

# Health Care Price Transparency and Price Competition

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**OVERVIEW** — *Growing numbers of consumers are in health plans that give them incentives to be more cost-conscious. Yet complex pricing systems and limited information may make it hard to choose among providers and treatment options. This report examines steps that insurers and others have taken to make better price information available, possible government measures to further promote price transparency or to simplify price comparisons, and the likely effects on consumer behavior and provider competition.*

## Contents

HEALTH CARE PRICES .....	4
Types of Provider Prices .....	4
Amounts Paid by Health Plan Enrollees .....	5
Table 1: Comparison of Patient Costs for In-Network and Out-of-Network Services in Hypothetical PPO Plan.....	7
PRICE INFORMATION FOR CONSUMERS .....	11
Types of Information Provided.....	11
Table 2: Sample Average Episode Cost Estimate for High-Severity Heart Failure .....	15
Table 3: Proposed Format for Disclosure of Average Estimated Costs by an Insurer Participating in the FEHB Program .....	15
Availability and Consumer Use of Price Information .....	16
Figure 1: Scope and Types of Provider and Cost Information Reported by Insurers Offering HSA or HRA Plans, 2005 .....	16
Figure 2: Percentage of Enrollees in Plans Providing Cost Information Who Tried to Use That Information, by Type of Plan and Provider, 2006 .....	17
PROMOTING GREATER TRANSPARENCY .....	17
Required Disclosure .....	17
Standardized Pricing .....	19
POSSIBLE EFFECTS OF GREATER PRICE TRANSPARENCY .....	20
Evidence on Consumer Behavior .....	21
Financial Incentives .....	25
Figure 3: Average Income Tax Deduction Claimed for HSA Contribution, 2004 .....	26
CONCLUDING OBSERVATIONS: THE ROLE OF HEALTH PLANS .....	27
ENDNOTES .....	28

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# Health Care Price Transparency and Price Competition

Employers, insurers, and policymakers have shown increasing interest in health benefit plans that are designed to make insured people more cost-conscious by requiring them to pay a larger share of their own expenses. Much of the recent discussion has focused on consumer-directed health plans, which combine a high initial deductible with a savings account funded through employer and/or enrollee contributions. (Similar products are now available to Medicare beneficiaries.) In addition, many enrollees in more traditional health insurance plans have faced steadily rising cost-sharing requirements.

Most people with private insurance now have at least some incentive to think about possible costs when choosing among available providers or treatments. Yet their ability to make informed decisions has been limited by the lack of publicly available information on provider prices and by complex pricing systems that make it difficult for patients to assess what they will actually have to pay out of pocket for different courses of care.

In response, many insurers, providers, state and federal agencies, and other third-party sources are beginning to make some form of price information available to the general public or to enrollees of a specific health plan. President Bush has issued an executive order requiring federal health programs and their contracting health plans to disclose prices to their beneficiaries or participants, and there are many other initiatives to increase “price transparency” through voluntary or mandatory reporting.<sup>1</sup>

So far, few of these initiatives provide health plan enrollees the data they might need to make informed choices among available providers or treatments. Even if more complete information is made available, there is an ongoing debate over the likely effects of greater transparency in health care pricing. Some people contend that informed consumers will be more likely to shop for better values and that providers will respond by competing on price and quality. Others say that these effects are likely to be limited because health care decisions are complicated and are often made quickly or at times of great personal stress. In this view, consumers may not be able or willing to shop for medical care in the same way they do for other goods and services, and the financial incentives for price-shopping may not be very strong.

This background paper begins with an explanation of (i) the different kinds of health care prices and (ii) which kinds of prices are relevant to consumers with different kinds of coverage in different situations. It then reviews

the price information now being made available to consumers through public or private sources, along with proposals for broader disclosure and standardization of pricing systems. Finally, it considers whether the combination of transparency and consumer-directed health plans is likely to lead to greater price competition among providers.

## HEALTH CARE PRICES

Most hospitals, doctors, and other health care providers charge different prices for different patients, depending on whether they have insurance coverage and what type of coverage they have. In addition, the actual amounts paid out of pocket by patients will often depend on whether they are using a provider who participates in their insurer's network, whether their spending has exceeded a plan's deductible or out-of-pocket limit, or what type of coinsurance, co-payments, or other cost-sharing their plan imposes.

### Types of Provider Prices

Three different "prices" are potentially relevant in determining what a consumer must pay for care: provider charges, contract prices negotiated between a health plan and a participating network provider, and the health plan's maximum allowance for services obtained from non-network providers.

**Provider Charge** – The provider's "list price" for the service.

The charge is the amount the provider would bill a self-pay patient—that is, a patient with no insurance or one with a health plan that has no contract with the provider. In the case of hospitals, charges in 2003-2004 averaged more than twice the actual cost of furnishing care; 10 percent of hospitals had charges that were four or more times their costs.<sup>2</sup> In practice, uninsured patients rarely pay the full charge. Data from the 2003 Medical Expenditure Panel Survey (MEPS) indicate that only 9 percent of hospital inpatients with no insurance or other third-party payment paid the hospital's full charges. Two-thirds paid nothing, usually because their charges were written off as charity care or bad debt.<sup>3</sup> Other providers, such as physicians in independent practice, may also have a standard charge that is higher than the amount they accept from most patients.

**Contracted Price** – The maximum amount a participating or network provider has agreed to accept for patients covered by a particular public program or private health plan.

In the case of Medicare and most Medicaid programs, the administering agency established payment rates, although some Medicaid programs

negotiate rates with providers for some services. Private health plans negotiate prices with hospitals and large physician groups; some smaller practices may be offered a rate on a take-it-or-leave-it basis. Both public and private plans generally require contracting or “participating” providers to accept the negotiated rate as payment in full. These providers may collect a co-payment or coinsurance from the patient but may not “balance bill,” that is, collect from the patient any of the difference between the contract price and their usual full charge. Medicare allows limited balance billing by nonparticipating physicians, but not by the overwhelming majority who are participating or by hospitals.

Contract prices are commonly well below the provider’s listed charge and may sometimes be less than the actual cost of services. In particular, providers and private insurers often contend that Medicare and Medicaid programs underpay, forcing providers to “cost shift,” or charge private payers more for their patients in order to cover losses for public program patients. These claims are hard to assess because of the limitations of the available data and because public programs’ payment policies change over time. For example, the Medicare Payment Advisory Commission (MedPAC) has estimated that aggregate Medicare payments to hospitals were greater than costs in 1997–2002 and less than costs in 2003 and 2004.<sup>4</sup>

**Maximum Allowance** – The maximum amount the health plan will pay when a service is obtained from a non-network provider.

This allowance or “charge screen” used by an insurer was once commonly based on an average of what different providers in the community charged that insurer for the service. Now insurers may use some other method—for example, fixing the maximum at some percentage of what Medicare would allow for the same service. When the maximum allowance set by a private insurer is less than the provider’s full charge, the provider can bill the patient for the balance, as well as for any required coinsurance amount. Public programs usually prohibit or limit balance billing.

## Amounts Paid by Health Plan Enrollees

In order to estimate the net amount they will have to pay different providers for particular services, health plan enrollees need to know not only provider prices but also their health plan’s payment and cost-sharing rules.

**Traditional health plans** — Most people with private insurance are in plans with some form of provider network. Among workers with employer coverage, 73 percent were in preferred provider organization (PPO) or point of service (POS) plans in 2006. These plans allow enrollees to use both network and non-network providers; however, higher

deductibles and cost sharing apply to non-network services, and enrollees may be subject to balance billing by non-network providers. Another 20 percent of workers were in health maintenance organizations (HMOs), which provide no coverage for non-network care except in emergencies; 4 percent were in consumer-directed plans, described in the next section, most of which also use networks; just 3 percent were still in non-network “indemnity” plans.<sup>5</sup> Indemnity plans may have a network of providers who have agreed not to balance bill, but deductibles and coinsurance are the same regardless of whether the enrollee uses a network or non-network provider.

Because PPO plans are most prevalent, it is useful to look at their payment rules in greater detail. Most PPOs have an in-network deductible; among those with a deductible, the average for single employees was \$473 in 2006.<sup>6</sup> Enrollees in these plans pay network providers the plan’s contract price (not full charges) for services until the deductible is reached. At that point—or from the outset, in a plan with no deductible—the enrollee usually pays a fixed co-payment, commonly \$15 or \$20, for physician visits; some plans instead require a coinsurance payment, commonly 20 or 25 percent of the contract price. (Many plans have separate deductible and coinsurance rules for inpatient hospital admissions, and nearly all plans have separate cost-sharing rules for prescription drugs.) Most plans have an annual out-of-pocket limit, such as \$1,500 or \$2,000 for a single enrollee. Once the enrollee’s total payments for deductibles, co-payments, and/or coinsurance during a year reach this limit, the plan pays the full negotiated price for any subsequent in-network care. (Some plans may not count deductible payments toward the out-of-pocket limit.)

Enrollees who go outside the network for nonemergency care are penalized in several ways. First, the plan may impose a higher deductible and require larger coinsurance payments for non-network services. Second, because there is no contract price for these services, the enrollee will pay the provider’s full charge until the deductible is reached. Third, in determining when the deductible has been reached, the plan may count only its maximum allowance for the service, even if the enrollee has paid the provider more than this amount. For example, in a plan with a \$500 deductible, if a provider charges \$750 and the plan’s maximum allowance is \$400, the enrollee might pay the provider \$750 and still be \$100 short of meeting the deductible. Finally, once the deductible is reached, the plan will pay a non-network provider its maximum allowance minus the applicable coinsurance percentage. The enrollee will then pay the coinsurance amount plus any difference between the maximum allowance and the provider’s full charge. An enrollee who has reached the out-of-pocket limit will not pay coinsurance but will still pay the difference between the allowance and the full charge.

**Consumers need to know both provider prices and their health plan’s payment rules in order to estimate their costs for a particular service.**

Table 1 further shows how the choice between network and non-network providers can affect a patient's out-of-pocket costs under a hypothetical PPO plan. In this example, Zelda has received an outpatient diagnostic procedure, followed by outpatient surgery. Charges for the latter include the surgeon's fee and a facility charge by a hospital or ambulatory surgical center.

**TABLE 1**  
**Comparison of Patient Costs for In-Network and Out-of-Network Services in Hypothetical PPO Plan**

**IN-NETWORK SERVICES**

After a \$500 deductible, the patient pays \$15 for each physician service; outpatient facility costs are covered in full.

In-Network Services	Provider Charge	Contract Price	Patient Pays	Plan Pays
<b>Outpatient Diagnostic Procedure</b>	\$ 750	\$ 400	\$ 400 <i>toward deductible</i>	\$ 0
<b>Outpatient Surgery</b> <i>(facility charge)</i>	\$ 5,000	\$ 4,400	\$ 100 <i>remaining on deductible, no other cost-sharing</i>	\$ 4,300
<b>Outpatient Surgery</b> <i>(physician charge)</i>	\$ 1,500	\$ 1,000	\$ 15 copay	\$ 985
<b>TOTAL PATIENT COSTS</b>			<b>\$ 515</b>	<b>\$ 5,285</b>

**OUT-OF-NETWORK SERVICES**

After a \$500 deductible, the plan pays 80% of allowed physician and outpatient facility charges. There is a \$1,500 out-of-pocket limit.

Out-of-Network Services	Provider Charge	Plan Maximum Allowance	Patient Pays	Plan Pays
<b>Outpatient Diagnostic Procedure</b>	\$ 750	\$ 400	\$ 750 <i>(only \$ 400 counted toward deductible)</i>	\$ 0
<b>Outpatient Surgery</b> <i>(facility charge)</i>	\$ 5,000	\$ 4,400	\$ 1,560 <i>(\$100 left on deductible + 20% of \$4,300 + \$600 difference between charge and allowance)</i>	\$ 3,440 <i>(80% of \$4,300)</i>
<b>Outpatient Surgery</b> <i>(physician charge)</i>	\$ 1,500	\$ 1,000	\$ 640 <i>(\$140 needed to reach out-of-pocket limit + \$500 difference between charge and allowance)</i>	\$ 860
<b>TOTAL PATIENT COSTS</b>			<b>\$ 2,950</b>	<b>\$ 4,300</b>

If Zelda uses network providers, she pays the PPO's contract price of \$400 for the diagnostic procedure. She pays \$100 toward the facility fee, meeting the remainder of her deductible, then pays \$15 for the surgeon's service. If Zelda uses non-network providers, she pays the full charge of \$750 for the diagnostic procedure, but the plan only counts \$400 toward the deductible. For the facility fee, the plan allows \$4,400. Zelda pays the first \$100, the plan pays 80 percent of the remaining \$4,300, and Zelda pays 20 percent of \$4,300 plus the difference between the facility's charge and the allowed amount. So far, Zelda has spent \$2,310, well over the out-of-pocket limit. But the plan has only counted \$1,360, ignoring the amounts she has paid in excess of the plan's maximum allowances. Therefore, for the surgeon's fee, Zelda must pay \$140 before the plan's catastrophic protection kicks in. And she must still pay the difference between the surgeon's fee and the plan's maximum allowance for that service.

Thus a consumer trying to decide whether to obtain a service and whether to use a network provider might need to know all three of the relevant prices (charges, contract price, and maximum allowance) to make a fully informed decision. On the other hand, a consumer who has met the deductible and is content to stay within the network may not need to know any prices at all to choose among network providers. Even if different providers have different charges and contract prices, the consumer's liability may be a flat amount in a plan that imposes fixed co-payments rather than coinsurance.

One recent development, tiered cost sharing for in-network services has changed the calculations somewhat for participants in PPOs and other network arrangements. Under a tiered system, the plan gives preferential treatment to some network providers—selected on the basis of some form of price and quality scoring—over others. (Tiered arrangements have long been common in prescription drug benefits, with lower cost-sharing for generic and preferred brand-name drugs.) An enrollee using the selected providers will pay a lower co-payment than one using other network providers. In 2005, 13 percent of enrollees in employer group PPO and POS plans, and 11 percent of those in HMOs, faced tiered cost-sharing for medical services.<sup>7</sup> While tiering can increase consumers' price sensitivity, it may also mean that consumers need even more information to make rational decisions.

**Consumer-directed health plans (CDHPs)** — While there are many different definitions of consumer-directed health care, two basic types of plans account for most current enrollment. The first are plans developed to comply with the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. These plans combine a high-deductible health plan (HDHP) with a health savings account (HSA) funded through employer and/or enrollee contributions. Within specified limits, the MMA allows enrollees in qualified HDHPs to deduct their contributions to the HSA, and

excludes employer contributions from employees' taxable income. See text box, below, for an explanation of how HDHP/HSA plans work.

The other common form of CDHP combines an employer health plan (which may or may not be a high-deductible plan) with a health reimbursement arrangement (HRA). An HRA is similar to an HSA in some respects and different in others. As with an HSA, the employer can make tax-exempt contributions to an HRA; however, employees cannot supplement these contributions with pre-tax dollars. Funds in an HRA can be drawn on at any time to pay for medical expenses, but the employer is free to decide what specific categories of expenses may be covered. HRAs are usually "notional" accounts, meaning the employer isn't actually depositing money anywhere but is simply crediting the worker with a specified amount to be made available as expenses are incurred. Whereas an HSA belongs to the employee even if he or she changes jobs, workers may

### High-Deductible Health Plans and Health Savings Accounts

The following is a very brief description of the rules for tax-qualified HDHP/HSA plans; dollar amounts noted are those in effect for 2007 and will be adjusted for inflation in subsequent years. (For a more complete description of how HDHPs/HSAs work, see Beth Fuchs and Lisa Potetz, *The Fundamentals of Health Savings Accounts and High-Deductible Health Plans*, National Health Policy Forum, forthcoming.)

#### HDHP

An HDHP must have a minimum deductible of \$1,100 for a self-only plan or \$2,200 for a family plan. Enrollees pay the entire cost for covered services until they have satisfied the deductible. However, the insurer *may* pay for some preventive care before the deductible is reached. Once an enrollee or family has met the deductible, the plan may pay in full for covered services or may require continued cost sharing (such as 20 percent coinsurance). The total amount paid by an enrollee for the deductible and other cost sharing is subject to an out-of-pocket limit, after which the HDHP pays 100 percent of covered expenses. For 2007, the limit is \$5,500 (individual) or \$11,000 (family). A plan may have a higher deductible than the minimum or a lower out-of-pocket limit, but it may not have a lower deductible or higher out-of-pocket limit. Like other health plans, an HDHP may have a network of participating providers and may require higher cost sharing for out-of-network services.

#### HSA

An HSA is a savings account, similar to an IRA (individual retirement account), held at a bank or other financial institution. The sum of enrollee and employer contributions to an HSA during a year may not exceed \$2,850 for an individual or \$5,650 for a family. Funds may be withdrawn from the HSA to pay for any qualified medical expense as defined by the Internal Revenue Code, except that the HSA may not be used to pay premiums for the HDHP or most other types of insurance. Expenses paid with HSA funds may include costs for services that would not be covered under the HDHP (for example, dental or vision care if the HDHP excludes these services), although these services would not count toward the deductible or out-of-pocket limit. The unused balance in the HSA may be carried over into later years. Interest or other income is tax free, and withdrawals in the future remain tax-exempt so long as they are used for qualified expenses.

not always be able to continue drawing on an HRA balance after terminating employment. In addition, the employer may or may not allow workers to carry unused HRA balances into future years. HRA arrangements are more commonly offered by large employer groups, while HSAs are more prevalent in the small group and individual markets.

Enrollees in either type of arrangement commonly have access to some form of provider network. One recent survey found that 95 percent of insurers offering an HDHP/HSA or HDHP/HRA plan made the same network available to enrollees in these plans and in the insurers' traditional PPO or HMO plans.<sup>8</sup> HDHPs commonly follow the same rules as conventional PPOs, giving enrollees access to contract prices when they use network providers and subjecting them to much higher costs for out-of-network care. The relative costs for network and non-network use may therefore resemble those shown above in the cost illustration for a traditional PPO enrollee. The only difference is that the HDHP enrollee faces a higher deductible and out-of-pocket limit. Even this is not always true: in 2006, 8 percent of single enrollees in employer PPO plans faced a deductible of \$1,000 or more, while 39 percent had an out-of-pocket limit greater than \$2,500 or no limit at all.<sup>9</sup>

Two factors affect the cost—real or perceived—of services for participants in an HDHP/HSA plan. The first is the HSA itself. If the employer is contributing to the HSA, some consumers may regard the care they receive as “free” until the employer’s contribution is exhausted. In 2006, 30 percent of enrollees in employer HDHP/HSA plans received no employer HSA contribution. Employers who did pay into HSAs contributed an average of \$988 for single workers, while the average single deductible was \$2,011, leaving a gap of about \$1,000 to be paid by the enrollee (directly or through a tax-favored employee contribution to the HSA).<sup>10</sup>

Second, a surprisingly large number of HDHP/HSA plans require no co-insurance payments after the deductible has been met. In 2004, 85.4 percent of individual HSA-eligible plans purchased through the online vendor eHealthInsurance covered the full cost of in-network services above the deductible.<sup>11</sup> For an enrollee in one of these plans, the effective out-of-pocket limit is identical to the deductible; the enrollee could incur additional costs after reaching the deductible only by using non-network providers or obtaining noncovered services.

Although enrollment in consumer-directed health plans has been growing, the vast majority of people with private health insurance are still in traditional plans. As of January 2006, insurers reported about 3.2 million enrollees in HDHP/HSA plans: 855,000 individual buyers, 1.4 million group enrollees, and 878,000 enrollees who could not be classified as individual or group. A 2006 survey of employers found that 4 percent of covered workers were in an HDHP with an HSA or HRA option. Enrollment in HDHP/HSA group plans grew from 0.8 million workers in 2005 to 1.4 million in 2006. (This estimate does not include dependents.<sup>12</sup>)

## PRICE INFORMATION FOR CONSUMERS

Many insurers, providers, state and federal agencies, and other third-party sources are beginning to make some form of price information available to the general public or to members of a specific health plan, and there are proposals to increase transparency of prices through voluntary or mandatory reporting requirements.

### Types of Information Provided

Insurers or other sources are providing information about different kinds of provider prices or ranges of prices. The following discussion provides a few examples of each of the basic types of information being made available (usually on the Internet) and is not meant to be a catalogue of all existing initiatives.

**Provider charges** — Some hospitals or other sources are now providing information about charges (list prices) for inpatient, and sometimes outpatient, services. No equivalent information appears to be available for charges for services rendered by physicians or other nonhospital providers.

California requires hospitals to publish their standard lists of charges for inpatient and outpatient services. These lists (known as chargemasters) run for hundred of pages and can include nearly 25,000 individual prices for such services as “leukopoor platelet pheresis” or “CT scan reformatting 1 plane.” As consumers rarely know which or how many of these services they might consume during an inpatient stay or outpatient visit, these lists may be of little help. The hospitals also provide a short list of charges for commonly used services, such as an echocardiogram, an intermediate emergency room visit, or a day of room and care in an intensive care unit. These lists still tell consumers nothing about what they will actually pay for the long list of items that might appear on their final bill. Consumers might try to use the short charge list as a rough gauge of which hospitals are more costly than others. They might be misled: charge lists include different mark-ups over cost for different services.<sup>13</sup> The hospital with the lowest charges for the short-list services might have relatively high charges for many other services. (Hospitals might even have an incentive to quote lower mark-ups on the short-list services.)

Several sources are providing aggregated data that might be more useful. In Wisconsin, the WHA Information Center, a subsidiary of the state hospital association, provides information on its Web site on total charges per hospital admission by diagnosis-related group or DRG. DRGs are the categories Medicare and many other payers use to classify inpatient admissions by diagnosis, complications, and/or procedures performed, for example, “cardiac arrhythmia and conduction disorders with complications.” For each hospital and DRG, the site lists number of discharges, length of stay, and average and median charge; each hospital can be compared to all others in the county or state or all others with a similar volume of cases. Louisiana

Health Inform provides similar information on outpatient care, giving low, high, and average charges for common ambulatory payment classifications (APCs, the outpatient counterpart of DRGs).

As noted earlier, charge data are useful to enrollees in most plans only if they are considering using an out-of-network provider. Moreover, hospital charge information excludes the separately billed charges for physician or other professional services furnished during an inpatient stay or outpatient visit. Because a low-cost hospital might have high-cost physicians, the hospital data give an incomplete comparison of total costs for which a user might be liable. The issue of “global” costs is considered further below (see “Evidence on Consumer Behavior” section).

**Contract prices** — Some health plans are beginning to provide information about the actual contract prices they have negotiated with providers for selected procedures. CIGNA is providing average prices for some outpatient procedures, such as colonoscopies and MRIs (magnetic resonance imaging tests), at different facilities.<sup>14</sup> Aetna has been providing prices for a list of representative procedures (varying by specialty) for each physician in Cincinnati and has begun to extend the project to a few other localities. One obvious limitation of this information is that patients usually come to a physician with some symptom or complaint, not looking for a specific procedure. Even if they know what major procedure they want, they cannot predict what lab tests or other associated services they might need. This might not be a problem if insurers are uniformly paying some physicians higher contract prices than others across all procedures, as appears to be the case in the Aetna price lists.<sup>15</sup> Enrollees could then get a general notion of which providers are more costly, even if they couldn’t determine what mix of services they would be using.

Physicians point to another problem with posting contract prices: the procedures for which they bill the insurer are not necessarily the ones for which they will be paid, because insurers will disallow some charges or reclassify others. Humana has developed a system of real-time adjudication, under which a participating provider can submit a claim electronically and learn immediately what it will be paid and how much the patient will owe.<sup>16</sup> (Similar systems are quite common for pharmacy services.) This works only when the physician has the necessary linked computer system and, in any case, lets consumers know their costs only after services have been rendered, not when they are trying to choose a provider or decide what services to obtain.

A larger issue in posting negotiated prices is that the terms of insurer or provider contracts are confidential; insurers, providers, or both may object to contract prices being made public. Moreover, some economists contend that publication of negotiated prices may have perverse effects on

**One limitation of contract price information as a tool for evaluating cost is that patients usually come to a physician with some symptom or complaint, not looking for a specific procedure.**

competition; this question is considered further below (see “Required Disclosure” section).

In June 2006, the Centers for Medicare & Medicaid Services (CMS) posted data on Medicare payments to inpatient hospitals by state and county for the most common DRGs and some others “deemed of interest to the Medicare community.” Similar information for ambulatory surgery centers and common hospital outpatient and physician services was released later in 2006. This information is of little use to Medicare beneficiaries themselves, because their out-of-pocket costs for any given service do not vary according to their choice of provider. CMS acknowledges this, but suggests that “Medicare payment rates may provide a helpful benchmark, especially for uninsured individuals, to determine whether the charges they see on a hospital bill bear any relationship to what third-party fee-for-service payors pay to the hospital.”<sup>17</sup> However, Medicare payment rates are set using formulas that are uniform across providers; the ratio of these rates to the prices negotiated by other carriers is likely to vary from provider to provider. Even for a single provider, the ratio may not be constant for different services.

**Maximum allowances** — A health plan enrollee considering using a non-network provider, or an enrollee in a plan with no network, needs to know both the individual provider’s charges and the insurer’s maximum allowance for the service. The federal TRICARE program, which serves active and retired military personnel and their families, now posts its maximum allowable payments by geographic area for numerous physician services online.<sup>18</sup> It does not provide information on nonparticipating providers’ charges, but TRICARE enrollees may not need this information, because the program strictly limits balance billing.

Insurers could help enrollees evaluate non-network costs by publishing their own maximum allowances for specific services. However, insurers have historically been reluctant to reveal their maximum allowances, because this could undermine their negotiations with network providers and because of concerns of possible manipulation by non-network providers (for example, billing for the procedure code with the higher allowance). Insurers might also be able to report what non-network providers in an area are typically charging for various services. However, any one insurer could assemble charge information only if its enrollees were frequently using specific non-network providers and, because providers can change their charges at any time, any information might rapidly become obsolete.

**Episode costs** — Even if a consumer had full information about providers’ charges and contract prices and about insurers’ maximum allowances for every procedure, this might not be enough to establish which providers are more or less costly. A given physician might charge less than others for office visits, but order a great many more tests. In addition, medical care often involves multiple providers: the patient presents

a problem to primary physician A, who refers the patient to specialist B, who recommends that surgeon C perform a procedure at facility D. Knowing what physician A charges for visits or procedures tells the patient nothing about the likely ultimate cost of care for the entire episode of illness.

In theory, the patient could break the chain of connections among providers. When physician A recommends physician B, the patient could go home and see if there's some other less costly specialist available. The patient could suggest that the surgeon use less costly facility E instead of D. However, because practitioners may have established ties to particular facilities, this might require dramatic changes in the organization of medical practice and thus be unlikely to happen. In the current system, patients trying to make provider choices on the basis of price or quality may need some way of comparing the whole, loosely connected set of providers A-B-C-D to some alternative set, E-F-G-H or I-J-K-L. The original concept of managed competition assumed just this sort of comparison: the consumer would choose between health plans whose premium costs would reflect the relative efficiency of their affiliated provider networks. However, health plans may now contract with most providers in a community, and consumer-directed care is designed to shift the focus of competition from the level of health plans to the level of providers.

A number of measurement systems have been developed that attempt to capture differences among providers in overall spending for an entire episode of care. These include Symmetry's episode treatment groups (ETGs), Medstat episode groups (MEGs), and the Cave Marketbasket System. Each of these systems collects claims information from all the providers involved in treating a defined episode. ETGs and MEGs report costs by individual provider and type of episode—for example, "coronary disease, without acute myocardial infarction, with cardiac catheterization." A cardiologist treating many kinds of cases could have a different score for each kind. The Cave Marketbasket provides a single overall score for each provider, adjusting the data to show how costs would compare if each provider saw the same mix of cases. (The systems also aim to develop effectiveness or outcome scores, in addition to price comparisons.)

To be useful and credible to patients, insurers, and providers, any system must meet some basic tests:<sup>19</sup>

- There must be enough cases to allow reliable estimates for each provider. This may not be possible, especially at the individual practitioner level, when the system uses claims data from a single insurer.
- There must be a method to adjust for case mix, in the event that some providers are treating patients who are more seriously ill or who have several complicating conditions.

**Even if a consumer had full information about providers' charges, contract prices, and maximum allowances, this might not be enough to establish which providers are more or less costly.**

- There must be an acceptable way of attributing the cost or quality score to one of the many providers a patient may have seen during an episode. This isn't a problem if providers A-B-C-D consistently work together. But what if provider A sometimes refers patients to B-C-D and sometimes to less efficient E-F-G? Should A be scored on the basis of their performance?

A preliminary analysis of two of the systems by MedPAC has found that they are useful tools for examining resource use. However, providers—perhaps especially individual practitioners—are likely to question the adequacy or fairness of the methods for case mix adjustment and provider attribution. Perhaps more important, MedPAC had access to the very large samples available in Medicare data. Insurers and employers have been pressing CMS to release similar Medicare data to them, so that they can conduct their own assessments of individual provider efficiency and quality, but CMS has so far declined on confidentiality grounds.<sup>20</sup> Massachusetts is now preparing to grant researchers access to an inpatient hospital admission database that includes physician identifiers and that could be used to develop utilization and cost profiles at the individual physician level.<sup>21</sup> Blue Cross Blue Shield Plans, which have announced a national data collection initiative, may have sufficient market share in many geographic areas to produce meaningful numbers at the practitioner level.<sup>22</sup>

So far, no insurer is reporting individual providers' episode cost scores directly to members. Aetna and Humana are using a mix of ETG and Cave price and quality scores as one of the criteria in selecting the favored providers in plans with tiered cost sharing. In a few localities, Aetna members can learn whether a particular favored physician has met Aetna's efficiency criteria, which compare a physician's case mix adjusted total resource use to that of similar specialists in the area. Actual scores are not disclosed.

Several insurers, including Aetna and PacifiCare, provide members with information on average total costs for some types of episodes, by geographic area instead of specific provider.

Table 2 (above, right) shows the Aetna estimates for "high-severity heart failure" in one Pennsylvania county in 2006.

The Federal Employees Health Benefits (FEHB) Program is asking its participating health plans to provide similar information beginning in 2007. Each plan would make data available to enrollees in a format similar to that shown in Table 3.

While these data are only averages, they would at least give

**TABLE 2**  
**Sample Average Episode Cost Estimate for High-Severity Heart Failure**

Types of Cost	Amount
Facility	\$ 6,568
Doctor	\$ 1,044
Pharmacy	\$ 670
Medical Tests	\$ 1,587
<b>Total Annual Costs</b>	<b>\$ 9,869</b>

Source: Aetna (members-only Web site), May 9, 2006.

**TABLE 3**  
**Proposed Format for Disclosure of Average Estimated Costs by an Insurer Participating in the FEHB Program**

Procedure	Network	Non-network	Inpatient / Outpatient
Breast Biopsy	\$ 2,000	\$ 3,400	OP
Colonoscopy	\$ 1,500	\$ 2,500	OP
Inguinal Hernia Repair	\$ 3,800	\$ 7,900	OP
Hysterectomy	\$ 8,300	\$ 21,200	IP
Arthroscopy Knee / Shoulder	\$ 4,200	\$ 9,700	OP

Source: U.S. Office of Personnel Management, Federal Employees Health Benefits Program Call Letter, FEHBP Program Carrier Letter 2006-09, April 4, 2006.

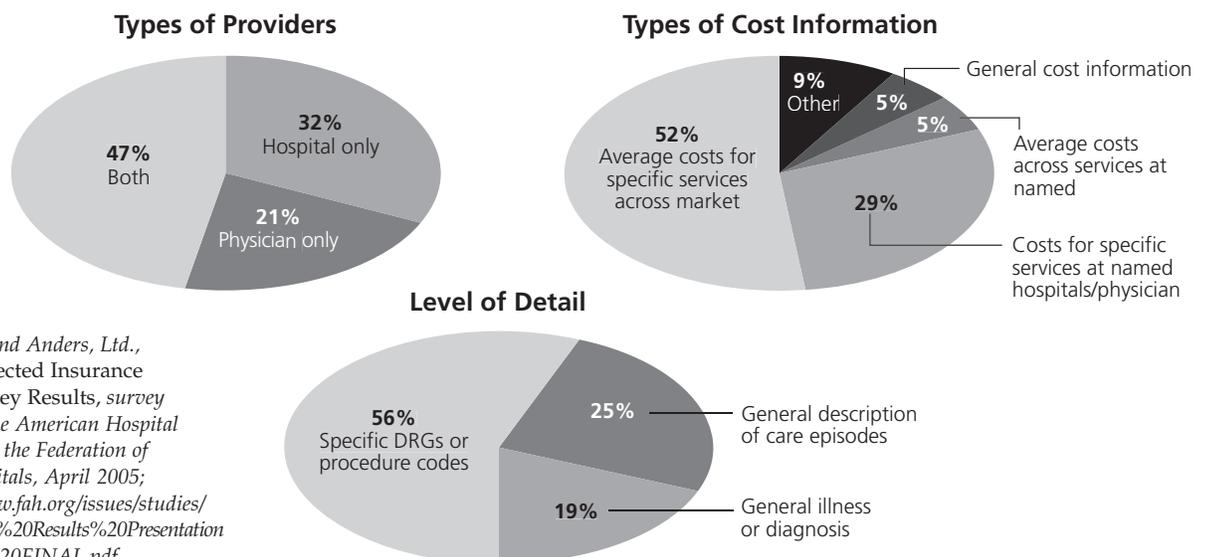
enrollees some idea of what they would be risking if they chose to go out of network (though it is unclear whether the figures in the non-network column are supposed to represent average charges or the insurer's maximum allowance for the service). In addition, if enrollees are considering alternative treatment options, data might indicate the relative costs of different courses of care. However, the figures would not help an enrollee choose from among in-network providers.

### Availability and Consumer Use of Price Information

In a 2005 survey of insurers selling HSA or HRA plans, 56 percent reported that they were making some form of cost information available to enrollees.<sup>23</sup> (No equivalent information is available about the information provided by insurers selling traditional PPO or other plans, although many of the surveyed entities are probably in both markets.) Figure 1 gives some details about the types of information insurers are reporting. Most are providing area-wide averages or ranges of costs, rather than costs at particular providers. In addition, costs tend to be reported for specific procedures, rather than for total episodes of care.

When health plan enrollees, as opposed to insurers, are surveyed, they are much less likely to report that their plan is providing cost information. In one 2006 survey, only 22 to 27 percent of enrollees in HDHPs or CDHPs, and two-fifths of those in traditional plans, reported that information was

**FIGURE 1**  
**Scope and Types of Provider and Cost Information Reported by Insurers Offering HSA or HRA Plans, 2005**

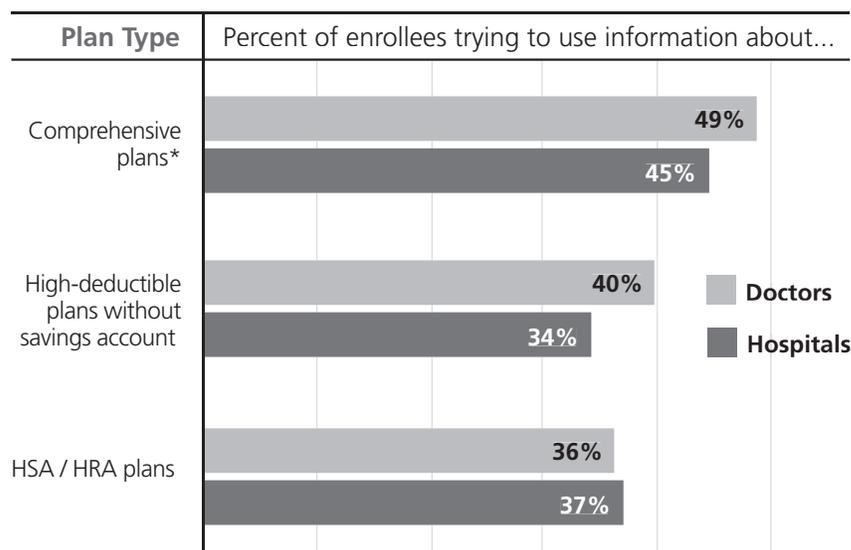


Source: Reden and Anders, Ltd., Consumer Directed Insurance Products: Survey Results, survey conducted for the American Hospital Association and the Federation of American Hospitals, April 2005; available at [www.fah.org/issues/studies/HSA%20Survey%20Results%20Presentation%2004-20-05%20FINAL.pdf](http://www.fah.org/issues/studies/HSA%20Survey%20Results%20Presentation%2004-20-05%20FINAL.pdf).

provided on doctors and/or hospitals.<sup>24</sup> Some of the disparity presumably reflects the different samples, but there may be two other factors. First, some plan enrollees may not be aware of all the information available from their insurer's Web site or other publications. (A different survey found that 62 percent of CDHP enrollees knew that their plan made provider information available on its Web site.<sup>25</sup>) Second, some enrollees may not regard the general or average data provided by many plans as constituting meaningful cost information.

Of enrollees who reported that their plan furnished cost information, those in high-deductible plans, with or without an HRA or HSA account, were somewhat less likely to have "tried to use it" than those in traditional employer plans (Figure 2). Another survey found the reverse; 20 percent of enrollees in consumer-directed plans had sought information—whether from the plan or any other source—on the cost of physician visits, compared with 14 percent of enrollees in traditional plans. A third survey found that enrollees in CDHPs and other employer plans were equally likely to have used their plans' Web sites to compare the cost of providers; just 5 percent of enrollees in each group had done so.<sup>26</sup>

**FIGURE 2**  
**Percentage of Enrollees in Plans Providing Cost Information Who Tried to Use That Information, by Type of Plan and Provider, 2006**



\* Comprehensive plans had no deductible or a deductible less than \$1,000 (individual) or \$2,000 (family).

Source: Paul Fronstin and Sara R. Collins, The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans, *Employee Benefit Research Institute issue brief 300*, December 2006; available at [www.cnwof.org/publications/publications\\_show.htm?doc\\_id=430598](http://www.cnwof.org/publications/publications_show.htm?doc_id=430598).

## PROMOTING GREATER TRANSPARENCY

While there are many voluntary initiatives to make price information available to consumers, there is also growing interest in the possibility of federal action to require providers and/or purchasers to publish specific information. Other proposals would go further, by requiring some form of standardization to make prices more easily understandable or fairer.

### Required Disclosure

An Executive Order issued by President Bush on August 22, 2006, established new standards for quality improvement and data interoperability for federal health programs (including Medicare, the FEHB Program, TRICARE,

and Veterans Affairs, but not Medicaid). One provision requires agencies administering these programs to make “the prices they pay for procedures” available to program participants and, optionally, to the public. Prices to be disclosed include those paid to participating providers by health plans contracting with the federal programs. Agencies are also directed to work with other stakeholders to develop episode-level cost information.<sup>27</sup>

The agencies have not yet announced how this order will be implemented. As suggested earlier, reporting of direct provider payment rates paid by Medicare or other agencies may not be especially useful to the general public or even program beneficiaries. However, most major health plans in the large group market also contract with Medicare, the FEHB Program, or both. The order could be read as requiring these plans to disclose every negotiated price with every individual provider in their networks. While the information might be made available only to the plans’ federal enrollees, it is doubtful that rate schedules would remain confidential for very long. Moreover, as plans are unlikely to negotiate separate prices for federal and private enrollees, the result could be that most people with private coverage would know all the rates their plans are paying. On the other hand, agencies might adopt a less sweeping interpretation of the vague phrase “the prices they pay,” requiring that plans disclose only average or median payment rates. The reporting would then be similar to the benchmark information the FEHB Program has already asked its plans to make available.

In 2003, the Department of Health Human Services (HHS) Office of the Inspector General proposed new rules intended to help Medicare detect when providers were billing Medicare more than their usual charges to other payers.<sup>28</sup> To justify their billed Medicare charges, providers would have been required to report the median amounts actually accepted from private payers—net of any contractual discounts—for each procedure or service. While this rule was never finalized, at one point in the legislative process a comparable requirement was inserted in the Health Information Technology Promotion Act (H.R. 4157) passed by the House of Representatives in July 2006. (The requirement was included in the version of the bill considered by the House Committee on Rules but was dropped from the version reported by the Committee to the full House.) For selected procedures, the hospitals would have been required to report to HHS the range of prices charged to or paid by Medicare, Medicaid, other public insurance programs, private insurers, other insurers, and self-pay patients. Reporting would have been by class of payer; for example, a hospital would have been required to report price ranges paid by all private insurers, but not the specific prices paid by different plans.

While disclosure of the prices negotiated by health plans and providers might be helpful to consumers, there is some debate about the possible effects on competition among providers and/or health plans. Suppose that all hospitals and health plans in an area knew all the prices paid for

a given procedure. If a hospital learned that a given insurer was paying other hospitals more for the procedure than it was receiving, it might demand the higher price. Conversely, if a health plan learned that a hospital had granted steeper discounts to competing insurers, it might ask for the same discount.

Whether providers or health plans would prevail in this scenario would depend on which had the greater bargaining power. Some observers believe that, because of the growing degree of concentration in the hospital sector—some areas are served by only two or three major hospital systems—full transparency might mean that hospital rates would actually rise.<sup>29</sup> (Aetna reports that its publication of negotiated physician prices has not yet led many physicians to ask to renegotiate rates.<sup>30</sup>) On the other hand, physicians argue that it is the insurance industry which is growing more concentrated, with a handful of insurers serving most of the population in some areas.<sup>31</sup> In these markets, general disclosure of negotiated rates might be expected to drive prices down. Whether there exists an oligopoly of a few providers or an oligopsony of a few insurers, regulators have always been concerned about the anticompetitive effects of shared price information. Transparency could be seen as institutionalizing what has in the past been a private (and perhaps, under antitrust law, illegal) exchange of data.

**Regulators have always been concerned about the anticompetitive effects of shared price information.**

## Standardized Pricing

Because providers may quote charges or prices for many different procedures or services, and because consumers cannot know exactly which services they will consume, some analysts have suggested some form of standardization that would make it easier for consumers to compare the relative costs of using different providers.

One option would be to require providers to quote a standard price unit for all the services they furnish.<sup>32</sup> Under the Medicare resource-based relative value scale (RBRVS), different physician services are assigned different relative weights; for example, in 2007 an office visit for a minor problem has a weight of 1.02, while an echocardiogram exam has a weight of 5.4. Medicare multiplies this weight by a unit price, known as the conversion factor, set nationally at \$37.8975 for 2007. Thus a physician would be paid \$38.66 for the office visit and \$204.65 for the echocardiogram. (Actual payment amounts vary by geographic area. For a more detailed explanation of the RBRVS, see Laura A. Dummit, “Updating Medicare’s Physician Fees: The Sustainable Growth Rate Methodology,” National Health Policy Forum.<sup>33</sup>) Under the standardization proposal, each physician would set his or her own unit price for private patients, but would then use Medicare’s relative weights to determine the specific price for each possible service. For example, a surgeon who quoted a \$50 multiplier would charge \$51 for the office visit and \$270 for

the echocardiogram. Physicians might have different multipliers for different payers—say, \$40 for self-pay patients and \$30 for enrollees in Acme Health Plan, but patients with a given type of coverage could clearly see which available providers were more expensive.

Another proposal would go further and would require that providers accept the same price from every purchaser: self-pay patients, insurers, and even Medicare and Medicaid.<sup>34</sup> Some states have in the past had “all-payer” systems, which required hospitals to accept the same rates for every patient; Maryland’s is the last of these systems still operational. In all cases, these states established the rates through regulation or negotiation. Under this proposal, however, providers would set their own rates, so long as they were uniform for all purchasers.

Because this specific proposal includes Medicare and Medicaid, it would require redesign of payment systems and could potentially have a major impact on public spending—if, as providers allege, public program beneficiaries are often subsidized by the privately insured. A less sweeping option might apply to private payers only: that is, providers would have the same price for all insured and self-pay patients, without the large discounts some insurers may obtain. The authors of the proposal contend that the cost of providing a service does not depend on who is paying for it, and that there is thus no justification for differential pricing.<sup>35</sup> Perhaps more important, the practice of giving different insurers different discounts means that price competition remains at the level of health plans—insurers that command bigger discounts can offer lower premiums—instead of at the level of providers, which some proponents of competition would prefer. Finally, any form of all-payer price system may competitively disadvantage providers who have high costs because they furnish charity care, train residents, or conduct clinical research; other ways might need to be found to finance these social goods.

## POSSIBLE EFFECTS OF GREATER PRICE TRANSPARENCY

Proponents of greater transparency in health care pricing contend that informed consumers will be more likely to shop for better values and that providers will respond by competing on price and quality. Others say that these effects are likely to be limited, for at least two reasons. First, because health care decisions are complicated and are often made quickly or at times of great personal stress, consumers may not be able or willing to shop for medical care in the same way they do for other goods and services. Second, the financial incentives for price-shopping may not be very strong. Even HDHPs, because of their benefit structure and use of provider networks, leave enrollees exposed to only a fraction of their true costs, reducing the pressure to look for bargains.

This section begins with a review of the evidence—including limited experience from consumer-directed plans—on how financial incentives affect

care-seeking behavior. It then discusses the incentives for price-shopping under currently available consumer-directed plans.

## Evidence on Consumer Behavior

There is an extensive literature showing that, when consumers pay more of their own health care expenses, they obtain fewer services and incur lower overall costs than consumers with comprehensive, “first-dollar” coverage. The most commonly cited study is the RAND Health Insurance Experiment conducted nearly 30 years ago (see box, right). While health care and health insurance have changed markedly since then, this comprehensive experiment was costly and has never been repeated. More recent, smaller-scale studies have shown similar effects. Cost sharing leads people to reduce utilization and overall spending.<sup>36</sup> It may deter use of unnecessary services but may prevent consumers from seeking care for more serious symptoms.<sup>37</sup> It may also reduce use of preventive services such as mammograms;<sup>38</sup> it is for this reason that the MMA provisions for HDHP/HSA plans allow insurers to pay for preventive services for enrollees who have not yet met the HDHP deductible.

Because consumer-directed health plans are still quite new, there have only been a few independent studies of their effects on consumer behavior. Some other studies, not summarized here, have examined changes in spending levels but not the behaviors that led to those changes.<sup>39</sup> And nothing is yet known about the effects of CDHPs on quality or outcomes of care.

**Kaiser Foundation** — A survey of enrollees in CDHPs and other employer plans found that 71 percent of CDHP enrollees agreed with the statement, “The terms of my health plan make me consider cost when deciding to see a doctor or fill a prescription,” compared with 49 percent of non-CDHP

## The Health Insurance Experiment

The Health Insurance Experiment (HIE) was conducted by the RAND Corporation, with funding from HHS, between 1974 and 1982. The HIE randomly assigned 5,809 enrollees to a variety of health insurance plans, including a plan that included no cost-sharing (the “free” plan) and plans requiring coinsurance payments of 25 percent, 50 percent, or 95 percent (subject to income-based limits on total out-of-pocket expenditures).

The key findings of the HIE were these:\*

**Cost sharing reduced the probability that individuals would seek care for any particular medical condition.**

The strongest deterrent effects occurred among the poor, especially poor children. They were at least 40 percent less likely to obtain care for a given problem than children in the free plan. However, there were reductions in utilization for all income groups.

**Cost sharing deterred enrollees from obtaining both “appropriate” and “inappropriate” medical care.**

Low-income enrollees in the cost-sharing plans were less likely to seek care for conditions for which medical care is highly effective as well as for conditions for which medical care is rarely effective. In a few instances, such as control of high blood pressure, those in the cost-sharing plans had worse medical outcomes than those in the free plan, but outcomes did not vary significantly on most other measures.

**While cost-sharing prevented enrollees from initiating an episode of medical care, it did not change the course of treatment once an individual had entered the medical care system.**

For any given type of inpatient admission or ambulatory episode of care, total spending for the enrollees in high cost-sharing plans was the same as for other study participants.

\*Emmett B. Keeler and John E. Rolph, “How Cost Sharing Reduced Medical Spending of Participants in the Health Insurance Experiment,” *Journal of the American Medical Association*, 249, no. 16 (April 22, 1983): pp. 2220–2222, and Kathleen N. Lohr et al., “Use of Medical Care in the Rand Health Insurance Experiment,” *Medical Care*, 24, no. 9, supplement (September 1986): ch. 8, pp. S72–S87.

enrollees. CDHP enrollees were more likely to ask about visit costs or alternative treatments and to choose a lower-cost treatment option.<sup>40</sup>

**Employee Benefit Research Institute (EBRI)/Commonwealth** — A survey of people in HDHP and comprehensive plans found little difference in utilization, even within specific income and health status groups. However, one-third of people with an HDHP reported delaying or avoiding care, compared with 17 percent in comprehensive plans. Among people in fair or poor health or with a chronic condition, 40 percent of HDHP enrollees delayed or avoided care, compared with 21 percent of enrollees in comprehensive plans.<sup>41</sup>

**University of Oregon** — People who switched from a PPO to a lower-deductible or higher-deductible HDHP/HRA plan were more likely than non-switchers to begin engaging in what the authors characterize as “risky” cost-saving behaviors, such as not going to the doctor when they thought they should, delaying a procedure or surgery, or deciding to have a less expensive diagnostic test. The study also measured the rates of “unproductive” medical visits (a concept similar to the HIE’s “inappropriate” care). Use of such visits dropped only for people switching to the lower deductible (\$2,000) HDHP plan; use by people in the higher-deductible (\$3,000) plan went unchanged.<sup>42</sup>

**McKinsey** — Enrollees in “full replacement” plans—cases in which an employer switched everyone from comprehensive coverage to an HDHP/HRA—were twice as likely as other enrollees to forgo all care when they regarded their condition as “not very serious”; there was no statistically significant difference for conditions regarded as “somewhat” or “very” serious.<sup>43</sup> There was evidence that enrollees shifted to more cost-effective settings for some care; for example, use of urgent care centers rose and use of emergency rooms dropped.

**University of Minnesota** — Enrollees who switched from a PPO or HMO to an HDHP/HRA plan had lower case-mix adjusted total and out-of-pocket spending than non-switchers in the year before changing plans. Within two years, however, their spending levels approached those of people remaining in the PPO and were higher than those of people in the HMO.<sup>44</sup> These unexpected results might be atypical because the HDHP had a fairly small gap between the employer’s HRA contribution and the deductible and because the plan paid 100 percent for in-network services above the deductible. One commenter also argues that the results for the small sample could have been distorted by a few high-cost outliers.<sup>45</sup>

Although the early results are mixed, they generally support the view that high-deductible plans can reduce “moral hazard”—the tendency of people with insurance to seek more care than they would if they had to pay for it themselves—and may lead some people to choose less costly treatment options. However, none of these studies shows that consumers will actually shop for better prices for specific health care services.

A consumer with a health problem or concern must (a) decide whether to seek care at all, may then (b) choose among different possible treatment courses, and might then (c) learn which provider offers the best price and quality for the selected treatment option. The distinctions among these three kinds of choices may often be fuzzy, especially when services are bundled or globally priced. For example, a hospital offering a lower price for an inpatient stay might provide different treatment from its competitor or might be supplying the same treatment at a lower cost. Still, there are many cases in which decisions about treatments are clearly separable from price choices.

Consider a patient found to have prostate cancer. An older patient or one with early-stage disease might choose watchful waiting, that is, no treatment at all unless the disease advances. A patient who decides to obtain treatment may choose between surgery or radiation therapy (with or without associated hormone therapy). Having decided on surgery, the patient might then look for the surgeon offering the best price for a prostatectomy. The cost of care might certainly (and perhaps sometimes inappropriately) be a factor in the first two decisions, as could other “opportunity costs”—for example, a patient might feel that he cannot afford to miss work during a weeks-long course of radiation. But only the third kind of decision, in which the patient directly considers which provider offers the best value, is likely to promote the price competition—one of the ostensible goals of consumer-directed care.<sup>46</sup>

That studies so far have not found evidence of price-shopping does not mean that it might not occur. The studies were not designed to measure these effects, and lack of price information or limited incentives for shopping in first-generation HDHPs may have prevented behavioral changes that would emerge in a fully informed population with stronger incentives. One possible way of learning about shopping behavior would be to look at services that are generally not covered by insurance at all and are paid for entirely out of pocket. One recent study examined purchases of LASIK eye surgery, in vitro fertilization, cosmetic rhinoplasty, and dental crowns. The authors found no evidence of price-shopping; people went to the provider recommended by a physician or friends (or, for crowns, they used their usual dentist). However, price comparisons for these services may be difficult, because a provider may not quote a price for a particular patient without having conducted an initial screening exam. So obtaining multiple “bids” could be costly and time-consuming.<sup>47</sup>

In the absence of hard evidence, there has been a long-running theoretical debate over whether, given sufficient incentives and information, people could be induced to shop for medical care as they do for other goods and

**That studies so far have not found evidence of price-shopping does not mean that it might not occur.**

services, or whether medical care is fundamentally different. One of the earliest and most influential studies in health economics, a 1963 article by Kenneth Arrow, identified a number of characteristics of the medical market that make it different from other markets.<sup>48</sup> Perhaps the most important for this discussion is “asymmetry of information.” People buy medical care infrequently, they know little about it, and they rely on their physicians—who presumably know more and are supposed to be acting in the patient’s interest—to make purchasing decisions for them.

Some people contend that the world has changed since 1963: new information sources have already made patients much better equipped to evaluate treatment choices and compare available providers. However, the very proliferation of information may leave consumers uncertain whom to trust; there are so many Web sites offering treatment advice and comparisons of providers that there have now emerged health Web sites that just evaluate other Web sites. In addition, there is still much progress to be made in developing meaningful and accessible measures that will let consumers balance quality as well as price in selecting among providers.<sup>49</sup>

Even if adequate price and quality information is available, patients with a serious medical problem might not be able or inclined to process information and make complex choices. And there is a time element: patients may not be able to delay care while they conduct the sort of comprehensive review of options they might undertake when buying a car.<sup>50</sup>

A more optimistic view is that shopping may be more practical for some kinds of services than others. One recent analysis distinguishes between “experience goods”—things that people buy again and again, like breakfast cereal—and “credence goods,” things people may buy rarely or only once in a lifetime. For experience goods, people develop their own preferences over time, while buyers of credence goods must fall back on a trusted agent (such as the physician) or on reputation (as when friends recommend a provider).<sup>51</sup> It could be that competition is more likely to emerge for the kinds of medical care that people buy often, such as pediatric care, prescription drugs for common conditions, and routine care for persons with chronic conditions.<sup>52</sup> This competition might or might not produce substantial system-wide savings; the share of total health spending affected may depend on exactly which services might be considered experience goods. Still, it could be that market competition would emerge in at least some health sectors.

Finally, physicians themselves could play a more active role in helping their patients select providers. Currently it is uncommon for physicians and patients to discuss costs at all.<sup>53</sup> But some people believe physicians might become more proactive if the growth in HDHPs means that their

**Price shopping may be most practical for services that consumers buy often, such as pediatric care or routine care for chronic conditions.**

patients, rather than insurers, are likely to be at financial risk.<sup>54</sup> This could, in turn, mean that physicians would become more conscious of the costs and benefits of the services and providers they recommend to patients with traditional coverage.

## Financial Incentives

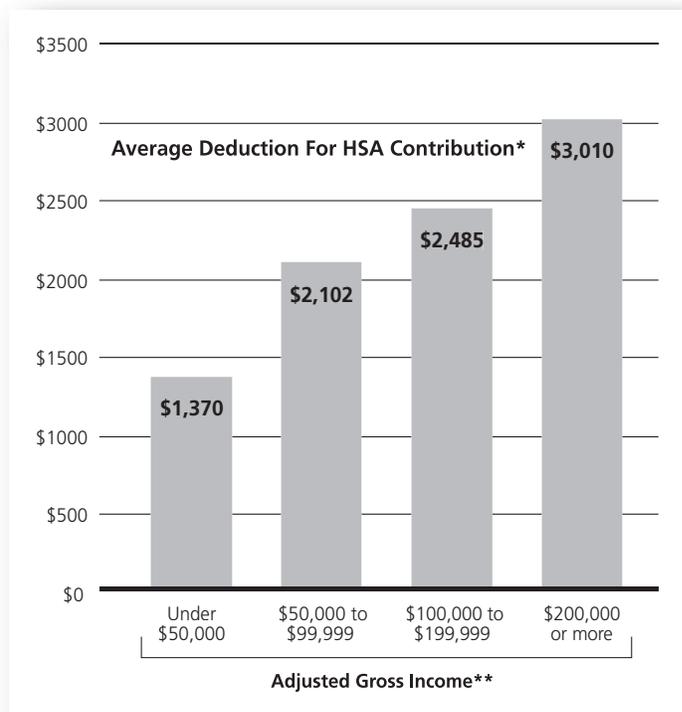
Many people have questioned whether consumer-directed plans can have a significant effect on overall costs because so much of total health care spending is for the small number of people who will exceed the plans' out-of-pocket limits and then have no incentive to control their spending. (This issue could be addressed by setting a higher limit or requiring some continued coinsurance, but only at the risk of burdening very vulnerable patients.) If enough people with more modest expenditures begin to consider prices, at least for very common services, real price competition might develop. However, two key features of standard HDHP/HSA arrangements limit the incentives for participants to give much weight to the cost of specific services.

**Possible effects of HSAs and HRAs on price sensitivity** — As noted earlier, the availability of an employer-funded HSA or HRA can mean that some HDHP enrollees have limited cost exposure. The employer pays for care up to the limit of the HSA/HRA contribution, the employee pays up to the deductible, and then the insurer assumes some or all responsibility for any remainder. Some employers have set high initial contribution levels, partly to cushion the transition to HDHPs. If the gap between the employer's contribution and the deductible is small, this may dampen any incentive for price-shopping.

Even without an employer contribution, the tax benefits for a self-funded employee or individual HSA reduce the effective costs of services purchased with it, especially for higher-income participants. For someone in the lowest federal tax bracket in a state without an income tax, the HSA reduces the effective price of a service by 10 percent. For someone in the highest federal bracket in a state with a steeply progressive income tax, the HSA can reduce the effective price by as much as 45 percent.<sup>55</sup> If two providers have different prices, the high-income taxpayer would pay only about half the difference. The Government Accountability Office (GAO) has reviewed a sample of tax returns from taxpayers enrolled in an HSA-eligible plan in 2004 (Figure 3, see next page). Average HSA contributions are highest for high-income taxpayers, meaning HSAs may actually reduce price sensitivity for people who might not have been especially price-sensitive in the first place.<sup>56</sup>

It is conceivable that account holders would still consider prices because they would want to conserve their accounts for possible medical needs in future years. However, many people may not be so prudent. In the University of Minnesota study cited earlier, 60 percent of participants with an

**FIGURE 3**  
**Average Income Tax Deduction Claimed for HSA Contribution, 2004**



\* HSA deductions represent the amount individuals claimed they, or someone other than their employer, contributed to their HSA. Deductions do not include employer contributions, although employers may contribute to employees' HSAs. Average deduction amounts do not include HSA contributions individuals may have made through pretax payroll deductions and therefore may understate the amount individuals contributed to their HSAs. In 2004, most HSA-eligible plan enrollees purchased coverage in the individual market rather than obtaining coverage through an employer. These data are reported on a per-return basis and thus could include contributions to more than one HSA in some instances. Moreover, the data do not distinguish between deductions claimed for HSA contributions made by enrollees with single and family coverage or between HSA-eligible coverage obtained in the group and individual market. The maximum allowable HSA contribution in 2004 was \$2,600 for single coverage and \$5,150 for family coverage; account holders aged 55 or over and not enrolled in Medicare could contribute an additional \$500.

\*\* Adjusted gross income may include income earned by family members who are not covered under HSA-eligible plans.

Source: Adapted from U.S. Government Accountability Office (GAO), Consumer Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans, GAO-06-798, August 2006; available at [www.gao.gov/new.items/d06798.pdf](http://www.gao.gov/new.items/d06798.pdf).

HRA that allowed year-to-year carry over of unused funds had used up their accounts by the end of the first year, and 72 percent by the end of the second year.<sup>57</sup> The effects might be different for HSAs, which allow lifetime portability. One study of enrollees in an HSA arrangement found that only 46 percent used up their account in the first year.<sup>58</sup> Similarly, the GAO study found that only 45 percent of taxpayers who contributed to an HSA in 2004 withdrew any funds during that year.<sup>59</sup>

**Network prices** — Most plans offer enrollees access to negotiated network prices. For physician and other ambulatory services, these may not vary widely for a particular insurer in a particular community. For example, an Aetna enrollee in Toledo, Ohio, in need of an inguinal hernia repair would see physician contract prices ranging from \$458.33 to \$527.07—a difference of \$68.74.<sup>60</sup> If the enrollee had already met the deductible for the year and was in a plan with 20 percent coinsurance, the price difference would shrink to just \$14, surely too little to outweigh such other considerations as convenience or the provider's reputation. And many HDHP plans require no further cost-sharing after the deductible, reducing the consumer's share of the price difference to zero.

Of course, enrollees would see much bigger price differences if they contemplated using a surgeon outside the network. But the financial penalty

for doing so may be so large as to make this option simply unthinkable, except for the least costly services. There are also likely to be substantial differences among network hospitals in negotiated prices for comparable services. However, because cost sharing for a single admission could immediately take many patients to the out-of-pocket limit, patients would have the same final cost regardless of which facility they chose. (One suggested solution is to change the rules so that patients who had reached the out-of-pocket limit would still be responsible for some share of the cost difference for low-priced and high-priced providers.<sup>61</sup>)

## CONCLUDING OBSERVATIONS: THE ROLE OF HEALTH PLANS

For proponents of consumer-directed plans, the availability of networks presents something of a paradox. Without access to network prices, people shifting to HDHPs would suddenly find themselves paying full charges. Over time, if a large share of consumers were in HDHPs without networks, providers' "list price" charges to these consumers might drop to more realistic levels. But non-network HDHPs are unlikely to gain a sufficient market share for this to occur, precisely because people who joined them would suffer immediate sticker shock.

In addition, the hope in some quarters that consumers could replace insurers at the bargaining table might not be realized. Some people think that insurers will always be able to command better prices than individual patients. Even if insurers have had to broaden their networks to satisfy enrollees' desire for greater choice—some now include 80 to 90 percent of providers in a community—their ability to threaten providers with exclusion will still give the insurers greater bargaining power than any single consumer.<sup>62</sup> But the persistence of network-negotiated prices could reduce support for the concept of consumer-driven care by provider groups that were hoping to stop dealing with insurers and instead deal directly with patients.

Meanwhile, the strong incentives to stay in-network reduce the consumer autonomy the new models were supposed to promote. One survey shows that enrollees in consumer-driven plans are even less satisfied with their choice of providers than enrollees in traditional plans,<sup>63</sup> perhaps in part because one of the selling points of the new options was that they were supposed to free participants from network restrictions.

Finally, whatever the progress toward price transparency (and its elusive companion, reliable quality reporting), it may be a very long time before consumers are really equipped to make complex decisions about price and quality in medical care. Some observers hope that health plans could evolve to assume the "trusted agent" role once occupied by personal physicians.<sup>64</sup> Does this conflict with the goal of consumerism? One analyst argues that, while people don't use agents when they want to buy cereal, they often do when they want to buy mutual funds; agency

and consumer autonomy are not necessarily incompatible.<sup>65</sup> Still, to the extent that interest in consumerism has been driven in part by the “managed care backlash,” fixing the troubled marriage of health plans and enrollees may be a long process.

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