Health Care

Principles:

- Increased Choices – Health care reform should be individual-centered, where choice means personal decision options for care, treatment, providers, education, participation, lifestyle, wellness activities and disease support programs.
- A Culture of Health – A culture of health focuses on wellness and prevention rather than disease and treatments. Health activities should measure and reward participation in wellness assessments, compliance with a condition management programs (e.g. taking medications, diet, exercise, office visits), and maintenance of good health characteristics (e.g. blood pressure, cholesterol, body mass index, etc).
- Security for the Sickest – Any health care reform must work for the healthy as well as those who are sick or chronically ill.
- Behavioral Change, Not Cost Shifting – Market-based health care reform is more than high deductible health plans with an attached savings account. It is about transforming a health plan into one that puts economic purchasing power – and decision-making – in the hands of participants. It's about supplying the information and decision support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering health and health care purchasing behaviors.
- Affordability through Choice – Affordability is not just dollars paid for insurance premiums, it includes rewards, incentives, dividends and rebates that offset the cost of insurance, lower the cost sharing features of an insurance policy, and/or add to health savings vehicles.
- Personal Responsibility – Health care reform should combine personal responsibility with financial involvement to incentivize program participation, reward compliance and support better personal health management. Incentives that reinforce a culture of health, well-being, self-help and shared responsibility can have a significant effect on outcomes.
- Market-based – The legal and regulatory environment should allow a creative, entrepreneurial market to develop the health insurance products and services.
- Increased Competition – Competition in a free market is the best approach to lower prices, better service, higher quality and more choices.
- Minimizing Third-Party Reimbursements – Third-party reimbursements foster an environment of entitlement and unlimited demand for health care services. Minimizing third-party reimbursements puts more financial power in the hands of consumers by using health savings vehicles such as Health Savings Accounts, Health Reimbursement Arrangements and Flexible Savings Accounts.
- Individual Ownership – Health care reform should give individuals opportunities to accumulate funds through "shared savings." That is, plan members can be financially rewarded for taking appropriate actions that improve their health and save money. The real value of HSAs is creating ownership that empowers individuals to make their own health and health care choices. Health care should be viewed as an accumulating asset rather than the narrow view of health care as a benefit to be used.
- Portability – Individual policies that do not rely on employer-based insurance should be encouraged and expanded. Health insurance should not be dependent upon a job or lost when one changes jobs.
- Transparency – Market-based systems can only be effective with an abundance of information that is easily available and understood by consumers. If properly integrated into care, information can be as important to health and health care as a medical test, medication, or treatment. With good information people can achieve better health outcomes at lower costs.
- Technology – New technology provides great opportunities to reduce errors, reduce costs, enhance diagnosis and empower individuals to improve their health.

Agenda:

- Encourage the federal government to follow Georgia's lead and eliminate the discrimination in the tax code against individuals purchasing their own insurance
- Allow employees of small businesses to pay for individual insurance through their employer
- Reduce the uninsured by limiting gaps in health insurance coverage
- Encourage a focus on prevention, identification, education and effective treatment of chronic diseases:
  - Implement Health Incentive Accounts for public employees and retirees
  - Support local, community-based organizations and clinics
- Create a High-Risk Pool for "uninsurables"
- Adequately fund Georgia's trauma network
- Improve quality and access for low-income Georgians

Facts:

- The overall median for persons with health-care expenses in 2005 was $1,166. This means that of the individuals in the United States who spent money on health care in 2005, half spent less than $1,166 and half spent more.[1]
- Fifty percent of health care costs in the United States are attributable to lifestyle: Smoking, alcohol abuse, improper diet, lack of exercise.[2]
- Roughly 75 percent of all health care spending is associated with patients that have one or more chronic health care conditions.[3]
- Chronic conditions account for 83 percent of the total spending in Medicaid and about 96 percent of the costs of Medicare.[4]
- Chronically ill patients receive approximately 56 percent of the clinically recommended preventive health care services.[5]
- The seven most common chronic diseases are cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental disorders.
- In 17 states, the uninsured rate for auto insurance is higher than that for health insurance, despite mandates and penalties for driving without auto insurance coverage.[6]
- For each person in the Uninsured/Medicaid population we are spending about $1,500 per year through direct subsidies and cost shifting.[7]
- Nearly one-third of doctors do not accept any Medicaid patients and, among those who do, many limit the number they will treat. Access to care at outpatient clinics and specialist care is also limited for Medicaid patients.[8]

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[1] "National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population," Agency for Healthcare Research and Quality, December 2007, http://www.meps.ahrq.gov/mepsweb/data_files/publications/st193/stat193.pdf

[2] National Institutes of Health, 2004

[3] "Reframing The Debate Over Health Care Reform: The Role Of System Performance And Affordability," Kenneth E. Thorpe, Emory University, 2007, http://content.healthaffairs.org/cgi/content/full/26/6/1560

[4] "Chronic Conditions: Making the Case for Ongoing Care," page 19, September 2004, http://www.partnershipforsolutions.org/DMS/files/chronicbook2004.pdf. The presentation is an update of a 1996 study by Catherine Hoffman and Dorothy Rice, "Chronic Care in America: A 21st Century Challenge."

[5] "Reframing The Debate Over Health Care Reform: The Role Of System Performance And Affordability," Kenneth E. Thorpe, Emory University, 2007, http://content.healthaffairs.org/cgi/content/full/26/6/1560

[6] "Will Mandatory Health Insurance Work?," National Center for Policy Analysis, September 2006, http://www.ncpa.org/pub/ba/ba569/

[7] "Who Pays for Health Care When Workers Are Uninsured?," Commonwealth Fund, May 2, 2008, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=683563

[8] Potential medical providers, including physicians and clinics, were called by surveyors who posed variously as Medicaid, uninsured or insured patients seeking an appointment for a specific condition with a set of symptoms. The conditions described by the callers are considered medically urgent. Attempted access was considered successful when the caller was able to schedule an appointment within seven days. The surveys were conducted in major, geographically-dispersed urban areas. Brent R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory

- The largest amounts of uncompensated care are generated by Medicare and Medicaid patients. This occurs because Medicaid and Medicare pay providers less than cost. Reducing the uninsured by putting them on Medicaid may actually increase the amount of uncompensated care by eliminating the payments the uninsured make for their own care, increasing utilization and increasing administrative overhead. In the 1990s, Tennessee insured everyone in the state under the TennCare program. The program was supposed to eliminate uncompensated care, but by the late 1990s uncompensated care had increased.[9]
- The emergency department served as the route of admission to hospital inpatient services for roughly 50 percent of non-obstetric hospital patients in 2006, up from 36 percent in 1996.[10]
- Patients with Medicaid use the emergency department more frequently than patients with private insurance – 82 per 100 persons for Medicaid vs. 21 per 100 for private insurance.[11]
- Most of the individuals who are injured due to negligence (malpractice) do not sue. In fact, 97 percent of the patients who suffered negligent injury did not sue.[12]
- Physicians are much more likely to be sued for rendering non-negligent care. Of MAG Mutual's cases that have gone to trial since 1982 in Georgia, 82 percent have resulted in verdicts in favor of the physician.[13]
- Our current malpractice system has not improved patient safety. Repeated studies over time and across several states show a consistent rate of adverse medical events due to negligence. In 1974, a California study reported that 1 percent of all hospitalized patients have significant injury due to physician negligence. The Harvard Medical Practice Study of 1984 in New York State reported a 1 percent injury rate due to physician negligence. A similar study in Colorado and Utah in 1992 again found a 1 percent physician negligence rate.[14]

Average Annual Individual Health Insurance Premiums (2006-2007)[15]

	Single	Family
Georgia	$2,419	$4,668
United States	$2,613	$5,799

Average Annual Small Group Health Insurance Premiums (2006)[16]

	Single	Family
Georgia	$3,588	$9,396
United States	$3,732	$9,768

Medicaid Payments per Enrollee, FY 2005[17]

	Adult	Child
Georgia	$2,768	$1,447
United States	$2,102	$1,617

Care Follow-Up Appointments," Journal of the American Medical Association, Vol. 294, No. 10, September 14, 2005, pages 1,248-54.

[9] Emmett B. Keeler, "Effects of Cost Sharing on Use of Medical Services and Health," Medical Practice Management, summer 1992, page 318. http://www.rand.org/pubs/reprints/2005/RP1114.pdf.

[10] National Hospital Ambulatory Medical Care Survey: 2006 Emergency Department Summary, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, August 6, 2008, http://www.cdc.gov/nchs/data/nhsr/nhsr007.pdf

[11] Ibid

[12] Harvard School of Public Health

[13] MAG Mutual Insurance Company

[14] Harvard School of Public Health

[15] "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," America's Health Insurance Plans (AHIP), December 2007, http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf

[16] "Small Group Health Insurance in 2006," America's Health Insurance Plans (AHIP), September 2006, http://www.ahipresearch.org/pdfs/FINALSmallGroupPaper.pdf

[17] "State Health Facts," Kaiser Family Foundation, http://www.statehealthfacts.org/comparetable.jsp?cat=4&ind=183

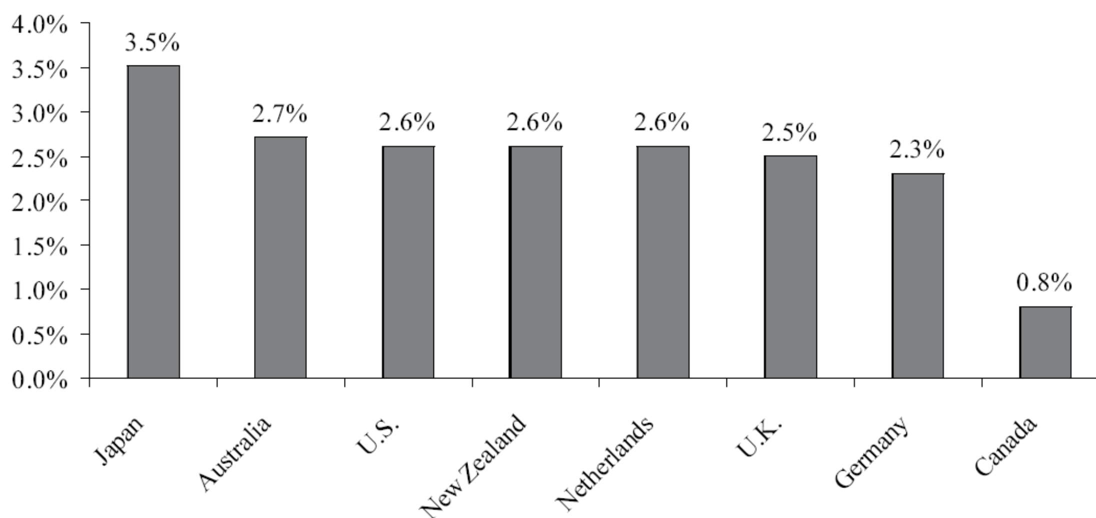
There is significant dissatisfaction with the health care system in both the United States and countries with single-payer health care systems.[18]

Overall Views of the Health Care System in Seven Countries, 2007

Percent reported:	AUS	CAN	GER	NETH	NZ	UK	US
Only minor changes needed	24	26	20	42	26	26	16
Fundamental changes needed	55	60	51	49	56	57	48
Rebuild completely	18	12	27	9	17	15	34

During the 1990s, health care spending in all but 3 of 15 OECD (Organization for Economic Cooperation and Development) countries studied grew at about the same rate as in the United States – or higher.[19]

Average Annual Real Growth in per Capita Health Spending (1960–1998)



Source: Gerard F. Anderson et al., "Health Spending and Outcomes: Trends in OECD Countries, 1960–1998," *Health Affairs,* May/June 2000.

[18] "The Commonwealth Fund 2007 International Health Policy Survey in Seven Countries," Commonwealth Fund, November 2007, http://www.commonwealthfund.org/usr_doc/Schoen_intlhltpolicysurvey2007_chartpack.pdf?section=4056, page 4.
[19] "Health Care in a Free Society Rebutting the Myths of National Health Insurance," Cato Institute, January 27, 2005, http://www.cato.org/pubs/pas/pa532.pdf, pages 15-16.

Health care spending in the United States is remarkably equally distributed among all income categories.[20]

SOURCE: Gary Burtless, Brookings Institution, based on 2003 medical expenditure panel survey.
Reprinted from The Washington Post

Recently Passed Georgia Health Care Laws

- Funding for a state Web site to provide cost and quality data for consumers
- Elimination of state and local premium taxes on high-deductible health plans (HDHPs)
- Deductibility of premiums on state income tax returns for individuals purchasing HDHPs
- Fast-track approval of new HDHP products
- Legalization of rewards and incentives for participation and compliance with wellness and health promotion programs, disease and condition management programs and health risk appraisal programs
- Legalization of Health Reimbursement Arrangement (HRA)-only plans for businesses. Employees may use those pre-tax funds to purchase portable individual health insurance plans.
- Tax credits for small businesses that offer HDHPs – $250 for each employee enrolled for 12 consecutive months for businesses of 50 employees or less

Comments on the recent legislation:

"*Georgia is now the second state in the union to allow employers to help their employees obtain personal and portable health insurance – the type of insurance that employees own and can take with them when they move from job to job."* – John Goodman, President and CEO of the National Center for Policy Analysis

"Insurers are ready to develop the more flexible and affordable products allowed under this legislation. Brokers and insurance agents are excited about reaching out to many previously uninsured Georgians who will now be able to afford private insurance. This also establishes affordable individual portable coverage not dependent on employment, with many of the tax advantages of employment-based

[20] "Health Policy Matters" newsletter, Galen Institute, September 12, 2008, http://www.galen.org/component,8/action,show_content/id,14/category_id,0/blog_id,1080/type,33/

coverage." – Ron Bachman, a Georgia-based actuary with extensive experience in health care strategy for payers, providers and employers

"It will be interesting to compare the results of this legislation to the Massachusetts experience. This approach has the potential to actually lower health care costs, something Massachusetts didn't even try." – Greg Scandlen, senior fellow for health care policy at the Heartland Institute

Georgia passed legislation in 2008 that addresses some of health care's biggest challenges – the high cost of insurance, inequities in the tax code, the lack of portability and the increasing toll of chronic disease. Cost is the biggest challenge in health care, and stories abound about businesses and individuals forced to drop their insurance as it eventually became unaffordable. Georgia's legislation authorizes the state's insurance commissioner to fast-track approval of the most affordable type of health insurance – high-deductible health plans (HDHPs). Switching from traditional to high-deductible policies can reduce premiums 30 percent to 40 percent, the annual cost increase for these policies is much lower than traditional plans and these plans reward healthier behavior and personal responsibility. The legislation also eliminated state and local premium taxes – as high as nearly 5 percent in some counties – on these policies.

Most uninsured Georgians work for small businesses and do not have access to health insurance. To make matters worse, the tax code currently discriminates against such individuals by denying them the opportunity to deduct the cost of health insurance while businesses can deduct 100 percent of the cost. For a middle-class family, this effectively almost doubles the cost of insurance. The new legislation allows individuals to deduct 100 percent of their insurance premiums from their state income taxes. Georgia should now petition the federal government to follow the state's lead and eliminate this unfair bias once and for all.

Additionally, small businesses that may have recently been priced out of the market will now be able to fund a stand-alone Health Reimbursement Account (HRA), a type of flexible spending plan that employees can access to fund the purchase of individual insurance. Better yet, such insurance is personal because employees can choose the type of policy they want from hundreds of options, it is portable so they need not worry when they change jobs, and it is guaranteed renewable so they won't be dropped or face premium increases if they get sick.

Most importantly, Georgia's new legislation addresses chronic disease. Spending on individuals with chronic diseases such as diabetes, heart disease, high blood pressure or depression makes up 75 percent of all the money spent on health care in Georgia. The right medicine and disease management plans can prevent many such Georgians from developing costly and debilitating complications. Nevertheless, many individuals fail to follow these guidelines. Studies and real world experience, however, show that compliance is much higher if individuals can earn financial rewards and incentives. In Georgia, such incentives have been deemed "unfair business practices" – until now. Now, insurance plans will be able to reward individuals for taking better care of themselves. The return on investment is tremendous, not only in dollars, but also in productivity in the workplace and, most importantly, in the happiness of an individual living a long, healthy life.

If consumers are spending more of their own money and incentivized to pursue preventive care, they will need better information. In October 2008, the State of Georgia is scheduled to unveil a Web site to do just that. The site will provide consumers with cost and quality data on hospitals, pharmaceutical prices from pharmacies throughout the state and disease management and wellness information from the Mayo Clinic. The site will build on the success of a similar resource in Florida[21] that provides information such as complication rates for such things as infections after surgery and mortality rates for surgical procedures and retail prices charged by pharmacies for the 50 most frequently prescribed medications.

[21] http://www.floridahealthfinder.gov

Background

Below are excerpts from "The Handbook on State Health Care Reform" published by the National Center for Policy Analysis (2007).[22]

Personal and Portable Health Insurance. One of the strange features of our health care system is that most health insurance is not guaranteed to last for any significant period of time. Most insurance contracts are only for 12 months. Each year, employers can decide on a new health insurance plan or they may decide to cease offering health insurance altogether. In the intervening period, an employee might be laid off or voluntarily leave employment, and a change of jobs almost always entails a loss of the original insurance.

Similarly, a change of health plans usually means a change in coverage, and benefits provided under one plan may not be provided under the next or, if they are, the coverage may not be as extensive. A change of plans also usually entails a change of provider networks. For a person with a medical condition, a change of doctors means no continuity of care. Clearly, personal and portable health insurance is an idea whose time has come; and employers could play a role in helping workers obtain it. Imagine a system in which people owned their own health insurance and that it traveled with them as they moved from job to job. Employers could pay some or all of the premium, with payroll deductions for the balance, similar to the procedures for contributions to 401(k) accounts. Portable health insurance would also solve a major social problem: Under the current system, people who lose their job-connected insurance may be denied new coverage or face very high premiums because of a health condition.

Guaranteed Renewable Insurance. If personal and portable health insurance were similar to products in the individual insurance market, the insurance would be guaranteed renewable indefinitely into the future. Like individual insurance (and in contrast to the small group market in most states), premium increases would reflect cost increases for the pool as a whole and would be the same for everyone. Insurers would not be permitted to single out people who became ill and charge them higher premiums. Nor could they reduce rates for those who remained healthy. Such a system would be far superior to today's dysfunctional small group market – where groups are frequently rewarded or punished with premium changes in response to changes in health costs over which the members of the group have no control.

Destroying the Market for Risk. Unfortunately, many states have tried to address these problems with unwise legislation – including laws that encourage people to stay uninsured. A proliferation of state laws, for example, has made it increasingly easy for people to obtain insurance after they get sick. Guaranteed issue regulations (requiring insurers to take all applicants, regardless of health status) and community rating regulations (requiring insurers to charge the same premium to all enrollees, regardless of health status) are a free rider's heaven. They encourage everyone to remain uninsured while healthy, confident that they will always be able to obtain insurance once they get sick. Moreover, as healthy people respond by electing to be uninsured, the premiums to cover costs for those who remain in the insurance pool rises. These higher premiums, in turn, encourage even more healthy people to drop their coverage.

Federal legislation deserves a lot of blame for these developments. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 had a noble intent: to guarantee that people who have been paying premiums into the private insurance system do not lose coverage simply because they change jobs. However, HIPAA also includes a provision that allows any small business to obtain insurance regardless of the health status of its employees. This means that a small mom-and-pop operation can remain uninsured until a family member gets sick. Individuals also can opt out of an employer's plan and re-enroll after they get sick. They are entitled to full coverage for a pre-existing condition after an 18-month waiting

[22] http://www.ncpa.org/email/State_HC_Reform_6-8-07.pdf

period. A group health plan can apply pre-existing condition exclusions for no more than 12 months, except in the case of late enrollees, to whom exclusions can apply for only 18 months.

By far the worst consequence of this government regulation is the unintended harm done to the very people the laws intend to help. Precisely because high-risk individuals' expected health care costs are much higher than their premiums, insurers seek to avoid enrolling them in the first place. Because provider payments also do not reflect expected costs, they, too, have an incentive to avoid attracting the hard cases, especially among the chronically ill.

Recreating a Market for Risk. If health care markets worked the way normal markets do, health insurers and providers would vigorously compete for the business of the sick. In normal markets, entrepreneurs make profits by figuring out how to better solve other people's problems. In health care, by contrast, entrepreneurs run from sick people's problems.

People cannot make rational choices about risk if the price of risk avoidance is not set by the market. For that reason, risk should be freely priced in the marketplace, with government intervening to help specific individuals only in special cases. The risk-adjusted premiums in the Medicare Advantage program are a step in the right direction. When seniors enroll in private Medicare plans, the plans receive a premium payment based on the senior's expected health care costs. In the early years these adjustments were limited and inadequate. However, the federal government is developing a payment system that reflects 60 or 70 different variables. Similar risk-adjusted payments are being used in Florida's Medicaid program.

Who Are the Uninsured?

Despite claims that there is a growing health insurance crisis in the United States, the percentage of U.S. residents without insurance has fallen slightly over the last decade. The number of uninsured has grown; however, this increase is largely due to immigration and population growth. In 2006, according to Census Bureau surveys:

- More than 84 percent (250.4 million) of the 297.4 million U.S. residents were privately insured or enrolled in a government health program, such as Medicare, Medicaid or State Children's Health Insurance Programs (S-CHIP).
- An additional 10 million to 14 million adults and children qualified for government programs but had not enrolled, experts estimate.
- Nearly 18 million additional uninsured people live in households with annual incomes above $50,000 and could likely afford health insurance.

Thus, nearly 10 percent of U.S. residents theoretically have access to insurance but have chosen to forgo it. The remaining portion (about 6 percent of the population) earn less than $50,000 annually. Typically, those who lack insurance are uninsured for only a short period of time – around 75 percent of uninsured spells last one year or less. The Congressional Budget Office (CBO) estimated that 21 million to 31 million people had been uninsured for a year or more in 2002 – far short of the 46 million figure often cited.

The uninsured include diverse groups, each uninsured for a different reason.

Immigrants. According to estimates, nearly 12 million foreign-born residents lack health coverage. More than one-third of foreign-born U.S. residents lacked health insurance compared with only 13 percent of native-born Americans. Income may be a factor – but another explanation is that many immigrants come from cultures without a strong history of paying premiums for health insurance.

The Poor. Among households earning up to $25,000, the number of uninsured actually decreased by about 24 percent over the past 10 years.

The Young and Healthy. Nearly 19 million people ages 18 to 34 are uninsured. Most of them are healthy.

Higher-Income Workers. The number of uninsured among higher-income households actually increased during the past decade. Nearly 18 million uninsured individuals live in households earning more than $50,000. More than half of those earn more than $75,000.

Individuals Using the "Free Care" Alternative. Many people forgo health insurance because they know that free health care is available once they get sick. Federal law forbids hospital emergency rooms from turning away critical care patients. With the certainty of receiving free emergency care, many people forgo paying for coverage.[23]

Of the 1.7 million uninsured Georgians, PricewaterhouseCoopers estimates that 30 percent (510,000) have annual incomes of $50,000 or more, 22 percent (374,000) are estimated to be illegal aliens and 20 percent (340,000) are eligible for government programs but have chosen not to sign up.

The 1.7 Georgians that reported having no health insurance coverage during the year 2007 to the Census Bureau can be divided into three categories:

Category of Uninsured	Number	Percent
Household income of $50,000 or more	560,000	34%
Eligible for Existing Government Programs	332,000	20%
Income less than $50,000 – Not Eligible for Existing Government Programs	767,000	46%
Total	1,669.000	100%

The uninsured in Georgia can also be broken into these categories:

- 71% are uninsured for 1 year or less
- 68% are employed or self-employed
- 62% are age 34 or younger[24]
- 19% are not citizens[25]
- 15% are uninsurable due to an existing illness or condition[26]

Agenda

Encourage the federal government to follow Georgia's lead and eliminate the discrimination in the tax code against individuals purchasing their own insurance

The U.S. tax code is one of the primary culprits in our current dysfunctional health care system. Employer-provided health insurance is tax-deductible, but if an employer does not offer health insurance benefits, individuals who purchase insurance privately do not get the same tax deduction. This tax penalty

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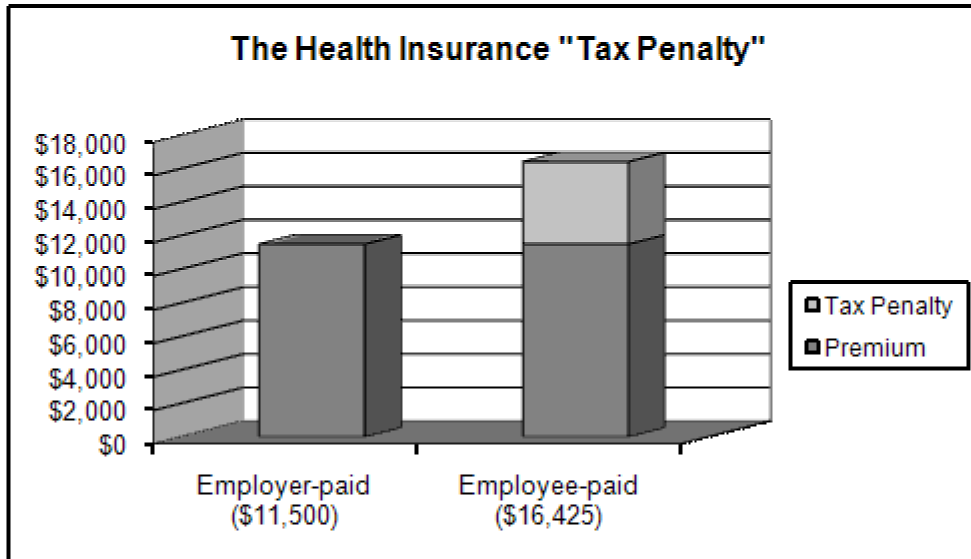
[23] Devon M. Herrick, "Crisis of the Uninsured: 2006 Update," National Center for Policy Analysis, September 6, 2006. See also Carmen DeNavas-Walt, Bernadette D. Proctor and Jessica Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2006," U.S. Department of Commerce, U.S. Census Bureau, publication P6-233, August 2007.

[24] U.S. Census Bureau, Current Population Survey, 2007, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[25] The Census Bureau estimates that half of uninsured non-citizens are illegal aliens, American Enterprise Institute, 2008, http://american.com/archive/2008/july-august-magazine-contents/what-do-we-know-about-the-uninsured

[26] Based on estimate of three percent of the Georgia population.

can often double the cost of insurance. As more and more businesses are forced to drop their insurance, it is not surprising that many employees remain uninsured – either by choice or necessity. As the graph shows, someone without access to employer-provided health insurance must earn $16,425 to afford the same health insurance an employer would purchase for $11,500. The Kaiser Family Foundation found that the tax penalty varies from 32 percent to 53 percent, depending on the income tax bracket of the individual.[27]



The Galen Institute, a non-profit health care research organization in Washington, D.C., notes that "Working Americans with incomes of around $25,000 are most likely to be uninsured and are caught in the trough – they earn too much to qualify for public programs but are unlikely to have the good jobs that provide health insurance as a tax-free benefit." The last thing we need to do as these families struggle to afford health insurance is to add on a substantial tax burden. Georgia eliminated this inequity in 2008. Georgians should urge the federal government to do the same.

Allow employees of small businesses to pay for individual insurance through their employer's cafeteria plan

Although most all small businesses would like to provide health insurance benefits to their employees, many have been priced out of the health insurance market. Employees that do not have access to health insurance at the workplace are more likely to go uninsured. One solution is commonly known as "list billing." This is where employees choose an individual insurance policy rather than a small group policy. Instead of billing the employees directly, the insurance carrier sends the itemized bill to the employer, who then deducts the appropriate amount from the employee's salary. If and when employees leave the company, their health insurance can follow them without any break in coverage.

Unfortunately, some insurance companies do not offer list billing because it is not clear in Georgia law that it is allowable. Georgia should clear up this gray area in the law by passing legislation that clearly allows insurance carriers to offer list billing. This would simplify the process and encourage more Georgians to purchase personal, portable insurance.

[27] "Tax Subsidies for Health Insurance," Kaiser Family Foundation, page 8, July 2008, http://www.kff.org/insurance/upload/7779.pdf

Reduce the uninsured by limiting gaps in health insurance coverage

A large number of the uninsured are uninsured for a short period of time. In fact, around 75 percent of uninsured spells last one year or less. One way to help this large number of individuals who are between jobs and cannot afford extensive COBRA premiums is to encourage employers to offer low-premium, high-deductible insurance coverage. If this option were available in addition to the traditional COBRA option, the take-up rate would likely be much higher. Not only would this reduce the number of uninsured, but it would lower the number of individuals exposed to the risk of developing a medical condition while uninsured and then becoming uninsurable. Currently, it is typically the least healthy employees who choose to continue COBRA coverage. Although the employee must pay the entire premium under COBRA, the employer's future insurance rates are often increased to reflect these higher-cost COBRA participants. Younger and healthier employees either go uninsured or can find cheaper products in the individual market. If employers offered HSA-eligible, low premium options it would help keep these increases in check and would limit the number of former employees who go uninsured.

Implement Health Incentive Accounts for public employees and retirees

The future of health care is about empowering individuals with information and financial responsibility to support a position of ownership. It's about supporting and rewarding healthy behaviors. It's about engaging employees, providers, carriers and other stakeholders in a new relationship that deals with health rather than sickness and disease. It's about transforming health insurance from a "benefit" into an "accumulating asset" where employees have a real sense of ownership through a "shared savings" model.

One of the most important concepts is the development of Health Incentive Accounts (HIAs) that are simply HRAs that accumulate solely from incentives and rewards. HIAs can be more flexible than HSAs. HIAs can be added to any plan design, including all of the many different designs available under the State Health Benefit Plan (SHBP). HIA account additions are developed from "shared savings." Individual participation and compliance with wellness and disease or condition management programs can be rewarded with extra HIA benefit dollars added to the individual's account.

Through HIAs or HSAs with incentives, patients can address underlying health conditions not covered by traditional insurance. For example, a patient with high cholesterol and a family history of heart disease might find it extremely valuable to have a CT-heart scan to determine the degree of calcification. Although this test is typically not covered by insurance, the information may help motivate the patient to comply with their cholesterol medication. Similarly, depending on the plan design, consumers who believe in the value of alternative or complementary medicine can potentially use account values based upon patient preferences.

These approaches combine personal responsibility with patient financial involvement to incentivize program participation and reward compliance as well as create better personal health management. The possibilities are many and depend on what type of behavior a plan is trying to encourage. Incentives that reinforce a culture of health, well-being, self help and shared responsibility can have a significant effect on outcomes. The potential savings could be more than $1 billion over the next five years just based on current employees. The savings for retirees is likely to be greater.

Support local, community-based organizations and clinics

Community Health Works (CHW) is a success story of managing chronic conditions right here in Georgia. CHW is a regional, nonprofit collaborative of health care providers, community leaders and government officials in Bibb, Crawford, Houston, Jones, Monroe, Peach and Twiggs counties in Middle Georgia. Targeting uninsured, adult residents with hypertension, heart disease, diabetes or depression, CHW's average patient has an annual income of less than $5,000, has three different chronic diseases and takes five different medications. CHW uses an individual-centered, care management model based on the unique needs of each community it serves. Dr. William S. Custer of Georgia State University found that in addition to saving the regional health system more than $340,000, more than 95 percent of patient

members report improved health status. The program's patients use 40 percent less hospital care and 18 percent less emergency room care compared to a national control group. By reducing emergency room visits and hospitalization, this proactive, community-based effort has proven that improving health while saving money is possible.

There are several similar community networks focused on chronic disease across the state. In addition to identifying individuals with chronic disease, these community efforts help people take advantage of the programs that the pharmaceutical companies offer to lower- and modest-income people to help with their drug bills, accessible through the Partnership for Prescription Assistance at www.pparx.org and Together Rx Access at http://www.togetherrxaccess.com.

Georgia is also home to many free clinics. According to the Georgia State Auditor, the clinics associated with the Georgia Free Clinic Network provide $200 million to $400 million of care while only reaching 10 percent of the uninsured population. According to the Georgia Free Clinic Network, Georgia's charitable clinics delivered health care services to approximately 140,000 low-income, uninsured Georgians in 2006, an increase of 25 percent from 2005. Eighty percent of free clinic patients have one or more chronic illnesses, requiring extensive and ongoing medical care, care coordination and patient education. Despite the increase in patients served during the last two years, clinics were forced to turn away an estimated 30,000 Georgians due to lack of capacity.

Not only are the free clinics a tremendous saving to taxpayers and hospitals, they also provide a primary care base and a place where patients can return for routine care. For example, a study in one community revealed that a typical ER visit to diagnose and treat a sore throat is $270. A patient visit at a free clinic is $29, including medication.

As Georgia addresses the challenge of the uninsured, it should look carefully for ways to strengthen these local efforts through funding for infrastructure, electronic medical records or programs focusing on chronic disease.

Create a High Risk Pool for "uninsurables"

Georgia is one of only five states that provide no insurance option for individuals with serious medical conditions.

High-risk health insurance pools have been created in 33 states in order to provide affordable and quality private health insurance options for individuals with catastrophic medical conditions who do not have access to the group insurance market. By serving the state’s small but critical medically uninsurable population, pools not only provide a coverage home for very vulnerable and high end medical care consumers, they also help stabilize the remainder of the state’s health insurance market by guaranteeing that very high-risk individuals are covered in a contained, private market environment. A high-risk pool would help reduce health insurance costs for all of the rest of Georgia’s individual health insurance consumers in two key ways. First, since the pool would provide individual market carriers with a predictable means of assessing risk, it would encourage greater competition in the general marketplace. Secondly, as coverage becomes more and more affordable, the incentive for healthy individuals to enter that market grows, further reducing costs for everyone.

The stabilizing presence of a high-risk pool in the individual market also benefits the purchasers of group health insurance coverage. Since a pool creates an affordable option for medically uninsurable people in the individual market, there would be little incentive for very sick consumers to try and “game” the system and obtain guaranteed-issue coverage in the small group market. Currently there is no means in Georgia for seriously ill people to obtain guaranteed-issue individual coverage, but federal law requires small group health insurance coverage to be guaranteed issue. Therefore, there exists an unfortunate incentive for very sick individuals to try to create a “group” in order to obtain needed health coverage. Healthy people do not have this incentive, since they can currently obtain coverage in the individual market.

These uninsurable “groups,” in addition to being oftentimes fraudulent, hurt the overall small-group health insurance market pool, since there is no need for people to create them unless they anticipate that they will be costly high-end users of the health insurance system. Reducing the number of these groups in Georgia could help reduce the acceleration of small-group health insurance rates.

In most states, participants are charged 125-150 percent of regular premium rates. This does not cover the total annual expense, but it does avoid creating an unintended consequence: If there is no penalty for those who chose not to buy health insurance when they are sick, it would create an incentive for many healthy people to drop their health insurance because their would be no financial risk if they got sick when uninsured. The sticking point in Georgia in the debate over a high-risk pool is how the state chooses to finance the costs of the pool that exceed the premiums.

Some states fund their pool losses with an assessment on all health insurance carriers in the state, including re-insurers providing stop-loss coverage to self-funded health plans, based on the number of lives each carrier covers. Some states finance their losses with an assessment on hospitals from general revenues.

With traditional insurance and regular high-risk pooling plan designs and administration, the cost of high-risk pool subsidies seems financially and politically untenable. Georgia needs a new approach. A model based on health savings accounts and high-deductible health plans can be implemented that transforms the concept of a high-risk pool into a more realistic and cost-effective solution.

Members of the high-risk pool should be required to participate in disease management programs. The plan would provide varying benefits based upon compliance with care and health outcomes. With this new approach, the costs should be lower than the traditional high-risk pool. When incentives for staying healthy are applied, the costs for these previously uninsurable individuals could be reduced.

On the funding side, the best policy is to spread the cost of the high-risk pool as broadly as possible. Rather than constant debate over which segment of the market to assess, the solution is to fund the plan with general tax revenues. The benefit of a stable health insurance market and avoiding excessive regulation will more than offset the cost of the pool to the state taxpayers.

Adequately fund Georgia's trauma network

Funding a comprehensive trauma care system would provide life-saving treatment in the event of a natural disaster (tornados, widespread fires, etc.) or bio-terror attack. A comprehensive trauma care system would also ensure access to emergency medical care in rural parts of the state when traveling. Because everyone benefits from the trauma network in one way or another, it is appropriate to fund this network from general revenues. The needs of the trauma networks will change over time and the Legislature should have the flexibility to adjust funding to meet these needs. In addition, trauma funding should be prioritized along with all other needs of the state. Although automobile accidents place a large demand on the state’s trauma network, they are clearly not the only culprit.

Improve quality and access for low-income Georgians

Principles for Medicaid reform:

- Medicaid should empower recipients to select insurance that will best meet their basic needs at the best value.
- Medicaid should participate in a common marketplace through a system that emphasizes competition, quality and transparency.

Today’s government run programs (e.g. Medicaid, Medicare, SCHIP) have evolved into segmented systems of access and care. Many high quality providers limit the number of patients they care for in government-run

programs. Treatment options are limited, care is restrictive, and provider reimbursements are generally lower than private market programs. These programs involve misuse of coverage (excessive use of emergency rooms), little emphasis on health (limited use of appropriate preventive care), a lack of personal responsibility (few have a primary care physician), and high levels of fraud and abuse (estimated to be 10-40 percent).

All citizens should be a part of the same health insurance system. Only when everyone has similar access will the gap between diversity of care and outcomes close. The access and delivery of care and treatments should be the same for all. Any difference should only be in the financing of the insurance. As with other necessities of life (e.g. food, housing), low income individuals may need financial support to afford coverage.

Florida implemented Medicaid reforms in 2006 that should be watched closely. In an effort to control costs, enhance access and improve the quality of care, Florida Medicaid implemented several major reforms including incentives for wellness activities, choice of competing plans, counseling and risk-adjusted premium payments.[28]

Called "Empowered Care" by Florida leaders, the program gives Medicaid recipients a set amount of money per month, adjusted by health risks, with which to enroll in private health plans. Recipients also receive counseling on how to choose among the various options to find coverage and provider networks best suited to their family's needs.

Just two years into the implementation, it's too early to draw definitive conclusions about Florida's Medicaid reform. But there are several indicators of progress toward the goals of the plan, including increased choice, patient satisfaction and fiscal restraint:

- After the reform plan was implemented, the number of managed-care options increased from 15 to 22 in Broward and Duval counties, including a specialty network serving children with chronic conditions; many of the pre-existing plans introduced new coverage options, as well.
- In the first year of operation, expenditures for the elderly and disabled component of the Medicaid caseload came in at nearly 8 percent below the authorized budget.
- The program gives all Medicaid recipients "enhanced benefit account" from which they can spend cash on additional services; the state then credits these accounts as enrollees provide proof of such activities as annual physicals and vaccinations.[29]

Convert current subsidies for uncompensated care to direct subsidies for the low-income uninsured

Rather than paying a subsidy for providing uncompensated care, the state should first make those dollars available as direct subsidies for low-income uninsureds. Current subsidies are inefficient because they do not target those most in need of financial support. There is also a concern that hospital uncompensated care is overstated by measuring “retail” prices rather than the true cost of care. By expanding insurance coverage to a larger portion of the population there will be less uncompensated care and less need for the indirect subsidies. If eligible individuals chose not to claim their subsidy by purchasing insurance, those subsidies should then flow to support uncompensated care in their community.

A common misconception is that health insurance reform costs money. For example, if health insurance for 40 million uninsured people costs $1,500 a person, some conclude that the government would need to spend an additional $60 billion a year to get the job done. But this conclusion overlooks the fact that taxpayers are already spending $60 billion on free care for the uninsured, and if all 40 million uninsured suddenly became insured they would – in that act – free up the $60 billion from the social safety net.

[28] “An Evaluation of the Pilot Project To Reform Florida’s Medicaid Program,” James Madison Institute, July 2008, http://www.jamesmadison.org/pdf/materials/641.pdf
[29] "Medicaid in Florida," 'Empowered Care' may provide lessons," Carolina Journal, August 2008, http://www.johnlocke.org/acrobat/cjPrintEdition/cj-aug2008-web.pdf

Each person in the uninsured/Medicaid population costs about $1,500 per year through direct subsidies and cost shifting. Thus the health care system offers a family of four with few assets and low income "public insurance" worth about $6,000 a year. That compares to an average premium for individually-purchased family coverage in Georgia of $5,799. Making these subsidies available to individuals first will give many Georgians access to personal, portable health insurance while still ensuring that uncompensated care is funded for those who do not purchase insurance.

Premium Assistance

One of the problems with insuring individuals through government programs is continuity of coverage because individuals move in and out of eligibility as their income changes. One study concludes that the main reason why six million children are eligible but not enrolled in Medicaid and S-CHIP (called PeachCare in Georgia) is due to changes in eligibility. Also, children with discontinuous coverage are 13 times as likely to face delayed care as children who are continuously insured, according to another study.

In contrast to spending money on programs for which people's eligibility constantly changes, a better strategy is income support. Under this approach, the state offers a subsidy to be applied to private insurance. As family income rises and falls from year to year, the subsidy falls and rises in an offsetting way. In the process, there is no reason for the underlying health insurance to change. This can also avoid the problem of "crowd out" where expansions of public health care programs simply encourage people who already have private coverage to exchange their private for publicly subsidized coverage.

Economists David Cutler and Jonathan Gruber found that Medicaid expansions in the early 1990s were substantially offset by reductions in private coverage. For every additional dollar spent on Medicaid, private sector health care spending was reduced by 50 cents to 75 cents, on the average. Thus taxpayers incurred a considerable burden, but at least half, and perhaps as much as three-fourths, of the expenditures replaced private sector spending rather than buying more or better medical services. A similar principle applies to SCHIP. A recent Congressional Budget Office report estimated a crowd-out rate of 25 percent to 50 percent. Jonathon Gruber estimates the crowd-out rate at 60 percent.

In addition to reducing crowd out, if a portion of the subsidy were put in a Health Savings Account, individuals would have a source of paying for health care expenses even after exceeding eligibility requirements. If government is spending $1,500 a year per person enrolled in Medicaid, it ought to be willing to spend an identical sum on private insurance instead.

Encourage the Use of Assets and Private Insurance to Finance Long-Term Care

Long-term care is the fastest growing expense in the Medicaid program. As 77 million baby boomers reach retirement within the coming decade, the program can only grow more insolvent. However, with proper estate planning – using techniques and programs that are already largely available – the impact on seniors does not have to be as bleak.

There are more than 13 million households headed by people aged 62 years or older. Many seniors own their homes but are reluctant to tap their equity to pay for nursing home care for fear of losing those homes. A possible solution to this problem is a reverse mortgage. This is a home loan that does not have to be repaid as long as the owner (which could include the spouse of a nursing home resident) lives in the house. By one estimate, more than 6 million senior households could access more than $72,000 in home equity per household using reverse mortgages.[30] This would pay for a year or more of nursing home care and two or more years of home care in most areas.

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[30] "Use Your Home to Stay at Home: Program Study Shows That Reverse Mortgages Can Help Many with Long-Term Care Expenses," National Council on the Aging, Press Release and Fact Sheet, April 15, 2004

States now have a new way to encourage private long-term care insurance. It is an outgrowth of a pilot project in New York, Connecticut, California and Indiana called the Partnerships for Long-Term Care that provided financial incentives to purchase long-term care insurance. The plan allowed people to shelter their assets by purchasing a qualifying private insurance policy with a defined amount of coverage. When a policyholder entered a nursing home, he or she first relied on the insurance. When the insurance was exhausted, special eligibility rules allowed them to receive Medicaid benefits while retaining assets equal to the value of the policy.

In January 2007, Georgia, along with four other states, started an educational campaign to promote long-term care planning.

Educate low-income Georgians about the availability of programs

A large number of Georgians are eligible for Medicaid and SCHIP but do not enroll in the programs. These uninsureds do not have a medical home, they heavily use the ER and unnecessarily add to the problems of urgent and emergency care units while increasing the cost of health care for all Georgians. Use of faith-based outreach to those who qualify for existing government programs should be encouraged and supported.

This education effort could be combined with an effort to increase the filling of low-income working families for the federal Earned Income Tax Credit (EITC). Georgians failed to claim 61 percent of the EITC funds they were eligible for in 2004 (the last year data was available by state), a loss of $2.7 billion.[31]

In 2007, families with adjusted gross income as high as $39,783 were eligible for credits of up to $4,716.[32] As part of an outreach initiative to identify families eligible for a tax credit, the families without health insurance could be offered an opportunity to sign up for Medicaid, if eligible, or to apply for private health insurance.

Further reading:

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APPENDIX

Questions and Answers Regarding Consumer-Driven Health Care

1. Do HSA-eligible policies require coverage for all existing Georgia mandates?

Yes, HSA-eligible policies are subject to the same insurance laws and regulations as other policies (HMOs, PPOs, indemnity policies, etc.). This means that the same benefit mandates, premium regulations and consumer protections prescribed by each state (and the federal government) apply to these policies. No existing mandates are added or removed by the proposed legislation.

2. Do HSA-eligible policies offer first-dollar coverage of preventive care?

Yes, HSA-eligible policies are allowed by federal law to pay for preventive care services and screenings at 100 percent before the application of any plan deductible. HSA-eligible plans voluntarily cover preventive care services at a higher rate (84 percent of the time) than traditional insurance. The changes proposed in the Georgia law would also allow "dividend" additions (in the form of rewards and incentives) to be added to HSA accounts to further cover preventive care and wellness at 100 percent while satisfying any deductible.

3. Do HSA-eligible plans with preventive care cover well-child care, women's health and male screenings?

In a recent survey of policies offering first-dollar 100 percent coverage for preventive care before the application of any plan deductible:

- 100% cover well-baby and well-child care
- 100% cover child and adult immunizations
- 100% cover mammography
- 100% cover Pap tests
- 100% cover annual physical exams
- 90% cover prostate cancer screenings
- 80% cover colonoscopies

4. Can HSA-eligible policies help reduce the number of low-income uninsured?

Yes, approximately one of every three HSA-eligible policies sold are sold to individuals who were previously uninsured. Some insurers found that about one of every two purchasers with incomes under $35,000 had not had coverage for at least six months prior to enrollment. HSA-eligible policies are particularly attractive to seasonal and part-time workers, the unemployed between jobs, employees of small companies that do not offer coverage, and younger adults who cannot afford and do not find value in traditional insurance coverage.

5. Do HSA-eligible plans reduce the increasing cost of health insurance?

Yes, in 2007 Cigna's consumer-driven plan cost trends were less than half the trend for its PPO and HMO enrollees. This is a continuation of lower costs trend in prior years. The 2005 trend for Cigna's consumer-driven plans was plans between 1.2%-4.8% versus an overall trend of 10.3%. In 2006 the trend for Aetna's HSA-eligible policies and similar consumer-driven health plans was 2.6%, versus 7.4% for HMOs, 7.5% for PPOs, 7.3% for POS, and 6.6% for traditional indemnity coverage. Aetna reported on four years of experience with consumer-driven plans and found a 1 percent annual increase for full-replacement employers and 6.7% for employers that offered them as an option. eHealthInsurance reported that premium costs for HSAs eligible plans dropped 17% for individuals and 4.6% for families from 2004 to 2005.

6. Do HSAs empower individuals and support greater personal responsibility and better health?

Yes, UnitedHealth Group recently reported that those covered by consumer-driven plans are:

- More likely to see a doctor for diabetes (73% vs. 54%) and 16% more likely to receive HbA1c tests if they have diabetes.
- 22% more likely to have lipid tests if they have coronary artery disease.
- 6% more likely to use ACE inhibitors, 41% more likely to get creatinine tests and 26% more likely to receive potassium tests if they have congestive heart failure.
- 16% more likely to get cervical and prostate screening
- 10% more likely to get cholesterol screening

The Blue Cross Blue Shield Association reported in 2006 that HSA-eligible plans are:

- More likely to use nurse hotlines (10% vs. 6%)
- More frequent participants in wellness programs (20% vs. 8%)
- More likely to use more provider information tools (39% vs. 10%)
- Higher users of prescription drug cost and comparison tools (42% vs. 19%)
- More likely to use Web site based coverage information (53% vs. 32%)

A more recent report from the Blue Cross Blue Shield Association summed up the survey by saying, "These findings show us that consumer-driven plans are beginning to deliver on their promise. Our survey shows that consumer-driven plans empower consumers and help them become more engaged in their health care decisions."

7. Do HSA-eligible plans cause greater delays in seeking care?

No, regardless of the type of insurance policies, Americans tend to procrastinate in going to the doctor. A comparison of HSA-eligible plans to others shows HSA enrollees are no more likely to forego care:

- Did Not Go To Doctor: 18% of HSAs; 18% of other plan types
- Delayed Treatment: 17% of HSAs; 17% of other plan types
- Delayed Prescription: 15% of HSAs; 15% of other plan types

8. Are the lower cost and healthy habits in HSA-eligible plans due to healthier enrollment?

No, Cigna found the savings were not the result of healthier enrollment. Cigna studied the consumer-driven experience and compared it to the experience of their PPO and HMO products. It found 24% lower costs for inpatient care, and 10.7% lower for outpatient care. Cigna found that consumer-driven enrollees were 12% more likely to use preventive care, more compliant with medications that manage ongoing conditions, and more discerning in their use of medications with over-the-counter alternatives." These findings were confirmed by Cigna in October 2007 in a follow-up report that said "First year member preventive visits increased and second-year member visits remained significantly higher than those among traditional plan members (and) use of maintenance medications that support chronic conditions increased while costs decreased."

9. Do HSA-eligible plans encourage better treatment compliance and lower use of Emergency Rooms?

Yes, in a McKinsey study, consumer-driven plans are more likely to comply with treatments than people in traditional plans (36% vs. 27% for diabetes, and 51% vs. 31% for high blood pressure), 25% more likely to engage in healthy behaviors and 30% more likely to get an annual physical. A 2007 Harvard study in the *Journal of the American Medical Association* found that people in consumer-driven plans have 10% fewer Emergency Room visits overall and 25% fewer repeat visits. The drop in ER visits was almost

entirely for non-severe conditions. The Harvard Medical School lead author said, “Patients went to the emergency room less frequently for non-emergency conditions.”

10. Are HSA-eligible plans necessarily high deductible health insurance?

No, with rewards and incentives allowed under the new Georgia law, the net deductible under an HDHP may be zero ($0)! To be HSA-eligible under federal law, a plan must meet the standards for a federally defined “High Deductible Health Plan”. These are sometimes referred to as HDHPs. HDHPs are quite different from the generically used term “high deductible health insurance.” HSA-eligible plans can have an initial plan deductible as low as $1,100. With new plan designs made available under the Georgia law, rewards and incentives for healthy behaviors, compliance with the doctor’s treatment plans, and using preventive benefits (well-child, immunizations, smoking cessation, etc.) can lower the effective plan deductible to zero.

With HSA-eligible plans, federal law requires patient protections on the total financial exposure to an individual or family. For 2008, to be HSA-eligible the total out-of-pocket limit cannot be higher than $5,600 for self-only coverage or $11,200 for family coverage. There is no federal or state limit to protect families with other types of policies.

11. Do low-income families really save money in HSAs? Is there a limit on HSA funding?

In 2008, even with a $1,100 deductible policy, the allowed HSA funding is $2,900 for an individual and $5,800 for a family. Annual indexing increases the allowed HSA contribution limit each year. In addition, individuals over 55 can make an additional contribution of $900 in 2008, increasing to $1,000 in 2009. With increased personal responsibility and good healthy choices, the rewards and incentives allowed under the Georgia proposal support the accumulation of HSA dollars that can be created to cover all care expenses. Family members or other individuals can contribute to other individual’s HSAs. In addition, governmental entities can contribute to HSA accounts, e.g., transition from Medicaid to HSA-eligible plans.

In 2006, United Health Group found that 80 percent of low-income individuals (those earning $25,000 or less annually) with an HSA-eligible plan opened their HSA accounts. The rate of HSA account openings only varies from 80% to 84% across all income ranges. When an employer does not contribute to the HSA account they are still opened by:

- 23% of those earning less than $25,000
- 39% of those earning $25,000 to $49,000
- 50% of those earning $50,000 to $99,000
- 58% of those earning $100,000 or more

Among consumers who open an account, 67% contribute their own dollars – an average of $1,206 each. Among low-income individuals (earning $25,000 or less per year), 56% of account holders make their own contributions to the account. 86% of individuals carried an HSA balance into the next year. The average amount carried forward was $815.

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