TRANSPARENCY IN HEALTH CARE: THE TIME HAS COME

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with Better Information About Healthcare Service Costs"
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Executive Summary

Thank you, Mr. Chairman, for this invitation to testify on the importance of making health care cost information publicly available. Transparency and better public information on cost and quality are essential for three reasons: 1) to help providers improve by benchmarking their performance against others; 2) to encourage private insurers and public programs to reward quality and efficiency; and 3) to help patients make informed choices about their care. Transparency is also important to level the playing field. The widespread practice of charging patients different prices for the same care is inherently inequitable, especially when the uninsured are charged more than other patients.

But it is unreasonable to expect that information on prices, total bills (total costs to patients and insurers), and quality will cause health care market to perform like markets for other goods and services. Health care is not a homogeneous commodity. Patients will never have as much information about the care they need as the physicians who care for them. Health care decisions are often made under emergency conditions and emotional stress. Both the insurance industry and the health care delivery sector are highly concentrated, leaving patients with few genuine choices. In short, all the conditions required for perfectly competitive markets do not exist in health care, making the health care market quite different than markets for other goods and services.

- **Price Information Is of Little Value By Itself**
    - Knowing prices of health care services is of little value without information on the total cost of caring for a given condition and the quality or outcomes of that care.

- **The Current State of Information Is Inadequate**
    - Patients report that they rarely have cost and quality information available to them.
    - Physicians rarely have comparative information on the quality of their own care or on the quality the care of the physicians to whom they refer patients.
- **Patient Use of Information Is Not Likely to Transform Health Care**
    - 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.
    - Most health care costs are incurred by very sick patients—patients with heart attacks, strokes, cancer, mental illness, fractures, and injuries—often under emergency conditions. Shopping for the best physician or hospital is impractical in such circumstances.
- **Higher Patient Cost-Sharing and High-Deductible Health Plans Are the Wrong Prescription**
    - Placing a greater financial burden on the sickest and poorest patients is not the right prescription for what ails the health care system.
    - Americans already pay far more out-of-pocket for their health care than citizens in other industrialized countries that have far lower costs.
    - Few people are currently enrolled in health savings accounts (HSAs) coupled with high-deductible health plans, and 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.
    - Most troubling is that people in high deductible plans 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.

- When people with high-deductible health plans do access health care, there is evidence that they are more likely to have problems paying bills and accumulating medical debt.

What Needs to Be Done

To achieve transparency in our health system, the following steps could be taken:

- Medicare can assume a leadership role in making cost and quality information by provider and by patient condition publicly available. It should forge public-private partnerships to create a multi-payer database, uniform quality metrics, and transparent methodologies for adjusting quality and costs.
- Create a National Quality Coordination Board within the U.S. Department of Health and Human Services, as the Institute of Medicine has recommended. The board will set priorities, oversee the development of appropriate quality and efficiency measures, ensure the collection of timely and accurate information 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.
- Invest in health information technology, which is essential to ensure the right information is available at the right time to patients, providers, and payers.
- Make fundamental changes in current payment methods. Medicare's physician group practice demonstration is a step in the right direction and should yield valuable insight into whether gains in efficiency and quality can be achieved simultaneously.
- Modify HSA legislation to reduce its potentially harmful effects on vulnerable populations. High-deductible health plans raise the risk that patients will fail to get the early care that could catch serious conditions at an early stage, and fail to get the medications that could control their risk factors and chronic conditions. Legislative modifications to minimize these risks might include:
    - Permit lower HSA eligible deductibles for lower-wage workers
    - 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

Price transparency is a beginning, but it is unlikely to have a major impact in the absence of better information on quality and the total bills for the treatment of various acute and chronic conditions. Creating such a database is certainly feasible but requires federal leadership. This hearing is an important step toward achieving that desirable outcome.

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Thank you, Mr. Chairman, for this invitation to testify on the importance of making health care cost information publicly available. Transparency and better public information on cost and quality are essential for three reasons: 1) to help providers improve by benchmarking their performance against others; 2) to encourage private insurers and public programs to reward quality and efficiency; and 3) to help patients make informed choices about their care. Transparency is also important to level the playing field. The widespread practice of charging patients different prices for the same care is inherently inequitable, especially when the uninsured are charged more than other patients, rather than less.

But it is unreasonable to expect that information on prices, total bills (or total cost to patients and insurers), and quality will cause the health care market to perform like markets for other goods and services. Health care is not a homogeneous commodity. Patients will never have as much information about the care they need as the physicians who care for them. Decisions are often made under emergency conditions and emotional stress. Both the insurance industry and the health care delivery sector are highly concentrated, leaving patients with few genuine choices. The way insurers pay for care gives providers powerful financial incentives to perform more and more complex services and procedures. There are a myriad of physicians and other providers involved in an episode of care for a complex or serious condition; patients are not given the choice of anesthesiologist, pathologist, radiologist, or many of the consultants involved in care. No one provider quotes a price for all of the care needed over time for an acute episode, such as a hip replacement, or for a chronic condition that persists over time, such as congestive heart failure. In short, all the conditions required for perfectly competitive markets do not exist in health care, making the health care market quite different than markets for other goods and services.

High-deductible health plans that expose families to high out-of-pocket costs are the wrong prescription for these problems. The purpose of insurance is to ensure that

patients have access to essential care and are not burdened by medical bills. Making patients pay even more for health care undermines the very reason why insurance exists.

Price Information Is of Little Value by Itself

As important as transparency is, knowing prices of health care services is of little value without information on the total cost of caring for a given condition and the quality or outcomes of that care. Health care is not a homogeneous commodity. Patients are not always well advised to seek out the surgeon with the lowest fee, for example. It is important to know the quality of care provided and a surgeon's track record with complications or mortality. Even if a hospital room charge is lower, it's no bargain if the patient is more likely to stay longer or be readmitted for an infection or complication.

Additionally, the price of an individual service is just one element in the total cost that a patient or insurer faces. There is often no standard set of services that are provided to patients with a given condition. The total bill can depend on the tests ordered, the length of the hospital stay, and the number of specialist consultants involved in the care. A surgeon's fee is an important component of the total bill, but so is the anesthesiologist's fee, the radiologist's fee, and the pathologist's fee. One study found that the percentage of patients seeing 10 or more physicians for a hip fracture varied across academic medical centers from 16 percent for those in the lowest quintile to 35 percent for those in the highest quintile (Figure 1).[1] Similar variations occurred over a year's time for patients with colorectal cancer and heart attacks.

Most hospitalized patients have no idea how many physicians will be involved in their care or what their total bills for care, including hospital and physician charges, will amount to. What a patient needs to know is the expected out-of-pocket cost from the beginning to end of treatment, as well as the outcomes of care. For example, for a hip replacement, the patient needs to know expected total bills, including the hospital bill, all physicians' bills (surgeon, anesthesiologist, radiologist, etc.) and bills for follow-up care (physical therapy, medication, follow-up physician visits, etc.). They also need to know the likelihood of complications or infections or need for repeat surgery and how soon

[1] E.S. Fisher et al., "Variations in the Longitudinal Efficiency of Academic Medical Centers," *Health Affairs* Web Exclusive, October 7, 2004.

they can expect to be pain-free and fully functioning. For a patient with a chronic condition such as congestive heart failure, for example, total bills may include not only an initial hospitalization but a high likelihood of a rehospitalization and multiple physician bills from cardiologists, pathologists, and other physicians, as well as follow-up care such as nurse home visits, medications, and office visits with their physician.

Information needs for insurers include total expected discounted charges over the course of treatment and the value or effectiveness of care. Employers may be interested in knowing how quickly an employee will be able to return to work, which could vary depending on the choice of treatment for a condition such as lower back pain.

Providers are likely to be concerned that information on cost and quality includes an appropriate adjustment for the severity of the patient's condition and any co-morbidities. Providers may also be interested in how the cost and quality of the portion of the care for which they are responsible varies, not just the total bill. And the patient wants to know not only if the operation is likely to be a success, but the likelihood of a hospital-acquired infection as well!

The Current State of Information Is Inadequate

It shouldn't come as a surprise that the information currently available doesn't begin to meet the needs of patients, payers, or providers. Patients report that they rarely have cost and quality information available to them. A national survey of adults by The Employee Benefit Research Institute (EBRI) and The Commonwealth Fund on consumerism in health care found that 14 to 16 percent of insured individuals—whether enrolled in a comprehensive plan or a high-deductible health plan—had information from their health plan on quality of care provided by their doctors and hospitals. Similarly, 12 to 16 percent had cost-of-care information for their doctors and hospitals (Figure 2).[2] About half of those with the information had tried using it.

Physicians rarely have comparative information on quality of their own care or on the care of the physicians to whom they refer patients. Only one in five physicians report receiving any process or clinical quality-of-care data on their own care, only one in four

[2] 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.

receive patient survey data, and only one in three receive any kind of quality data (Figure 3).[3] Perhaps even more shocking, only 5 percent of physicians say they always have information on the quality of care rendered by the physicians to whom they refer patients, and nearly two-thirds say they rarely or never have such information (Figure 4).[4]

Pennsylvania is the only state with extensive reporting on hospital charges and quality of care. Hospital charges per patient for the top 27 hospitals with 100 or more heart attack cases ranged from $11,000 to $88,000 in 2003 (Figure 5).[5] Only one hospital had a statistically significant different mortality rate (lower), and its average charge was around $22,000. Yet a patient with a heart attack in Philadelphia is unlikely to ask the ambulance driver to drive two hours to Allentown to have the benefit of its lower charges and better mortality rate. Nonetheless the data could be useful to payers in establishing payment rates—why pay more for poorer care? And it could help hospitals try to understand the best practices that led the Allentown hospital to achieve better results for median cost. But even these data fail to include physician charges—and provide only part of the story.

Data on patients' experiences with hospitals and physicians are just beginning to become available. The Massachusetts Health Quality Partnership and the California Health Care Foundation have piloted releasing patient-reported data on hospital care.[6] The Massachusetts Health Quality Partnership has published clinical quality data on Massachusetts medical groups, and recently released patient-reported data on experiences with physician care at the medical group level, but not at the individual physician level.[7] Integrated HealthCare Association in California similarly has pioneered reporting on patient experiences with care at the medical group level, and its pay-for-performance

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[3] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

[4] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

[5] Pennsylvania Health Care Cost Containment Council, Hospital Performance Results, Hospital discharges between January 1, 2003 and December 31, 2003, www.phc4.org.

[6] See http://www.calhospitalcompare.org/about/index.cfm?itemID=20824; http://www.mhqp.org/.

[7] The Commonwealth Fund, *Quality Matters:* Public Reporting of Physician Group Quality Data, February 2006, Vol. 16; Massachusetts Health Quality Partnership, "Landmark Report Provides Massachusetts Consumers Comprehensive Information on Quality of Care Based on Patients' Experiences," March 9, 2006.

schemes often reward medical groups for both high performance on clinical quality indicators and on patient experiences with care.[8] These are important path-breaking efforts—but, again, far from standard practice.

Medicare has lagged behind these private sector efforts, but is beginning to actively collect quality information. The Medicare Modernization Act and the Deficit Reduction Act reduce Medicare payment rates to hospitals by 0.4 percent and 2.0 percent respectively for those not "voluntarily" reporting selected hospital quality indicators. As a result, nearly all hospitals now submit the required information. A study supported by The Commonwealth Fund and published in the *New England Journal of Medicine* found wide variation in the Medicare hospital quality indicator data across hospitals and geographic areas (Figure 6).[9] Further, hospitals scoring highly on quality of care for heart attack patients typically did not score highly on quality of care for pneumonia patients—suggesting the difficulty of establishing networks of providers that patients can reliably expect to provide high-quality care regardless of the reason for which they are hospitalized. These data are potentially helpful, however, in helping all hospitals learn best practices that lead to superior results.[10] Medicare has also begun to ask physicians to submit quality data voluntarily.

Because Medicare has more than 40 million beneficiaries, its claims data are potentially valuable in profiling individual providers' quality and efficiency. Medicare should make publicly available total hospital and physician standardized charges over the course of treatment for patients with different health conditions and with different hospital or medical groups involved in their care. It should also join with private insurers in creating a multi-payer database that could be used for this purpose.

The federal Agency for Healthcare Research and Quality collects data on hospital cost, quality, and patient safety in 36 states under its Health Care Utilization Project. However, because of the data agreements with states and hospitals, these data aren't available publicly by name of hospital, or even by identified state.

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[8] See http://www.iha.org.

[9] A.K. Jha, Z. Li, E.J. Orav and A.M. Epstein, "Care in U.S. Hospitals—The Hospital Quality Alliance Program," *New England Journal of Medicine* 353 (July 21, 2005): 265–74.

[10] The Commonwealth Fund, *Quality Matters:* Performance Matters, December 2005, Vol. 14, Sheree Crute, "Case Study: Achieving High-Quality Care at Reid Hospital and Health Care Services."

Specialty societies are also starting to collect quality information but, again, this information is rarely in the public domain. Patients could benefit greatly by knowing five-year survival rates for different kinds of cancer by cancer center, and complications of cardiac surgery by hospital and surgical team.

Private insurers have started classifying providers by quality and costs, but their methods for doing so are not transparent and are often proprietary. Furthermore, most private insurers have too few patients with a given condition obtaining care from a given physician to create reliable quality and efficiency metrics. This is further complicated, fortunately, by the relatively low rate of complications (such as wrong site surgery). Even states like New York and Pennsylvania that report on cardiac surgery mortality are often differentiating hospitals with a 4 percent mortality from those with a 2 percent mortality. To accurately capture such variations in quality, a database on all patients, including those covered by Medicare, Medicaid, and private insurers, is needed.

The science of measuring quality and patient experiences with care has advanced considerably in the last decade, although the data are not routinely collected and made publicly available at the individual provider level. The science of measuring efficiency at the individual provider level with appropriate adjustment for patient complexity and other factors is somewhat less advanced.

But perhaps the greatest barrier to generating the kind of information that is needed is the resistance of providers to making quality information available. A Commonwealth Fund survey of physicians and quality of care in 2003 found that one-fourth of physicians would definitely or probably not be willing to make their own quality information available to the medical leadership of their organization or to other physicians; two in five would not make this information available to their own patients; and two- thirds definitely or probably would not make them available to the general public (Figure 7).[11] Similarly, in a Commonwealth Fund international survey in 2003, one-third of hospital CEOs in the U.S. indicated that information on mortality rates,

[11] A-M.J. Audet, M.M. Doty, J. Shamasdin and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings From The Commonwealth Fund National Survey of Physicians and Quality of Care*, The Commonwealth Fund, May 2005.

medical errors, and nosocomial infection rates should not be released to the public (Figure 8).[12]

Even the most optimistic estimate is that it will be 5 to 10 years before systematic information on quality and cost is available to all parties—and then only if the federal government, especially Medicare, demonstrates far greater leadership in creating the kinds of information databases necessary. The Institute of Medicine recently released a report, *Performance Measurement*, in response to a Congressional request that called for creation of a National Quality Coordination Board to approve quality measures and ensure creation of timely databases, among other things.[13]

Patient Use of Information Is Not Likely to Transform Health Care

It is unrealistic to expect that even with adequate information and patient financial incentives, the transformation of health care system will be driven by patient choice of provider. Patients are in the weakest position to demand greater quality and efficiency. By contrast, payers, federal and state governments, accrediting organizations, and professional societies are much better positioned to insist on high performance. Most health care costs are incurred by very sick patients—patients 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 9).[14] Shopping for the best physician or hospital is impractical in such circumstances.

Nor are patients accustomed to seeking such information or trusting the information that is available. The Employee Benefit Research Institute and Commonwealth Fund 2005 survey of consumerism found that the most trusted source of information is the patient's own physician (Figure 10). The least trusted sources of information are health plans and government agencies—with only about 1 in 20 trusting

[12] R.J. Blendon, C. Schoen, C.M. DesRoches, R. Osborn, K. Zapert and E. Raleigh, **"**Confronting Competing Demands To Improve Quality: A Five Country Survey," *Health Affairs* 2004 23(3):119-135.

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

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

those sources of information. Yet health plans and government agencies are far more likely to be able to assemble the required information.

Still, studies fairly systematically 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 avail themselves of this information.[15] The information was valuable because hospital CEOs investigated the reasons for poor performance and took necessary action—not because patients voted with their feet.[16]

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.[17] Hospitals who report quality information take steps to improve quality.[18] 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.[19]

Higher Patient Cost-Sharing Is the Wrong Prescription

Increasing patient cost-sharing is the wrong prescription for reining in U.S. health care costs. Americans already pay far more out-of-pocket for their health care than citizens in any other industrialized country (Figure 11).[20] In addition, real per capita out-of-pocket spending has been steadily rising since the late 1990s (Figure 12).[21] Higher

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[15] 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.

[16] 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.

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

[18] 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 Public Stimulate Quality Improvement Efforts?" *Health Affairs*, March/April 2003 22(2):84-94.

[19] 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 (August 2005): 407-434.

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

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

spending on health care, combined with sluggish growth in real incomes, also means that families are spending increasingly more of their incomes on medical costs. A recent 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 13).[22] 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 that they need. The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less essential health care.[23] Similarly, a study by Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and non-essential drugs and increased the risk of adverse health events (Figure 14).[24] Cathy Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, found that insured people with out-of-pocket costs that were high relative to their incomes were nearly as likely to report not accessing health care because of costs as were people without coverage at all.[25]

High-Deductible Health Plans and Health Savings Accounts

Proponents of health savings accounts (HSAs) coupled with high deductible health plans (HDHPs) say these plans make people better consumers of health care by giving them greater responsibility for the costs of their care. The Medicare Modernization Act of 2003 allowed people with HDHPs (now $1,050 for an individual and $2,100 for a family) to open an HSA into which they can contribute pre-tax dollars with the deductible amount not to exceed $2,600 for an individual or $5,200 for a family. Employers can also contribute up to the full amount of the cap.

Low enrollment so far. Consumer-driven health plans, as these plans have become known, have received considerable attention in the press. Yet few Americans

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[22] 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.

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

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

[25] 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.

have enrolled in them to date. The EBRI/Commonwealth Fund Consumerism in Health Care Survey 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 15).[26] An additional 9 percent had an HSA-eligible HDHP but had not yet opted to open an account. Other studies have found similarly low levels of enrollment. The General Accountability Office 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 (Figure 16).[27] A recent study by America's Health Insurance Plans estimates that there are currently about 3 million people enrolled in consumer-driven plans.[28]

Reflecting the fact that those in higher income tax brackets have the greatest tax benefits associated with HSAs, as the uncovered first dollar expenses, the plans have disproportionately attracted people with higher incomes and those who are in better health (Figures 17-18).[29] Unlike federal employees, most people who are enrolled in the plans did not have a choice. The EBRI/Commonwealth Fund survey found that less than half of those enrolled in the plans through an employer had a choice of plan (Figure 19).[30]

Low satisfaction. Among the small number of Americans who do have these plans, few are satisfied with them. The EBRI/Commonwealth Fund survey found that people with HDHPs both with and without HSAs were far more likely than people in more comprehensive plans to report dissatisfaction with several aspects of their health care including quality of care, out-of-pocket costs, and overall satisfaction with their

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[26] 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.

[27] 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.

[28] CQHealthBeat, "Ignagni: "Young Immortals Aren't Dominating HSA Enrollment," March 9, 2006.

[29] 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.

[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.

plans (Figures 20-23)[31]. 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 24-25).

High out-of-pocket costs. The high rates of dissatisfaction with the costs of consumer-driven plans likely stem from the substantial amount of income people in these plans allocate to their health care, particularly those with health problems or who are in households with lower incomes. The EBRI/Commonwealth Fund survey found that two-thirds of adults enrolled in a HDHP with an HSA or HRA with 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).

Cost-related access problems. The early experience with these plans 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 HSAs 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 consumer-driven plans with incomes of less than $50,000 reported delaying or avoiding care; this is rate is also nearly twice that of people in the same income group in more comprehensive plans. Similarly, people enrolled in high-deductible plans were more likely to skip doses of their medications to make them last longer or not fill their prescriptions at all; the rates of skipped medication were highest among people with health problems (Figures 28-29).

Risk of medical debt. When people with high-deductible health plans do 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 problems paying medical bills or that they were paying

[31] 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.

off medical debt over time (Figure 30).[32] 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.

Lower savings for retirement. 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 adults under age 65 with health insurance reported that they financed increased health care spending by using up all or most of their savings.[33]

HSAs will not solve the uninsured problem. The combination of HSAs and HDHPs will not significantly reduce the nation's growing number of people who are uninsured. In 2004, nearly 46 million people were without health insurance, an increase of 6 million over 2000.[34] Research by Sherry Glied and Dahlia Remler found that the tax benefits of HSAs would lower the number of uninsured by fewer than 1 million people. This is because 55 percent of those who are currently uninsured earn incomes that are so low that they pay no income tax and an additional 16 percent fall in the 10 percent tax bracket (Figure 31).[35]

What Needs to Be Done

The Committee is to be commended for focusing the nation's attention on the need for transparency in health care. The absence of public information on cost and quality at the individual provider level is undermining efforts to achieve a high performance health system. Better information benefits everyone. It helps patients know what to expect and become more active and engaged partners in their care. It helps providers know where their performance falls short and how it might be improved. It helps private insurers and public programs align financial incentives in a way that rewards higher quality and efficiency.

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[32] 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.

[33] 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.

[34] 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) August 2005.

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

To achieve transparency in our health system, Medicare needs to take a leadership role in making 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. This may require legislative authorization with a realistic timetable.

Multiple 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 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.[36]

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 in four physicians have electronic medical records, demonstrating that the benefits of modern information technology (IT) are far from being realized.[37] 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.

Armed with the right information, patients can contribute in a small way to better care by getting regular preventive care, becoming educated about the risks and benefits of elective procedures, sharing medical history with multiple providers helping to coordinate care and reduce waste and 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. High-deductible health plans run the risk that patients will fail to get the early care that could catch serious conditions at an early stage, and fail to get the

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

[37] 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

medications that could control their risk factors and chronic conditions. It is important that modifications be made to the health savings accounts 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 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.[38] A Fund-supported evaluation of the PacifiCare pay–for-performance initiative in California also found promising results.[39] 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.

But we will never have a high functioning health care system when we have an unprecedented number of Americans without adequate health insurance coverage. Health care needs to be made more affordable–not less affordable—for patients. We need to

[38] 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.

[39] 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.

cover the nation's 46 million uninsured, building on what works. Particularly promising are strategies to expand employer-based coverage, eliminate the two-year waiting period for coverage of the disabled under Medicare, let older adults buy-into Medicare, and build on state Children's Health Insurance Program to cover low-income parents and other adults.[40]

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 both difficulty obtaining needed care and heavy financial burdens.[41] Rather than insisting on minimum high deductibles at $2100 per family, our nation's health policy should be geared toward setting maximum limits on family cost-sharing, e.g. 5 percent of income for those in the lower tax brackets and ten percent of income for those with higher income. 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.

Price transparency is a beginning, but is unlikely to have a major impact without better information on quality and total bills for the treatment of different acute and chronic conditions. Creating such a database is certainly feasible but requires federal leadership. This hearing is an important step toward achieving that desirable outcome.

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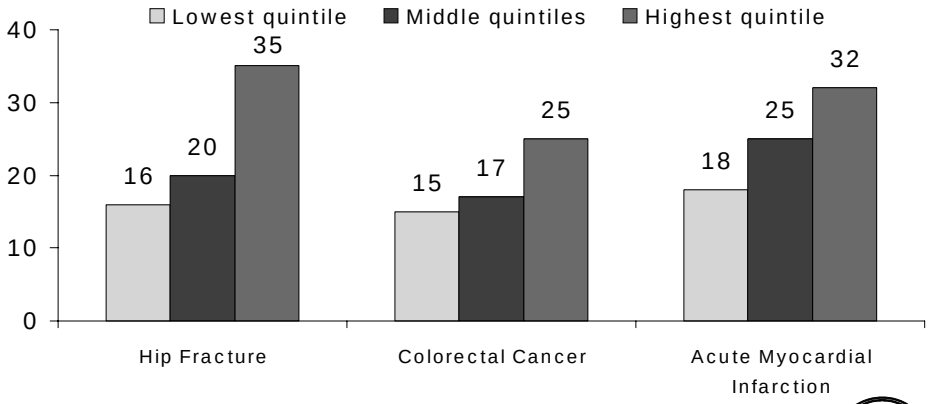
[40] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive, April 23, 2003.

[41] 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.

Figure 1. Percent of Patients Seen by 10 or More Physicians Varies Across Academic Medical Centers

Average percentage of patients seeing 10+ different physicians in first year of care within AMC hospitals



Note: Quintiles of practice intensity ("treatment groups") corresponded closely to regional differences in price and to illness-adjusted Medicare spending.
Source: E.S. Fisher et al., "Variations in the Longitudinal Efficiency of Academic Medical Centers," *Health Affairs* Web Exclusive, October 7, 2004.

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Figure 2. Private-Public Collaboration Needed to Improve Availability of Quality and Cost Information

	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.

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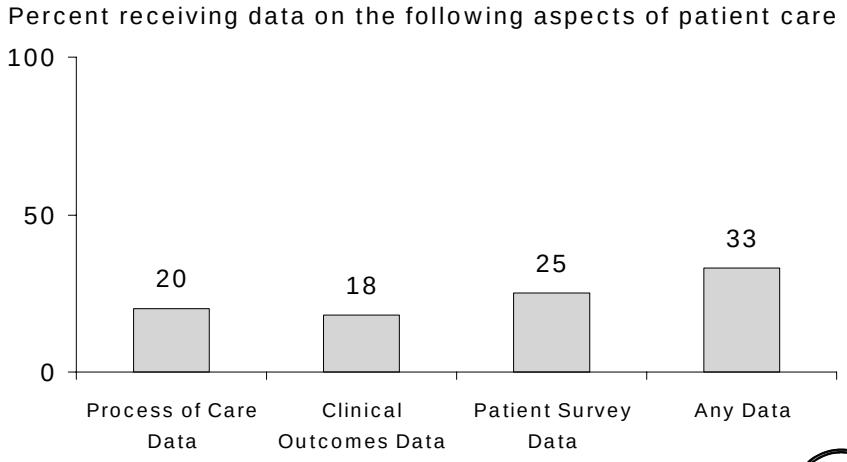
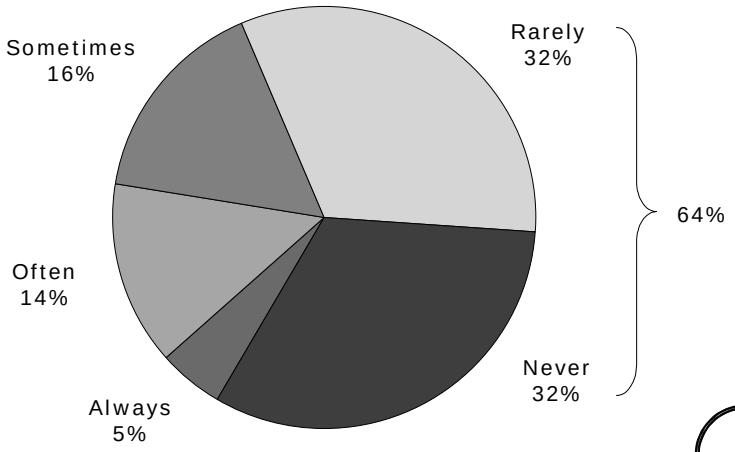
Figure 3. Physicians' Access to Quality-of-Care or Performance Data on Their Own Care



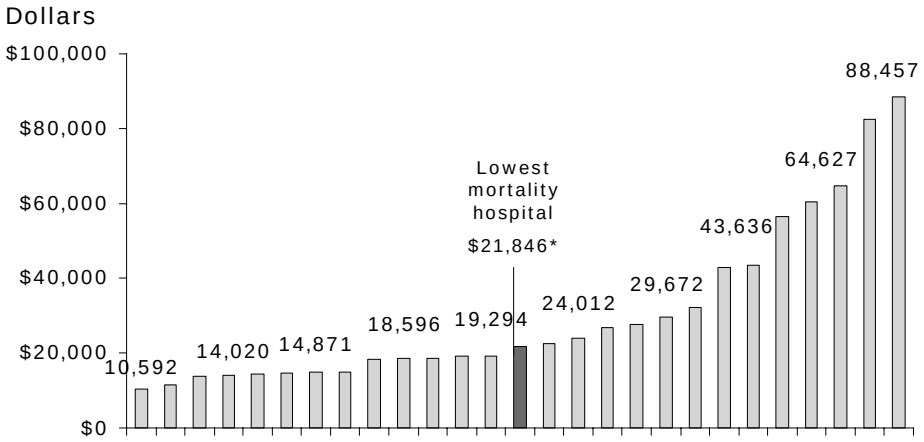
Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.

Figure 4. Availability of Quality-of-Care Data When Making Referrals



Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.

Figure 5. Hospital Charges for AMI–Medical Management Vary Eight-Fold Across Large Pennsylvania Hospitals



*This hospital demonstrated significantly lower than expected in-hospital mortality rates.
Note: Hospital charge equals patient total charge excluding professional fees; all hospitals shown provided advanced cardiac services (angioplasty/stent procedures), had >100 cases, and <5% of cases transferred to another acute care facility.
Source: Pennsylvania Health Care Cost Containment Council, Hospital Performance Results, Hospital discharges between January 1, 2003 and December 31, 2003, www.phc4.org.

Figure 6. Top-Ranked and Bottom-Ranked Performances in Measures of Quality of Care for AMI, CHF, and Pneumonia Among the 40 Largest Hospital-Referral Regions*

Hospital-Referral Region	AMI Score (%)	Hospital-Referral Region	CHF Score (%)	Hospital-Referral Region	Pneumonia Score (%)
Top-ranked		**Top-ranked**		**Top-ranked**	
Boston, MA	95	Boston, MA	89	Oklahoma City, OK	82
Minneapolis, MN	94	Detroit, MI	88	Indianapolis, IN	79
Kansas City, MO	94	Baltimore, MD	87	Kansas City, MO	78
Albany, NY	93	Camden, NJ	87	Camden, NJ	78
Indianapolis, IN	92	Cleveland, OH	86	Knoxville, TN	77
Bottom-ranked		**Bottom-ranked**		**Bottom-ranked**	
Little Rock, AK	86	San Diego, CA	77	Miami, FL	63
Orlando, FL	86	Nashville, TN	76	Chicago, IL	61
Miami, FL	85	Orlando, FL	74	San Diego, CA	60
Memphis, TN	84	Little Rock, AK	69	Los Angeles, CA	60
San Bernardino, CA	83	Lexington, KY	68	San Bernardino, CA	59

*AMI denotes acute myocardial infarction, and CHF congestive heart failure.
Source: A K. Jha, Z. Li, E. J. Orav, and A. M. Epstein, "Care in U.S. Hospitals—The Hospital Quality Alliance Program," *New England Journal of Medicine* 353 (July 21, 2005): 265–74.

Figure 7. Physicians' Willingness to Share Quality-of-Care Data

Willingness to share data with:*	Yes, Definitely/ Probably	No, Definitely/ Probably Not
Medical leadership	71%	27%
Physicians' own patients	55%	44%
General public	29%	69%
Other physicians	72%	26%

*Answers to survey question: "To improve high quality of care in the U.S., which of the following do you think should have access to 'Quality of Care' data about individual physicians?"
Source: The Commonwealth Fund National Survey of Physicians and Quality of Care.

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Figure 8. Hospital CEO Opposition to Disclosure of Quality Information to the Public

Percent saying should NOT be released to the public:	AUS	CAN	NZ	UK	US
Mortality rates for specific conditions	34%	26%	18%	16%	31%
Frequency of specific procedures	16	5	4	13	15
Medical error rate	31	18	25	15	40
Patient satisfaction ratings	5	2	0	1	17
Average waiting times for elective procedures	6	1	0	1	29
Nosocomial infection rates	25	10	25	9	29

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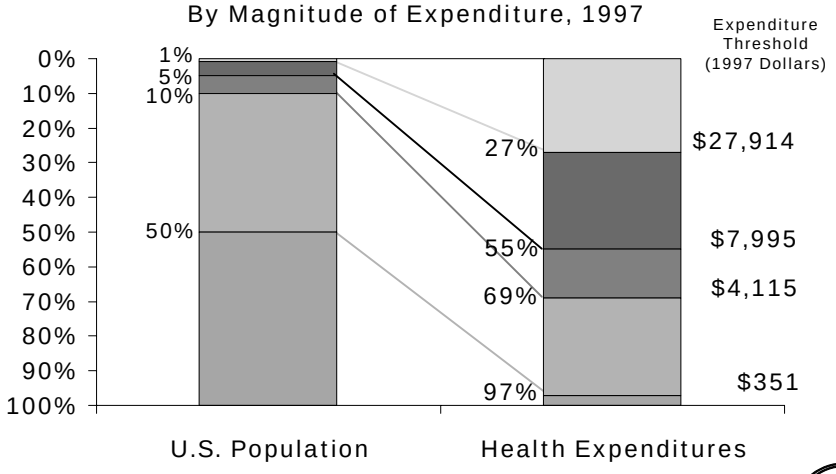
Source: The Commonwealth Fund 2003 International Health Policy Survey of Hospital Executives.

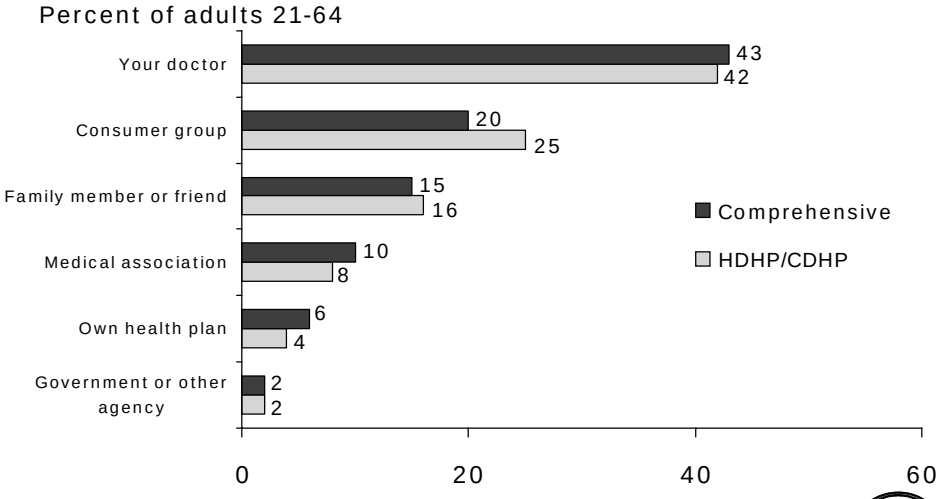
Figure 9. Most Costs Are Concentrated in the Very Sick

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.

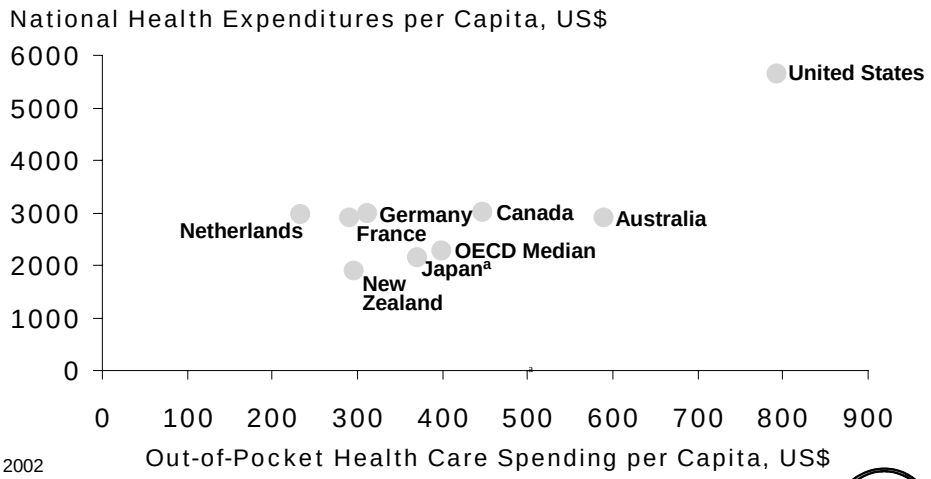
Figure 10. Most Trusted Sources for Information on Health Care Providers, by Insurance Source



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

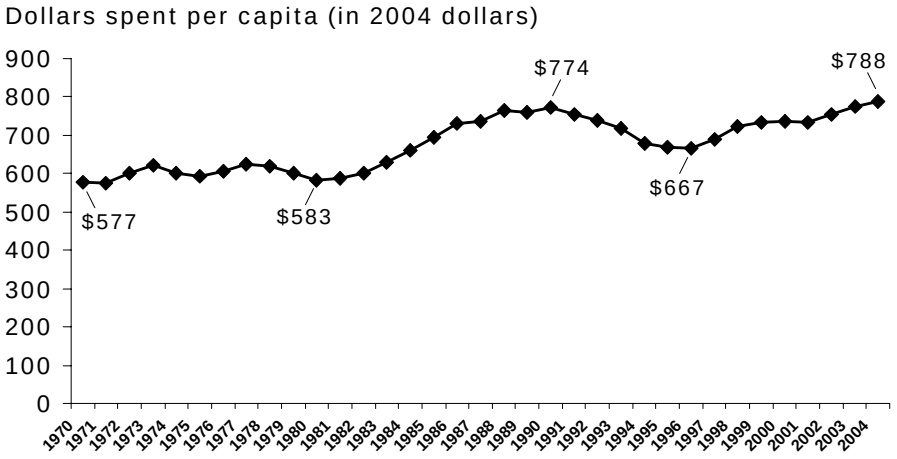
Figure 11. "Perception that Health Care Is Free"*Is Not the Problem



[a] 2002

*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.

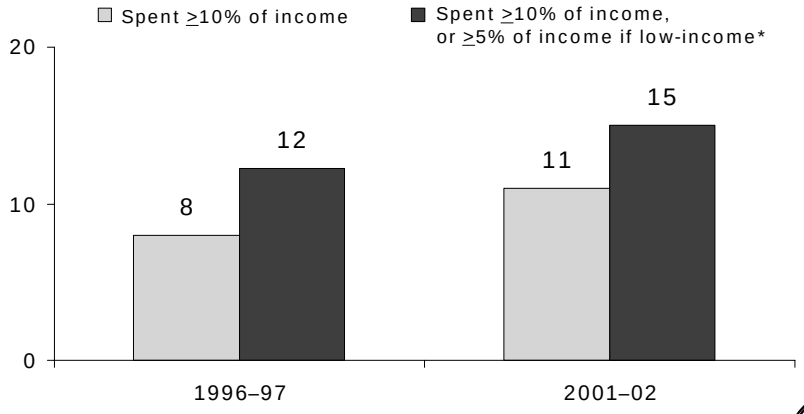
Figure 12. Consumers Spending More Out-of-Pocket for Health Care



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 13. 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.

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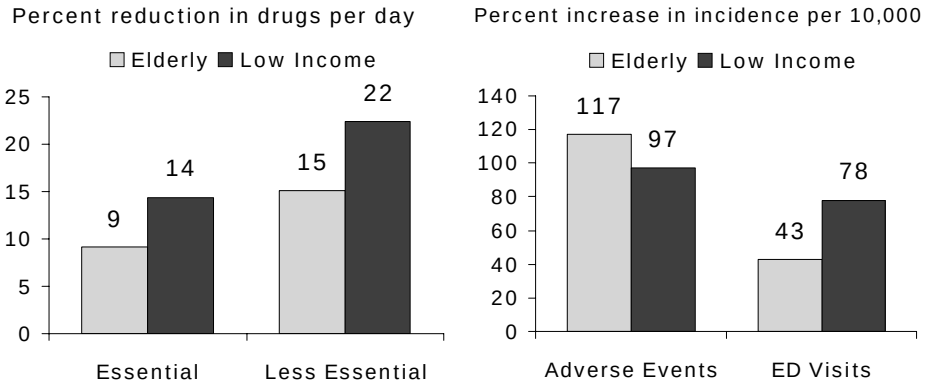
Figure 14. Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events



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.

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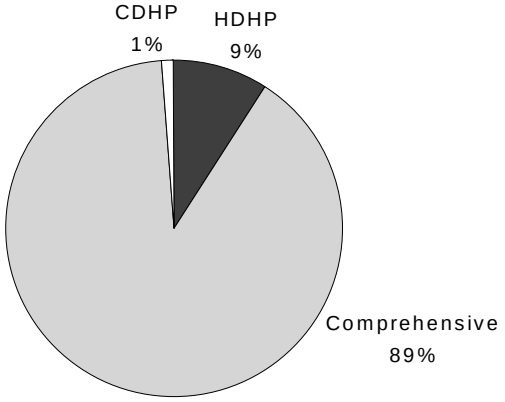
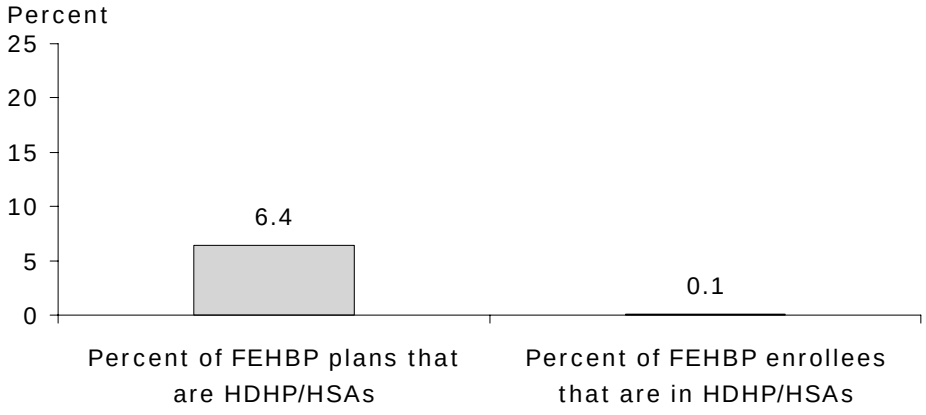
Figure 15. Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

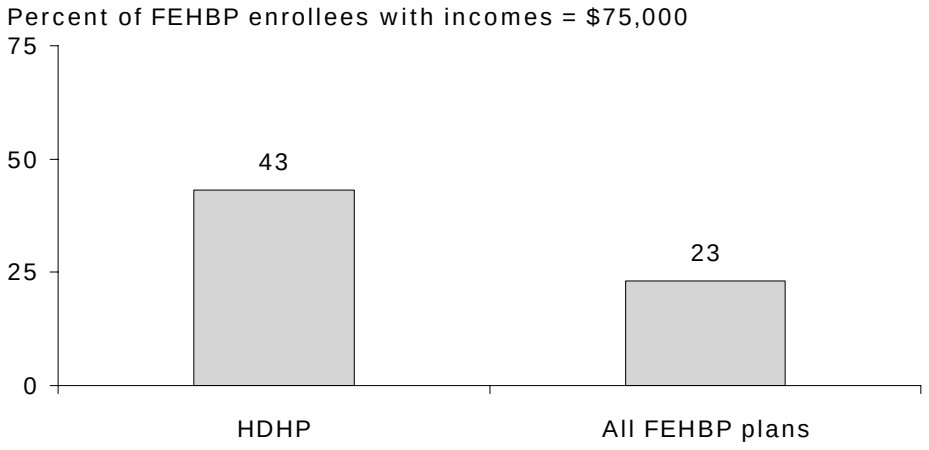
Figure 16. FEHBP HDHP/HSAs Plans Enroll 7,500 out of 9 Million Covered Lives



Note: As of March 2005.

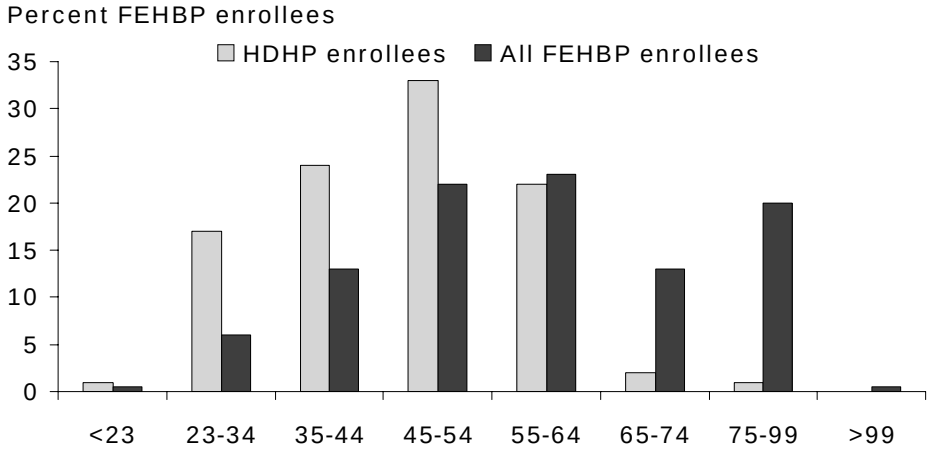
Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006; OPM, http://www.opm.gov/insure/handbook/FEHBhandbook.pdf

Figure 17. Enrollees Who Chose HDHPs from the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes



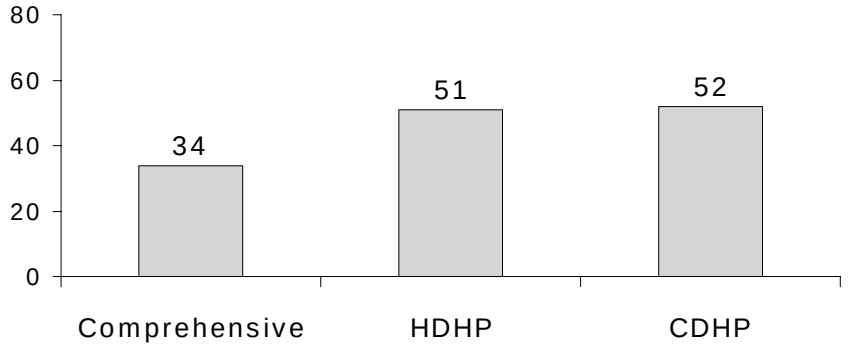
Source: Government Accountability Office, *Federal Employees Health Benefits Program First-Year Experience with High-Deductible Health Plans and Health Savings Accounts*, Washington, DC: GAO, January 2006.

Figure 18. 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, January 2006.

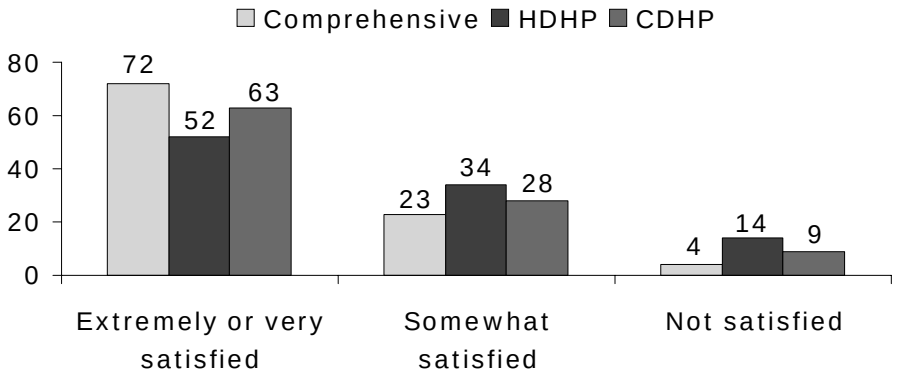
Figure 19. Percentage of Individuals Covered by Employment-Based Health Benefits With No Choice of Health Plan, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

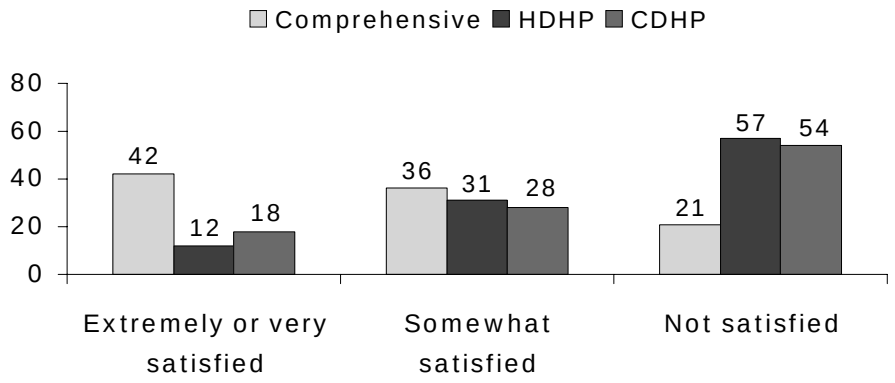
Figure 20. Satisfaction with Quality of Health Care Received, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

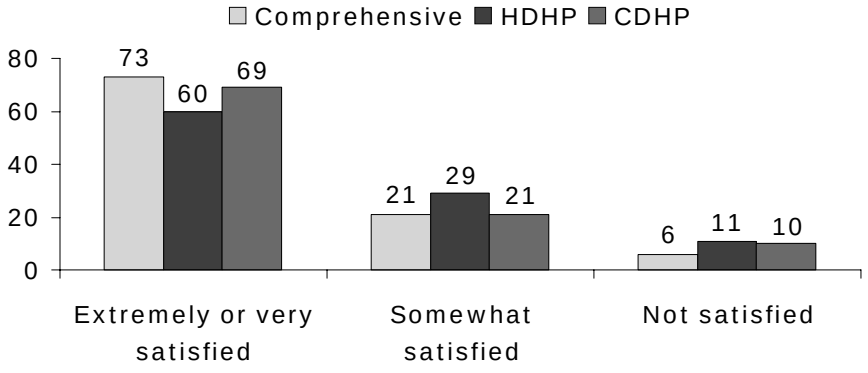
Figure 21. Satisfaction with Out-of-Pocket Costs for Health Care, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

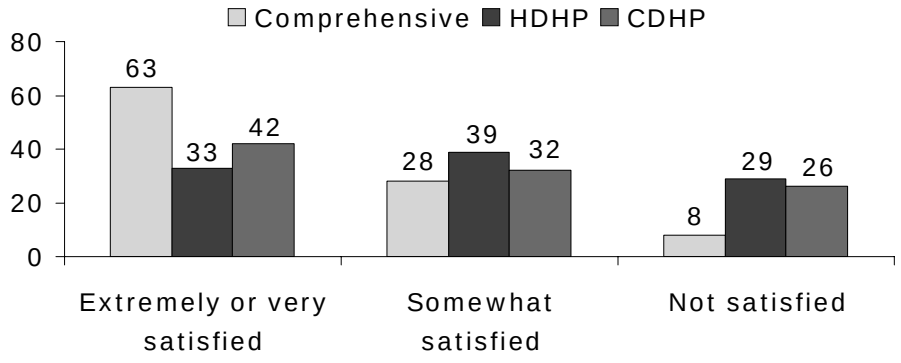
Figure 22. Satisfaction with Choice of Doctors, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

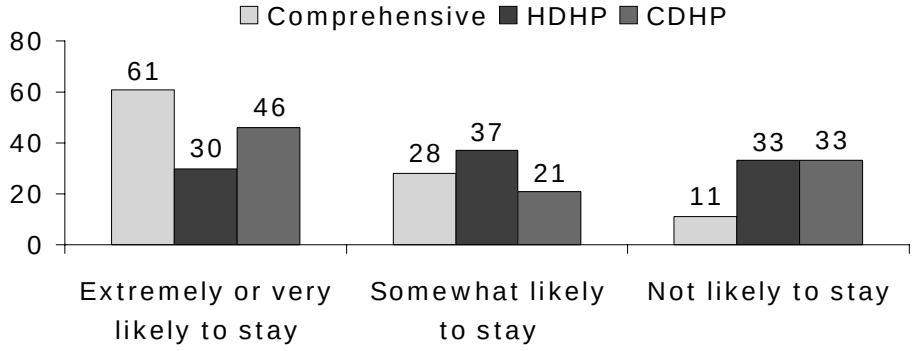
Figure 23. Overall Satisfaction with Health Plan, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

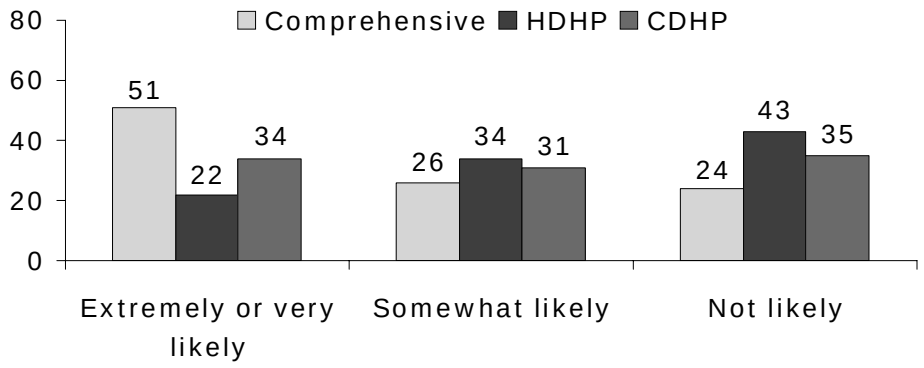
Figure 24. Likelihood of Staying With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan



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: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 25. Likelihood of Recommending Health Plan to Friend or Co-Worker, by Type of Health Plan

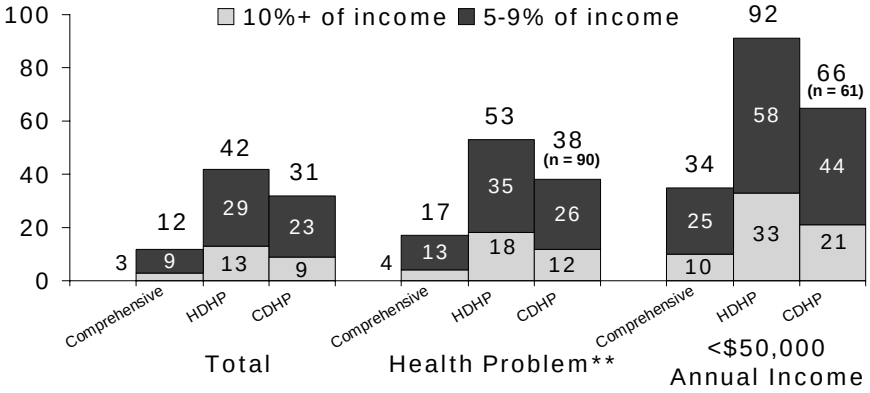


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 26. Percent of Income Spent Annually on Out-of-Pocket Medical Expenses, Including Premiums

Percent of adults 21-64 spending = 5% of income



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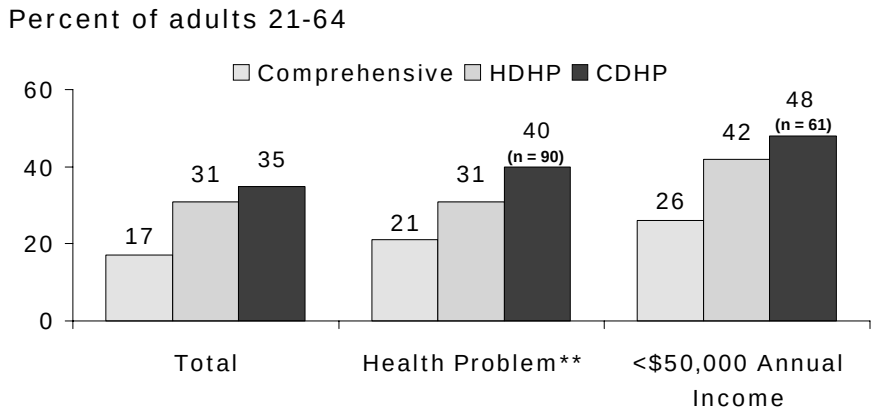
**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 27. Percent of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost



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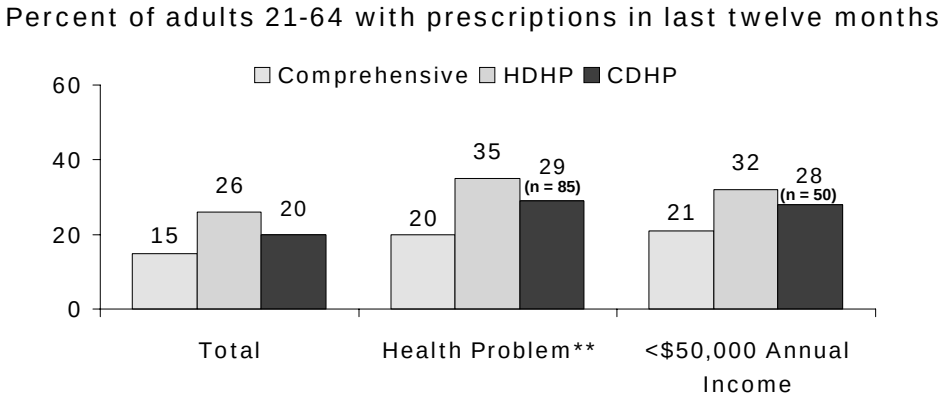
**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 28. Percent of Adults Who Have Skipped Doses to Make a Medication Last Longer

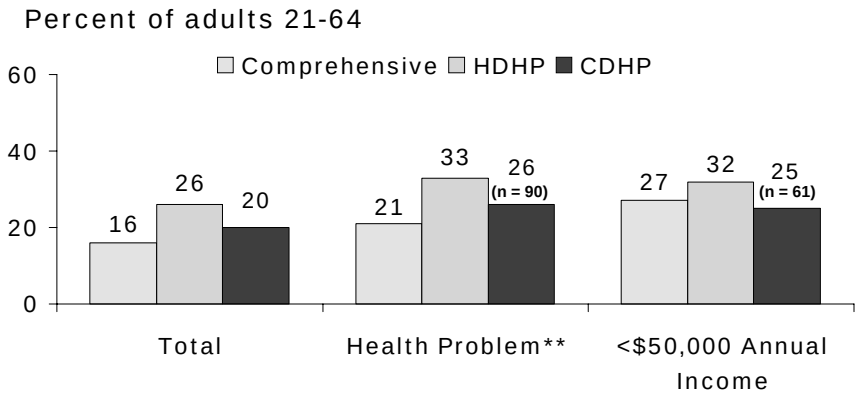


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

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

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 29. Percent of Adults Who Have Not Filled a Prescription Due to Cost

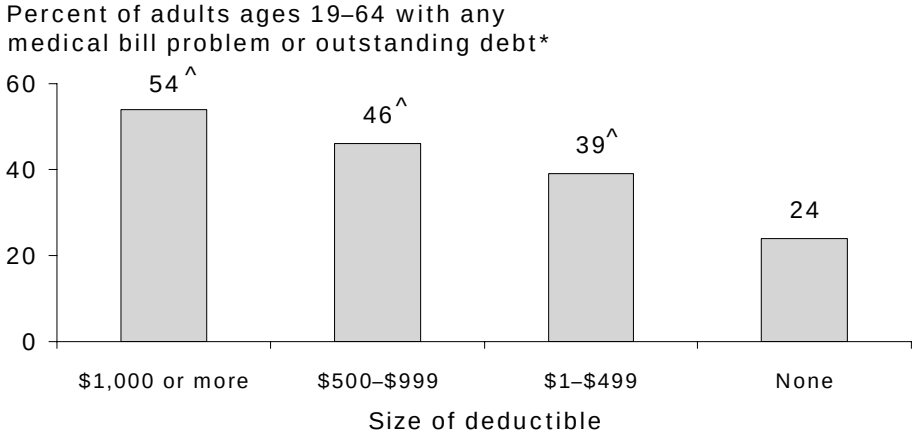


Note: Comprehensive = plan w/ no deductible or <$1000 (ind), <$2000 (fam); HDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), no account; CDHP = plan w/ deductible $1000+ (ind), $2000+ (fam), w/ account.

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

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.

Figure 30. Medical Bill or Debt Problems in Past Year, by Size of Deductible



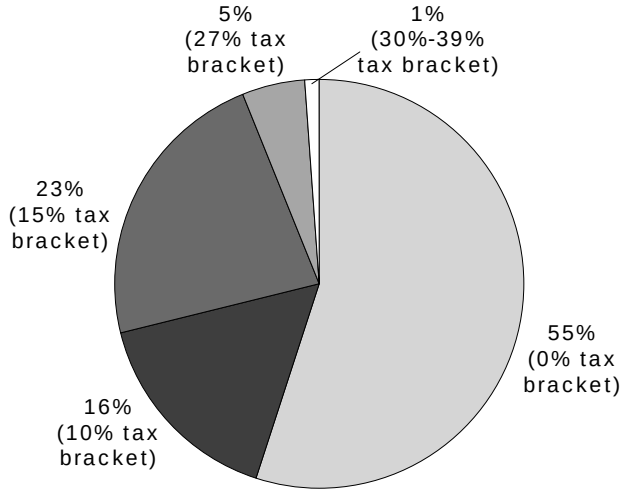
Note: Adjusted percentages based on logistic regression models; controlling for health status and income.

*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 31. 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, April 2005.

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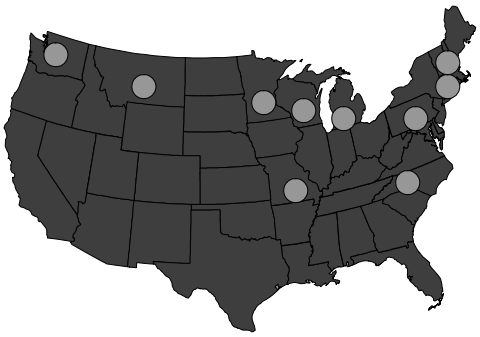
Figure 32. Medicare Physician Group Practice Demonstration



- The Everett Clinic (WA)
- Deaconess Billings Clinic
- Park Nicollet Health Services (MN)
- Marshfield Clinic (WI)
- St. John's Health System (MO)
- Univ. of Michigan Faculty Group Practice
- Geisinger Health System (PA)
- Forsyth Medical (NC)
- Middlesex Health (CN)
- Dartmouth-Hitchcock Clinic

- 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

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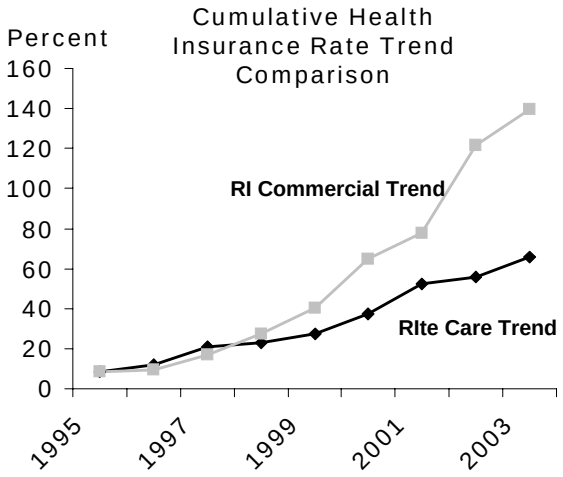
Source: "Medicare Physician Group Practice Demonstration," www.cms.gov, January 31, 2005.

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



- Quality targets and $ incentives
- Improved access, medical home
  - One third reduction in hospital and ER
  - Tripled primary care doctors
  - Doubled clinic visits
- Significant improvements in prenatal care, birth spacing, lead paint, infant mortality, preventive care

Source: Silow-Carroll, *Building Quality into RIte Care,* Commonwealth Fund, 2003. Tricia Leddy, *Outcome Update,* Presentation at Princeton Conference, May 20, 2005.

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