

Consumer-Driven Health Care: Promise And Performance

The performance of consumer-driven health care has fallen short of both the aspirations of its proponents and the fears of its critics.

by **James C. Robinson and Paul B. Ginsburg**

ABSTRACT: This paper analyzes the evolution of consumer-driven health care in terms of its original vision, its subsequent implementation, and the transformations it has endured as it moves into its second decade. The market is generating product designs that combine elements of consumerism with elements of managed care, but the trend is always toward a stronger role for consumer choice and a weaker role for management of those choices by physicians, insurers, employers, and regulators. [*Health Affairs* 28, no. 2 (2009): w272–w281 (published online 27 January 2009; 10.1377/hlthaff.28.2.w272)]

THE FUNDAMENTAL ECONOMIC PROBLEM is the reconciliation of limited resources and unlimited desires. In most sectors, this unpleasant task is accomplished by people spending their own money on their own needs, rationing their consumption based on their budgets and preferences. This economic problem in the health care sector is immeasurably complicated by the presence of insurance, which pools resources and thereby brings with it an important element of collective decision making. We spend other people's money in ways different from how we spend our own, and therein lies the tale.

The “consumer-driven” movement, now culminating its first decade, expresses a deeply felt desire for the reassertion of individual over collective decision making in health care. The backlash against managed care drew much of its cultural resonance from the denunciation of insurers that were viewed as interfering with the rights of individuals to make decisions for themselves (albeit with other people's money).¹ The hostility extended to employers and provider organizations, to the extent they were viewed as distant from the values and preferences of the people on whose behalf they purported to act. Much of the consumer-driven program hence revolved around the excision of any entity that stood between consumers and their preferences about which forms of medical care to consume. Insurance was to be restricted to truly catastrophic events, with payment for most services

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coming directly from the patient to the provider of service. Savings accounts were seen as providing liquidity to those consumers subject to more insurance risks. Employment-based coverage was to be replaced with the individual purchase of insurance, since employer provision of coverage was seen as interfering with consumer choice.

The vision of consumer-driven health care derived from multiple sources, and no one account can capture its diversity, complexity, and internal disputes. The available documentation is incomplete, with the philosophical advocates leaving more easily accessible materials than the business entrepreneurs who were busy trying to design programs that would make money and the policy entrepreneurs who were seizing an opportunity to change the tax code to encourage high-deductible health plans with savings options (HDHPs).

Nevertheless, the original promise and subsequent performance of consumer-driven health care can be sketched with reasonable confidence. Some once-heralded components have disappeared, others now are part of the institutional mainstream, and most are mutating into forms far removed from their original structure and purpose. In this, consumer-driven health care is following the same trajectory as managed care, which drew from many sources, failed to achieve many of its goals, and changed its strategies and structures so dramatically as to become almost unrecognizable when compared with its original vision.

This paper analyzes the evolution of consumer-driven health care in terms of that original vision, its subsequent implementation, and the transformations it has endured as it moves into its second decade. We describe the original promise, analyze its actual performance, and ponder the lessons learned from the effort to make health care the domain of personal rights and individual choice rather than one of social solidarity and collective choice.

Consumerism 1.0: The Promise

The backlash against managed care was a strange phenomenon indeed. Participants in the backlash were patients who believed that health maintenance organizations (HMOs) were limiting access to care, physicians who resented payment cuts and second-guessing of clinical decisions, liberals who interpreted managed care as an obstacle to a “single-payer” financing system, and conservatives who favored personal responsibility over government and corporate paternalism. All agreed on the virtues of the “consumer” and the vices of those who would “manage care” on his or her behalf. The shift reflects in part the resonance of the terms “consumer” and “choice” in the American lexicon, as evidenced in the ready embrace of these terms by Consumers’ Union in its skepticism of market forces and Alain Enthoven’s “consumer choice health plan” in his embrace of prepaid group practice, as well as by those who since have appropriated the terms for their own uses.²

■ **Health insurance.** The paradigmatic insurance plan for managed care had been the HMO, with its comprehensive benefit design, limited provider network,

and strong emphasis on medical management.³ The paradigmatic insurance plan for consumer-driven health care is the HDHP, characterized by thin benefits; a broad provider network; and only a modest, voluntary engagement with medical management.⁴ Philosophically, each of these components of the HDHP seeks to return decision-making rights and responsibilities to the individual patient and remove them from health plans and their actuaries, network contractors, and medical directors.

Benefit structure. The HDHP is designed around the principle that health insurance should function like true insurance, covering high-cost, unpredictable needs while leaving low-cost and predictable forms of care to be financed out of pocket by the patient. Out-of-pocket payments can be subsidized by permitting consumers to set aside funds in a health reimbursement arrangement (HRA) or health savings account (HSA) on a pretax basis. This benefit structure is designed to limit the moral hazard that accompanies third-party payment of expenses that can be anticipated and controlled by the enrollee.⁵

Price setting. The original vision of the HDHP also rejected the “provider network” principle inherent in managed care, according to which the HMO should channel patient volume to a subset of physicians and hospitals in exchange for fee discounts and cooperation with the plan’s medical management. In the HDHP ideal, prices would be set by doctors and hospitals, not through negotiations with health plans but, rather, based on their assessments of consumers’ willingness to pay. The consumer’s right freely to choose his or her provider would be extended to the provider’s right freely to set his or her own prices.

Clinical activities. The HDHP is skeptical concerning the clinical activities of the HMO, the “utilization management” and “disease management” and “case management” that purport to support patients’ and physicians’ decisions concerning the course of treatment. In the consumer-driven world view, patients should manage their own care, with the advice of their physicians and with information on prices and performance derived from Internet sites, patient groups, and personal advisers.

■ **Sponsorship.** In the domino theory of health system reform, as expressed by advocates of managed care, the employer and governmental programs that sponsor insurance coverage play a special role. Sponsors not only pay the lion’s share of the premiums, thereby pooling risk across their covered populations, but they also serve as active purchasers rather than passive sources of “reimbursement” for the care they finance.⁶ They are the first domino. The vision is one of pooling risk, purchasing power, and sophistication to push insurers to push providers to improve. Sponsors are assigned the task of monitoring performance and structuring consumer choice among health plans, ensuring that competition is on the basis of quality and price and not on the basis of underwriting and risk avoidance. The social insurance ideal of equal access is delegated to these large entities, with leading examples including the Federal Employees Health Benefits (FEHB) program and the Pacific Business

Group on Health (PBGH).⁷

While the employer's role in principle is one of supporting consumer choice, the reality too often has proved to be one of limiting choice. Many employers find daunting the tasks of risk adjustment and HMO contracting in each locality where employees live, and therefore they default to "total replacement" relationships with a single large insurer that can offer an acceptable provider network in all areas.⁸ These health plans, in their turn, accommodate employers' demand for access by broadening provider networks and favoring plain-vanilla preferred provider organization (PPO) products that have only limited means to stimulate improvements in quality or efficiency.

For the advocates of consumer-driven health care, employers are not the first domino in any sequence but one more intermediary responsible for the unresponsiveness of the health care system. There is no reason why a person's health plan should be chosen by the employer's human resources department. In the consumer-driven vision, quality and price are to be measured by independent rating agencies and assured by competition, not by employers.

Consumerism 2.0: The Performance

The performance of consumer-driven health care has fallen short of both the aspirations of its proponents and the fears of its critics. Growth of the favored organizational forms, including HDHPs and individually purchased insurance, has been anemic. The forms of insurance and sponsorship originally embodied in the consumer-driven vision have mutated into forms far from those originally envisaged. This process is not unique to consumerism, but one well known to managed care, where the original group-/staff-model HMO was diluted into the loosely structured independent practice association (IPA)-model plan and the sponsorship framework of managed competition into the "total replacement" purchasing format of self-insured employers.

■ **Health insurance.** The HDHP represents the most important product innovation in health insurance since the point-of-service (POS) product sought to balance the virtues of primary care coordination with those of specialty care choice in the 1990s. Widely heralded as the fundamental alternative to the managed care product portfolio, the HDHP has been a disappointment in terms of actual sales. Enrollment in HDHP/HSA plans, as measured by reports from insurers to America's Health Insurance Plans (AHIP), grew from 400,000 in September 2004 to 6.1 million in January 2008—a large absolute increase but still small in relation to overall enrollment in private insurance.⁹ Results from a survey of employers estimates that the percentage offering an HDHP with a savings option (HRA or HSA) increased from 4 percent in 2005 to 13 percent in 2008, but only 8 percent of those with employment-based coverage were enrolled in such products in 2008.¹⁰

Market penetration. Although boosters have reveled in the percentage growth rate of enrollment in the HDHP, the reality is that the product is still far from the mar-

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ket penetration that would influence the delivery of care. By comparison, the HMO product continues to hold onto 20 percent of those with employment-based coverage, and POS plans maintain another 12 percent. The start-up insurers that pioneered the HDHP-SO mostly have sold out to the multiproduct insurers they were designed to replace, although the latter sought out the start-up insurers to infuse some of their pioneering ideas into more traditional organizations.¹¹

Impact of the PPO. The insurance market has merged the ideas of consumer-driven health care with those of managed care instead of replacing the latter by the former.¹² The dominant form of health insurance today, by far, is the PPO. It combines network principles from managed care with some of the cost-sharing principles from consumer-driven health care; in 2008, PPOs accounted for 58 percent of enrollment in employment-based coverage.¹³ The PPO began to displace the HMO in the late 1990s as HMOs' gatekeeping and utilization review created too much consumer and provider animosity.

Despite the verbiage and vitriol on both sides, it appears that consumer-driven health care and managed care are complements more than they are substitutes for one another.¹⁴ The mainstream health insurance industry is reorienting itself to replace administrative controls with incentives and information but in a manner in which the health plan functions as an important intermediary for structuring choices and informing enrollees about provider price and quality.¹⁵

The PPO manifests considerably more cost sharing than it did at the beginning of the decade, but much less than does the HDHP. In 2008, PPOs imposed an average deductible of \$560 for single coverage, whereas HDHPs had an average deductible of \$1,812.¹⁶ AHIP's census reports that the average deductible in the best-selling HDHP product is \$2,600 in the individual market, \$2,244 in the small-group market, and \$2,046 in the large-group market. Even within the world of high-deductible plans, a growing range of services are exempted from the deductible and covered at no or low cost, including selected preventive tests, vaccinations, and prescription drugs for chronic illnesses.¹⁷ More departures from the high-deductible design might be pursued if not for tax law restrictions on qualifications for tax-favored savings accounts. The talk of the moment is around “value-based insurance design,” which is based on the notion that consumers need to be protected against their proclivity to avoid or delay valuable medical services as well as more elective ones when forced to pay with their own money, but HSA requirements make it easier to incorporate these principles into other products.¹⁸

The PPO exhibits broader physician and hospital networks than does the HMO but more restricted choice than the original HDHP ideal. Given that substantial network discounts can be obtained by PPOs, HDHPs in practice have long in-

cluded PPO networks. So instead of having consumers negotiate with providers over prices, payment in HDHP products is based on prices that insurers negotiate with providers, often based on the administered pricing systems used by Medicare.¹⁹ Whatever the potential for direct negotiation of prices, consumers recognize the advantages of having a powerful third party doing the negotiation on their behalf.

Network structures have been tightening—not loosening—as insurers have sought to channel patient volume toward “high-performing” physicians who have conservative practice styles or to exclude imaging providers not meeting quality standards.²⁰ For very costly services that demonstrate large variation in quality outcomes, such as organ transplantation or bariatric surgery, PPOs are following HMOs into even tighter contractual subnetworks, which they refer to as Centers of Excellence. Either coverage is limited to these subnetworks or much higher cost sharing is required of patients choosing other providers.²¹

A dilution of principles. The heart of the consumer-driven health plan is the philosophical belief that each individual should make his or her own health care decisions. Health care decisions should not be “managed” by third parties, and especially not by physicians and nurses employed by insurance companies. The consumer-driven health care movement has been obliged to dilute its principles in light of the overuse of inappropriate services and underuse of appropriate services in the real world.²² HDHPs now incorporate elements of disease management for enrollees with chronic conditions; case management for enrollees with complex or comorbid conditions; and utilization management for patients using particularly costly drugs, devices, or procedures. Most of these medical management programs are obtained from the same diversified insurers that offer HMO and PPO products. Indeed, the potential for integration with claims databases is leading insurers to acquire many formerly independent medical management vendors.²³

Integration of wellness programs. The most recent development has been health plans’ initiatives to promote wellness, both at the behest of their large employer clients and in insured products sold to small employers—a striking change over the past two to three years.²⁴ The most common initiative is incentives for employees and their families to fill out health risk assessment questionnaires, which lead to identification of undertreated chronic illnesses and high risk factors and to follow-up with referrals to physicians, enrollment in disease management programs, or incentives to work with a “health coach.” As this trend proceeds, positive financial incentives to participate could be supplemented by negative financial penalties for those who refuse.

■ **Sponsorship.** In their pursuit of individual over social choice as an organizing principle, the advocates of consumer-driven health care interpret the employment basis for private health insurance as an upstream obstacle to downstream innovation. The ills of the employment-based system are legion: so-called job lock that impedes the free flow of labor in a dynamic economy; an emphasis on comprehensive

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benefits (in part reflecting long-standing tax subsidies to employment-based health insurance); and a one-size-fits-all approach to benefit, network, and other product characteristics.²⁵

Employment-based health insurance continues to erode, from 81 percent of those under age sixty-five with insurance coverage in 2000 to less than 77 percent in 2006, but most of the erosion has been associated with increased coverage by government programs rather than increased purchase of individual coverage.²⁶ The percentage covered by Medicaid, the State Children’s Health Insurance Program (SCHIP), and other state programs increased from 10 percent to 14 percent during this period.²⁷ Medicaid and SCHIP sponsors are outsourcing the management of their programs to private health plans, but these entities are largely relying on managed care products rather than on HDHPs for these enrollees. In contrast, the percentage with private nongroup coverage showed little change, increasing from 6.1 percent in 2000 to 6.7 percent in 2006.²⁸ Likely factors behind limited growth in individual coverage are its higher premium (for a given benefit structure), underwriting restrictions for chronically ill individuals, and the lack of a tax subsidy for those not self-employed. Most employers, and almost all large employers, continue to offer coverage, and most employees prefer employment-based insurance over any of the alternatives.²⁹ Indeed, the Achilles’ heel of the consumer-driven critique of employment-based coverage is its overly optimistic view of the alternatives—of the measures necessary to improve access and affordability in the individual market.

Conclusions

Health care should be consumer driven for reasons of both efficiency and ethics. When in possession of adequate information and faced with appropriate incentives, consumers make better choices for their own health than does any third party, be that third party motivated by the most praiseworthy of intentions. Moreover, as a matter of ethics, it is the patient and consumer, not the physician or insurer or employer or regulator, who should be vested with the right to make trade-offs in the emotionally and sometimes spiritually charged domain of health care.

That said, one must acknowledge that consumers often need support if their choices are to promote their well-being and constraint when they are spending other people’s money. Health care is complex at best and not infrequently rife with nontransparent, anticompetitive, and even fraudulent behavior on the part of the many self-interested agents. Individual consumers can benefit from some of the efforts by governmental and employer sponsors, health insurance plans, provider organizations, and medical management programs. Consumers need others to cre-

ate meaningful products and processes from which they can choose—bundles of products and services that can be measured, priced, purchased, and used not only by the highly educated and motivated individual but by those who are sick and scared, of only modest means and financial sophistication.

The blind spot in the consumer-driven analysis of market performance concerns the importance of coordination in insurance, delivery, and sponsorship. The obdurate insistence on *à la carte* choice and retail purchasing pushed the theorists of consumerism into positing organizational and market dynamics that have not been observed in the real world. The important issue is not, however, the current status and structure of health care and health insurance but the trend into the future. It seems safe to say that insurance product design will continue to move toward consumer-driven elements and that managed care elements will be recrafted into forms in which consumers choose but are subject to incentives structured by insurers. Enrollees will have more information but also more financial responsibility at the time of receiving care. Products will continue to proliferate and differentiate to accommodate the preferences and purses of potential enrollees. Health plans will specialize in data collection, aggregation, and analysis that can be used not only to support patient choice but also to evaluate provider and product performance through registries, observational studies, and clinical epidemiology.

As it moves further along the consumer pathway, health insurance is likely to strengthen rather than weaken some vestiges of its managed care heritage, especially the development of programs seeking to improve the care of enrollees along the spectrum from full health to dire illness. These include preventive and wellness programs for healthy enrollees, service coordination for patients needing acute care, disease management for enrollees with chronic conditions, and intensive case management for enrollees with severe conditions. These likely will be presented as options rather than mandates, consistent with the consumer-driven ethos, although perhaps with higher cost sharing for those who are eligible but choose not to participate. What is unclear, over the long term, is the extent to which more choice for consumers will prevent health insurers from being able to continue to offer the steep discounts they currently wrest from their provider networks.

THE MARKET IS NO MORE STUCK on first-generation high-deductible insurance products and individually purchased coverage than it was stuck on HMO products and employment-based sponsorship models under managed care. The market continues to pioneer hybrid forms that incorporate elements of both managed care and of health care consumerism. We can name the emerging system “managed consumerism” or “facilitated consumerism,” or we can find some more felicitous phrase.³⁰ The important point is that for choice to be meaningful, it has to be choice among meaningful options, and meaningful options need to be designed, built, and managed.

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NOTES

1. For an extensive series of articles on the backlash against managed care, see the *Journal of Health Politics, Policy and Law* 24, no. 5 (1999).
2. G. Shearer, "Defined Contribution Health Plans: Attracting the Healthy and Well-Off," *Health Services Research* 39, no. 4, Part 2 (2004): 1159–1166; and A. Enthoven, "Consumer-Choice Health Plan [first of two parts], Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance," *New England Journal of Medicine* 298, no. 12 (1978): 650–658. Consumer-driven health care as an intellectual tradition includes many contributions; we here list only some of the more salient. None of these covers in depth all three aspects of the topic (insurance, delivery, and sponsorship), and they do not agree on all the specifics. Nevertheless, there is a community of policy interest and perspective that unites them. R. Herzlinger, *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America's Largest Service Industry* (Reading, Mass.: Addison-Wesley, 1997); MCOL, *Consumer Driven Health Care Guidebook 2005* (Modesto, Calif.: HealthQuest Publishers, 2004); M.V. Pauly and J.C. Goodman, "Tax Credits for Health Insurance and Medical Savings Accounts," *Health Affairs* 14, no. 1 (1995): 126–139; J.C. Goodman, "What Is Consumer-Directed Health Care?" *Health Affairs* 25, no. 6 (2006): w540–w543 (published online 24 October 2006; 10.1377/hlthaff.25.w540); W.H. Frist, "Health Care in the Twenty-first Century," *New England Journal of Medicine* 352, no. 3 (2005): 267–272; and J.C. Robinson, "The End of Managed Care," *Journal of the American Medical Association* 285, no. 20 (2001): 2622–2628.
3. A.C. Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Reading, Mass.: Addison-Wesley, 1980).
4. For purposes of this paper, the paradigmatic intellectual statement of consumer-driven health care is Herzlinger, *Market-Driven Health Care*. The paradigmatic business enterprise was Definity Health, a startup focused on developing high-deductible product designs for self-insured employers (ultimately Definity was acquired by UnitedHealth Group).
5. Ironically, the applicability of HSA funds to out-of-pocket services expands rather than contracts the tax subsidy for moral hazard. Presumably, advocates of consumer-driven health care believe that the incentive to adopt a benefit structure with a high deductible is more important than the dilution of incentives to make efficient choices in consumption of medical care.
6. A.C. Enthoven and R. Kronick, "A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy, Part 1," *New England Journal of Medicine* 320, no. 1 (1989): 29–37.
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9. T. Chovan and H. Yoo, "Health Savings Accounts Off to a Fast Start in the Individual Market," 12 January 2005, <http://www.ahipresearch.org/pdfs/AHIP-HSA-HDHPReportJan122005.pdf> (accessed 24 June 2008); and AHIP Center for Policy and Research, "January 2008 Census Shows 6.1 Million People Covered by HSA/High-Deductible Health Plans," April 2008, http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf (accessed 4 December 2008).
10. Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2008 Annual Survey* (Menlo Park, Calif.: Kaiser Family Foundation, 2008), 61, 64.
11. Definity was acquired by UnitedHealth Group; Lumenos was acquired by WellPoint Health Networks; and Destiny, long a subsidiary of an international life and health insurer, now partners with Stonebridge Life Insurance Company for its U.S. operations.
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13. Kaiser/HRET, *Employer Health Benefits: 2008 Annual Survey*, 64.
14. J.C. Robinson, "Managed Consumerism in Health Care," *Health Affairs* 24, no. 6 (2005): 1478–1489.

15. J.C. Robinson, "From Managed Care to Consumer Health Insurance: The Fall and Rise of Aetna," *Health Affairs* 23, no. 2 (2004): 43–55; and Robinson, "Reinvention of Health Insurance in the Consumer Era."
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17. AHIP Center for Policy and Research, *A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007* (Washington: AHIP, 2007).
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25. P.B. Ginsburg, "Employment-Based Health Benefits under Universal Coverage," *Health Affairs* 27, no. 3 (2008): 675–685.
26. Calculated from Exhibit 1 in J. Holahan and A. Cook, "The U.S. Economy and Changes in Health Insurance Coverage, 2000–2006," *Health Affairs* 27, no. 2 (2008): w135–w144 (published online 20 February 2008; 10.1377/hlthaff.27.2.w135). See also J.C. Robinson, "The Commercial Health Insurance Industry in an Era of Eroding Employer Coverage," *Health Affairs* 25, no. 6 (2006): 1475–1486.
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28. Ibid.
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