. 2005.

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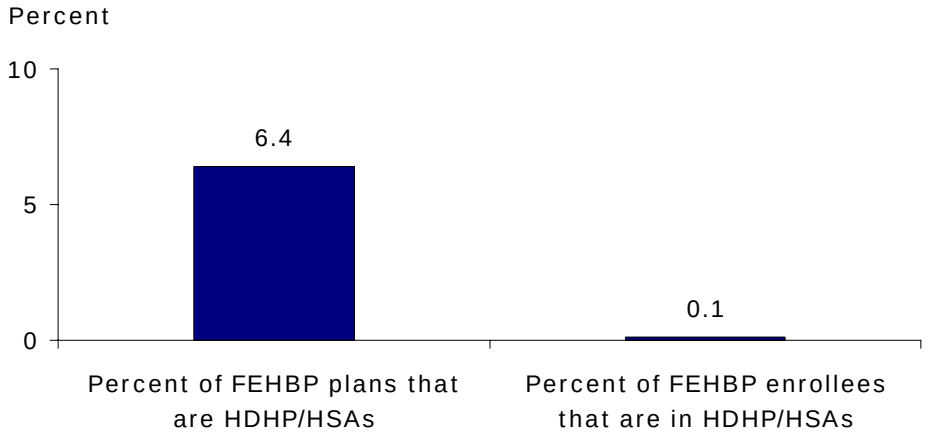
Figure 17. FEHBP HDHP/HSA Plans Enroll 7,500 Out of 9 Million Covered Lives



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, Jan. 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf

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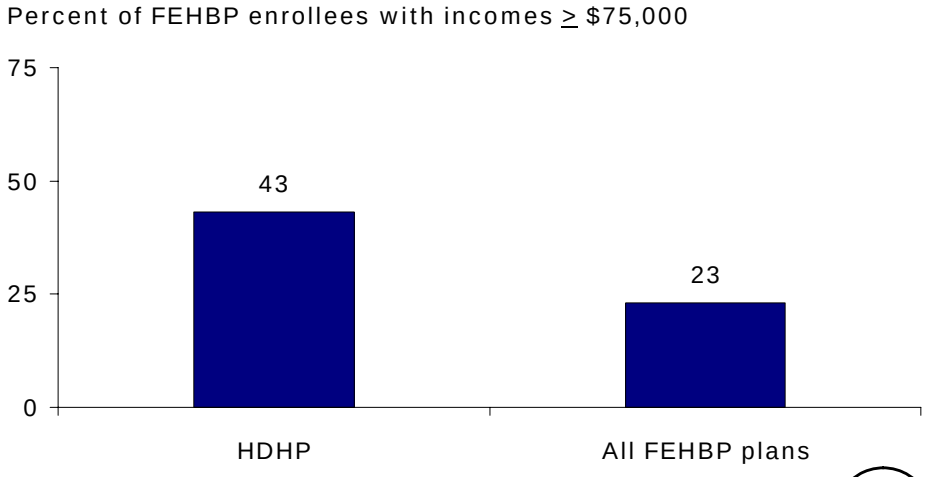
Figure 18. Enrollees Who Chose HDHPs from the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes



Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006.

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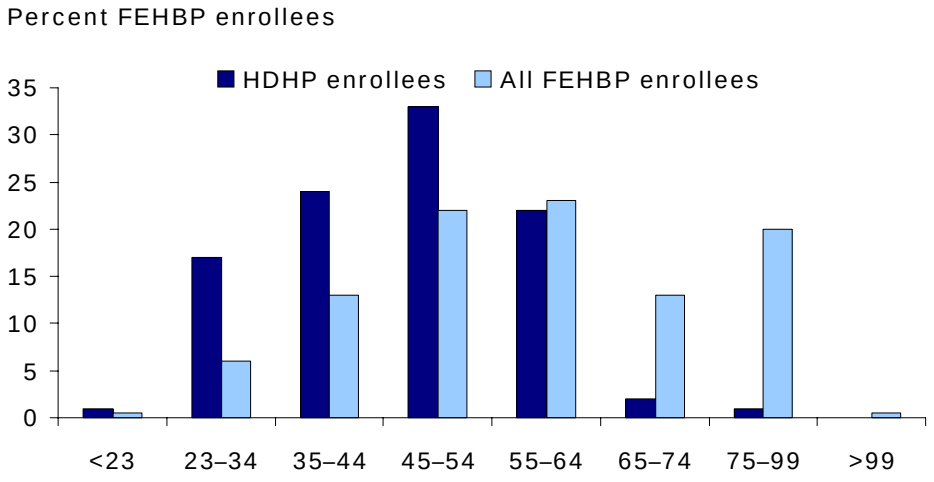
Figure 19. Age Distribution of HDHP and Other FEHBP Enrollees



Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, Jan. 2006.

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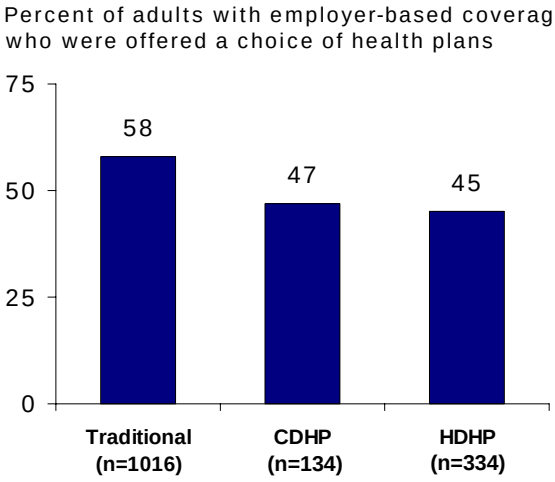
Figure 20. Less than Half of Those Enrolled in Employer-Based High-Deductible Health Plans Had a Choice



- 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, Dec. 2005.

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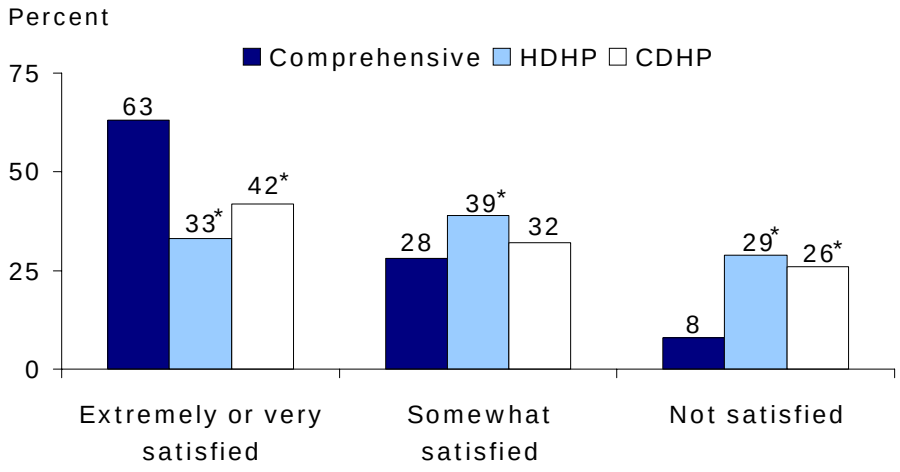
Figure 21. Enrollees of HDHP/CDHPs Are Less Satisfied with Their Coverage



* 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, Dec. 2005.

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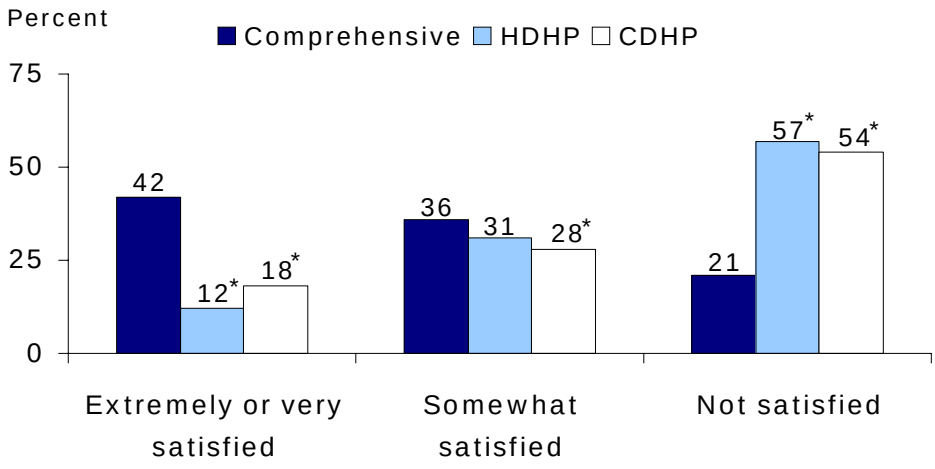
Figure 22. Enrollees of HDHP/CDHPs Are Less Satisfied with Out-of-Pocket Costs



* 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, Dec. 2005.

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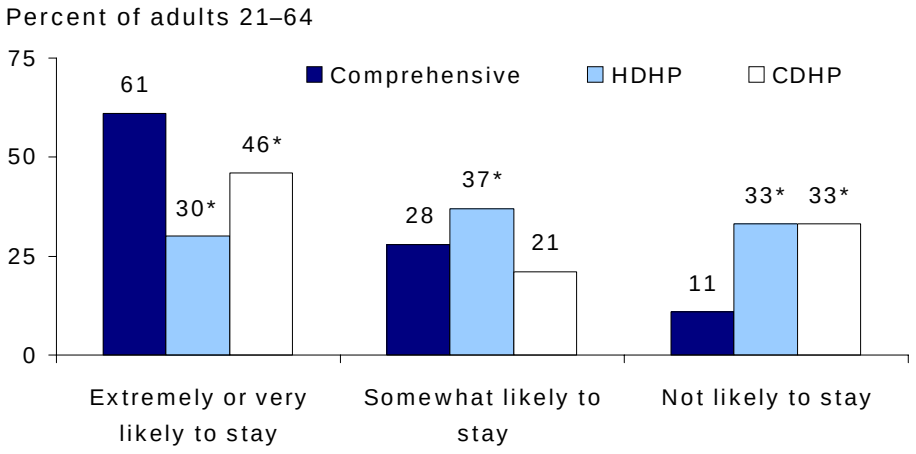
Figure 23. Enrollees of HDHP/CDHPs Are Less Likely to Stay with Their Current Health Plan If They Had the Opportunity to Change



* 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, Dec. 2005.

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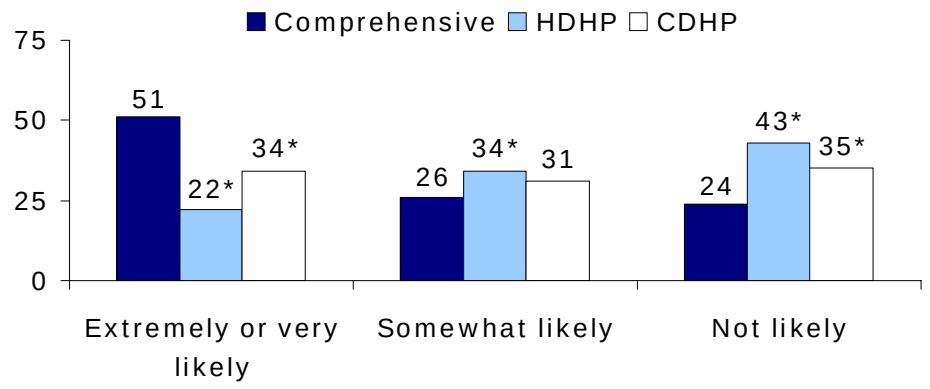
Figure 24. Enrollees of HDHP/CDHPs Are Less Likely to Recommend Their Plan to a Friend or Coworker



* 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, Dec. 2005.

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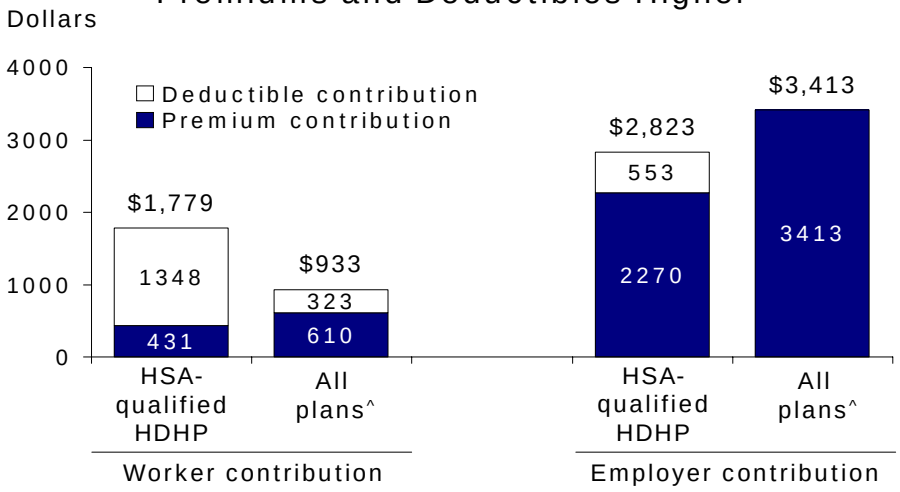
Figure 25. Employers' Contributions Lower for Workers in HSA-Qualified HDHPs; Employees' Premiums and Deductibles Higher



^ "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, Sept., 14, 2005; J. Gabel et al., "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs*, Sept./Oct. 2004.

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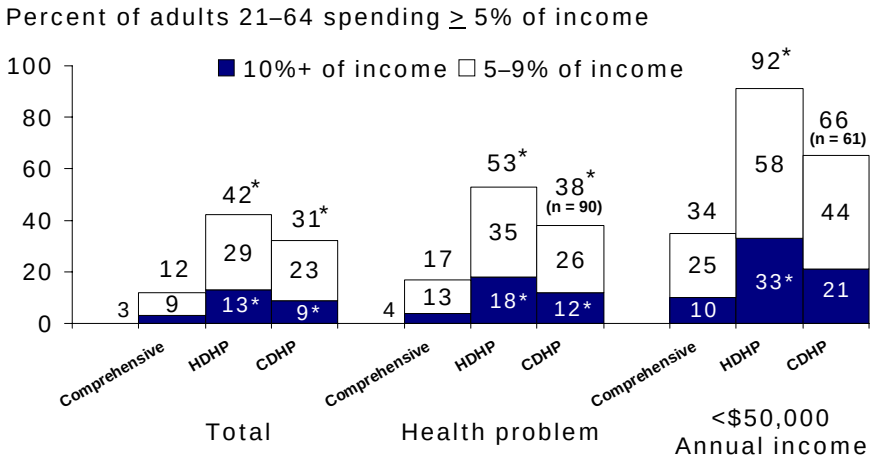
Figure 26. Enrollees of HDHP/CDHPs Spend Higher Percent of Income on Out-of-Pocket Medical Expenses and Premiums



* 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, Dec. 2005.

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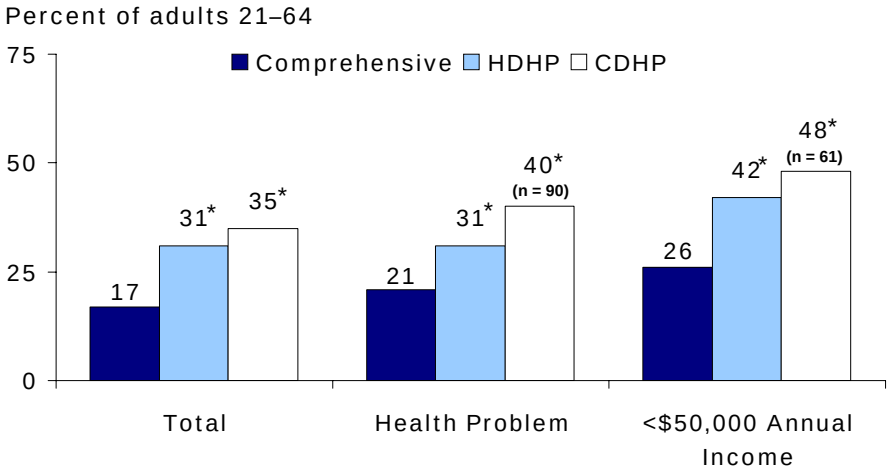
Figure 27. Enrollees of HDHP/CDHPs Are More Likely to Delay or Avoid Getting Health Care When Sick Due to Cost



* 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, Dec. 2005.

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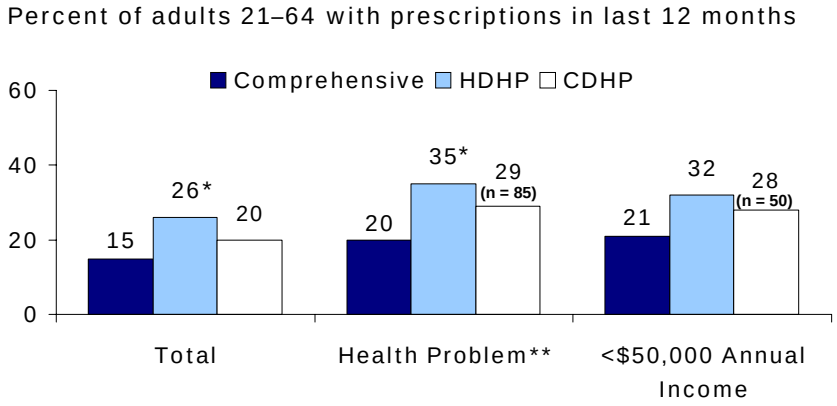
Figure 28. Enrollees of HDHP/CDHPs Are More Likely To Skip Doses to Make Medications Last



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

** 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, Dec. 2005.

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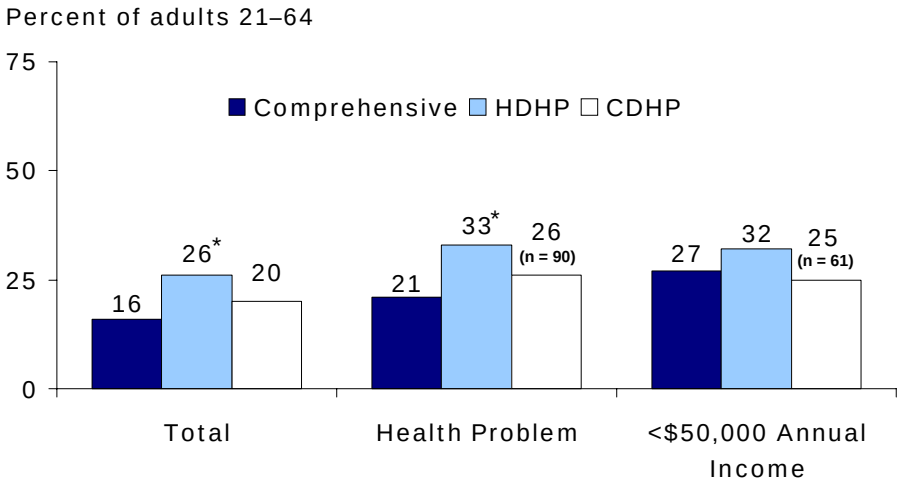
Figure 29. Enrollees of HDHP/CDHPs Are More Likely to Not Fill a Prescription Due to Cost



* 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, Dec. 2005.

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Figure 30. Most Insured Do Not Have Quality and Cost Information to Make Informed Choices

	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, Dec. 2005.

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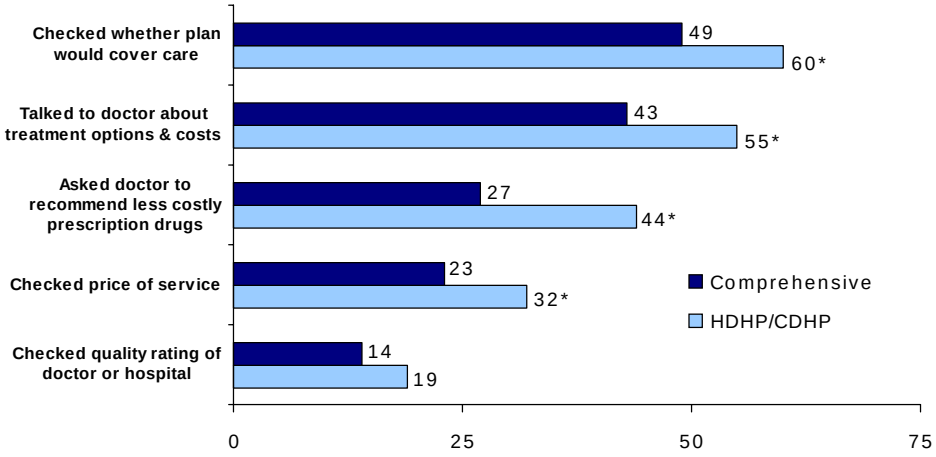
Figure 31. Cost Conscious Decision-Making, by Insurance Source

Percent of adults 21–64 who received health care in last 12 months



* Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ 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, Dec. 2005.

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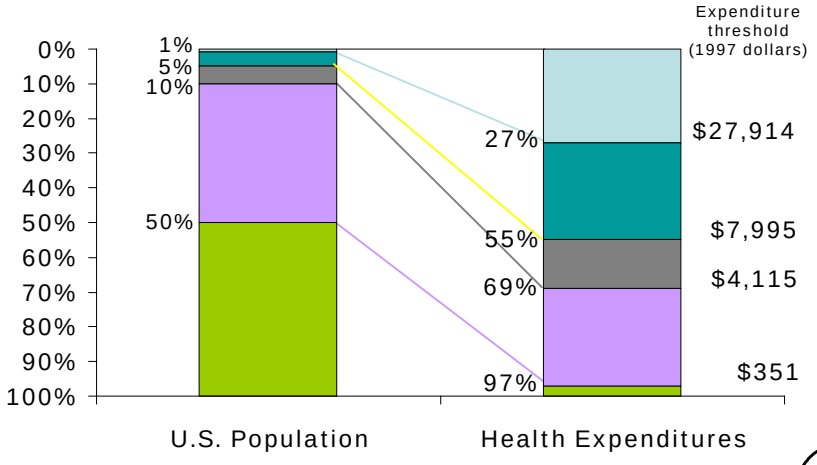
Figure 32. HSAs Won't Solve the Cost Problem: Most Costs Are Concentrated in the Very Sick

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.

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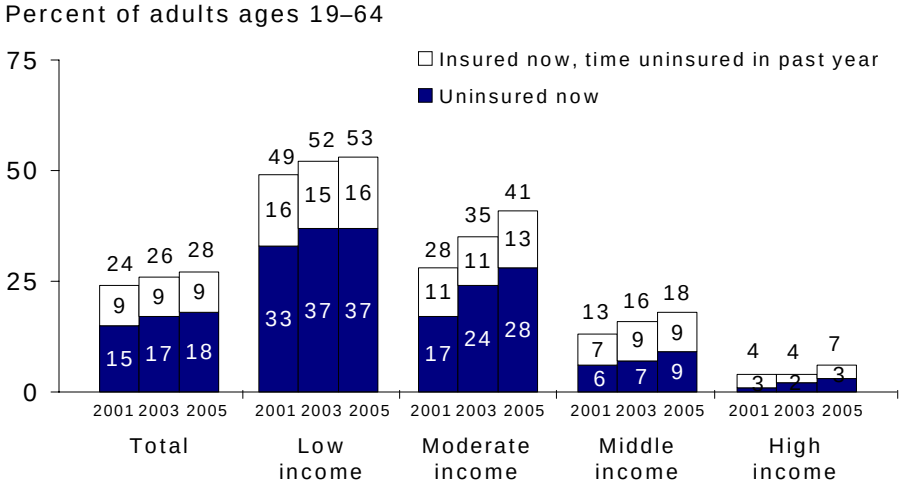
Figure 33. Uninsured Rates High Among Adults with Low and Moderate Incomes, 2001–2005



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, Apr. 2006.

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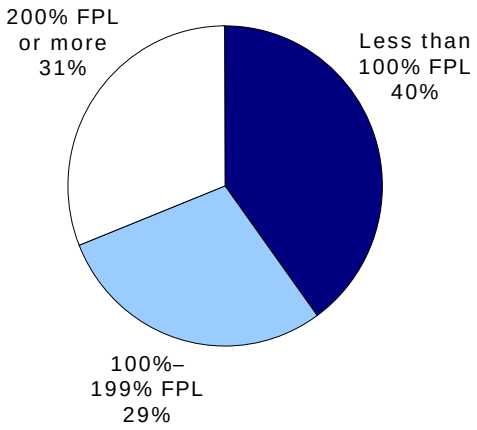
Figure 34. Distribution of Uninsured Young Adults 19–29 by Poverty Status, 2004



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

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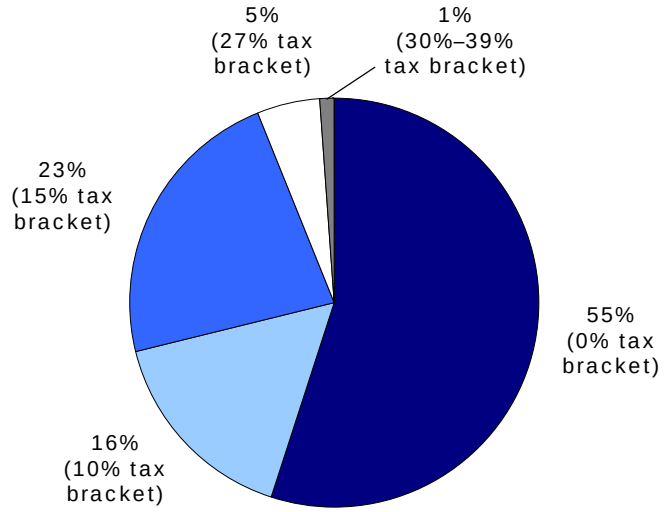
Figure 35. HSAs Won't Solve the Uninsured Problem: Income Tax Distribution of Uninsured



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

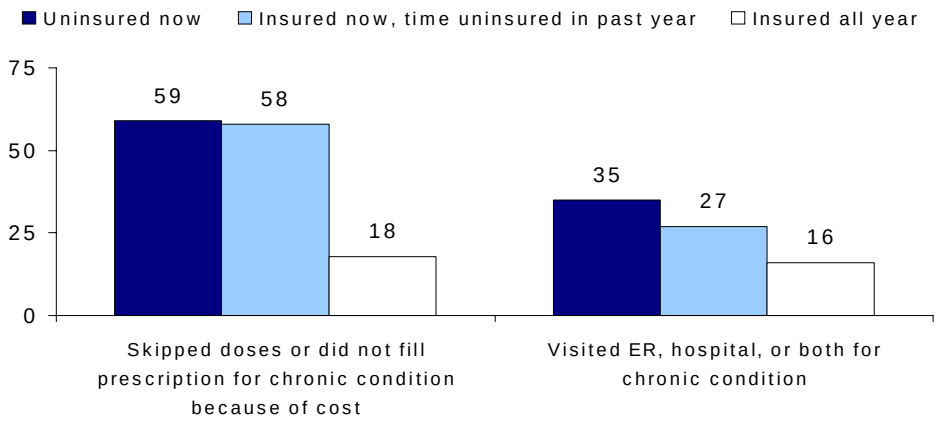
Figure 36. Individual Market Is Not an Affordable Option for Many People

Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a pre-existing condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: S.R. Collins, J.L. Kriss et al., *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families,* The Commonwealth Fund, Sept. 2006.

Figure 37. Lacking Health Insurance for Any Period Undermines Quality and Efficiency

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, Apr. 2006.

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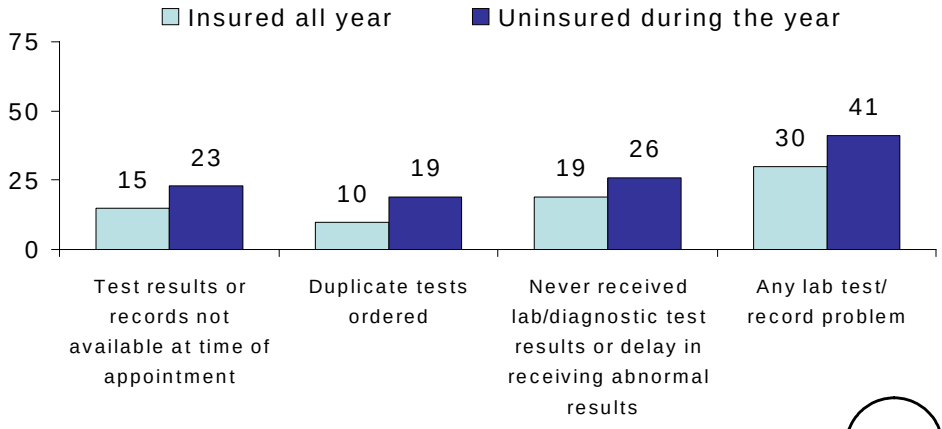
Figure 38. Adults Without Insurance Have More Problems With Lab Tests and Records

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, Apr. 2006.

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