HOW HIGH IS TOO HIGH?
IMPLICATIONS OF HIGH-DEDUCTIBLE HEALTH PLANS

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ABSTRACT: The move toward high-deductible health plans (HDHPs) was given impetus by 2003 legislation granting tax preferences to funds set aside to pay for out-of-pocket medical expenses—conditional on enrollment in a plan having a minimum deductible of $1,000 for individuals and $2,000 for families. The major purported advantages of HDHPs are that they will a) lower health care costs by causing patients to be more cost-conscious, and b) make insurance premiums more affordable for the uninsured. This report, based on the Commonwealth Fund Biennial Health Insurance Survey (2003), finds that such plans are unlikely to have a substantial effect on either costs or coverage. Furthermore, HDHPs can undermine the basic purposes of health insurance: to reduce financial barriers to needed care and protect against financial hardship. The authors suggest legislative modifications to protect lower-wage adults and ensure access to early preventive and primary care.

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EXECUTIVE SUMMARY

Many market advocates have turned to high-deductible health insurance plans (HDHPs) as a strategy for making patients more cost-conscious. In 2003, the move toward HDHPs was given impetus by a provision in the Medicare Modernization Act granting tax preferences to funds set aside to pay for out-of-pocket medical expenses—conditional on enrollment in a plan having a minimum deductible of $1,000 for individuals and $2,000 for families. So while only 8 percent of privately insured adults under age 65 (7 million people) have deductibles of $1,000 or more, this number could well grow in future years.

High-deductible plans can undermine the two basic purposes of health insurance: to reduce financial barriers to needed care and to protect against financial hardship. This report, based on the Commonwealth Fund Biennial Health Insurance Survey (2003), finds that:

- Adults with a high deductible have significantly greater difficulty accessing care due to cost compared to those with a lower or no deductible. Thirty-eight percent of adults with deductibles of $1,000 or more reported at least one of four cost-related access problems: not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up, or having a medical problem but not visiting a doctor or clinic. By contrast, 21 percent of adults with no deductible report one of these four access problems.
- High-deductible plans would be particularly problematic for lower-income Americans: a predicted 44 percent of people with incomes below $35,000 and with a deductible of $500 or more would experience cost-related access problems, compared with 21 percent of higher-income, insured adults with deductibles under $500.
- People who are sick would have a more difficult time obtaining needed care under an HDHP: among adults with a deductible of $500 who rate their health as fair or poor, or who have a chronic condition or disability, a predicted 45 percent would have a cost-related access problem, versus 19 percent of healthier adults with a deductible under $500.
- Medical bill problems are more common among those with higher deductibles. Over half (54%) of those with a deductible of $1,000 or more reported difficulties paying medical bills or are paying off accumulated medical debt, compared with just 24 percent of privately insured adults with no deductible.

- Medical bill problems and medical debt are greater among lower-income adults with higher deductibles. An estimated 55 percent of those with incomes under $35,000 and deductibles of $500 or more would experience medical bill problems or accrue medical debt, compared with 27 percent of adults with higher income and deductibles under $500.
- For insured adults who are ill, having higher deductibles would mean they would be more likely to have difficulties paying medical bills or accumulate medical debt: 59 percent of sick adults with deductibles of $500 or more would experience medical bill or debt problems, compared with just 24 percent of comparatively healthy adults with a lower deductible.

The major purported advantages of HDHPs are that they will a) lower health care costs by causing patients to be more cost-conscious in their health care decisions, and b) make health insurance premiums more affordable for the uninsured. The authors find, however, that such plans are unlikely to have a substantial effect on either costs or coverage.

- Only 4 percent of health care expenses are accounted for by households with spending below the minimum deductibles required for participation in a health savings account (HSA). Altering the financial incentives for patients with health care spending under the deductible is unlikely to affect health care outlays significantly.
- The major effect of high deductibles is not lower total health care costs, but rather a one-time shift in spending from insurance premiums to patient out-of-pocket outlays. In future years, premiums are likely to continue to rise.
- High-deductible plans in the individual health insurance market are unlikely to be affordable for those Americans who are currently uninsured. Two-thirds of the uninsured have incomes that are less than twice the federal poverty level. Premiums for HDHPs equal about 6 percent of income for a 25-year-old man living at twice the poverty level and about 20 percent of income for a 60-year-old woman at that same income level. Researchers have found that few low-income individuals can afford to purchase coverage if premiums exceed 5 percent of income.
- Low-income individuals and families would be at risk for spending substantial sums of income out-of-pocket. The ceiling on out-of-pocket expenses constitutes 26 percent of income for single individuals and families at twice the federal poverty level.

Little advantage can be gained from providing people with incentives to choose an HDHP. Such incentives are essentially a tax break for higher-income individuals and, moreover, drain the federal treasury of $6 billion to $16 billion over 10 years. Further tax incentives proposed by the President in the fiscal year 2006 budget would provide an additional $48 billion over 10 years in subsidies to small businesses and individuals for HDHP/HSAs—funds that might be better spent on covering the uninsured through public programs or helping states maintain or expand coverage through Medicaid or other state insurance programs.

If HSAs continue to be conditional on purchase of an HDHP, several policy changes might be considered to better target incentives and ensure access to care:

- Permit employers to lower deductibles for lower-wage workers.
- Exempt primary care and preventive services from the deductible.
- Guarantee choice of a comprehensive health plan to workers covered under employer plans.
- Permit greater flexibility in benefit design.
- Set an income ceiling on eligibility for HSAs.

High-deductible plans can deter patients from seeking needed care and add to financial burdens, particularly on low-income families and those with chronic illnesses. The modifications suggested here—particularly those intended to protect lower-wage adults and ensure access to early preventive and primary care—would help mitigate the most potentially harmful effects of these plans.

HOW HIGH IS TOO HIGH? IMPLICATIONS OF HIGH-DEDUCTIBLE HEALTH PLANS

INTRODUCTION

Disillusioned with the ability of managed care to stem rising health care costs, many market advocates have turned to high-deductible health plans (HDHPs) as a strategy for making patients more cost-conscious. Employers see in HDHPs the opportunity to achieve savings in insurance premiums. The Administration has predicated its initiatives to expand health insurance coverage and reduce health care costs on tax incentives for the purchase of such plans. But plans with deductibles of $1,000 to $5,000 have not appealed to consumers in the past, even in the nongroup market. Furthermore, attempts to promote them to American consumers could well provoke a response as potentially fierce as the managed care backlash of the 1990s.

High-deductible coverage is not what most Americans currently have. Data from The Commonwealth Fund Biennial Health Insurance Survey (2003) indicate that only 8 percent of privately insured adults ages 19 to 64—7 million people—had deductibles of $1,000 or more. High deductibles are more common in the individual insurance market, where in 2003, 34 percent of the individually insured had deductibles in excess of $1,000. Still, there is a strong trend toward higher deductibles in both the group and individual insurance markets.[1]

The move toward HDHPs was given impetus by enactment of the Medicare Modernization Act (MMA). The MMA included a provision granting tax preferences to funds set aside to pay for out-of-pocket medical expenses—conditional upon enrollment in an HDHP. Such plans must have a deductible of at least $1,000 for individuals and $2,000 for families, indexed to inflation. Funds set aside for out-of-pocket medical expenses up to the amount of the deductible (not to exceed $2,650 for an individual and $5,250 for a family in 2005) may be invested in a Health Savings Account (HSA). Contributions to such accounts are not taxed as income (whether or not individuals itemize deductions); earnings on investments and distributions from the account for qualified medical expenses are similarly exempt from taxation.

The rationale for selecting this particular insurance benefit design as a condition for tax-favored health savings is largely based on theoretical arguments. According to the 2004 *Economic Report of the President,* Americans have too much insurance, and incentives for joining higher-deductible plans are needed to address the phenomenon.[2] HDHPs, it is

said, will lower health care costs by inducing patients to be more cost-conscious and forgo care of marginal value.[3]

Critics, meanwhile, contend that high deductibles lead to underutilization of effective care and create financial hardships for working families and patients with chronic illnesses.[4] Indeed, the evidence that exists, largely drawn from the RAND Health Insurance Experiment of the late 1970s, finds that greater cost-sharing reduces appropriate and inappropriate care in roughly equal proportions.[5]

This report reviews the precedents leading up to the establishment of high-deductible health plans/health savings accounts (HDHP/HSAs) and presents empirical evidence from the Commonwealth Fund Biennial Health Insurance Survey of the effect of deductibles on access to care and financial burdens. It reviews the likelihood that HDHP/HSAs will improve health insurance coverage or curb rising costs. Finally, it suggests ways in which HDHP/HSAs could be modified to mitigate their potentially harmful effects on low-wage workers and adults with chronic conditions.

HIGH-DEDUCTIBLE HEALTH PLANS/HEALTH SAVINGS ACCOUNTS AND THEIR PRECURSORS

The enactment of the HDHP/HSA provision in the MMA followed several earlier initiatives that permitted individuals or employers to set aside funds for medical expenses not covered by health insurance plans. Early precursors include flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and Archer Medical Savings Accounts (MSAs).

Flexible Spending Accounts

Flexible spending accounts were created as part of the Revenue Act of 1978. Employees may contribute pre-tax dollars to an FSA to pay for health care services not covered by health insurance. Such contributions deducted regularly from employee paychecks throughout the year provide funds for employees to meet cost-sharing requirements under employer health insurance plans or to pay for noncovered services such as vision or dental care. Funds not used by the end of the year revert to the employer, although analyses find that only about 2 to 3 percent of funds set aside are typically lost.[6] The accounts have grown in popularity: one-fourth of employers with 10 or more employees offered an FSA in 2004, and 36 percent of eligible employees participated. An estimated 12 million to 18 million workers (out of a labor force of approximately 150 million) have the accounts.[7] The average contribution was $1,295 in 2004.

Health Reimbursement Arrangements

The tax treatment of HRAs was set forth by an Internal Revenue Service ruling on July 15, 2002. These accounts are funded by employers. As with FSAs, employees may use funds in an HRA to pay for health care services not covered by health insurance. Unlike FSAs, however, HRA funds do not have to be spent by the end of the year but can be carried over year to year (although employees usually lose balances when they leave their firm). Employers have complete discretion over the benefit design; for example, they can decide the amount of the deductible, exempt preventive services from the deductible, or set a separate lower deductible for prescription drugs. Typically, employers require workers to choose a high-deductible plan in order to have an HRA.

Enrollment in HRAs has been low: 2004 enrollment was estimated to be one million.[8] One percent of employers offered a plan with an HRA.[9] One study found that the median deductible for employee-only coverage was $1,500 among 23 plans studied, with an $800 employer contribution to the HRA.[10] For families, the median deductible was $4,000, with a median $1,900 employer contribution to the HRA. About one of 10 employees enrolled in a high-deductible HRA plan when it was offered as a choice along with lower-deductible, comprehensive health plans.[11]

Medical Savings Accounts

Archer Medical Savings Accounts (MSAs) were authorized as part of a demonstration under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To qualify, an individual must work for a firm with 50 or fewer employees, and be covered by a health plan that has an annual deductible between $1,700 and $2,600 for self-only coverage and between $3,450 and $5,150 for family coverage. Certain preventive services can be covered in full. Either the employer or employee may make contributions to the Archer MSA, but not both in a given year. Employer contributions are excluded from taxable income, and individual contributions are deductible from adjusted gross income. The maximum contribution is 65 percent of the deductible for individuals and 75 percent of the family deductible for families. Enrollment, or take-up, for this option has been low.[12] An estimated 80,000 people had Archer MSAs in 2001.[13] With enactment of HSAs, no new Archer MSAs are allowed after December 31, 2003.

Health Savings Accounts

To qualify for a tax-free contribution to the new HSAs, an individual must be covered by a health plan with an annual deductible of at least $1,000 for self-coverage and $2,000 for family coverage, indexed to inflation. Certain preventive services can be covered in full, not subject to the deductible. Plans must have a ceiling on out-of-pocket expenses of not

more than $5,100 for employee-only coverage and $10,200 for family coverage (in 2005). Both individuals and employers are allowed to contribute to an HSA.

Contributions to an HSA are excluded from workers' taxable income if made by the employer and are deductible from adjusted gross income if made by the individual. The maximum annual contribution, which cannot exceed the plan deductible, is $2,650 for self-only coverage and $5,250 for family coverage in 2005. Individuals are prohibited from participating in HSAs if they are covered by an FSA or HRA (except an FSA or HRA for limited purposes such as vision or dental care, or cost-sharing over the deductible). HSAs are projected by the Congressional Budget Office to cost the federal government $6 billion in forgone revenue over 10 years; the Administration puts the cost at $16 billion, due to varying assumptions about take-up rates.[14]

Individuals own their HSA accounts, may carry over balances from year to year, and may keep their balances when they leave their firms. Accounts may be administered by a bank, insurance company, or other nonbank trustee approved by the Internal Revenue Service (IRS). Interest, dividends, or capital gains on investments in the HSA are not subject to tax. The portability of HSA accounts should make them attractive to employees, but this feature may reduce the willingness of employers to contribute to such accounts.

HSA balances may be used to pay for qualified medical expenses not covered by health insurance and premiums for COBRA coverage or long-term care insurance. Individuals who become uninsured may use HSA balances to pay out-of-pocket medical expenses; those covered by unemployment insurance can use the funds to purchase health insurance coverage. Medicare beneficiaries, meanwhile, may use HSA balances to pay out-of-pocket medical expenses, Medicare premiums, premiums for Medicare Advantage plans, and their share of retiree health plan premiums.

There are, however, restrictions on the use of HSA balances for insurance coverage. They cannot be used to buy Medigap supplemental private coverage, nor can active workers use them to pick up the employee share of premiums. Balances at death can be left to a spousal HSA. Other heirs must pay income and estate taxes on the balances, which may be used for any purpose.

Since HDHP/HSAs are relatively new, very few individuals are enrolled in them. In September 2004, 438,000 people were covered by such plans, including 91,500 individuals covered through employer plans.[15] Most of those covered, however, are in

individual health insurance plans. While we do not know which individual purchasers opened HSAs, one-third of all individual health insurance holders in 2003 already had a deductible in excess of $1,000. To date, the major effect of the HSA/HDHP provision in the MMA has likely been to provide tax subsidies to those people already covered by high-deductible health insurance. One-third of those individuals were previously uninsured.

Now that the IRS has issued guidance on requirements regarding HDHP/HSAs, more employers may offer such plans in the future. The Federal Employees Health Benefits Program also initiated several HDHP/HSA offerings in its fall 2004 open-enrollment season. It remains to be seen, however, whether employers will prefer HSAs to HRAs when setting aside funds to help employees finance out-of-pocket health care expenses. The fact that employees take their HSAs with them when departing from a firm makes these accounts less attractive to employers.

The Congressional Joint Committee on Taxation projects that 3 million people will be covered by HDHP/HSAs by 2013; advocates project enrollment of 9 million.[16] The actual enrollment figures will depend greatly on the degree to which workers resist greater exposure to out-of-pocket costs as well as the actual or perceived shift of costs from employers to employees.

DEDUCTIBLES' EFFECT ON ACCESS TO CARE AND FINANCIAL BURDENS

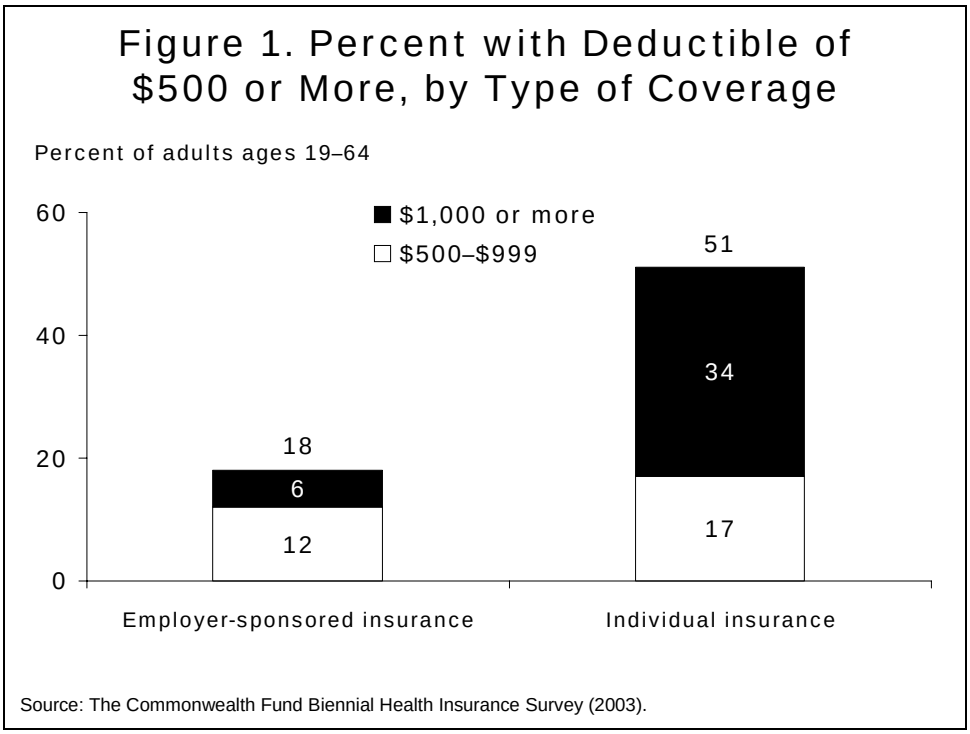
Health insurance has two basic purposes: to reduce financial barriers to needed care and to protect against financial hardship from medical bills. There has been much research documenting that uninsured individuals are far less likely to obtain preventive care and receive ongoing management of their chronic conditions, more likely to skip medication doses or not fill prescriptions at all, and more likely to suffer health consequences.[17] If deductibles are set too high or benefits are too limited, even insured individuals may have similar difficulty obtaining needed care or may incur burdensome medical bills. Indeed, a recent study indicates that three-fourths of people declaring bankruptcy for medical reasons were insured at the time they incurred the bills.[18]

Since experience to date with HRAs and HSAs is quite limited, assessing their effect on these insurance goals is difficult. It is possible, however, to determine the effect of deductibles of various sizes on patient behavior. Research over the last three decades documents that while higher patient cost-sharing reduces use of health care services, it is a blunt instrument for differentiating between use of effective services and inappropriate

care.[19] Patients with greater cost-sharing reduce use of effective services (e.g., use of cholesterol-reducing drugs or congestive heart failure medications) as well as inappropriate or marginally beneficial care.[20] Further, the impact on access to effective care for those with lower incomes or with chronic conditions is typically greater.[21]

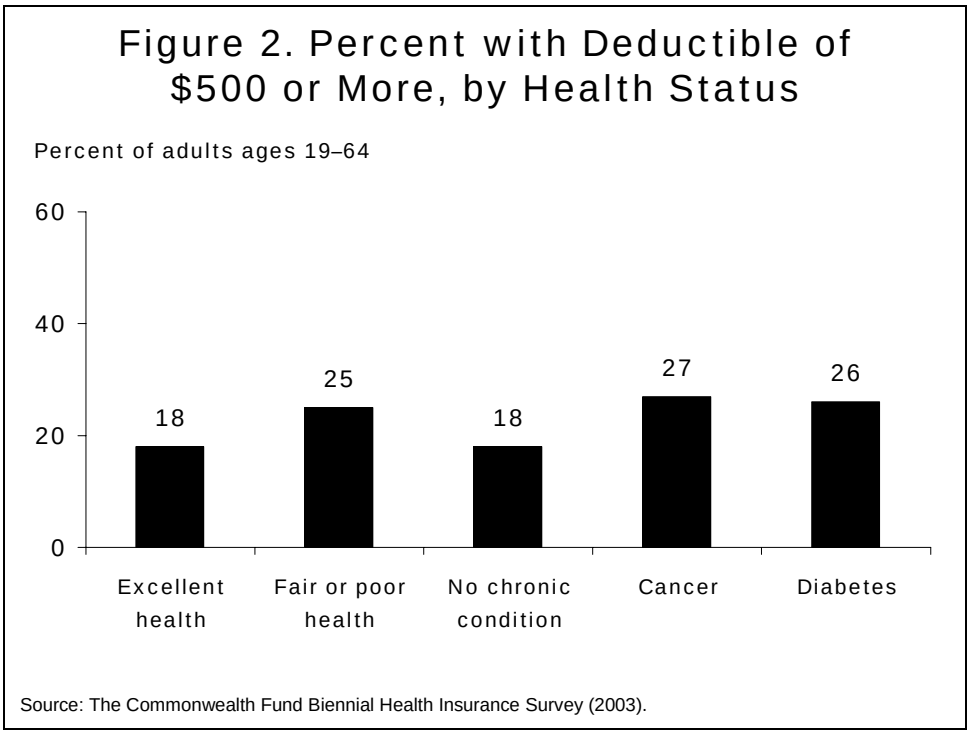
The Commonwealth Fund Biennial Health Insurance Survey, a nationally representative survey of 4,052 U.S. adults ages 19 and older, provided recent data on the relationship between deductibles of various sizes and access to care and financial burdens reported by patients. For the analyses presented here, the authors focus on the 1,648 respondents ages 19 to 64 who were insured all year by private insurance and who reported information on their deductibles. This subgroup includes 137 individuals with deductibles of $1,000 or more, 200 adults with deductibles of $500 to $999, and 1,311 with either no deductible or deductibles less than $500.[22] (See Appendix for more details on the study's methodology.) It should be noted that the survey provided no information on which individuals with large deductibles had HRAs, although given the limited enrollment in such accounts nationally as of 2003, the numbers are undoubtedly small. Further, the survey period—September 3, 2003, to January 4, 2004—predated implementation of the HSA legislation.

According to the Fund survey, 80 percent of all adults ages 19 to 64 who were privately insured all year had deductibles under $500, including 40 percent who reported not having a deductible. Higher deductibles are more common in the individual insurance market. Slightly more than half (51%) of those with individual insurance had deductibles of $500 or more, including 34 percent with deductibles of $1,000 or more (Figure 1). By contrast, only 18 percent of those covered by employer plans had deductibles of $500 or more, among them 6 percent with deductibles of at least $1,000. Still, because employer coverage is the dominant form of insurance coverage among nonelderly adults, 5 million of 7 million individuals with deductibles of $1,000 or more were covered by employer plans in 2003 (Table 1).



Higher deductibles are more common among older people than younger people. Although older adults are more likely to purchase individual insurance, given the use of underwriting in the individual market they are likely to be in better health than typical older adults. Nearly a quarter (23%) of the surveyed adults ages 50 to 64 had deductibles of $500 or more, compared with 16 percent of those ages 19 to 29 (Table 2).

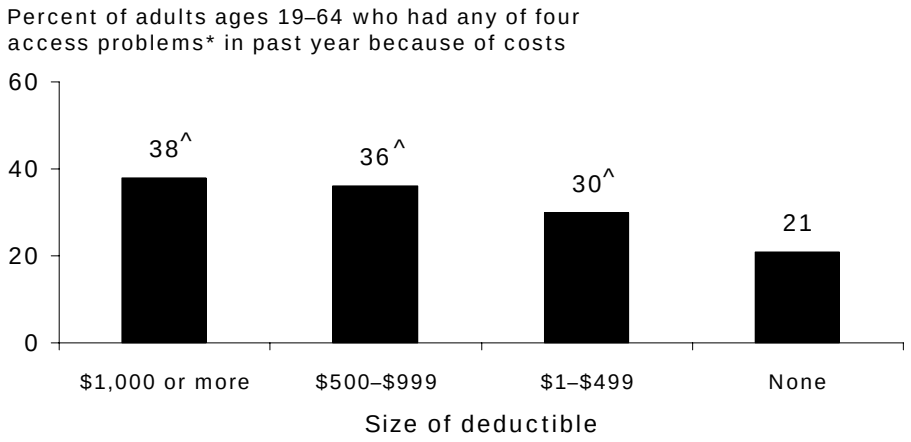
High deductibles are also somewhat more common among the groups likely to be most at risk for incurring heavy financial burdens from medical expenses—the very poor and those with health problems. Twenty-seven percent of those under the poverty level reported deductibles of $500 or more, compared with 20 percent of those living at more than twice the poverty level. Low-wage workers are more likely to work for small businesses that tend to have higher deductibles, in part because workers and small businesses alike find that premiums for more comprehensive plans are prohibitively expensive. Among survey respondents rating their health as fair or poor, 25 percent reported deductibles of $500 or more (Figure 2).[23] By contrast, 18 percent of those rating their health as excellent said they had deductibles of $500 or more.



Access to Care

Confirming prior studies, Americans with higher deductibles are significantly more likely than those with lower deductibles to report difficulty obtaining needed care. In fact, as deductibles increase, so do rates of problems accessing care. Thirty-eight percent of those with deductibles of $1,000 or more reported at least one of four cost-related access problems: not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up exam, or having a medical problem but not visiting a doctor or clinic (Figure 3; Table 3). On the other hand, a much lower share of adults with no deductible (21%) reported one of these four access problems.

Figure 3. Access Problems in Past Year, by Size of Deductible



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

* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic because of costs.

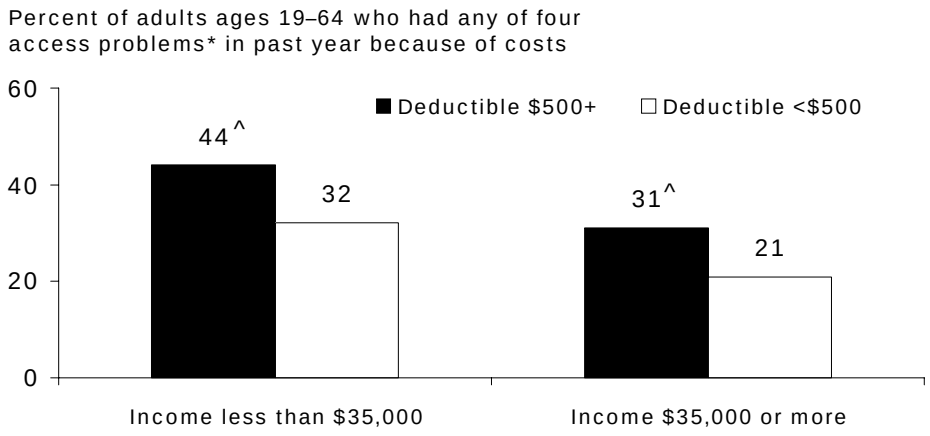
^ Significant difference at p < .05 or better; referent category = no deductible.

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

Those with deductibles of at least $500 are more likely than those with deductibles under $500 to: not fill prescriptions (23% vs. 17%); not get needed specialist care (12% vs. 7%); skip a recommended test or follow-up visit (19% vs. 10%); and report having a medical problem but not visiting a doctor or clinic (24% vs. 9%).

Those with incomes below $35,000 and deductibles of at least $500 were also more likely to report cost-related access problems. Forty-four percent of this vulnerable group reported at least one of four access problems, compared with 32 percent of lower-income, insured adults with deductibles under $500 and 21 percent of higher-income insured with deductibles under $500 (Figure 4).

Figure 4. Access Problems in Past Year, by Deductible and Income



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

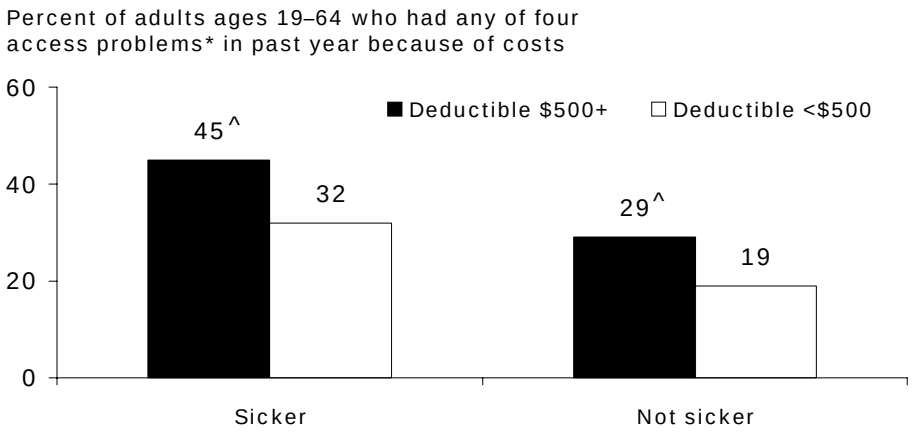
* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic because of costs.

^ Significant difference at $p < .05$ or better.

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

Insured adults with health problems are also at greater risk of having difficulty accessing care when they are covered by a higher-deductible plan. Among insured adults (ages 19 to 64) who have a deductible of $500 or more and rate their health as fair or poor, or report having a chronic condition or disability, 45 percent reported at least one of four access problems. This compares with 32 percent of adults who have a health problem but whose deductible is less than $500, and 19 percent of relatively healthy adults with a deductible under $500 (Figure 5, Table 5).

Figure 5. Access Problems in Past Year, by Deductible and Health Status



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

* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic because of costs.

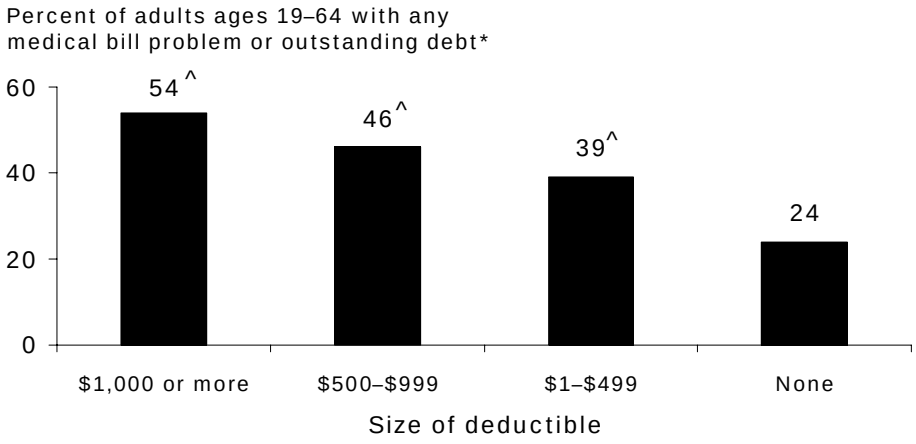
^ Significant difference at p < .05 or better.

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

Medical Bill Problems and Medical Debt

Medical bill problems are also more common among patients with higher deductibles. Over half (54%) of those in the survey with a deductible of $1,000 or more reported difficulties paying medical bills, or were paying off accumulated medical debt (Figure 6, Table 3). Medical bill problems include: having difficulty paying or not being able to pay medical bills; being contacted by a collection agency for a medical bill; or having to change your way of life to pay bills. Even among those with no deductible, almost one-fourth (24%) reported medical bill problems or accumulated medical debt, after adjusting for differences in income and health status. For those with deductibles of $500–$999, 46 percent reported medical bill problems or accumulated debt, as did 39 percent of those with deductibles of $1–$499.

Figure 6. 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.

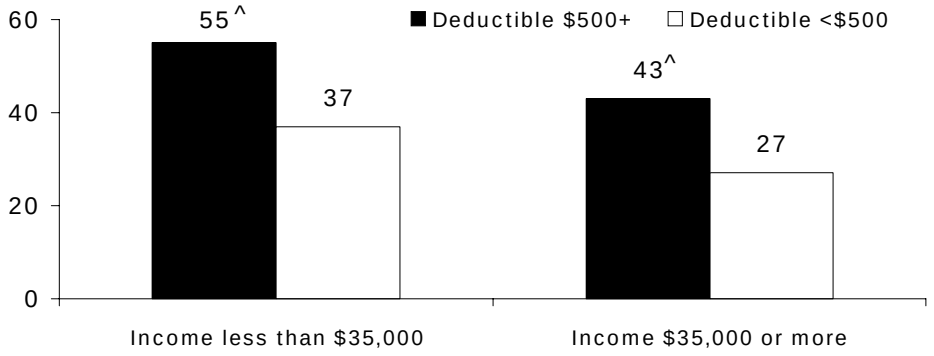
* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

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

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

Nor surprisingly, those with lower incomes have more problems paying medical bills; this is particularly the case for those with higher deductibles. For those with incomes under $35,000 and deductibles of $500 or more, 55 percent reported medical bill problems or medical debt compared with 37 percent of lower income insured with deductibles under $500 and 27 percent of higher income insured with deductibles under $500 (Figure 7, Table 4).

Figure 7. Medical Bill or Debt Problems in Past Year, by Deductible and Income



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

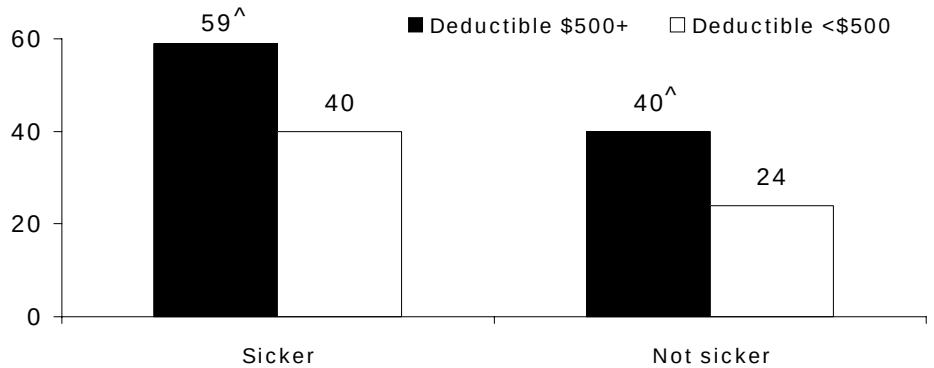
* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.

^ Significant difference at p < .05 or better.

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

Similarly, sicker insured adults with higher deductibles were more likely to report difficulties paying medical bills or accumulated medical debt. Fifty-nine percent of sicker adults with deductibles of $500 or more reported medical bill or debt problems, compared with 40 percent of sicker adults with a lower deductible and 24 percent of healthier adults with a lower deductible (Figure 8, Table 5).

Figure 8. Medical Bill or Debt Problems in Past Year, by Deductible and Health Status



Note: Adjusted percentages based on logistic regression models; controlling for 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.

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

WILL HIGH-DEDUCTIBLE PLANS REDUCE COSTS AND IMPROVE COVERAGE?

High out-of-pocket costs can lead to forgone medical care and serious financial difficulties, and these effects are more severe for individuals with lower incomes and serious health problems. But are these negatives outweighed by the purported advantages of HDHPs plans—namely, that they reduce total health care costs by making patients more cost-conscious and make health insurance more affordable for those who are currently uninsured?

Effect on Health Care Costs

The major rationale for increasing deductibles is to deter patients from using unnecessary health care services. In the late 1970s, the RAND Health Insurance Experiment (HIE) documented conclusively that higher deductibles do result in lower total spending. The RAND study gave participants insurance policies with zero, 25 percent, 50 percent, and 95 percent coinsurance, up to a total of $6,000 (in 2003 dollars).[24] In addition, ceilings placed on income reduced maximum out-of-pocket expenses for lower-income individuals.[25] Each participant (other than those in the no cost-sharing plan) was furthermore given an annual cash allowance of $6,000 to ensure that they were no worse off under any one of the options.[26]

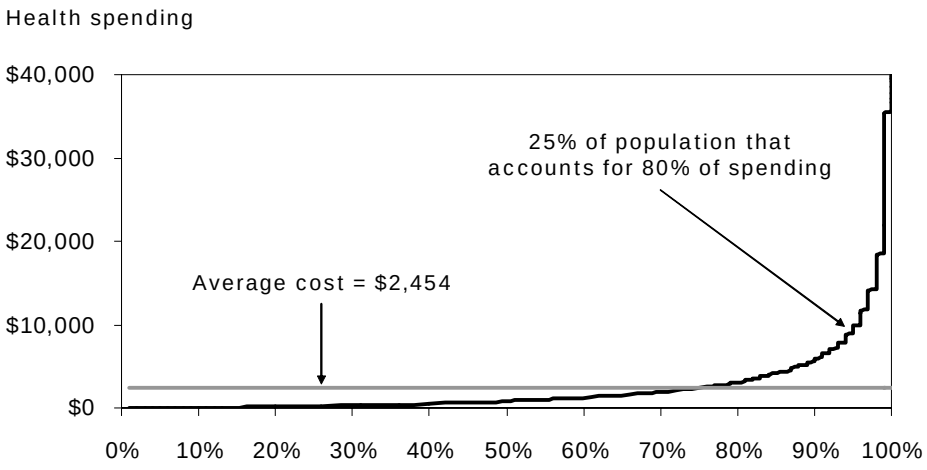
The evaluation of the RAND HIE found lower utilization of physician services and hospital stays, and lower total health spending, in higher cost-sharing options (Table 6).[27] For example, relative to participants in the 95 percent coinsurance plan (effectively, nearly the same as a $6,000 deductible), those with 50 percent coinsurance had 9 percent more in medical outlays, while those with 25 percent coinsurance had 18 percent more. The difference between the total health spending of those with 50 percent coinsurance and the spending of those with 25 percent coinsurance was about $85 per person annually (in 2003 dollars). While there were minimal or no effects on health status for the average enrollee, the reduction in use among those who were both poor and sick was harmful. In particular, the evaluation found that these patients' hypertension was less well controlled compared with others in that group, resulting in a 10 percent increase in the likelihood of death.

Other RAND studies documented that cost-sharing was a blunt instrument. It reduced utilization of appropriate and inappropriate care in roughly equal proportions, and had a greater adverse effect on lower-income adults and children.[28]

Joseph Newhouse, the chief economist on the RAND HIE, noted that while cost-sharing increased in the 1980s following release of the RAND results, there was no break in the surge of health care inflation. "In fact, the real rate of increase in health care costs in the 1980s was the highest of any decade since 1940 save for the 1960s," he pointed out. Newhouse concludes that patient cost-sharing primarily affects patients' decisions to seek physician care, and that other techniques like managed care are needed to control the costliness of episodes of treatment.

The modest impact on total spending of a $1,000 deductible should not be surprising, since most health care outlays are concentrated among a few people with very high expenditures. The healthiest half of the population incurs 3 percent of total health care outlays.[29] By contrast, Fronstin finds that 25 percent of the population ages 18 to 64 accounts for 80 percent of spending (Figure 9).[30]

Figure 9. Distribution of Health Spending, Adults Ages 18–64, 2001



Source: Paul Fronstin, *Health Savings Accounts and Other Account-Based Health Plans*, Employee Benefit Research Institute, September 2004. EBRI estimates from the 2001 Medical Expenditure Panel Survey.

More precise estimates of the likely effect of HSAs are provided by an analysis by the Urban Institute and Brookings Institution Tax Policy Center.[31] Using data from the Medical Expenditure Panel Survey, Blumberg and Burman estimate that 58 percent of individuals and 33 percent of families had medical expenses in 2004 below the HSA minimum deductible ($1,000 for individuals, $2,000 for families) (Table 7). Only 4 percent of health expenses are accounted for by these "low cost" households. Total expenditures below the deductible (both for those exceeding it and those with expenditures under the

deductible) are 21 percent of total spending. Since most people do not know whether they will have high expenses in a given year, cost-sharing may affect more than those with low expenses. However, coinsurance, rather than deductibles, may be more effective at giving patients an incentive to economize on care across a broader range of health outlays. The absence of income-related deductibles may deter particularly vulnerable patients (e.g., low-income) from seeking needed care.

The major effect of a high deductible is likely to be a one-time shift in spending from premiums to patient out-of-pocket outlays. Premiums to employers and workers would be reduced by 10 to 15 percent (depending on the difference between the standard plan deductible and the HDHP deductible), but most of that reduction would be a reduction in covered medical outlays and a shift to out-of-pocket expenses for which patients would be responsible. For example, one major insurer takes the 10 to 15 percent in premium savings for its Federal Employees Health Benefits Program offering and puts those funds in the employee's health savings account.[32] However, other employers may choose to use those savings to offset employer premium costs, with workers responsible either for their own contributions to the HSA and/or increased out-of-pocket costs.

In a dynamic market where health insurance premiums are rising 12 to 15 percent a year, this one-time shift would show up as either no increase in the premium for one year or a slight reduction, after which premiums would likely continue to increase by 12 to 15 percent a year. Unless employers compensated employees for their higher out-of-pocket costs with contributions to an HSA or increase in wages, the main effect would be to minimize employer premium cost increases for one year while shifting costs to employees. Employer HSA contributions would be difficult to maintain in future years as premiums resumed their normal rate of increase.

Other details of the way HDHP/HSAs are designed may also affect costs. One critical issue is whether such plans have discounted provider prices. When offered by major insurers with preferred provider organization (PPO) plans, such provider networks are likely to be extended to HDHP products. This would guarantee that individuals pay lower prices for services below the deductible than would otherwise be the case. Such claims, however, would be processed by insurers to determine allowable charges, adding to administrative costs.

Effect on the Uninsured

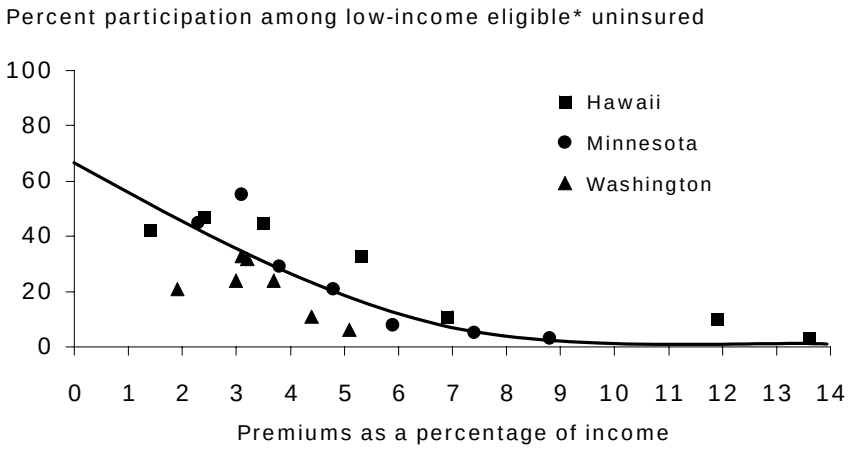
HDHP/HSAs could be expected to induce more health insurance coverage for two possible reasons. First, they provide tax incentives so individuals can offset part of the cost

of coverage by reduced taxes on savings. Glied and Remler, show, however, that the majority of the uninsured (56%) are in a zero tax bracket and thus not affected by income tax incentives, even if they have discretionary funds to commit to an HSA.[33] Only 6 percent of the uninsured have incomes that place them in an income tax bracket of 27 percent or more. Thirty-eight percent of the uninsured are in 10 to 15 percent marginal income tax brackets.

The second reason is that a premium for a HDHP will be lower than a premium for a more comprehensive health plan. Some uninsured individuals, therefore, might purchase a HDHP—even though they would have higher out-of-pocket expenses than if purchasing a comprehensive health plan—because they are primarily interested in "asset protection" and want assurance that they will not be forced into bankruptcy by catastrophic medical expenses.

But whether purchased through employers or through the individual market, few of the uninsured would be able to afford even a high-deductible premium. Studies typically find that few low-income individuals can afford to purchase coverage if premiums exceed 5 percent of income (Figure 10).[34]

Figure 10. Participation in Three Sliding-Scale Health Insurance Programs, by Premium as a Percentage of Income, 1995



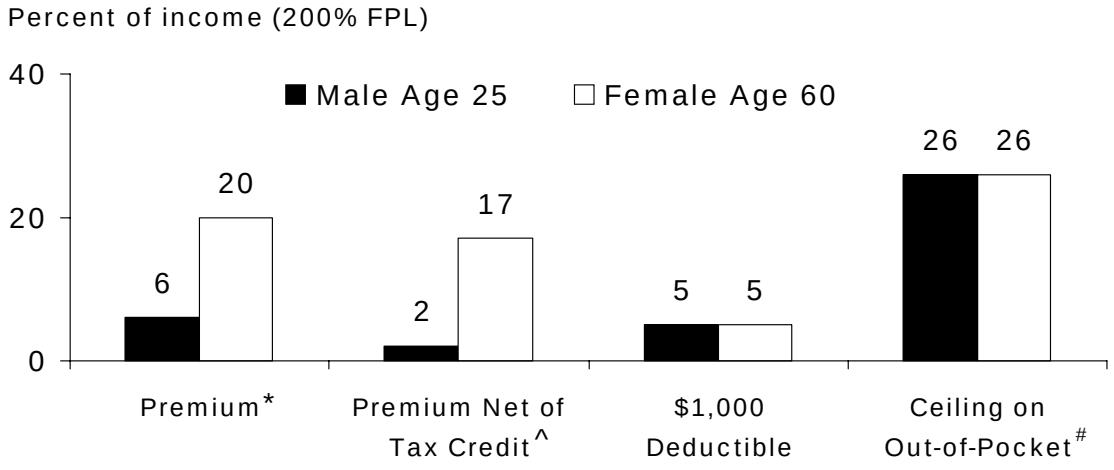
* Low-income eligible: up to 300% FPL in Hawaii; up to 275% FPL in Minnesota; up to 200% FPL in Washington.
Source: Leighton Ku and Teresa A. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States Experiences," *Inquiry* 36 (Winter 1999/2000): 471–80.

Currently, 11 million low-wage workers fail to take up offers of employer coverage, largely because they cannot afford their share of the premium.[35] The average

premium under an employer plan for a single person is $3,700, with a typical deductible of slightly under $300.[36] The employee share of the premium is normally 15 percent for single coverage, or about $555. Even if this share dropped by 10 to 15 percent for a high-deductible plan, the resulting $75 reduction in the annual employee premium could be expected to induce only a small fraction of uninsured workers to take up offers of employer coverage.

In the individual market, where costs typically vary with age, gender, and health status, premiums for single coverage with deductibles meeting the HSA threshold range from $780 to $5,509 for a 25-year-old male and from $2,244 to $8,039 for a 60-year-old-female in selected cities around the country (Table 8). With two-thirds of all the uninsured living below twice the poverty level—or slightly less than $20,000 for a single person in 2004—these prices are simply too high for most. A high-deductible individual health insurance plan would cost about 6 percent of income (range of 4% to 28%) for a 25-year-old male at twice the poverty level and about 20 percent of income (range of 11% to 41%) for a 60-year-old female at twice the poverty level (Figure 11).

Figure 11. Health Insurance Premiums in the Individual Market, $1,000 Deductible, and Ceiling on Out-of-Pocket Costs as a Percent of Income, for Individuals at 200 Percent of the Federal Poverty Level



* Median premium for 25 cities; lowest available for a $1,000 deductible plan with coverage of physician office visit, some coverage of prescription drugs (even if discount card), and some limit on a patient's out-of-pocket expenses.

^ Bush Administration's proposed tax credit of up to $1,000 per year for individuals, phasing out between $15,000 and $30,000 annual income. At an income of twice the federal poverty level, the credit would be $690.

Maximum annual out-of-pocket ceiling of $5,100 for self-only coverage specified in law for HSA plans; actual $1,000 deductible plans offered through www.ehealthinsurance.com ranged from $1,000 to $10,000 (which would not qualify as a HSA plan).

Source: Authors' calculations based on quotes from www.ehealthinsurance.com for nonsmoking, healthy individuals and HDHP plan specifications, March 2005.

In recognition of this affordability issue, the Administration has proposed tax credits of $1,000 for lower-income, single adults (with less than $25,000 of income) and $3,000 for lower-income families of three (with less than $60,000 of income) to offset part of the premium cost. While such credits would cover a substantial portion of HDHP premiums for young men, they fall short of making coverage affordable for older uninsured adults.

Even if uninsured, low-income individuals do purchase a high-deductible plan, they would be at risk for spending substantial sums of income out-of-pocket. Qualified HDHP/HSA-based plans must place caps of $5,100 on total out-of-pocket expenses for individuals and $10,200 for families. But this constitutes another 26 percent of income for those with incomes at twice the poverty level.

POLICY IMPLICATIONS

The potentially harmful impact of high deductibles on access to needed care and medical bill and medical debt problems raises a serious question about the advisability of the move toward HDHP/HSAs. There is very little advantage to requiring individuals to have high-deductible health plans. The main effect of the provisions is to increase the ability of higher-income individuals—who benefit most from the tax incentives and are most likely to have the funds to invest in the HSAs—to lower their taxes. In effect, the policy represents a $6 billion to $16 billion tax cut over 10 years (Congressional Budget Office and Administration estimates, respectively) for higher-income individuals.[37] This could be mitigated by capping income limits on eligibility for HSAs similar to those that now exist for individual retirement accounts, such as $55,000 for individuals and $75,000 for families.

The President in his fiscal year 2006 budget has proposed making HDHP premiums deductible from income (whether or not deductions are itemized) if plans are purchased in conjunction with an HSA. He has also proposed providing subsidies to small businesses to contribute to HSAs. Together, these benefits would provide an additional $48 billion over 10 years in subsidies to small businesses and individuals for HDHP/HSAs—but they would likely go disproportionately to higher-income households. Such expenditures might be better spent on covering low-income, uninsured workers through public programs, or on helping states maintain or expand health coverage under Medicaid and other state insurance programs.

Perhaps the greatest danger of HDHPs is that they will create new opportunities for risk segmentation in the market for health insurance. If sicker individuals enroll in comprehensive plans while healthier individuals enroll in HDHPs, premiums for comprehensive plans will spiral upward, threatening their economic viability. As a result, a

large proportion of consumers may be unable to purchase insurance products that offer them their preferred level of risk protection. This is a form of market failure and an inefficient outcome.

If HSAs continue to be conditional on purchase of a high-deductible health plan, several policy changes might be considered to better target incentives and ensure access to care:

- **Smaller deductibles for lower-wage workers or lower-income families.** The HSA legislation could be amended to permit employers to lower deductibles for lower-wage workers. Another strategy would be to provide tax credits for families with premiums and out-of-pocket expenses in excess of a given income ceiling (e.g., 5% to 10% of family income).

- **Exempt primary care as well as preventive services from the deductible.** Currently, the IRS permits exemption of preventive services and selected prescription drugs that prevent disease or recurrence of disease. But most primary care is important for providing quick, low-cost treatment of acute conditions (such as urinary tract infections or ear infections for children) or to manage chronic conditions (such as asthma and diabetes) *before* they require costly emergency room use or hospitalization. In fact, studies tend to find underutilization of preventive and primary care services, while overutilization tends to occur with "big ticket" items such as surgery, imaging and diagnostic tests, end-of-life care, and specialty consultations.

  Rather than exempt only preventive services, a bundle of high-value preventive and primary care services could be exempt. There are several promising options. One is to cover, not subject to a deductible, all evidence-based, effective preventive and primary care. A second is to cover an actuarial, fixed-dollar bundle of services, also exempt from the deductible, as some major employers now offer to their part-time workers—for example, a $600 bundle of services including $350 of medical visits, $100 of preventive services, two dental visits a year, and an annual eye exam, plus annual coverage for five medications.[38] A third option is to offer a capitated payment rate of $500 to $600 to primary care physicians, community health centers, and other primary care practices or clinics willing to provide all indicated preventive and primary care services and prescription drugs to patients who select that source of care as a "medical home." Putting such practices at partial or total financial risk for primary care services would minimize any overutilization of services, while reporting on quality of care could be a safeguard against underutilization.

- **Guarantee choice of a comprehensive health plan to workers covered under employer plans.** Another safeguard would be to provide tax incentives only when employees and individuals have a choice of a comprehensive health plan but freely choose a higher-deductible plan. High-deductible plans that were offered as a "replacement product" for other choices would not qualify for tax incentives. This would permit those for whom high-deductible plans are not suitable—such as low-wage workers or those with a major illness—to seek coverage under a plan that better fits their needs. Care would need to be taken, however, to make sure that employee premium shares are "risk-adjusted" and do not lead to higher premiums for those with the poorest health status.
- **Permit greater flexibility in benefit design.** Policymakers could also permit any health insurance plan with an actuarial value equivalent to that of an acceptable HSA plan to qualify for HSA tax incentives. If the rationale is to reduce the degree to which people are "overinsured," there are multiple ways to structure benefits to enhance cost-sensitivity across a wider range of health care outlays while still protecting against undue financial burdens. This would permit plans to offer—instead of a high deductible—coinsurance, subject to a ceiling on out-of-pocket costs, as a percent of income; a separate deductible or tiered cost-sharing for prescription drugs; or lower cost-sharing for primary and preventive care but higher cost-sharing for expensive procedures and tests that are frequently overutilized.
- **Limit the disproportionate advantages to higher-income families.** Since the income tax is progressive, funds in HSAs are of greater value to higher-income families. For example, higher-income parents receive a larger discount than lower-income parents do when buying braces for their adolescents using HSA balances, since every dollar in an HSA is worth more to wealthier parents. Savings rates are also greater for higher-income families. Consequently, the tax advantages are likely to go disproportionately to higher-income families. This situation could be addressed at least in part by capping income eligibility for HSAs.

High-deductible health plans, as shown in this report, can deter patients from seeking needed care and can add to the financial burdens faced by the poor and the chronically ill. The modifications suggested here—particularly protecting lower-wage individuals and ensuring access to early preventive and primary care—would mitigate the most potentially harmful effects of high-deductible plans.

APPENDIX. STUDY METHODOLOGY

Data for this issue brief come from the Commonwealth Fund Biennial Health Insurance Survey (2003), a national telephone survey conducted September 3, 2003, through January 4, 2004, among a random, nationally representative sample of 4,052 adults ages 19 and older living in the continental United States. The survey consisted of 25-minute telephone interviews administered in English or Spanish.

Using a stratified sampling design, the study over-sampled low-income African American and Hispanic households. The sample was drawn using random-digit dialing methods, which selected telephone numbers disproportionately from area code–exchange combinations with higher-than-average density of low-income households. The final data were weighted to correct for the disproportionate sample design and to make the sample representative of all adults age 19 and older living in the continental United States. Data were weighted by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption using the U.S. Census Bureau's 2003 Annual Social and Economic Supplement (ASEC). The resulting weighted sample is representative of the approximately 207 million adults ages 19 and older, including the 171.9 million adults ages 19 to 64. The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level. The 50 percent survey response rate was calculated consistent with standards of the American Association for Public Opinion Research.

We restricted the analysis to adults, ages 19 to 64, who were insured all year by private coverage and who report information on their deductibles, including 137 individuals with deductibles of $1,000 or more, 200 adults with deductibles of $500 to $999, and 1,311 with either no deductible or deductibles of less than $500—for a total analysis sample of 1,648. The study classified adults by deductible size, annual income, and health status. We used a combination of bivariate and multivariate analyses to examine the effect of high deductibles on health care access and financial burdens due to medical bills.

Because part of the observed differences by high deductibles may also be due to differences in income and health status, logistic regression models were estimated to explore the independent effects of high deductibles on cost-related access problems and medical bill burdens, controlling for income and health status. We estimated predicted probabilities, holding income and health status constant, and, for ease of interpretation, expressed these estimates as adjusted percentages. Income is based on those above and below 200 percent of the federal poverty level. Health status is split into those who are

sicker versus those who are healthier, where sicker adults are defined as having self-reported fair or poor health, any chronic condition (cancer, diabetes, heart attack, diabetes, high cholesterol, hypertension, or arthritis), or disability. All analyses used statistical software (STATA 7.0) that takes into account the clustered sampling strategy when computing the standard errors.

Table 1. Annual Deductibles by Type of Private Insurance

Base: Respondents Ages 19–64, Insured All Year—Private Coverage

	Insurance Source		
Deductibles	**Total Private**	**Employer**	**Individual**
Total in Millions (estimated)	119.0 (N=1,648)	109.8 (N=1,528)	9.2 (N=120)
Annual Deductible Per Person			
No deductible	40%	41%	28%
Less than $100	7	7	7
$100–$499	33	34	14
$500–$999	12	12	17
$1,000 or more	8	6	34
Annual Deductible Per Person (millions of people)			
No deductible	36.9	35.1	1.8
Less than $100	6.6	6.2	0.4
$100–$499	30.1	29.2	0.9
$500–$999	11.4	10.3	1.1
$1,000 or more	7.3	5.1	2.2

Note: Columns may not sum to 100% because of rounding.

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

Table 2. Percentage Distribution of Those with Deductibles Over and Under $500 by Demographic Characteristics

Base: Respondents Ages 19–64, Insured All Year—Private Coverage

	Deductible	
	Less than $500	**$500 or more**
Percent of population 19–64, insured all year:	80%	20%
Age		
19–29	84	16
30–49	80	20
50–64	77	23
Gender		
Men	79	21
Women	80	20
Race/Ethnicity		
White	79	21
Black	86	14
Hispanic	84	16
Income		
Less than $20,000	80	20
$20,000–$34,999	84	16
$35,000–$59,999	80	20
$60,000 or more	79	21
Under $35,000	82	18
$35,000 or more	79	21
Poverty		
Under 100%	73	27
100%–199%	83	17
Under 200%	81	19
200% or more	80	20
Health Status		
Excellent	82	18
Very good	81	19
Good	78	22
Fair or poor	75	25
Chronic Condition		
Cancer	73	27
Diabetes	74	26
Any chronic condition★	76	24
None	82	18
Sicker^		
Yes	77	23
No	82	18

Note: Only includes respondents reporting a deductible amount.

★ Chronic condition includes cancer, diabetes, heart attack/diabetes, high cholesterol, hypertension, and arthritis.

^ Sicker defined as fair or poor health, any chronic condition, or disability.

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

Table 3. Access Problems and Medical Bill Burdens, by Size of Deductible

Base: Respondents Ages 19–64, Insured All Year—Private Coverage
(adjusted percentages based on logit models)

Deductible	Any access problems due to cost#		Any bill problem or medical debt†	
	Unadjusted	Adjusted^	Unadjusted	Adjusted^
None	20%	21%	23%	24%
$1–$499	29	30**	39	39***
$500–$999	35	36***	45	46***
$1,000 or more	38	38***	54	54***

Note: Significantly different from No Deductible at * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

^ Model controls for health status and income.

Access problems included did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.

† Medical bill problems or medical debt included 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; has medical debt being paid off over time.

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

Table 4. Relationship Between Access Problems, Medical Bill Burdens, and Deductibles, by Income

Base: Respondents Ages 19–64, Insured All Year—Private Coverage
(adjusted percentages based on logit models)

	Total Population Insured All Year—Private Coverage^		Predicted Probability if Income Less than $35,000#		Predicted Probability if Income $35,000 or more#	
	Deductible $500 or more		Deductible $500 or more		Deductible $500 or more	
	Yes	No	Yes	No	Yes	No
Access Problems in Past Year						
Went without needed care in past year due to costs:						
Did not fill prescription	23%★	17%	28%★★★	20%	20%	15%
Did not get needed specialist care	12★	7	15★	9	10	6
Skipped recommended test or follow up	19★★★	10	25★★	13	15★★	7
Had a medical problem, did not visit doctor or clinic	24★★★	9	34★★★	14	18★★★	7
At least one of four access problems due to inability to pay	37★★	26	44★★	32	31★	21
Medical Bill Problems in Past Year						
Any bill problem	34★★★	22	43★	30	27★★★	17
Any bill problem or medical debt	49★★★	32	55★★	37	43★★★	27

Note 1: ★ $p \leq .05$; ★★ $p \leq .01$; ★★★ $p \leq .001$

Note 2: Health Status refers to sicker vs. healthier. Sicker defined as fair or poor health, any chronic condition, or disability (chronic condition includes cancer, diabetes, heart attack/diabetes, high cholesterol, hypertension, and arthritis).

^ Model controls for health status and income.

Models show predicted probabilities (expressed as percentages) of having access problems and bill problems under different scenarios: having income <$35,000 with a deductible <$500 or having a $500 or higher deductible; having income $35,000 or more with a deductible <$500 or a $500 or higher deductible.

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

Table 5. Relationship Between Access Problems, Medical Bill Burdens, and Deductibles, by Health Status

Base: Respondents Ages 19–64, Insured All Year—Private Coverage
(adjusted percentages based on logit models)

	Total Population Insured All Year—Private Coverage^		Predicted Probability if Sicker#~		Predicted Probability if Healthier#	
	Deductible $500 or more		Deductible $500 or more		Deductible $500 or more	
	Yes	No	Yes	No	Yes	No
Access Problems in Past Year						
Went without needed care in past year due to costs:						
Did not fill prescription	23%★	17%	30%	22%	17%	12%
Did not get needed specialist care	12★	7	15	9	9★	5
Skipped recommended test or follow up	19★★★	10	26★★★	13	13	6
Had a medical problem, did not visit doctor or clinic	24★★★	9	29★★★	12	19★★	7
At least one of four access problems due to inability to pay	37★★	26	45★★	32	29★	19
Medical Bill Problems in Past Year						
Any bill problem	34★★★	22	44★★★	29	25★	15
Any bill problem or medical debt	49★★★	32	59★★★	40	40★★★	24

Note 1: ★ $p \leq .05$; ★★ $p \leq .01$; ★★★ $p \leq .001$

Note 2: Health Status refers to sicker vs. healthier.

^ Model controls for health status and income.

Models show predicted probabilities (expressed as percentages) of having access problems and bill problems under different scenarios: being sicker~ with a deductible <$500 or having a $500 or higher deductible; being healthier with a deductible <$500 or a $500 or higher deductible.

~ Sicker defined as fair or poor health, any chronic condition, or disability (chronic condition includes cancer, diabetes, heart attack/diabetes, high cholesterol, hypertension, and arthritis).

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

Table 6. Use and Spending per Person in the RAND Health Insurance Experiment

Coinsurance	Visit Rates	Admission Rates	Spending (2003$)
0 percent (free care)	4.55	0.128	$1,377
25 percent	3.33	0.105	$1,116
50 percent	3.03	0.092	$1,032
95 percent (high deductible)	2.73	0.099	$946

Note: The spending values shown are predicted from a multipart model; raw means are similar except that the spending figure for the 50 percent coinsurance plan is considerably higher because of one outlier that accounted for one-sixth of all spending on that plan. All plans with coinsurance had a $1,000 stop-loss feature, which was scaled down for lower-income families.

Source: Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 23 (6): 107–113.

Table 7. Total Health Care Expenses Below HSA Deductible Thresholds, Nonelderly Households Covered by Health Insurance, 2004

	Household		
	Total	**Single Individual ($1,000 Deductible)**	**Family ($2,000 Deductible)**
Total health expenses ($ billions)	$451.9	$97.6	$354.3
Percent of households with expenses below HSA deductible	43.6%	58.0%	32.6%
Expenses incurred for these households ($ billions)	$19.3	$5.7	$13.5
Percent of total expenses	4.2%	5.8%	3.8%
Total expenses below deductible ($ billions)	$96.9	$20.7	$76.2
Percent of total dollars falling below deductible	21.4%	21.2%	21.5%

Note: Tabulations of pooled data from the 1998, 1999, and 2000 waves of the MEPS household samples. Expenditures adjusted to 2004 dollars. Sample includes all nonelderly health insurance units (households with some private health insurance), excluding child-only units. Medical expenses include both out-of-pocket expenditures and those reimbursed by insurance.

Source: Linda Blumberg and Leonard E. Burman, *Most Households' Medical Expenses Exceed HSA Deductibles,* Urban Institute and Brookings Institution, Tax Policy Center, Tax Notes, August 16, 2004; Analysis by the Urban Institute of the Medical Expenditure Panel Survey (MEPS) 1998, 1999, and 2000.

Table 8. Health Insurance Premiums in the Individual Market for $1,000 Deductible Plans,* Annual Premiums as a Percent of Income for 25-Year-Old Male and 60-Year-Old Female at 200% Federal Poverty Level

	Male Age 25		Female Age 60	
	Annual Premium#	**Percent of Income for Individual 200% FPL^**	**Annual Premium#**	**Percent of Income for Individual 200% FPL^**
MEDIAN	$1,095	6%	$4,017	20%
CITY, STATE				
Phoenix, AZ	780	4	3,712	20
Cleveland, OH	856	4	2,665	14
Nashville, TN	865	4	2,746	14
Baltimore, MD	960	5	2,244	11
Kansas City, KS	997	5	4,017	20
Atlanta, GA	1,020	5	3,900	20
Denver, CO	1,040	5	3,713	19
Detroit, MI	1,050	5	3,566	18
Durham, NC	1,079	5	3,627	18
Chicago, IL	1,080	5	3,668	19
Des Moines, IA	1,085	6	4,339	22
Hartford, CT	1,095	6	3,487	18
Seattle, WA	1,128	6	4,020	21
Houston, TX	1,140	6	3,564	18
Milwaukee, WI	1,193	6	4,295	22
New Orleans, LA	1,207	6	5,003	25
Los Angeles, CA	1,368	7	5,976	30
Cheyenne, WY	1,450	7	5,095	26
Philadelphia, PA	1,534	8	5,213	28
Pierre, SD	1,566	8	6,350	34
Helena, MT	1,804	9	7,045	36
Miami, FL	1,882	10	8,039	41
Newark, NJ †	5,509	28	5,509	29
New York, NY †	No Plan	No Plan	No Plan	No Plan
Providence, RI	No Plan	No Plan	No Plan	No Plan

* $1,000 is in-network deductible; out-of-network deductibles are higher for some plans.

Premium shown is lowest available for a $1,000 deductible plan with coverage of physician office visit, some coverage of prescription drugs (even if discount card), and some limit on a patient's out-of-pocket expenses.

^ 200% FPL equals annual income of $19,654 for an individual under age 65 in 2004 based on U.S. Census Bureau.

† New York and New Jersey require health plans to charge the same rate for the same benefit package irrespective of age, sex, or health status

Source: Authors' compilation based on quotes from www.ehealthinsurance.com, March 2005 for non-smoking, healthy individuals.

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[23] N=102 for yes diabetes; N=1537 for no diabetes. Margin of sampling error of +/– 12 percentage points.

[24] Newhouse inflated the $1,000 deductible in late 1970s to 2003 dollars using growth in per capita health spending over that period to derive the estimated equivalent deductible of $6,000. Joseph P. Newhouse, "Consumer-Directed Health Plans and the RAND Health Insurance Experiment," *Health Affairs* 21 (November/December 2004): 107–13.

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