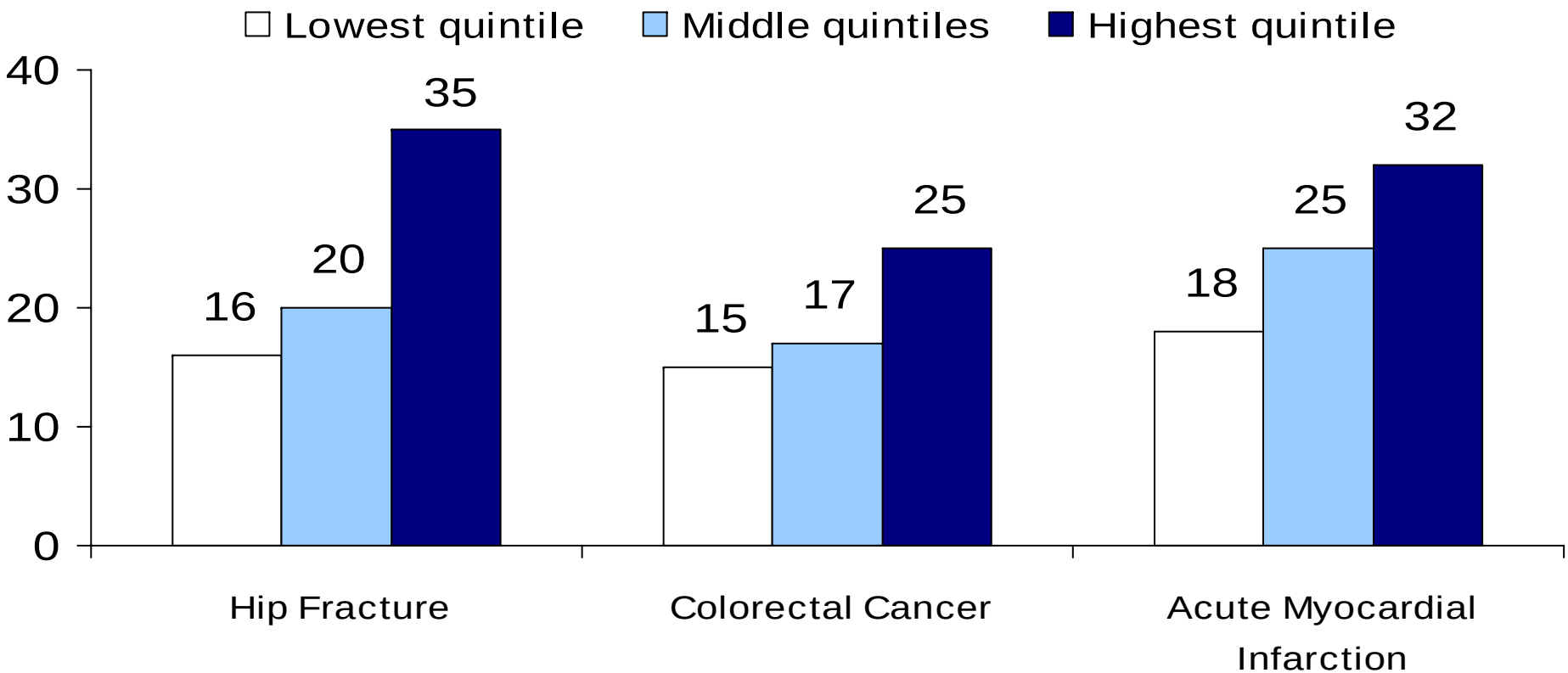
Figure 1. Percent of Patients Seen by 10 or More Physicians Varies Across Academic Medical Centers

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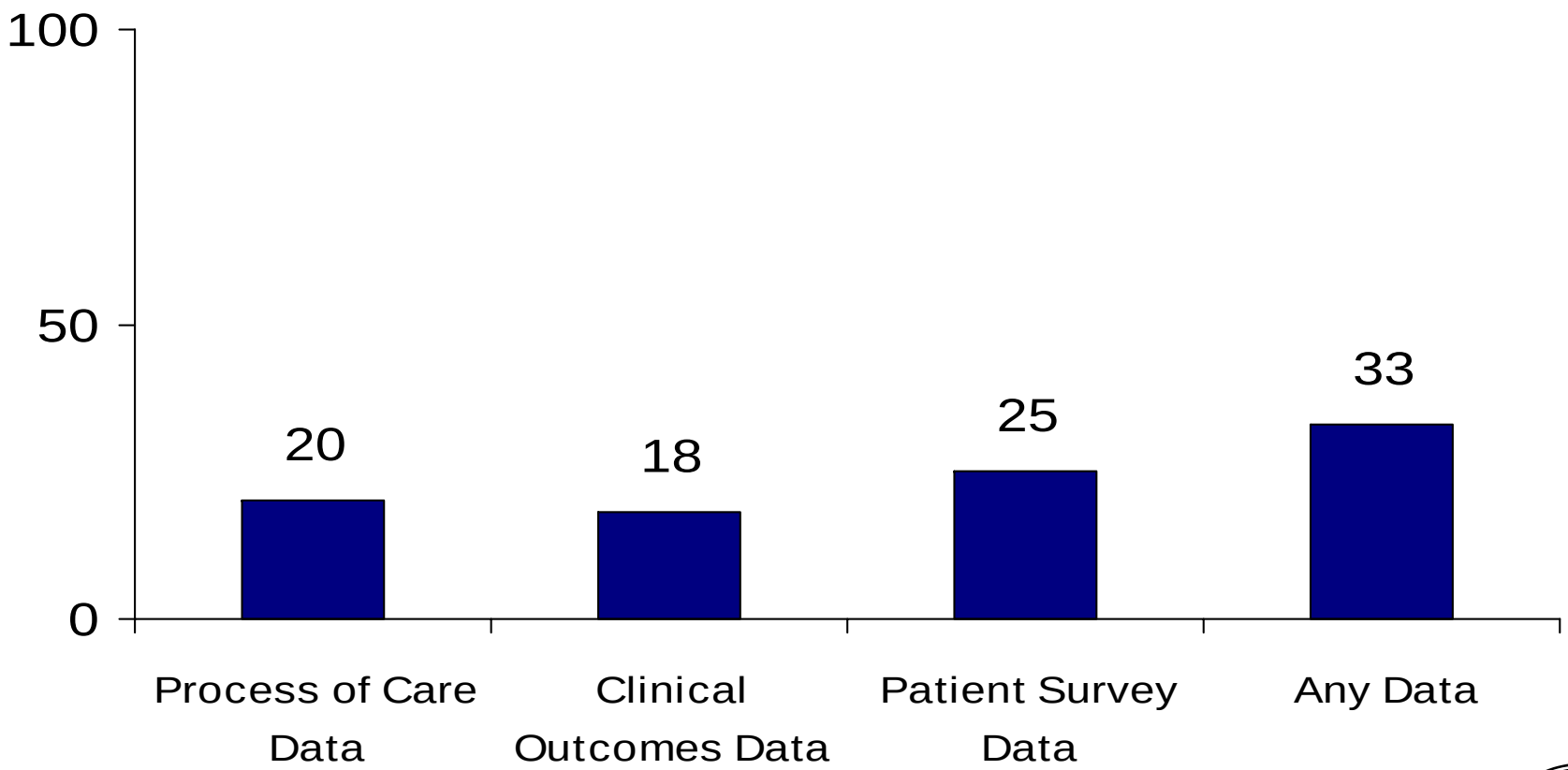
Figure 3. Physicians' Access to Quality-of-Care or Performance Data on Their Own Care

Percent receiving data on the following aspects of patient care



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

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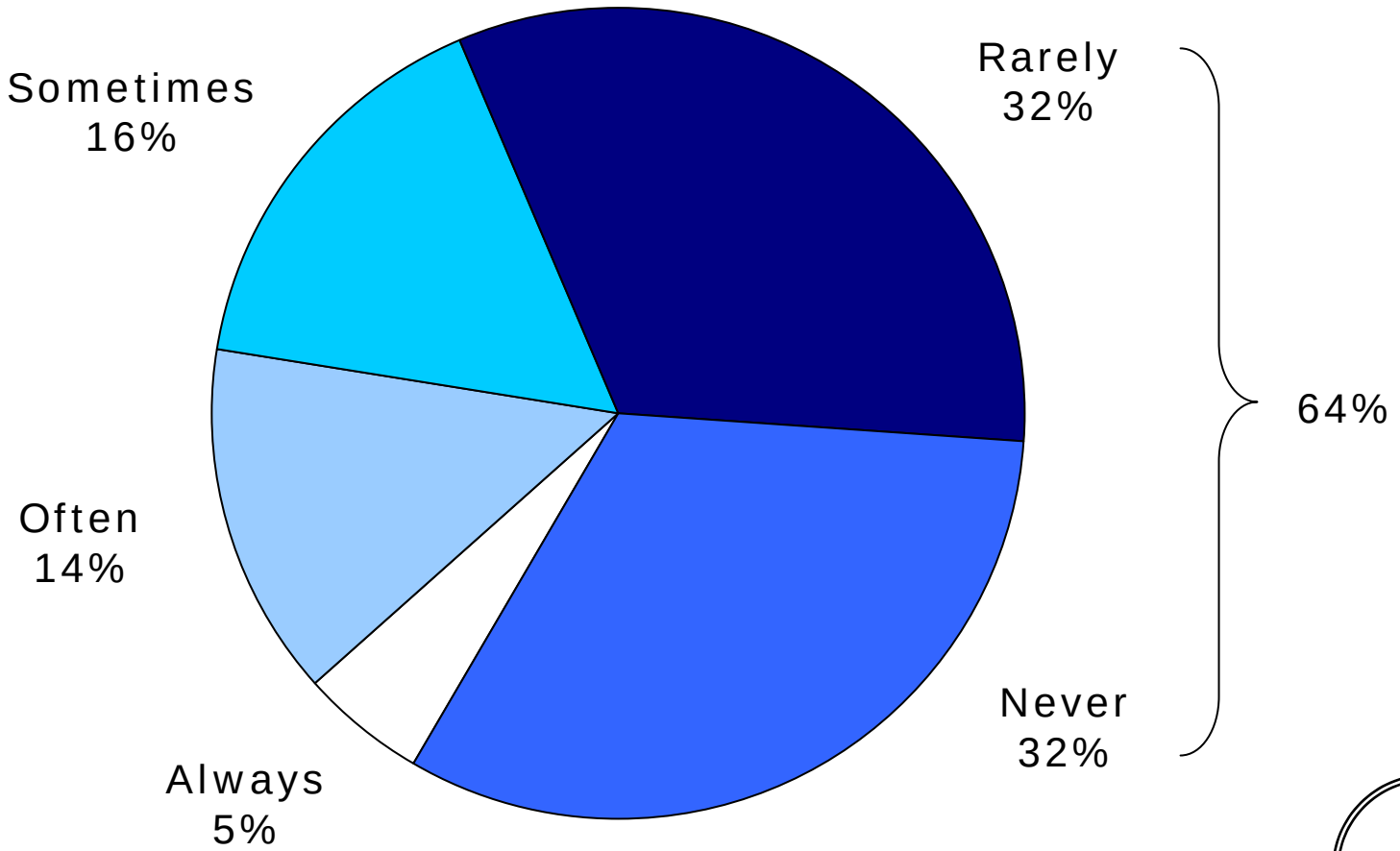
Figure 4. Availability of Quality-of-Care Data When Making Referrals

Percent indicating how often they have any data about a physician's quality of care when making referrals



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

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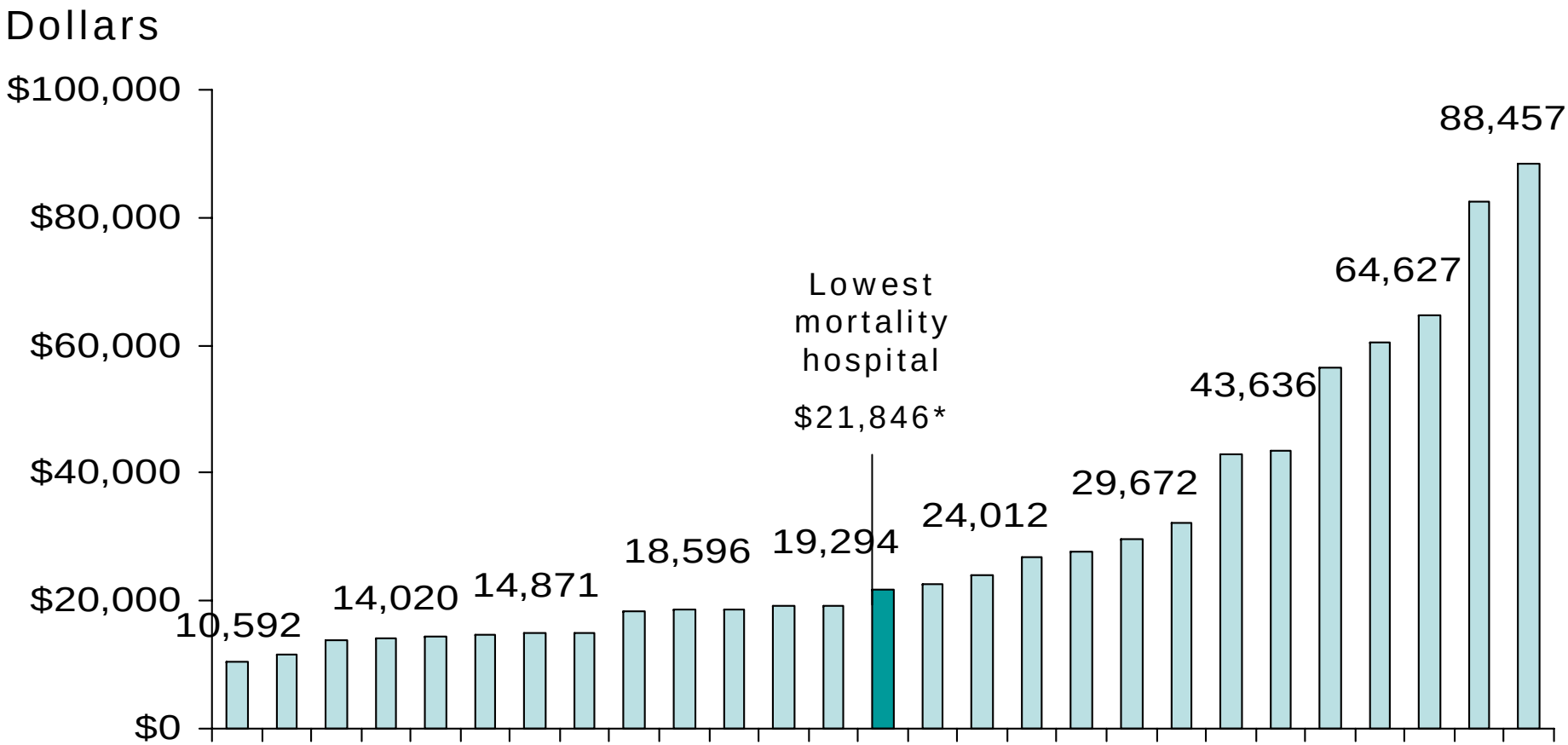
Figure 5. Hospital Charges for AMI–Medical Management Vary Eight-Fold Across Large Pennsylvania Hospitals



*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.

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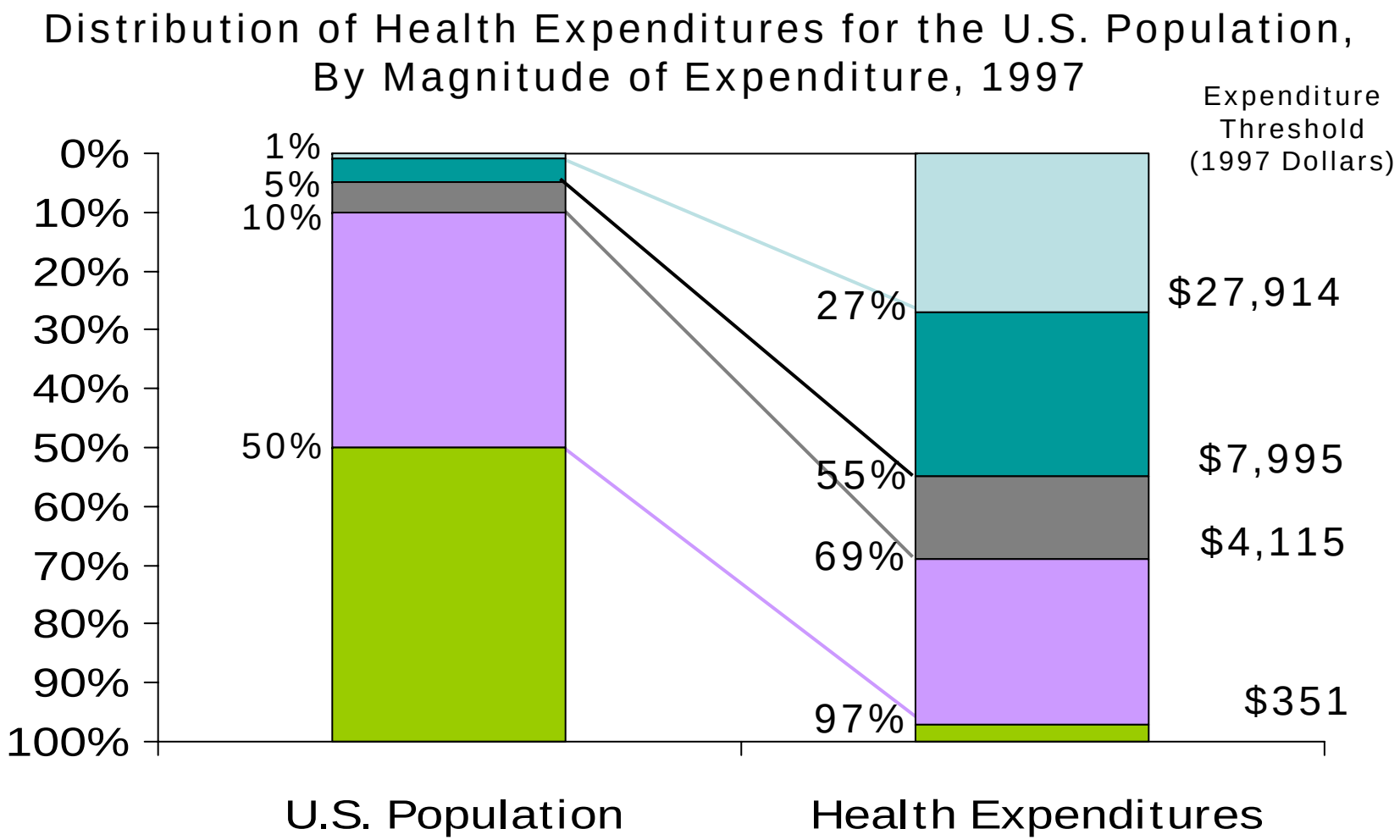
Source: The Commonwealth Fund 2003 International Health Policy Survey of Hospital Executives.

Figure 9. Most Costs Are Concentrated in the Very Sick



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

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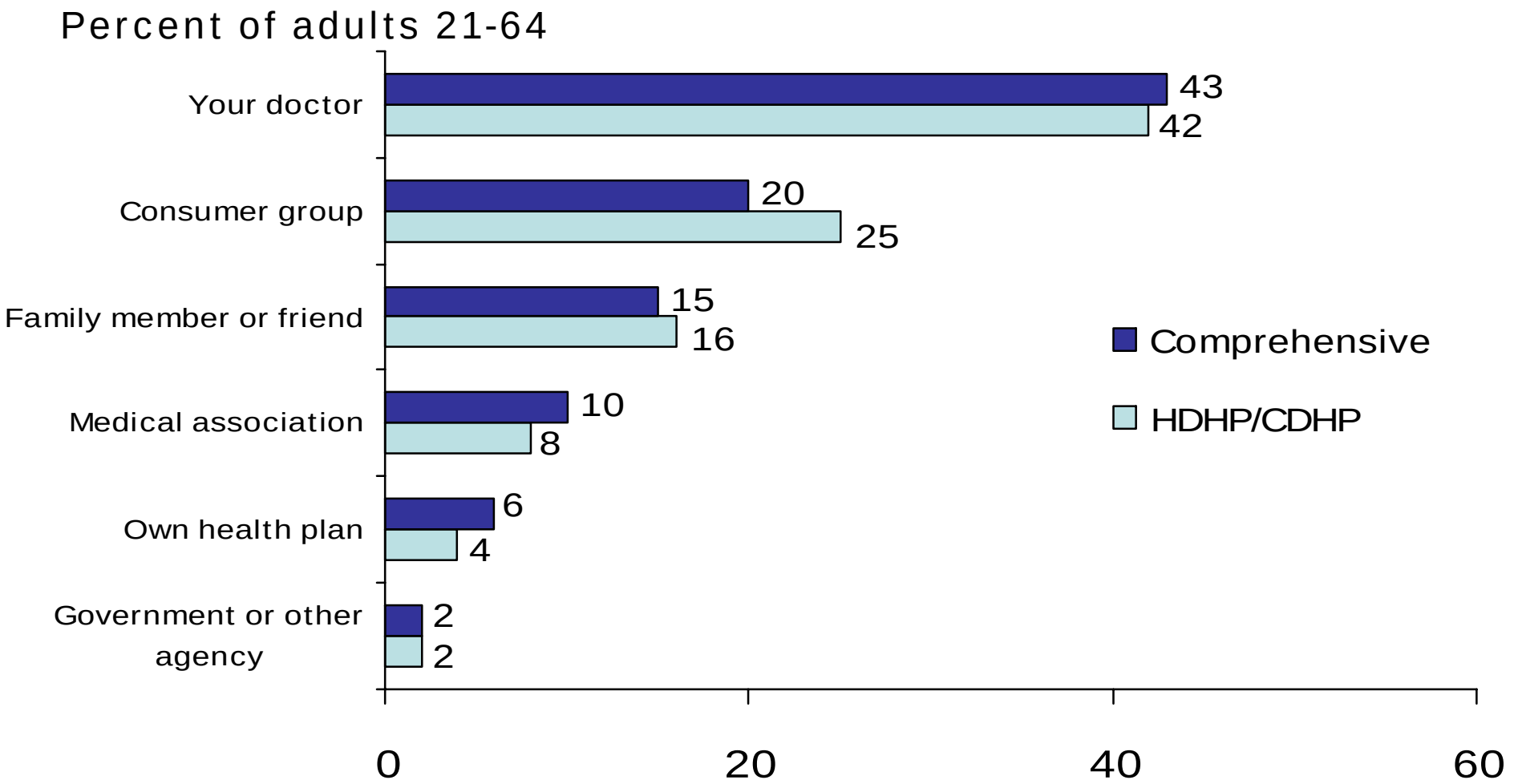
Figure 10. Most Trusted Sources for Information on Health Care Providers, by Insurance Source



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.

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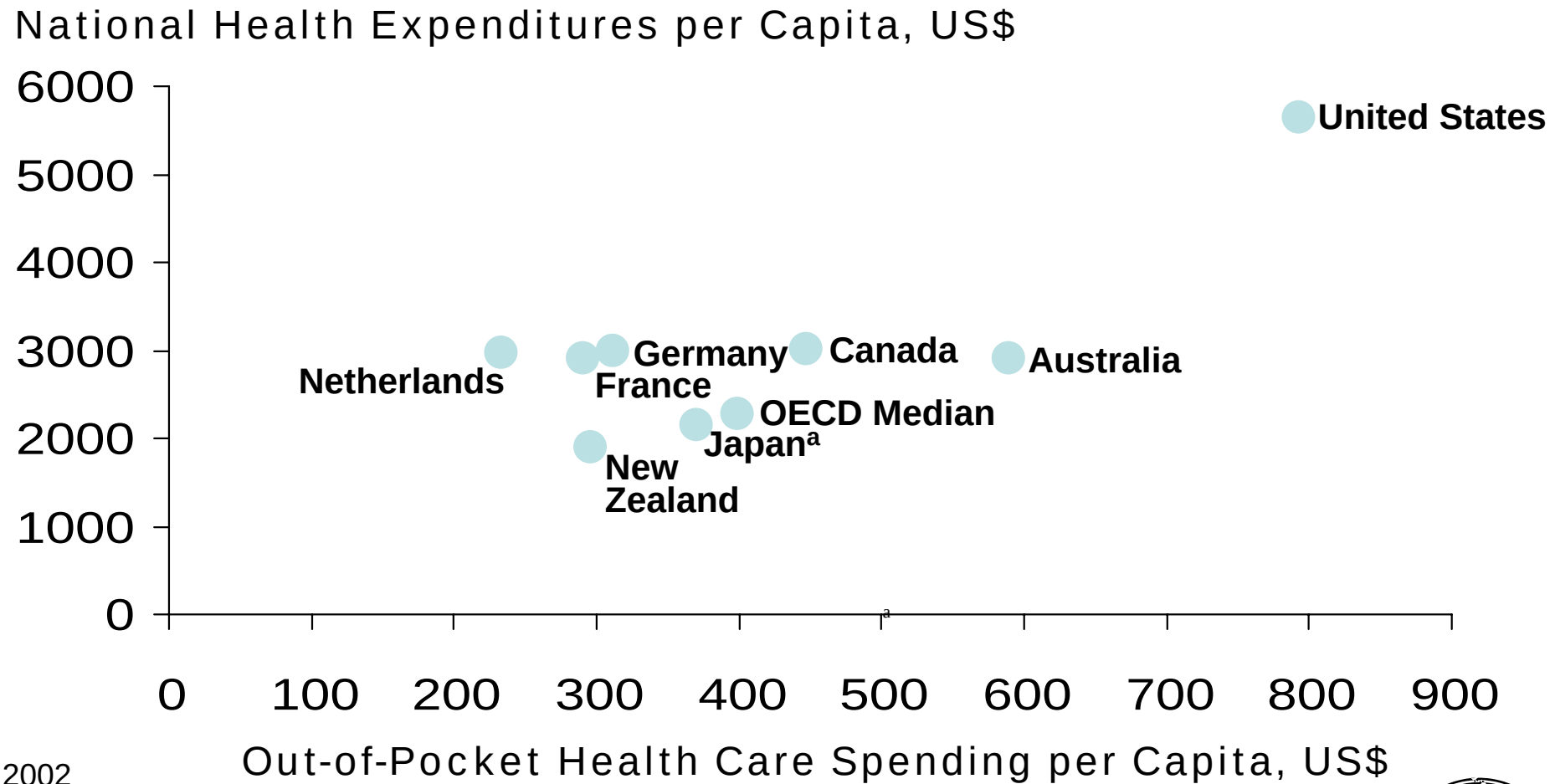
Figure 11. "Perception that Health Care Is Free"*Is Not the Problem



[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.

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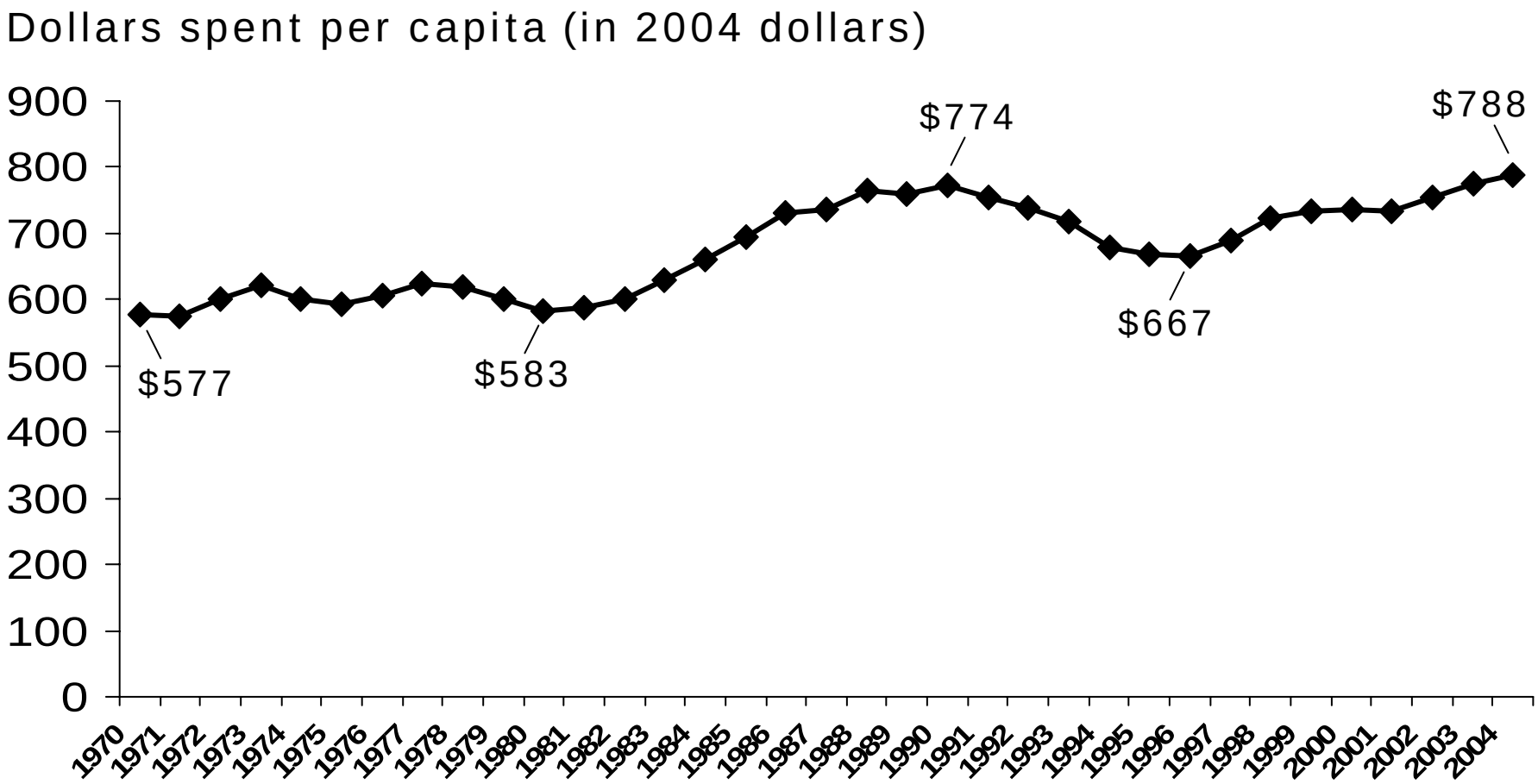
Figure 12. Consumers Spending More Out-of-Pocket for Health Care



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

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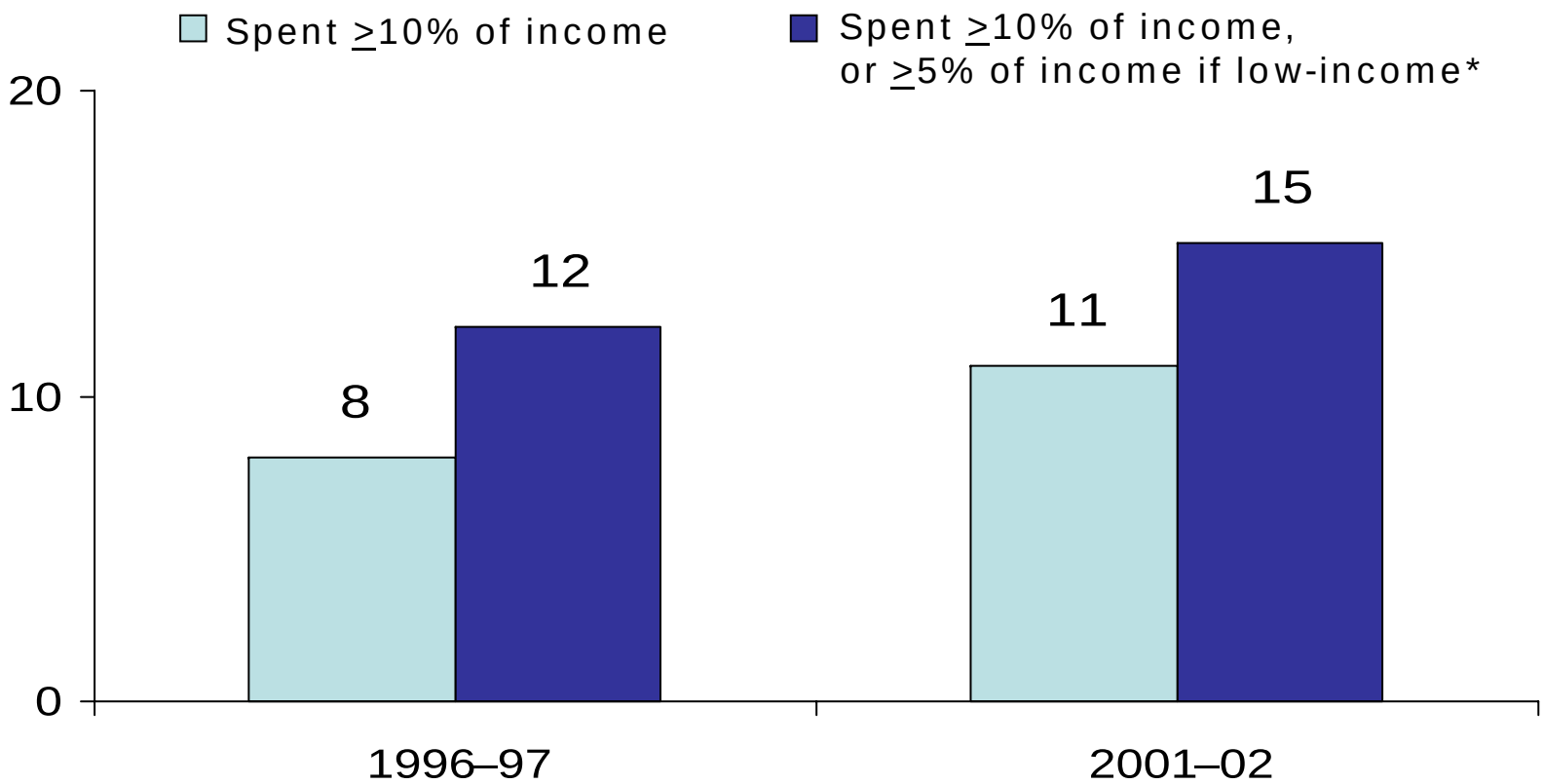
Figure 13. Nearly One of Six Families Spent 10% or More of Income (or 5% or More if Low-Income) on Out-of-Pocket Medical Costs, 2001–02

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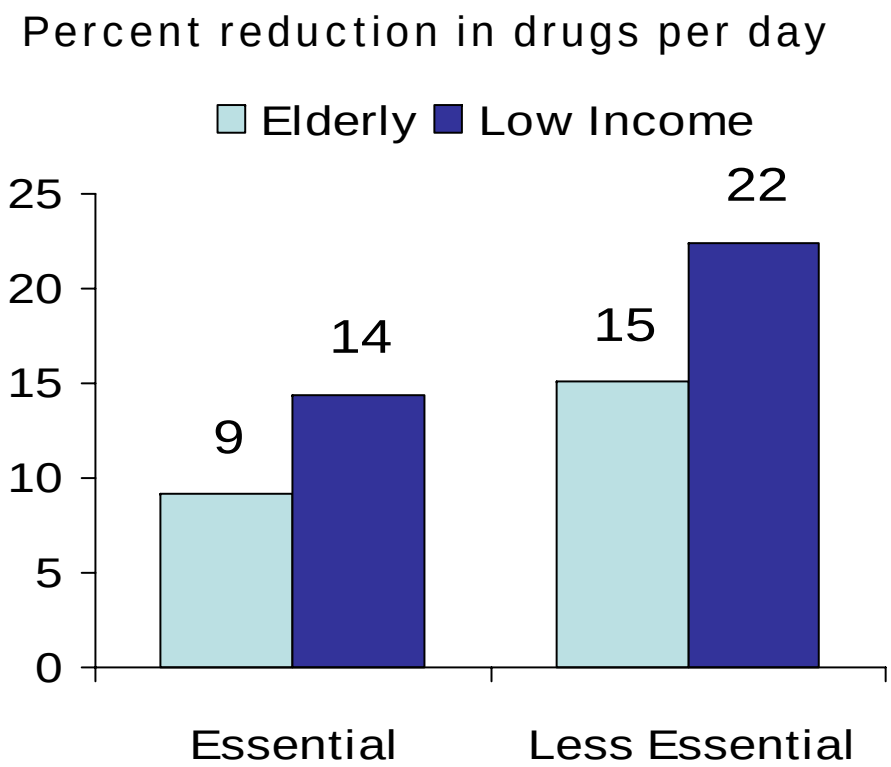
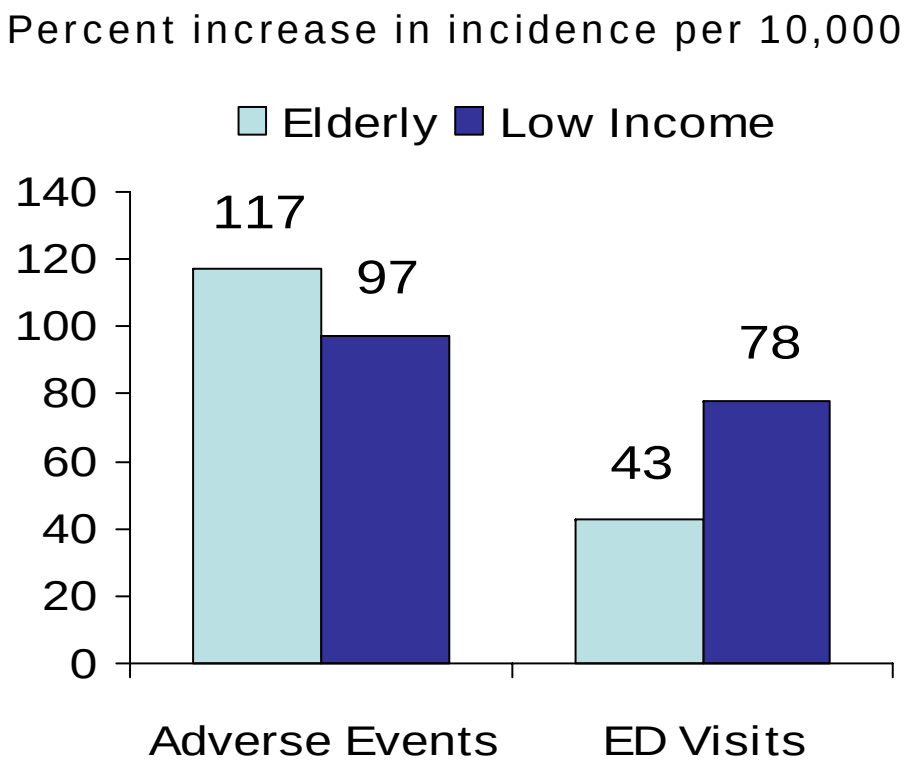
Figure 14. Cost-Sharing Reduces Use of Both Essential and Less Essential Drugs and Increases Risk of Adverse Events





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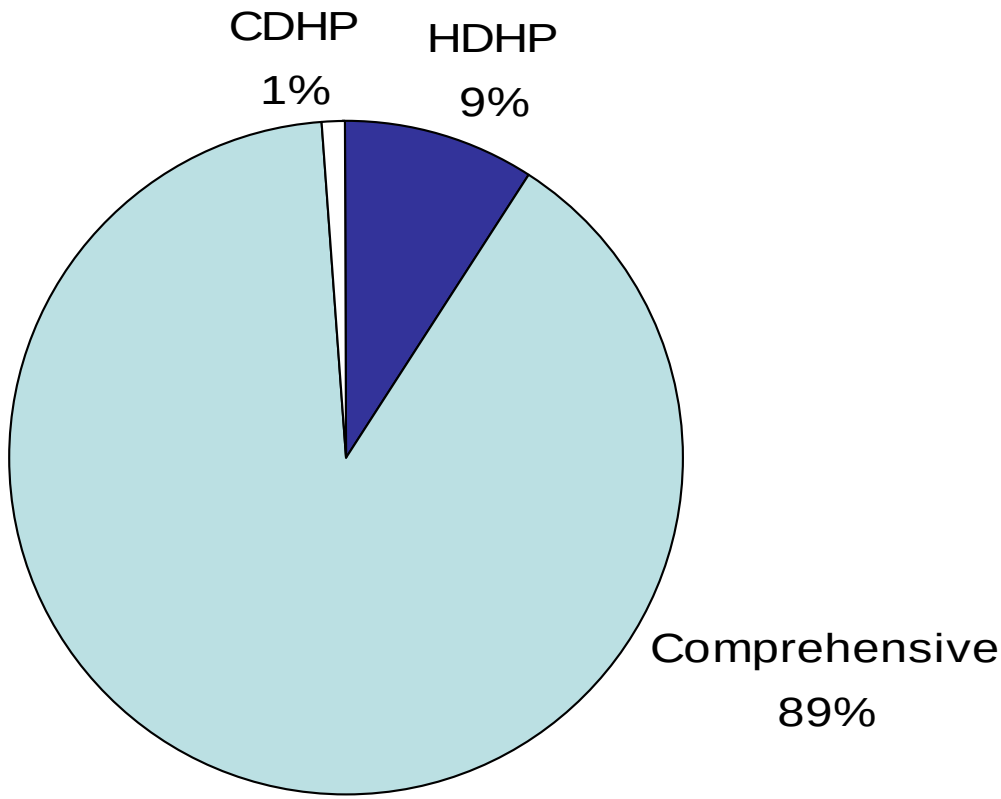
Figure 15. Distribution of Individuals Covered by Private Health Insurance, by Type of Health Plan



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.

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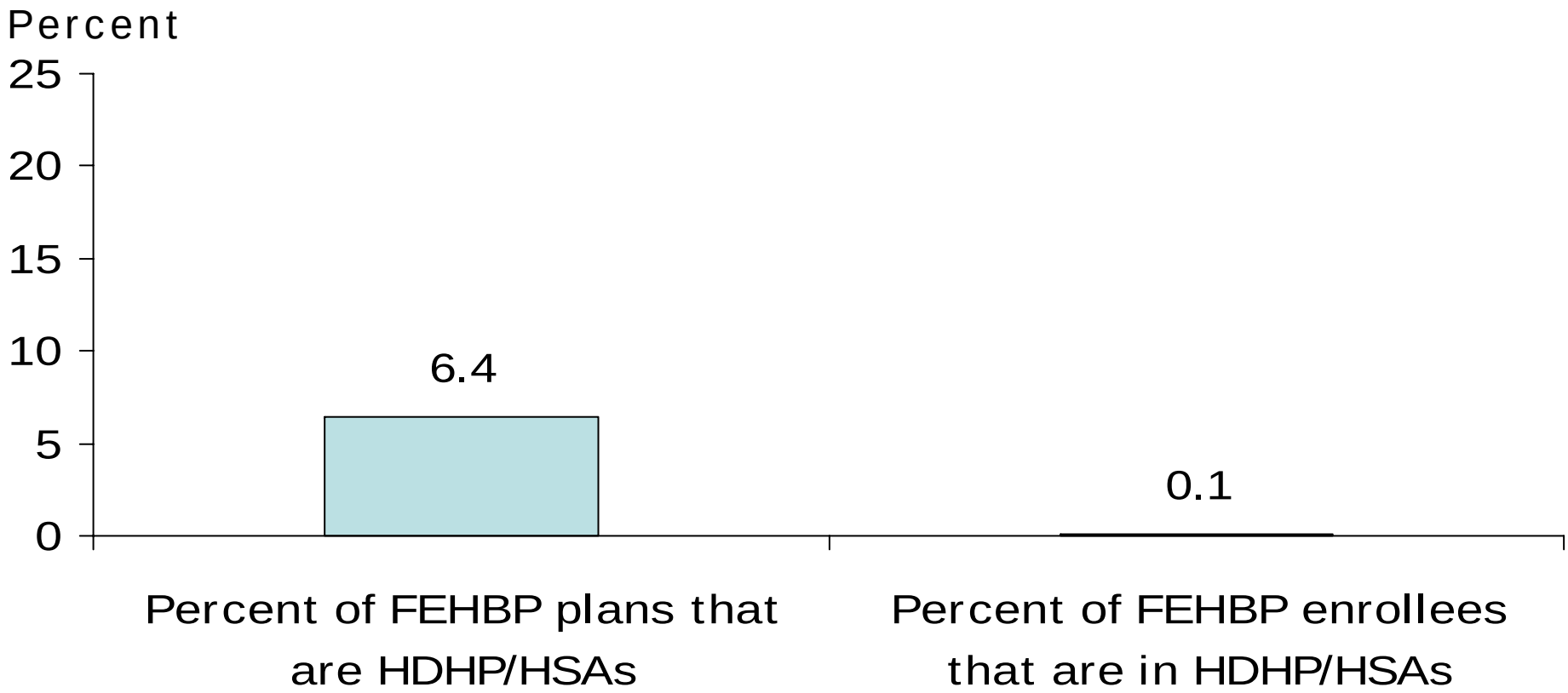
Figure 16. FEHBP HDHP/HSAs Plans Enroll 7,500 out of 9 Million Covered Lives



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

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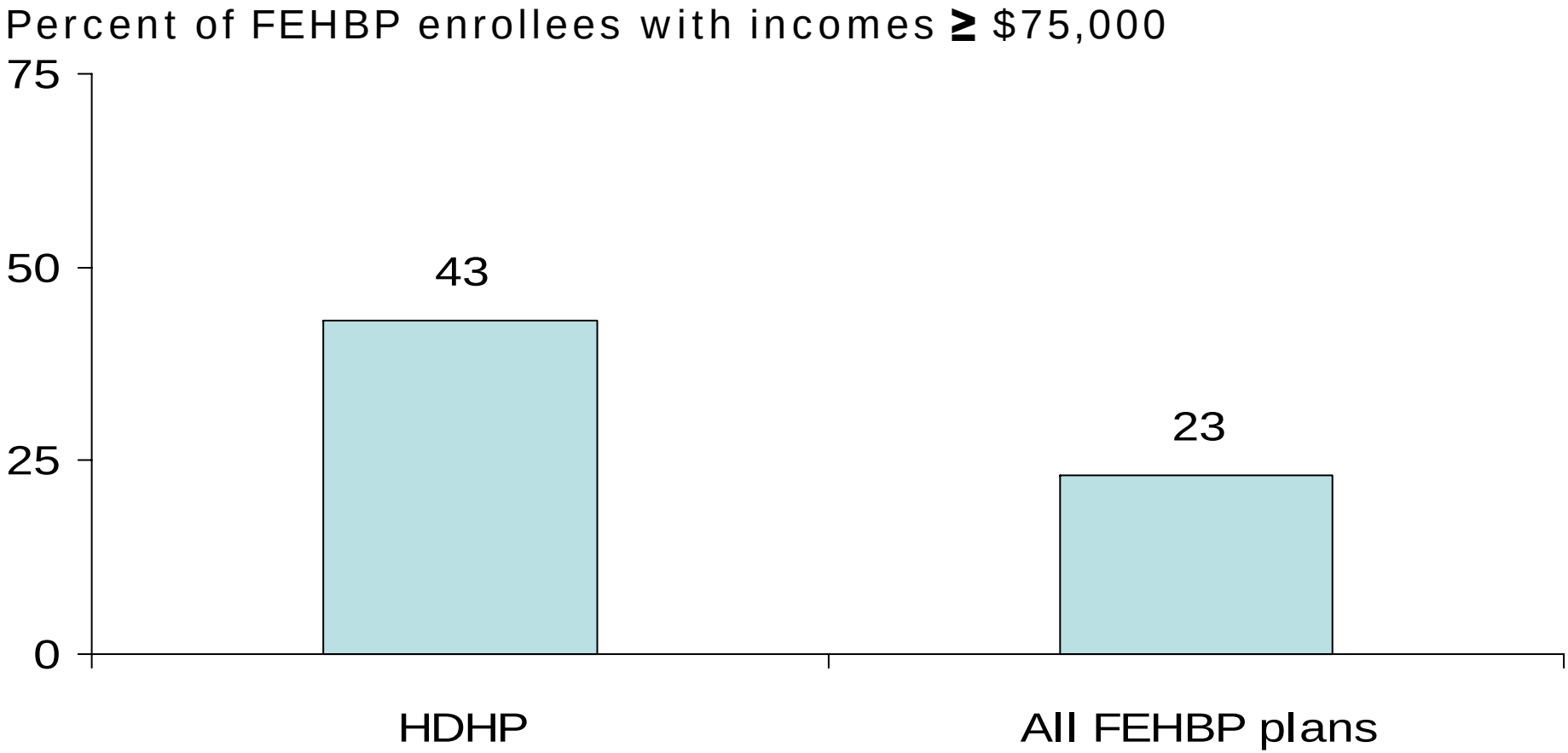
Figure 17. Enrollees Who Chose HDHPs from the Federal Employees Health Benefits Program Are More Likely to Earn Higher Incomes



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.

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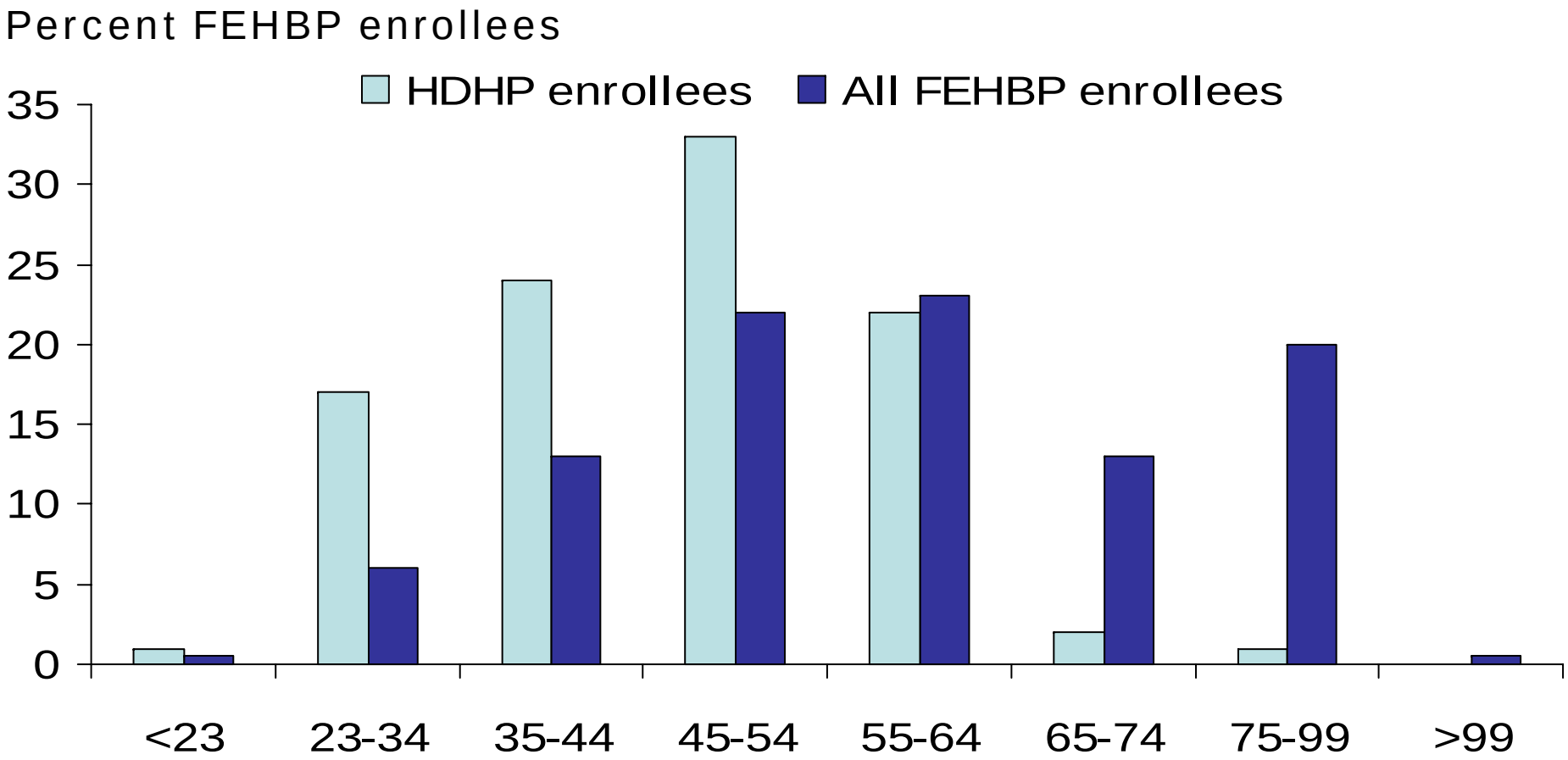
Figure 18. Age Distribution of HDHP and Other FEHBP Enrollees



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.

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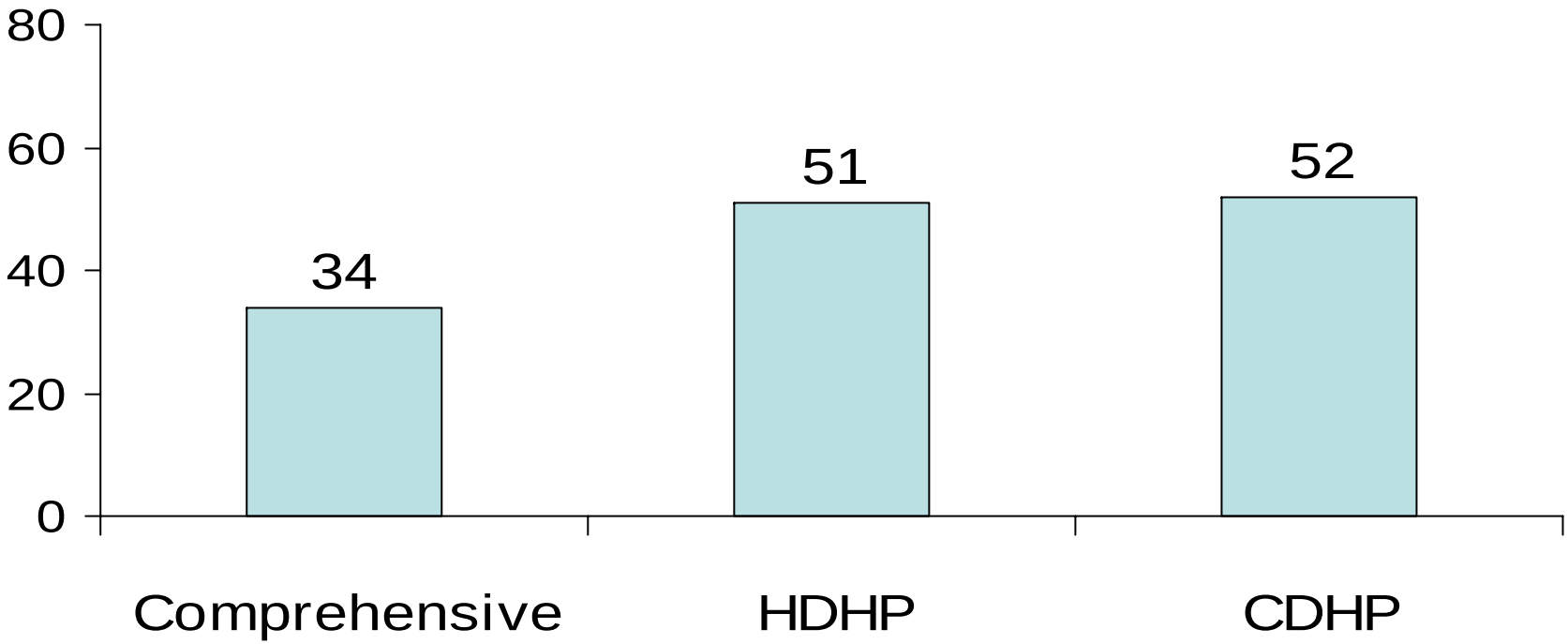
Figure 19. Percentage of Individuals Covered by Employment-Based Health Benefits With No Choice of Health Plan, by Type of Health Plan



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.

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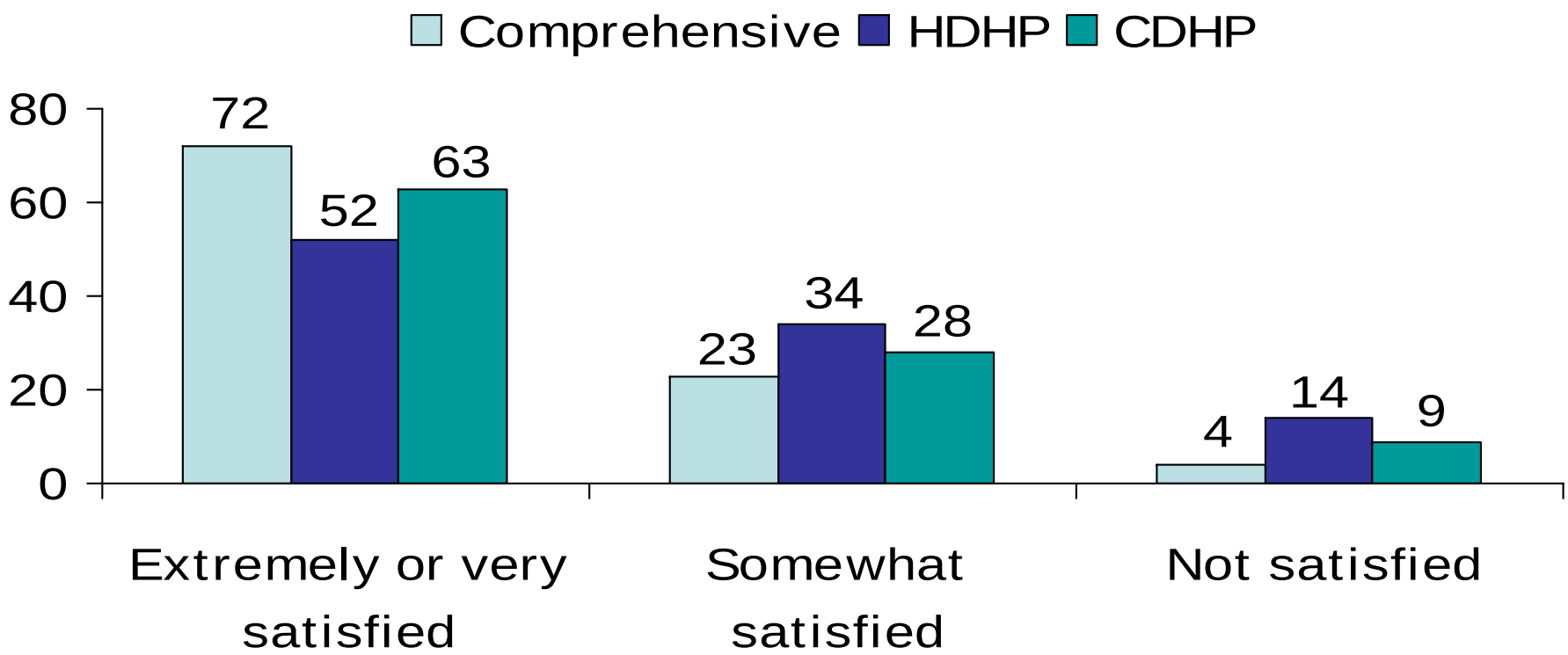
Figure 20. Satisfaction with Quality of Health Care Received, by Type of Health Plan



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.

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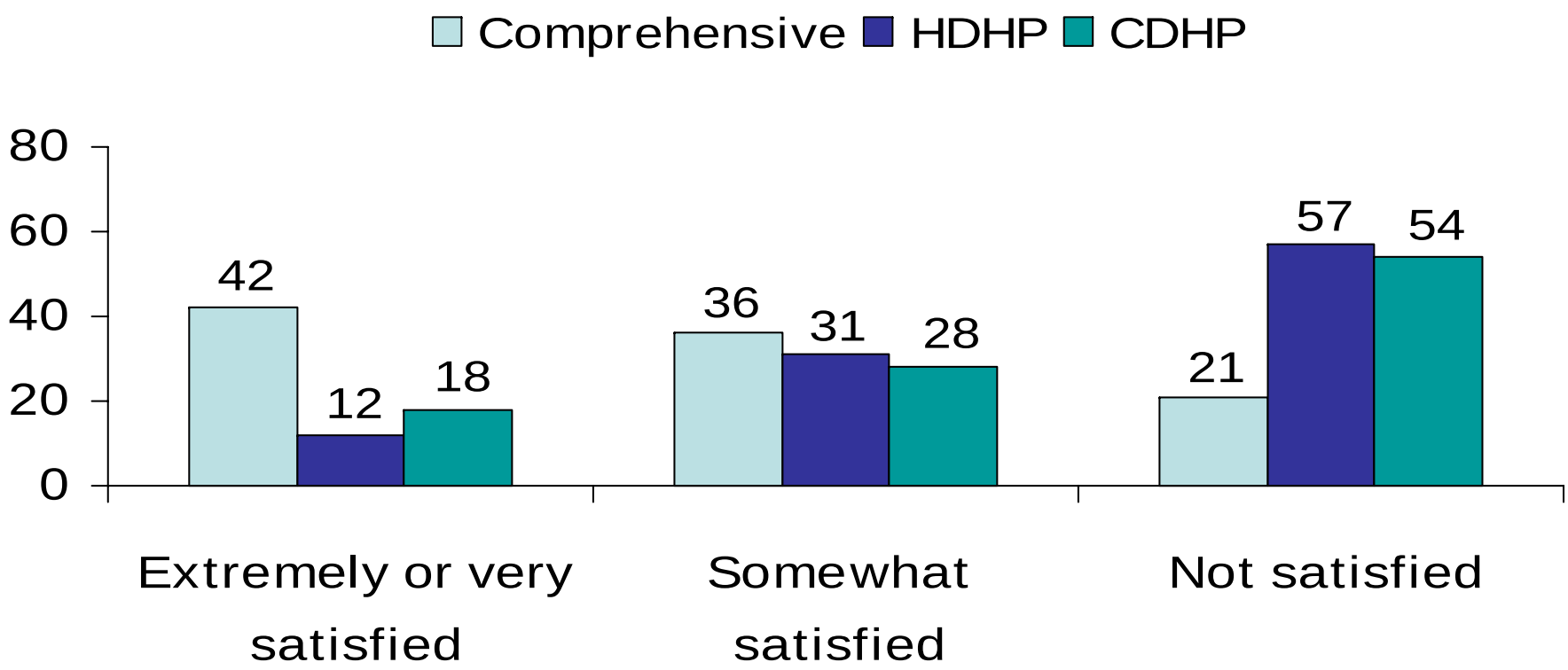
Figure 21. Satisfaction with Out-of-Pocket Costs for Health Care, by Type of Health Plan



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.

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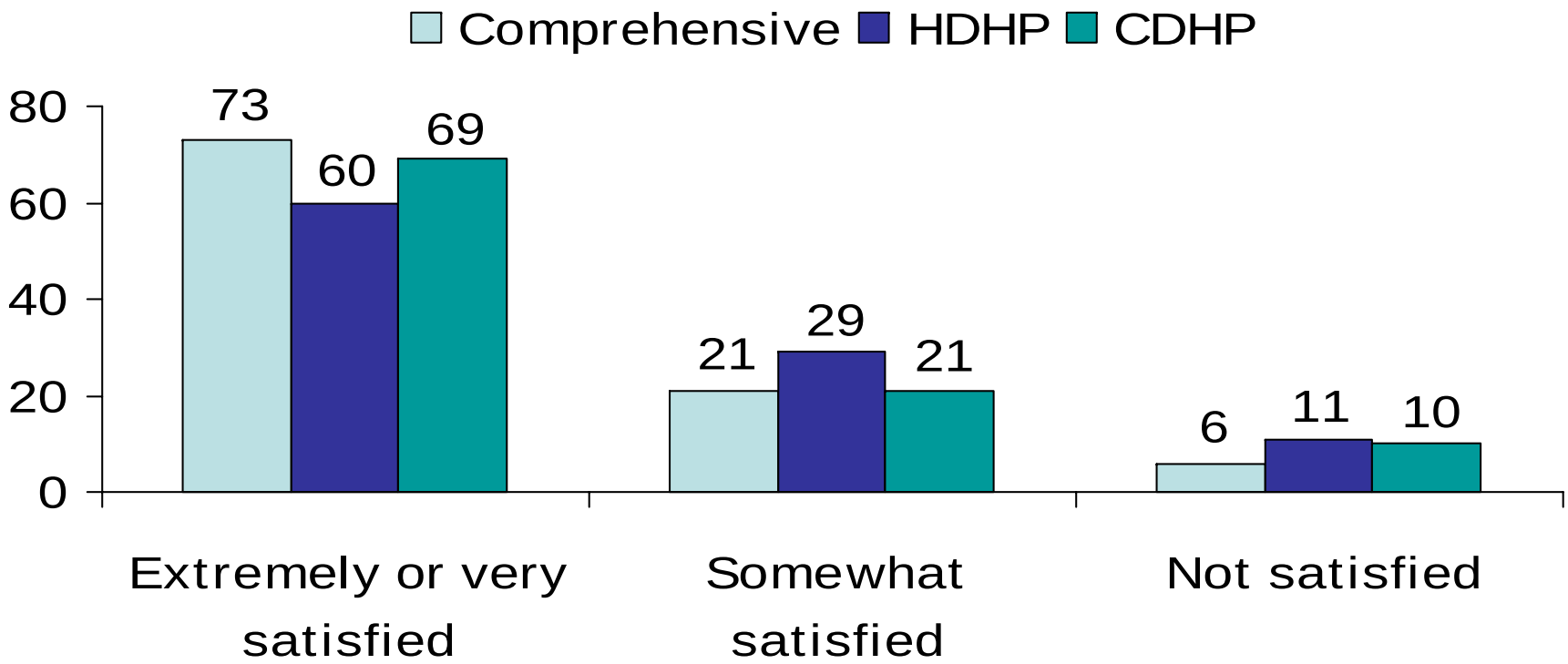
Figure 22. Satisfaction with Choice of Doctors, by Type of Health Plan



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.

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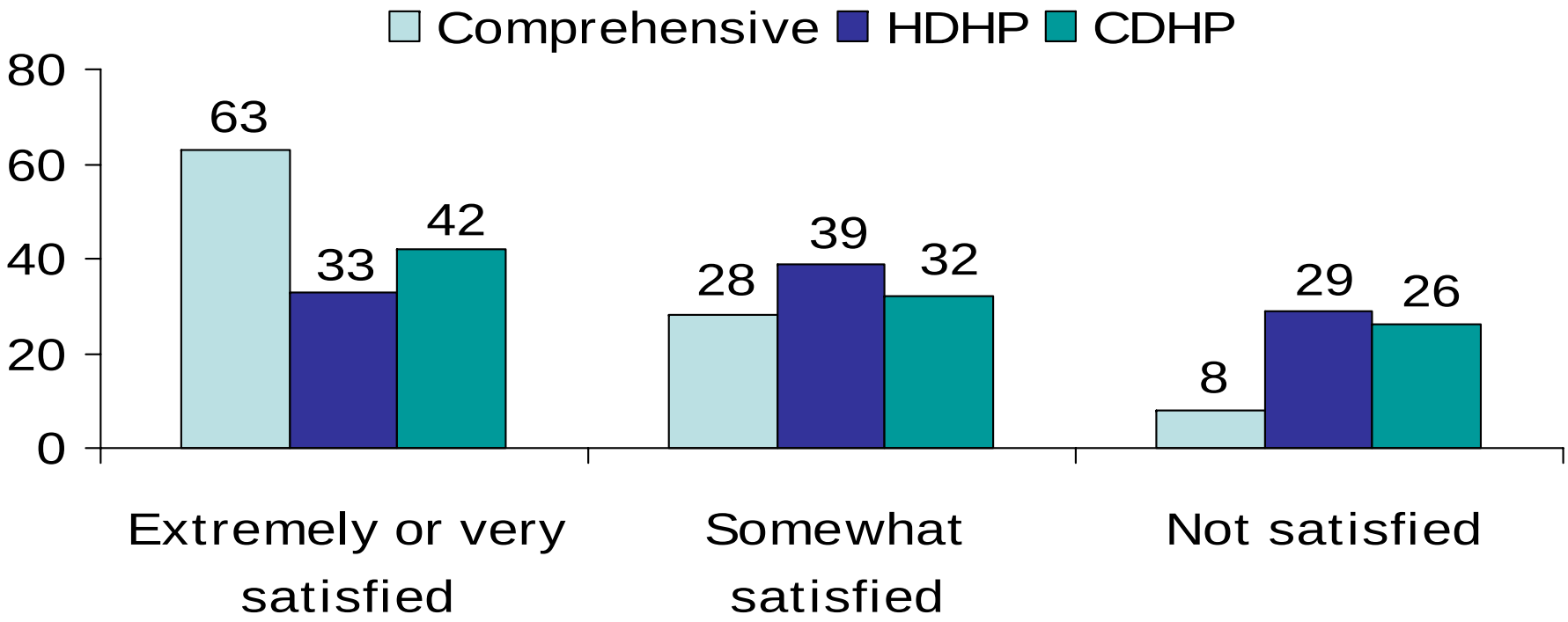
Figure 23. Overall Satisfaction with Health Plan, by Type of Health Plan



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.

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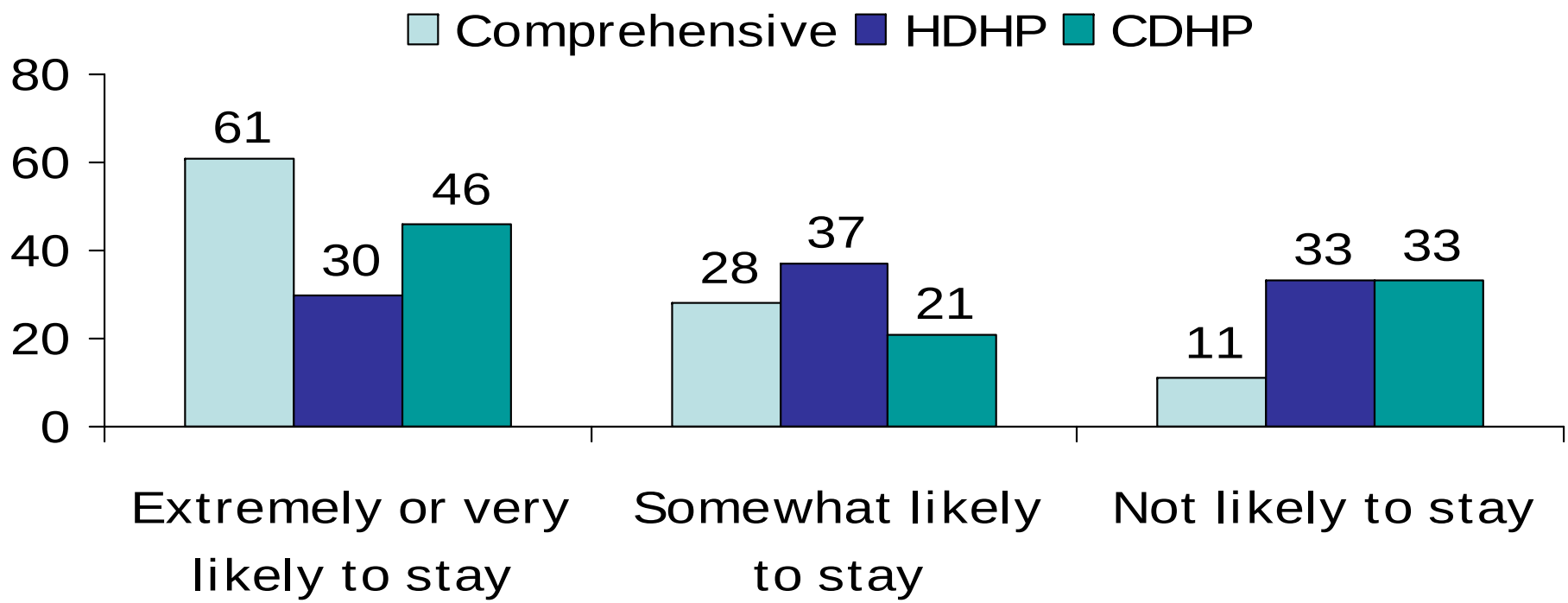
Figure 24. Likelihood of Staying With Current Health Plan If Had the Opportunity to Change, by Type of Health Plan



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.

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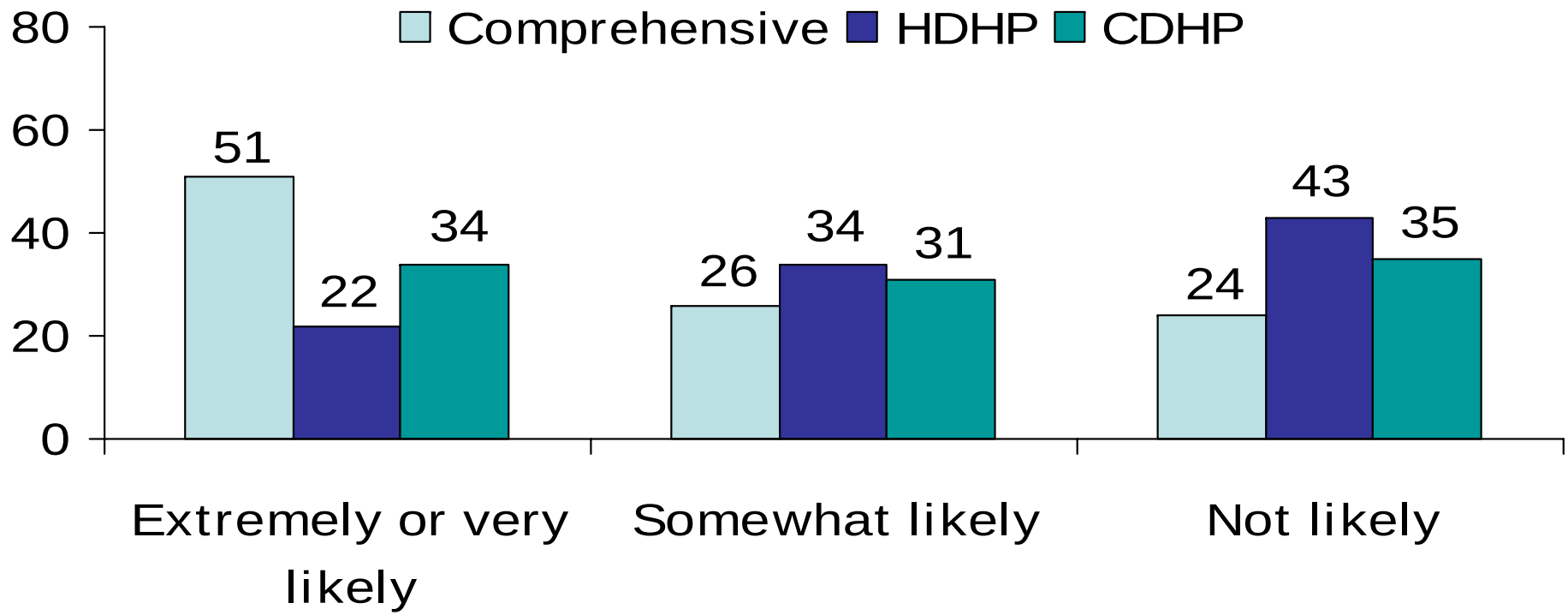
Figure 25. Likelihood of Recommending Health Plan to Friend or Co-Worker, by Type of Health Plan



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.

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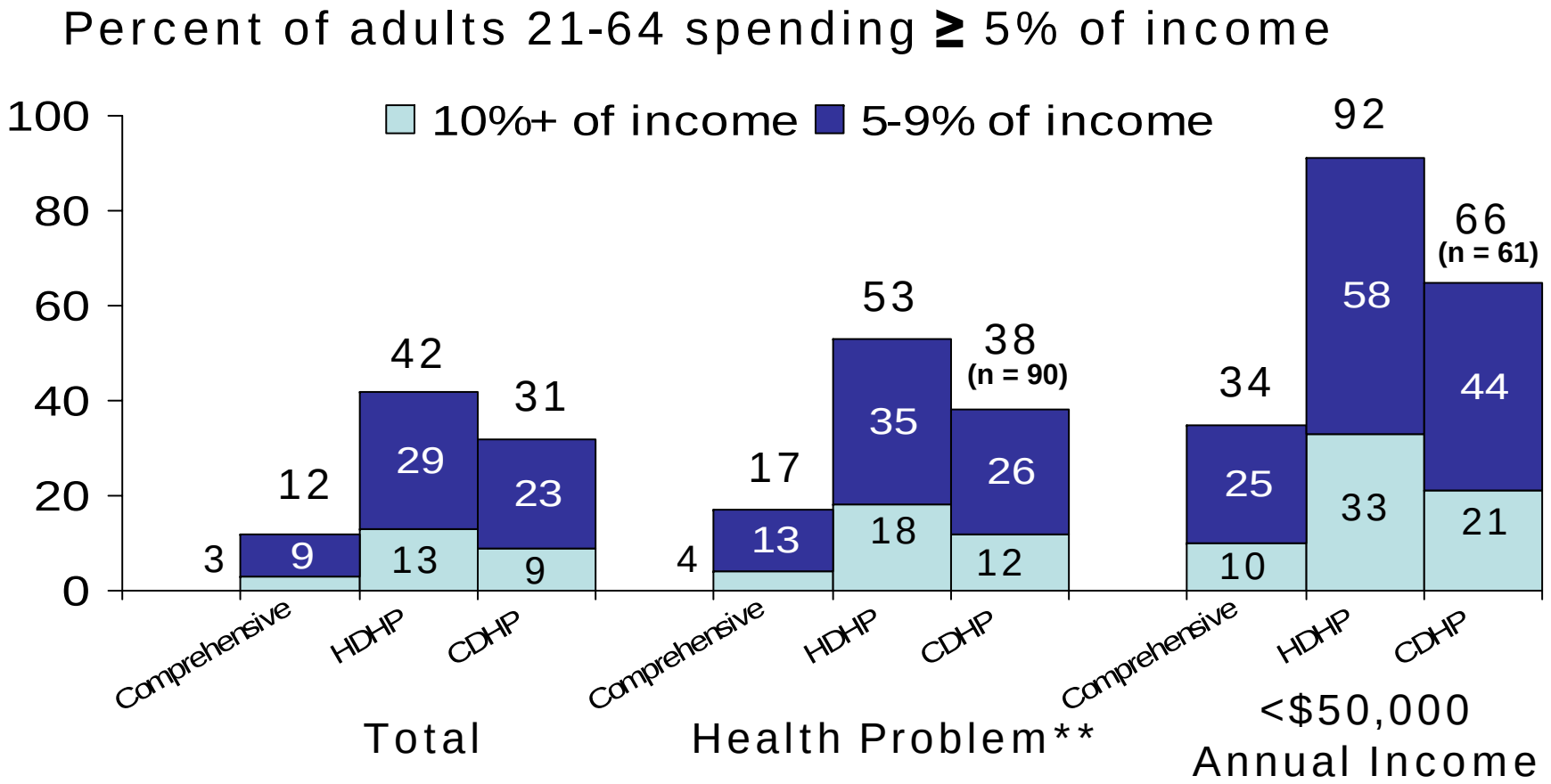
Figure 26. Percent of Income Spent Annually on Out-of-Pocket Medical Expenses, Including Premiums



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.

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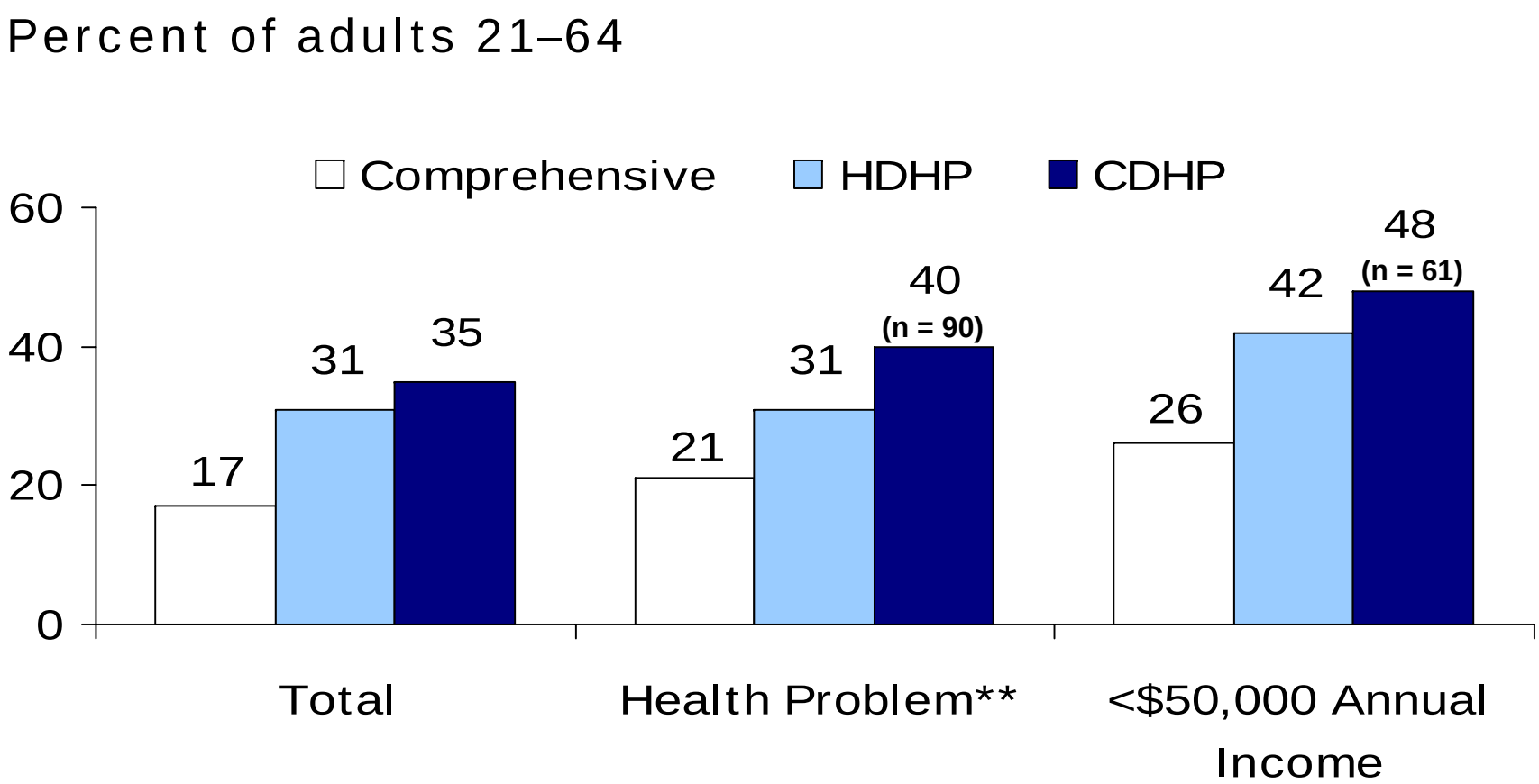
Figure 27. Percent of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost



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.

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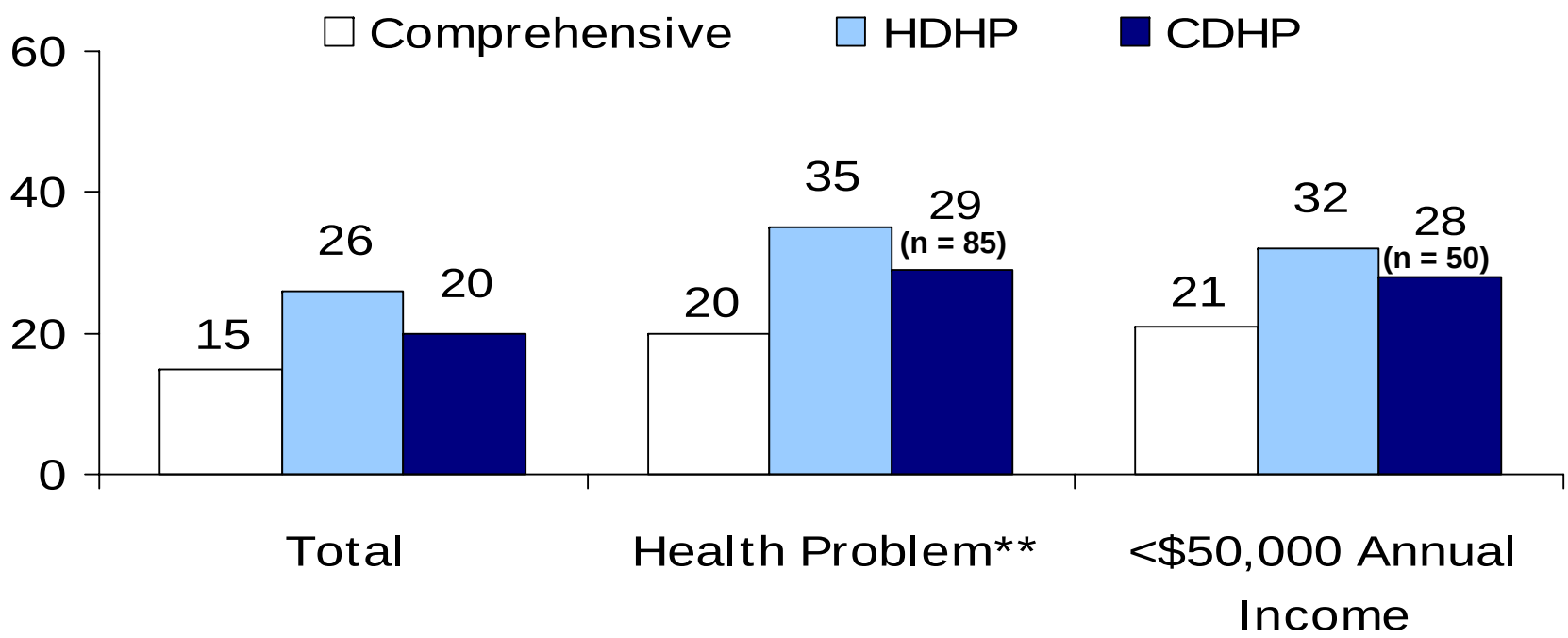
Figure 28. Percent of Adults Who Have Skipped Doses to Make a Medication Last Longer

Percent of adults 21-64 with prescriptions in last 12 months



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.

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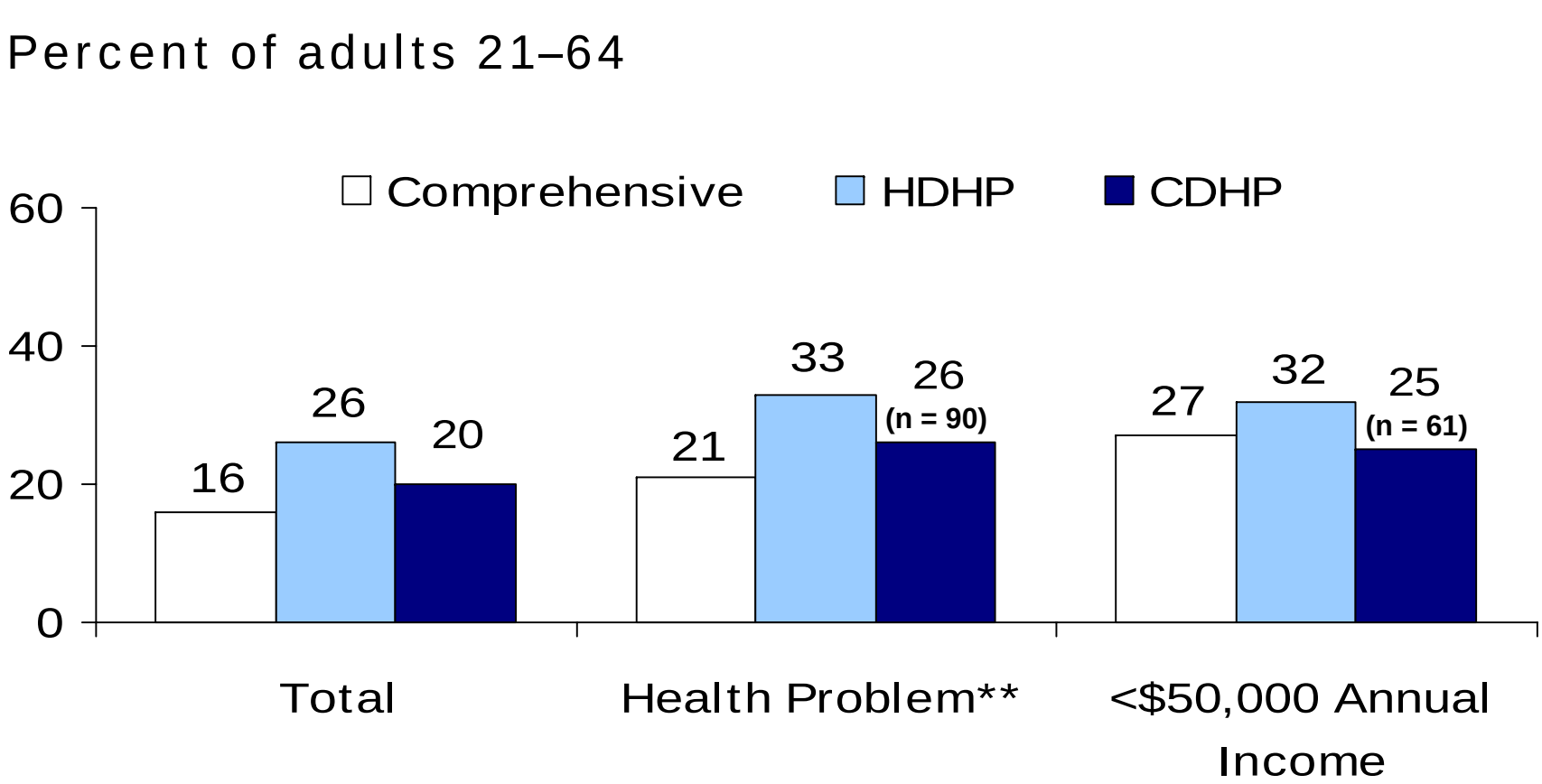
Figure 29. Percent of Adults Who Have Not Filled a Prescription Due to Cost



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.

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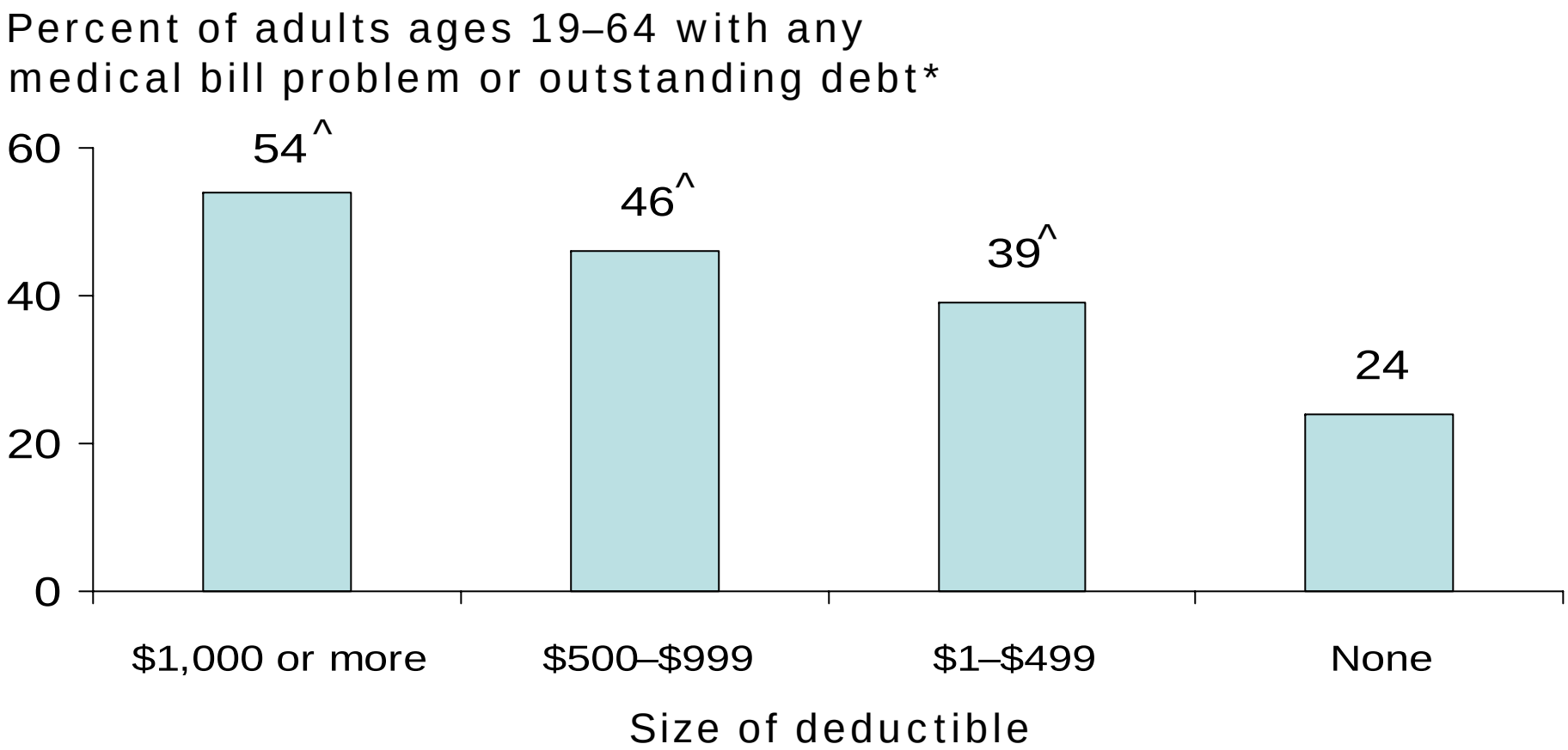
Figure 30. Medical Bill or Debt Problems in Past Year, by Size of Deductible



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).

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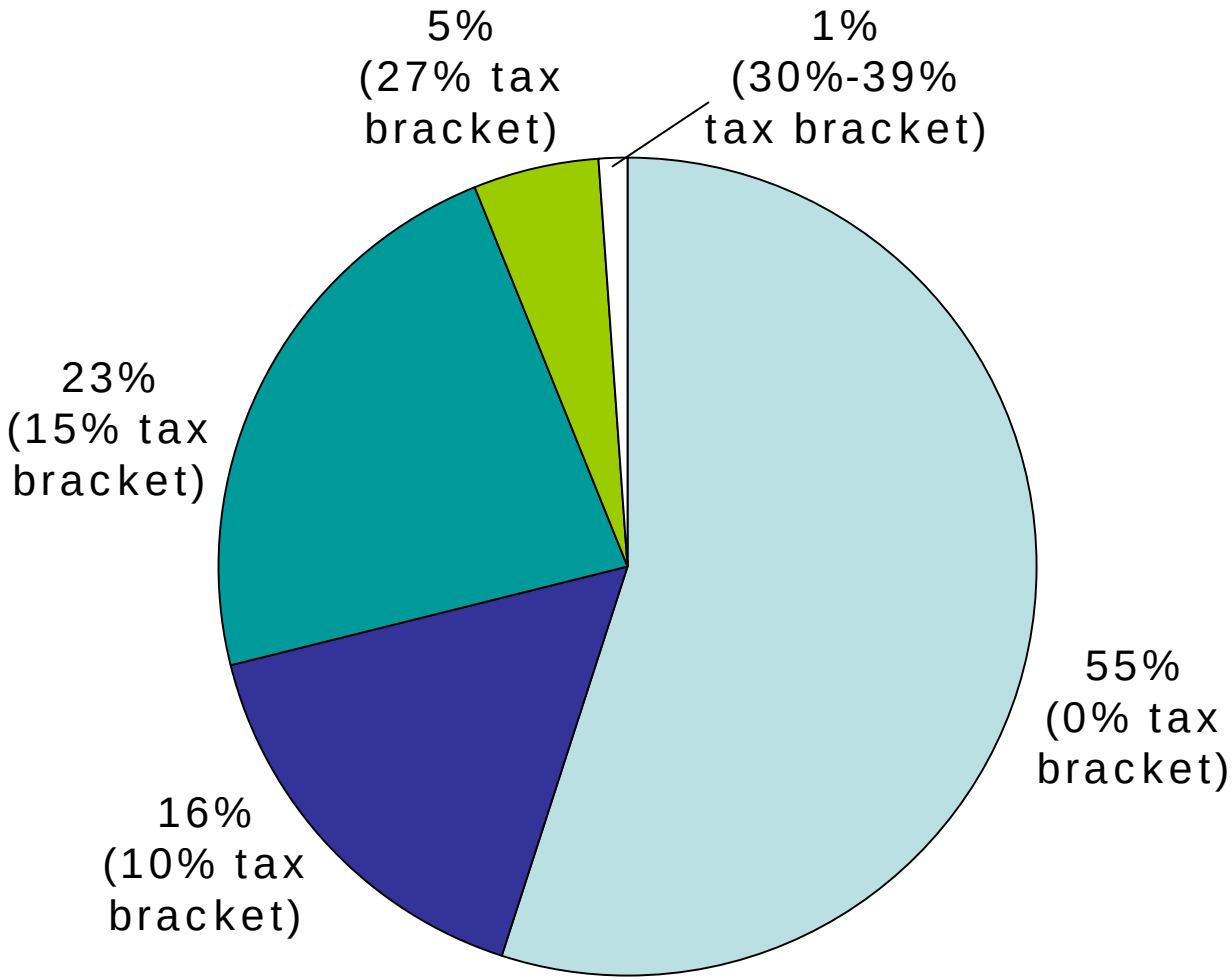
Figure 31. HSAs Won't Solve the Uninsured Problem: Income Tax Distribution of Uninsured



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

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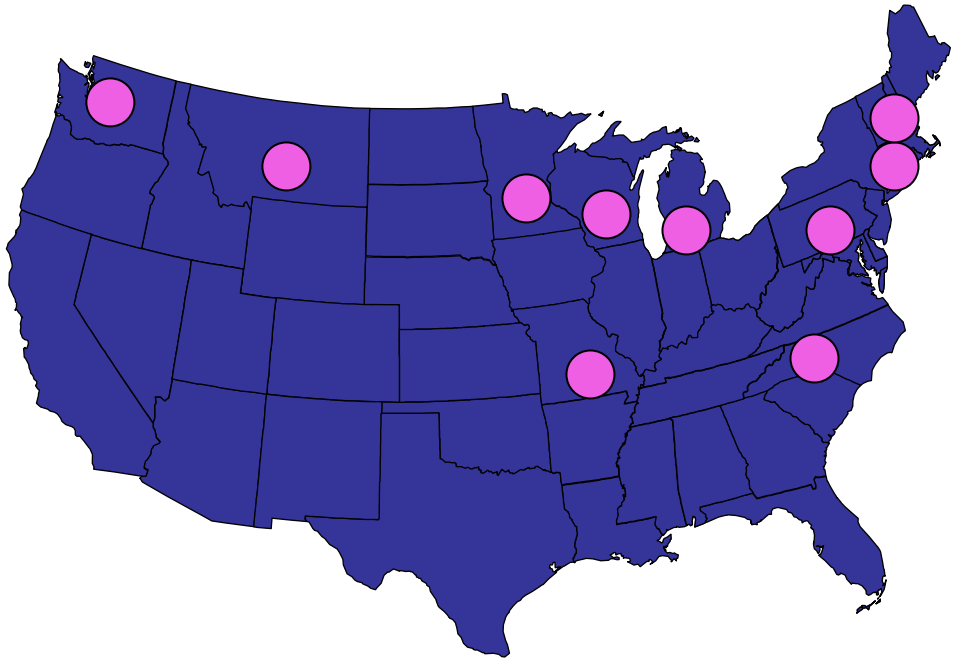
Figure 32. Medicare Physician Group Practice Demonstration



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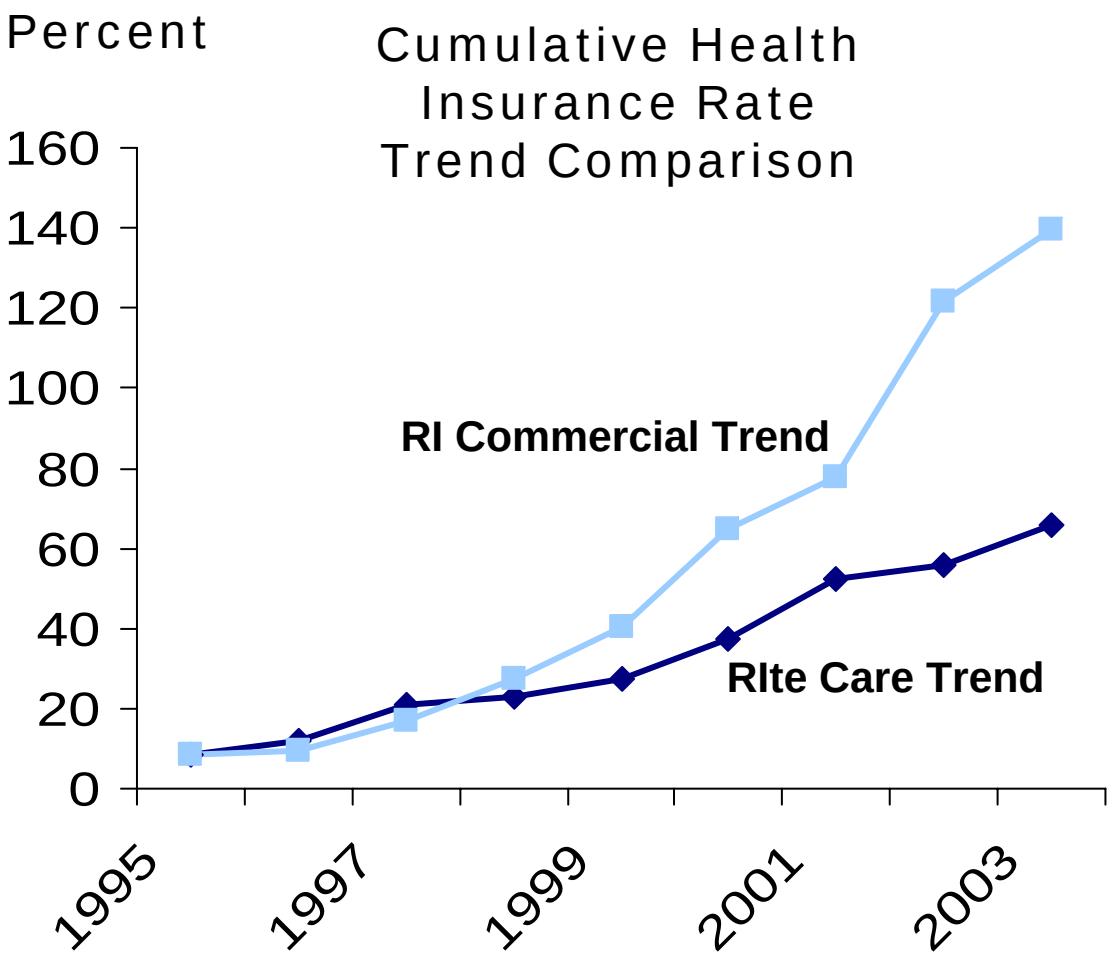
Source: "Medicare Physician Group Practice Demonstration," www.cms.gov, January 31, 2005.

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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