**The Commonwealth Fund Health Care Opinion Leaders Survey**
February 2005

## Introduction

The Commonwealth Fund Health Care Opinion Leaders Survey was conducted by Harris Interactive on behalf of The Commonwealth Fund, with a broad group of more than 250 opinion leaders in health policy and innovators in health care delivery and finance. Respondents were clustered into four major groups: those employed by academic or research institutions; those involved in the delivery of health care services; those employed by businesses or health industry including health insurance and managed care plans; and those working for government or labor/consumer advocacy organizations. It was the second in a series of six bimonthly surveys designed to highlight leaders' perspectives on the most important and pressing health policy issues facing the nation. This survey focused on health insurance issues, including goals for the next 10 years, the future of employer-sponsored coverage, group purchasing options for small employers, individual mandates, health savings accounts, and state public program expansions. Potential respondents were identified through a two-step process involving a "nomination" survey with a core group of experts in multiple fields who were asked to name additional leaders both within and outside their areas of expertise, as well as a review of published lists and directories of recognized health experts. The detailed methodology is provided in Appendix.

## Summary

The inaugural study, conducted in November/December of 2004, found that expanding coverage to the uninsured is the top concern that health care opinion leaders would like Congress to address over the next five years. The second survey focused specifically on health insurance and insurance-related policy initiatives.

**Goals for the Next 10 Years**: Health care costs, market pressures, and public and private policies are changing insurance coverage in the United States. We asked opinion leaders about target or policy actions that are *both* desirable and achievable for various components of the health care system over the next decade. Leaders agree that within 10 years the proportion of the under-65 population without health insurance can and should be cut in half (8% vs. 18% currently). Typically, respondents said that the maximum amount of money spent out of pocket on health care expenses and premiums should be less than 10 percent.

**Future of Employer-Sponsored Coverage**: There is also consensus that employer-sponsored coverage should not be allowed to continue to decline, and that policy efforts should be made to stem this trend. Leaders' top choices to strengthen employer-sponsored coverage are: giving employers incentives to provide insurance that meets minimum standards (favored by 82%), providing low-wage workers with tax credits or other subsidies to help them enroll in employer plans (favored by 79%), and requiring employers who do not provide benefits to contribute to a fund to insure workers and their families (favored by 70%). Only 12 percent think it is appropriate to let employer-sponsored coverage continue to decline, while a slight majority (52%) would favor mandating that employers offer and contribute to coverage.

**Association Health Plans and Small Business Purchasing Pools modeled on the Federal Employees Health Benefits Program:** There was agreement among opinion leaders about strategies to help small employers and the self-employed join together to buy health benefits and share the advantages of large group purchasing. Some policy proposals would make it easier to form association health plans (AHPs) by making them subject to federal oversight and exempting these plans from state-mandated benefits,

financial reserve requirements, and other state regulations on premiums, underwriting, and eligibility for coverage or renewal. Half of respondents oppose association health plans (AHPs) and the overwhelming majority (84%) favors options similar to the Federal Employees Health Benefits Program (FEHBP). By a large margin, respondents believe that plans modeled on FEHBP are more effective than AHPs in expanding coverage to the uninsured, providing greater value for premium dollars for both employers and employees, providing more essential benefits, and in expanding health plan choices. While respondents rank FEHBPs higher than AHPs in terms of their effectiveness in cutting costs to employers and employees, they express skepticism about either option being effective in achieving this goal.

**Individual Mandates**: In general, respondents from all sectors indicated that they favor individual mandates to expand health coverage, which would require all individuals to buy insurance, with federal premium assistance for low-income insured. Assuming that there would be some sort of premium assistance for mandated coverage, the favored approach among all respondents is giving the uninsured the option of enrolling in a federal group plan such as FEHBP or, if they fail to do so, automatically enrolling them in the state Medicaid/State Children's Health Insurance Program (CHIP) with an income-assessed premium.

**Health Savings Accounts:** Congress recently enacted legislation allowing consumers to set up tax-protected HSAs, available to anyone with health insurance with a deductible of $1,000 or higher for an individual and $2,000 or higher for a family. While opinion leaders agree that the number of Americans with HSAs will increase in the near future, the majority of respondents oppose HSAs as a way to cut costs and make high-deductible plan coverage more widely available.

**Expansion of Medicaid/CHIP**: Respondents from all sectors favor providing new federal matching funds to support state efforts to expand Medicaid and CHIP to eligible low-income adults and families.

# Key Findings

## Health Care Insurance: Goals for the Next 10 Years (Table 1)

Respondents were asked to indicate what they see as both desirable and achievable targets for policy action over the next 10 years. Respondents were clustered into four major groups: those employed by academic or research institutions; those involved in the delivery of health care services; those employed by businesses or health industry including health insurance and managed care plans; and those working for government or labor/consumer advocacy organizations.

- The proportion of under-65 population without health insurance (now about 18%). Leaders agree that within 10 years it is both desirable and achievable that the proportion of uninsured among the under-65 population should be less than half what it is now. The median number cited across all groups is 8 percent. The figures for individual sectors ranged from 5 percent to 10 percent.
    - ◊ Academic/Research Institution: 5% (median)
    - ◊ Health Care Delivery: 7% (median)
    - ◊ Business/Insurance/Other Health Care Industry: 10% (median)
    - ◊ Government/Labor/Consumer Advocacy: 7% (median)

- Percent of under-65 population with employer-provided insurance (now about 63%). Overall, respondents say that it is both desirable and achievable that there will be a 2 percent increase in the number insured by employer plans over the next 10 years. Government/labor/consumer advocacy respondents are the most optimistic.

- ◊ Academic/Research Institution: 65% (median)
  - ◊ Health Care Delivery: 66% (median)
  - ◊ Business/Insurance/Other Health Care Industry: 66% (median)
  - ◊ Government/Labor/Consumer Advocacy: 73% (median)

- Percent of under-65 privately insured population with a deductible of $1,000 or more (now about 7%). There is consensus among all sectors that there will be an increase in the proportion of the privately insured with deductibles of $1,000 or more (to 11%). Business/insurance/other health care industry are the most likely to think high deductibles will and should increase.
  - ◊ Academic/Research Institution: 10%
  - ◊ Health Care Delivery: 11%
  - ◊ Business/Insurance/Other Health Care Industry: 15%
  - ◊ Government/Labor/Consumer Advocacy: 10%

- Percent of population with HSAs (now less than 1%). Overall, respondents say that it is both desirable and achievable that in 10 years the percentage of the population with HSAs will grow to 5 percent. As with the question about deductibles, the business/insurance/other health care industry sector predicts the greatest increase over the next 10 years.
  - ◊ Academic/Research Institution: 5% (median)
  - ◊ Health Care Delivery: 7% (median)
  - ◊ Business/Insurance/Other Health Care Industry: 11% (median)
  - ◊ Government/Labor/Consumer Advocacy: 5% (median)

- Total cost of health care as a percentage of the gross domestic product (GDP) (now about 15%). All sectors report that, over the next decade, it is both desirable and achievable that health care spending as a percentage of GDP will remain nearly the same as the current level, with only a one to two percentage point increase.
  - ◊ Academic/Research Institution: 16% (median)
  - ◊ Health Care Delivery: 16% (median)
  - ◊ Business/Insurance/Other Health Care Industry: 17% (median)
  - ◊ Government/Labor/Consumer Advocacy: 15% (median)

## Health Care Insurance: Maximum Out-Of-Pocket Expenses (Table 2)

Respondents were asked to indicate what they think is the maximum percentage of income a consumer should spend for out-of-pocket health care expenses and premiums.

- Surprisingly, all sectors are in near-consensus about the maximum percentage of income a consumer should spend for out-of-pocket expenses and premiums: the median reported across all groups is 9 percent.
  - ◊ Academic/Research Institution: 10% (median)
  - ◊ Health Care Delivery: 10% (median)
  - ◊ Business/Insurance/Other Health Care Industry: 11% (median)
  - ◊ Government/Labor/Consumer Advocacy: 9% (median)

## Future of Employer-Sponsored Coverage (Table 3)

Respondents were asked to indicate whether they would favor or oppose a range of options for employer-sponsored coverage in the future.

- The large majority of respondents from all sectors say that employer-sponsored coverage should not be allowed to continue to decline without policy efforts made to stem this trend (75%).
    - ◊ Academic/Research Institution: 70%
    - ◊ Health Care Delivery: 79%
    - ◊ Business/Insurance/Other Health Care Industry: 80%
    - ◊ Government/Labor/Consumer Advocacy: 85%

- Employers should be given incentives to provide insurance that meets minimum standards tops the list of options, with more than four of five respondents overall (82%) favoring this approach. Respondents from the health care delivery sector are much more likely to favor this than those from academia.
    - ◊ Academic/Research Institution: 81%
    - ◊ Health Care Delivery: 92%
    - ◊ Business/Insurance/Other Health Care Industry: 86%
    - ◊ Government/Labor/Consumer Advocacy: 85%

- Low-wage workers should receive tax credits or other subsidies to help them enroll in employer plans is the second most popular option among respondents. Seventy-nine percent favor some type of subsidy for low-wage workers.
    - ◊ Academic/Research Institution: 79%
    - ◊ Health Care Delivery: 74%
    - ◊ Business/Insurance/Other Health Care Industry: 82%
    - ◊ Government/Labor/Consumer Advocacy: 85%

- Many opinion leaders (70%) also think that all employers who do not provide benefits should contribute to a fund to insure their workers and their families. All sectors have similar views on that option (ranges from 70 to 73%).

- There is much less agreement that employers should be allowed to buy into Medicaid/CHIP coverage for their employees. Overall, three of five opinion leaders (60%) would support this. However, respondents from academia are much more likely than business/insurance/other health care industry respondents to back this approach.
    - ◊ Academic/Research Institution: 66%
    - ◊ Health Care Delivery: 58%
    - ◊ Business/Insurance/Other Health Care Industry: 52%
    - ◊ Government/Labor/Consumer Advocacy: 81%

- About half of all respondents (52%) believe that all employers should be required to offer and help finance health benefits for their workers and their families, with views varying among the different sectors (ranging from 48 to 62%).

- Only about one of four respondents in the business/insurance/other health care industry favors the replacement of employer coverage with a single-payer plan, with current employer premium contributions redirected to help pay for coverage. Forty-two percent of opinion leaders as a whole support this. Academia and health care industry respondents support this at a much higher rate than those in business/insurance/other health industry.
    - ◊ Academic/Research Institution: 45%

- ◊ Health Care Delivery: 49%
- ◊ Business/Insurance/Other Health Care Industry: 27%
- ◊ Government/Labor/Consumer Advocacy: 46%

### Group Purchasing Options for Small Employers (Table 4)

In light of Congress' consideration of various strategies to help small employers and the self-employed join together to buy health benefits and share the advantages of large group purchasing, respondents were asked to favor or oppose two strategies. Thirty-three percent favor AHPs, while 84 percent favor giving small businesses and uninsured individuals the option of purchasing coverage through a program like FEHFP.

- Only about one-third of respondents favor plans that would make it easier to form AHPs by making them subject to federal oversight and exempting these plans from state-mandated benefits, financial reserve requirements, and other state regulations on premiums, underwriting, and eligibility for coverage. However the level of support varies by industry sector, health care delivery is more likely than academia to favor such measures. Percent who favor:
  - ◊ Academic/Research Institution: 32%
  - ◊ Health Care Delivery: 49%
  - ◊ Business/Insurance/Other Health Care Industry: 38%
  - ◊ Government/Labor/Consumer Advocacy: 12%

- Respondents were much more favorable to options similar to the FEHBP that would let individuals and small businesses buy into FEHBP or a new parallel program with similar plan choices. In sharp contrast to respondents' opposition to AHPs, more than four of five (84%) favor options building on FEHBP or a similar plan. Respondents from academia and the health care delivery sector are more likely than business/insurance/other industry respondents to support this strategy. Percent who favor:
  - ◊ Academic/Research Institution: 88%
  - ◊ Health Care Delivery: 89%
  - ◊ Business/Insurance/Other Health Care Industry: 74%
  - ◊ Government/Labor/Consumer Advocacy: 85%

### AHPs vs. FEHBPs (Tables 5–6)

Respondents were asked to evaluate the potential effectiveness of AHPs and FEHBP-like options in achieving a range of goals. Overall, respondents report that options building on FEHBP or a similar plan would be more effective than AHPs in achieving all of the goals that they were asked to consider. More than half feel that FEHBP-like options would be more effective than AHPs in avoiding segmentation of healthier enrollees and sicker enrollees into different plans, providing greater value for the dollar, providing more essential benefits, and expanding health plan choices, while less than 10 percent think AHPs would be more effective at achieving these goals.

- Expanding coverage to the uninsured. Overall, only 10 percent of respondents think AHPs would be more effective than FEHBP in covering the uninsured, while 48 percent think FEHBP-like purchasing pools would be more effective. Sixteen percent think both would be effective, and 18 percent think neither would be effective.
  - ◊ Academic/Research Institution: 7% AHPs more effective, 53% FEHBPs
  - ◊ Health Care Delivery: 13% AHPs more effective, 40% FEHBPs

    - ◊ Business/Insurance/Other Health Care Industry: 20% AHPs more effective, 39% FEHBPs
    - ◊ Government/Labor/Consumer Advocacy: 4% AHPs more effective, 42% FEHBPs

- Avoiding risk segmentation. Only 4 percent of respondents think AHPs would be more effective than FEHBP in avoiding risk segmentation, while 57 percent think FEHBP-like purchasing pools would be more effective. Thirteen percent think both would be effective, and 20 percent think neither would be effective.
    - ◊ Academic/Research Institution: 3% AHPs more effective, 60% FEHBPs
    - ◊ Health Care Delivery: 4% AHPs more effective, 45% FEHBPs
    - ◊ Business/Insurance/Other Health Care Industry: 6% AHPs more effective, 48% FEHBPs
    - ◊ Government/Labor/Consumer Advocacy: 4% AHPs more effective, 65% FEHBPs

- Providing greater value for premium dollars for employers and employees. Only 5 percent of respondents think AHPs would be more effective than FEHBPs in providing greater value for premium dollars, while 59 percent think FEHBP-like purchasing pools would be more effective. Eighteen percent think both would be effective, and 11 percent think neither would be effective.
    - ◊ Academic/Research Institution: 3% AHPs more effective, 61% FEHBPs
    - ◊ Health Care Delivery: 4% AHPs more effective, 45% FEHBPs
    - ◊ Business/Insurance/Other Health Care Industry: 6% AHPs more effective, 52% FEHBPs
    - ◊ Government/Labor/Consumer Advocacy: 12% AHPs more effective, 73% FEHBPs

- Providing essential benefits. Only 2 percent of respondents think AHPs would be more effective than FEHBP in providing essential benefits, while 59 percent think FEHBP-like purchasing pools would be more effective. Twenty-two percent think both would be effective, and 9 percent think neither would be effective.
    - ◊ Academic/Research Institution: 1% AHPs more effective, 59% FEHBPs
    - ◊ Health Care Delivery: 2% AHPs more effective, 49% FEHBPs
    - ◊ Business/Insurance/Other Health Care Industry: 3% AHPs more effective, 58% FEHBPs
    - ◊ Government/Labor/Consumer Advocacy: 4% AHPs more effective, 69% FEHBPs

- Expanding health plan choices. Only 8 percent of respondents think AHPs would be more effective than FEHBPs in expanding choices of health plans, while 58 percent think FEHBP-like purchasing pools would be more effective. Twenty percent think both would be effective, and 7 percent think neither would be effective.
    - ◊ Academic/Research Institution: 8% AHPs more effective, 59% FEHBPs
    - ◊ Health Care Delivery: 8% AHPs more effective, 47% FEHBPs
    - ◊ Business/Insurance/Other Health Care Industry: 12% AHPs more effective, 45% FEHBPs
    - ◊ Government/Labor/Consumer Advocacy: 8% AHPs more effective, 69% FEHBPs

- Nearly one-third (32%) of opinion leaders believe that neither FEHBP-like options nor AHPs would be effective at cutting costs to employers and employees. This skepticism resonates with respondents from all sectors. The same number (32%) think FEHBPs would be more effective, while 11 percent think AHPs would be more effective in this regard. However, respondents from academia are more likely than health care delivery respondents to favor FEHBP-like options as an effective way to cut costs (36% vs. 19%).

### Individual Mandates (Table 7)

Respondents were asked to indicate whether they favor or oppose the general concept of individual mandates to expand health coverage. The mandate would require all individuals to buy insurance, with federal premium assistance available to make it more affordable for low-income uninsured.

- Overall, most respondents (57%) favor the concept of individual mandates that would require individuals to buy insurance. Furthermore, this level of support is given throughout all sectors.
    - ◊ Academic/Research Institution: 62%
    - ◊ Health Care Delivery: 60%
    - ◊ Business/Insurance/Other Health Care Industry: 61%
    - ◊ Government/Labor/Consumer Advocacy: 46%

### Premium Assistance for Individual Mandates (Table 8)

Assuming that individual mandates with some sort of premium assistance are a likely policy development, respondents were asked to indicate which approach they would favor most for improving availability of coverage.

- There is broad consensus across the different sectors about the best type of premium assistance to improve availability of coverage. Respondents strongly favor an active approach in the matter. By far the most popular option among respondents is giving the uninsured a choice of enrolling in a federal group plan (e.g., a FEBHP-like option) at community group rates. Anyone failing to do so would automatically be enrolled in the state Medicaid/CHIP program and assessed an income-related premium (50% overall). A distant second choice is mandating coverage and offering a federal group option (e.g., a FEBHP-like option) or some other group option in each state without a default plan (18% overall). Even fewer favor mandating coverage with no federal group plan and allowing each state to determine group and default options, subject to some minimum benefit guidelines (6% overall) and mandating coverage but leaving it to the market to decide how people find insurance (5% overall).

### Health Savings Accounts (Table 9)

- Congress recently enacted legislation allowing consumers to set up tax-protected HSAs, available to anyone with health insurance with a deductible of $1,000 or higher for an individual and $2,000 or higher for a family. Respondents were asked whether they support HSAs as a way to cut costs and make high-deductible plan coverage more widely available. Only about one of five (22%) support HSAs as part of an effort to cut costs and make high-deductible plan coverage more widely available. Overall, few respondents in all sectors support this approach, but those from academia are least likely to be in support.
    - ◊ Academic/Research Institution: 19%
    - ◊ Health Care Delivery: 25%
    - ◊ Business/Insurance/Other Health Care Industry: 33%
    - ◊ Government/Labor/Consumer Advocacy: 19%

### Medicaid/CHIP Program Expansion (Table 10)

Respondents were asked whether they favor or oppose expanding health coverage by expanding Medicaid and CHIP programs to low-income adults and families by providing new federal matching funds to states and expanding eligibility to anyone with incomes under 150 percent of poverty.

- A strong majority of respondents overall (68%) as well as majorities in all sectors favor providing new federal matching funds to support state efforts to expand Medicaid and CHIP programs to low-income adults and families. This would be done by expanding eligibility to anyone with incomes under 150 percent of poverty.
    - ◊ Academic/Research Institution: 69%
    - ◊ Health Care Delivery: 60%
    - ◊ Business/Insurance/Other Health Care Industry: 73%
    - ◊ Government/Labor/Consumer Advocacy: 81%

## About the Respondents (Tables 11 and 12)

Respondents come from a broad range of employment positions and settings. For analytical purposes we combined respondents into four sectors (for a more detailed description of respondents' place of employment please refer to Table 11):

- Academic/Research Institutions (58%)*
- Health Care Delivery (21%),* including medical societies or professional associations or organizations, allied health societies or professional associations or organizations, hospital or related professional associations or organizations, hospitals, nursing homes/long-term care facilities, clinics, and physician or other clinical practices.
- Business/Insurance/Other Health Care Industry (26%),* including health insurance, pharmaceutical, other industries/business, and health care improvement organizations.
- Government/Labor/Consumer Advocacy (10%),* including government, labor, and consumer advocacy.

Respondents mentioned most often that they are teachers, researchers, or professors (40%), followed by policy analysts (23%), CEOs and presidents (22%), and physicians (22%). Others are consultants (12%) or work in administration/management (11%).

* Percentages total to more than 100 percent since respondents were able to give more than one answer.

**TABLE 1**
**GOALS FOR THE NEXT 10 YEARS**
"Please indicate what you would see as both an achievable and a desirable target or goal for policy action for the next 10 years."
Base: 255 Respondents

| | Total | Academic/ Research Institution | Health Care Delivery | Business/ Insurance/ Other Health Care Industry | Government/ Labor/ Consumer Advocacy |
|---|---|---|---|---|---|
| | Median % | Median % | Median % | Median % | Median % |
| The proportion of under-65 population that has no health insurance (now about 18%) | 8 | 5 | 7 | 10 | 7 |
| The total cost of health care as a percentage of the GDP (now about 15%) | 16 | 16 | 16 | 17 | 15 |
| Percent of under-65 population with employer-provided insurance (now about 63%) | 65 | 65 | 66 | 66 | 73 |
| Percent of under-65 privately insured population with a deductible of $1,000 or more (now about 7%) | 11 | 10 | 11 | 15 | 10 |
| Percent of population with a health savings account (now less than 1%) | 5 | 5 | 7 | 11 | 5 |

**TABLE 2**
**OUT-OF-POCKET EXPENSES**
"What do you think is the maximum percentage of income a consumer should spend for out-of-pocket health care expenses and premiums?"
Base: 255 Respondents

| | Total | Academic/ Research Institution | Health Care Delivery | Business/ Insurance/ Other Health Care Industry | Government/ Labor/ Consumer Advocacy |
|---|---|---|---|---|---|
| | Median % | Median % | Median % | Median % | Median % |
| Maximum percentage of income for out-of pocket health care expenses and premiums | 9 | 10 | 10 | 11 | 9 |

**TABLE 3**
**FUTURE OF EMPLOYER-SPONSORED COVERAGE**
"About 160 million Americans get health insurance coverage through their employers, who spend more than $400 billion on such benefits. Would you favor or oppose the following options for such coverage in the future?"

Base: 255 Respondents

| | **Total** | | **Academic/ Research Institution** | | **Health Care Delivery** | | **Business/ Insurance/ Other Health Care Industry** | | **Government/ Labor/ Consumer Advocacy** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **%** | | **%** | | **%** | | **%** | | **%** | |
| | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose |
| Employer-sponsored coverage should be allowed to continue to decline, with no policy efforts to stem this trend. | 12 | 75 | 14 | 70 | 13 | 79 | 11 | 80 | 4 | 85 |
| Employers should be given incentives to provide insurance that meets minimum standards. Incentives could include access to reinsurance, group-purchased favorable rates, or some type of tax credit. | 82 | 12 | 81 | 13 | 92 | 4 | 86 | 12 | 85 | 8 |
| Low-wage workers should receive tax credits or other subsidies. | 79 | 11 | 79 | 12 | 74 | 9 | 82 | 12 | 85 | 8 |
| All employers who do not provide benefits should contribute to a fund to insure workers and their families. | 70 | 19 | 70 | 20 | 72 | 15 | 73 | 20 | 73 | 4 |
| Employers should be allowed to buy into Medicaid/CHIP coverage for their employees. | 60 | 20 | 66 | 18 | 58 | 30 | 52 | 20 | 81 | 4 |
| All employers should be required to offer and help finance health benefits for their workers and their families. | 52 | 32 | 51 | 34 | 57 | 21 | 48 | 30 | 62 | 23 |
| Employer coverage should be replaced with a single-payer plan, with current employer premium contributions redirected to help pay for coverage. | 42 | 40 | 45 | 37 | 49 | 34 | 27 | 58 | 46 | 23 |

Note: Numbers may not total 100 percent since some respondents expressed no opinion or indicated they were not sure.

**TABLE 4**
**FUTURE OF EMPLOYER-SPONSORED COVERAGE**
"About 160 million Americans get health insurance coverage through their employers, who spend more than $400 billion on such benefits. Would you favor or oppose the following options for such coverage in the future?"

Base: 255 Respondents

| | **Total** | | **Academic/ Research Institution** | | **Health Care Delivery** | | **Business/ Insurance/ Other Health Care Industry** | | **Government/ Labor/ Consumer Advocacy** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **%** | | **%** | | **%** | | **%** | | **%** | |
| | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose |
| Association health plans (AHPs): Some proposals would make it easier to form AHPs by making them subject to federal oversight and exempting these plans from state-mandated benefits, financial reserve requirements, and other state regulations on premiums, underwriting, and eligibility for coverage or renewal. | 33 | 50 | 32 | 52 | 49 | 25 | 38 | 42 | 12 | 65 |
| Options like the Federal Employees Health Benefits Program (FEHBP): these would let individuals and small businesses buy into FEHBP or a new parallel program with similar plan choices. | 84 | 6 | 88 | 4 | 89 | - | 74 | 11 | 85 | 12 |

**TABLE 5**
**FUTURE OF EMPLOYER-SPONSORED COVERAGE (cont.)**
"Thinking about association health plans (AHPs) and Federal Employees Health Benefits Program–like options (FEHBPs), which would be more effective in achieving each of the following goals?"

Base: 255 Respondents

| | **Total** | | | |
|---|---|---|---|---|
| | **%** | | | |
| | AHPs | FEHBP | Neither is effective | Both are equally effective |
| Expand coverage to uninsured workers | 10 | 48 | 18 | 16 |
| Avoid risk segmentation | 4 | 57 | 20 | 13 |
| Provide greater value for premium dollars for employers and employees | 5 | 59 | 11 | 18 |
| Provide more essential benefits | 2 | 59 | 9 | 22 |
| Expand health plan choices | 8 | 58 | 7 | 20 |
| Cut costs to employers and employees | 11 | 32 | 32 | 18 |

**TABLE 6**
**FUTURE OF EMPLOYER-SPONSORED COVERAGE (cont.)**
"Thinking about association health plans (AHPs) and Federal Employees Health Benefits Program–like Options (FEHBPs), which would be more effective in achieving each of the following goals?"

Base: 255 Respondents

| | **Academic/ Research Institution** | | | | **Health Care Delivery** | | | | **Business/ Insurance/ Other Health Care Industry** | | | | **Government/ Labor/ Consumer Advocacy** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **%** | | | | **%** | | | | **%** | | | | **%** | | | |
| | AHPs | FEHBP | Neither | Both | AHPs | FEHBP | Neither | Both | AHPs | FEHBP | Neither | Both | AHPs | FEHP | Neither | Both |
| Expand coverage to uninsured workers | 7 | 53 | 19 | 13 | 13 | 40 | 15 | 19 | 20 | 39 | 12 | 23 | 4 | 42 | 38 | 12 |
| Avoid risk segmentation | 3 | 60 | 19 | 10 | 4 | 45 | 13 | 23 | 6 | 48 | 24 | 17 | 4 | 65 | 23 | 8 |
| Provide greater value for premium dollars for employers and employees | 3 | 61 | 9 | 18 | 4 | 45 | 4 | 30 | 6 | 52 | 20 | 18 | 12 | 73 | 8 | 8 |
| Provide more essential benefits | 1 | 59 | 9 | 22 | 2 | 49 | 8 | 28 | 3 | 58 | 8 | 24 | 4 | 69 | 12 | 15 |
| Expand health plan choices | 8 | 59 | 6 | 19 | 8 | 47 | 8 | 23 | 12 | 45 | 14 | 24 | 8 | 69 | 4 | 19 |
| Cut costs to employers and employees | 11 | 36 | 30 | 16 | 17 | 19 | 26 | 21 | 9 | 24 | 38 | 21 | 19 | 27 | 38 | 15 |

**TABLE 7**
**INDIVIDUAL MANDATES**
"Some proposals to expand health coverage would require all individuals to buy insurance, with federal premium assistance available to make that more affordable for low-income uninsured. Acknowledging such issues as availability and affordability, do you favor or oppose the general concept of individual mandates?"

Base: 255 Respondents

| | **Total** | | **Academic/ Research Institution** | | **Health Care Delivery** | | **Business/ Insurance/ Other Health Care Industry** | | **Government/ Labor/ Consumer Advocacy** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **%** | | **%** | | **%** | | **%** | | **%** | |
| | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose |
| Do you favor or oppose the general concept of individual mandates? | 57 | 24 | 62 | 20 | 60 | 19 | 61 | 24 | 46 | 31 |

**TABLE 8**
**INDIVIDUAL MANDATES (cont.)**
"Assuming individual mandates were likely, with some type of premium assistance, which one of the following approaches do you favor most for improving availability of coverage?"

Base: 255 Respondents

| | Total | Academic/ Research Institution | Health Care Delivery | Business/ Insurance/ Other Health Care Industry | Government/ Labor/ Consumer Advocacy |
|---|---|---|---|---|---|
| | % | % | % | % | % |
| Give the uninsured a choice of enrolling in a federal group plan (e.g., a FEBHP-like option) at community group rates. Anyone failing to do so would automatically be enrolled in the state Medicaid/CHIP program and assessed an income-related premium. | 50 | 52 | 58 | 44 | 58 |
| Mandate coverage and offer a federal group option (e.g., a FEBHP-like option) or some other group option in each state. There would be no default plan. | 18 | 17 | 19 | 21 | 8 |
| Mandate coverage with no federal group plan and allow each state to determine group and default options, subject to some minimum benefit guidelines. | 6 | 5 | 2 | 8 | 8 |
| Mandate coverage but leave it to the market to decide how people find insurance. | 5 | 5 | 2 | 5 | - |
| None of these | 9 | 10 | 8 | 11 | 15 |
| Not sure | 11 | 10 | 11 | 12 | 12 |

**TABLE 9**
**HEALTH SAVINGS ACCOUNTS**
Congress recently enacted legislation allowing consumers to set up tax-protected health savings accounts (HSAs). These would be available to anyone with health insurance with a deductible of $1,000 or higher for an individual and $2,000 or higher for a family. Those supporting HSAs see them as a way to cut costs and make high-deductible plan coverage more widely available. Do you favor or oppose HSAs as the centerpiece of such an effort?

Base: 255 Respondents

| | Total | | Academic/ Research Institution | | Health Care Delivery | | Business/ Insurance/ Other Health Care Industry | | Government/ Labor/ Consumer Advocacy | |
|---|---|---|---|---|---|---|---|---|---|---|
| | % | | % | | % | | % | | % | |
| | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose |
| Favor or oppose HSAs | 22 | 62 | 19 | 66 | 25 | 55 | 33 | 48 | 19 | 62 |

**TABLE 10**
**STATE PUBLIC PROGRAM EXPANSION**

A different strategy to expand health coverage would be to provide new federal matching funds to support state efforts to expand state Medicaid and CHIP programs to low-income adults and families. One option would expand eligibility to everyone with incomes under 150 percent of poverty ($14,360 in 2004 if single and $18,482 in 2004 if a two-person family).

Base: 255 Respondents

| | **Total** | | **Academic/ Research Institution** | | **Health Care Delivery** | | **Business/ Insurance/ Other Health Care Industry** | | **Government/ Labor/ Consumer Advocacy** | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **%** | | **%** | | **%** | | **%** | | **%** | |
| | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose | Favor | Oppose |
| Favor or oppose federal matching funds | 68 | 18 | 69 | 17 | 60 | 21 | 73 | 15 | 81 | 12 |

**TABLE 11**
**PLACE OF EMPLOYMENT**
"Which of the following best describes the type of place or institution for which you work or, if retired, last worked?"

Base: 255 Respondents

| | % |
|---|---|
| **Academic and Research Institutions** | |
| Medical, public health, nursing, or other health professional school | 31 |
| Think tank/health care institute/policy research institution | 16 |
| University setting not in a medical, public health, nursing, or other health professional school | 12 |
| Foundation | 5 |
| Medical publisher | 1 |
| **Health Care Delivery and Professional, Trade, or Consumer Organizations** | |
| Medical society or professional association or organization | 7 |
| Hospital | 6 |
| Physician practice/other clinical practice (patient care) | 5 |
| Clinic | 4 |
| Hospital or related professional association or organization | 3 |
| Nursing home/long-term care facility | 1 |
| Allied health society or professional association or organization | 2 |
| **Other Industry/Business Settings** | |
| Health care consulting firm | 7 |
| CEO, CFO, benefits manager | 4 |
| Accrediting body and organization (non-governmental) | 1 |
| Polling organization | * |
| Other | 5 |
| **Labor Consumer Advocacy Groups and Health Care Improvement Organizations** | |
| Labor/consumer/seniors' advocacy group | 3 |
| Health care improvement organization | 4 |
| **Health Insurance and Professional Organization** | |
| Health insurance/managed care industry | 7 |
| Health insurance and business association or organization | 3 |
| **Government** | |
| Non-elected federal executive branch official | 4 |
| Staff for federal elected official | * |
| Non-elected state executive branch official | 2 |
| Staff for a state elected official or state legislative committee | 1 |
| Staff for non-elected federal executive branch official | * |
| Staff for non-elected state executive branch official | * |
| **Pharmaceutical Industry and Professional Organization** | |
| Drug manufacturer | 2 |
| Pharmaceutical/medical device trade association organization | - |
| Biotech company | * |
| Device company | - |

**TABLE 12**
**TYPE OF EMPLOYMENT**
"How would you describe your current employment position?"

Base: 255 Respondents

| | % |
|---|---|
| Teacher, Researcher, Professor | 40 |
| Policy Analyst | 23 |
| Physician | 22 |
| CEO/President | 22 |
| Consultant | 12 |
| Administration/Management | 11 |
| Health care purchaser | 5 |
| Department head/Dean | 5 |
| Foundation officer | 4 |
| Consumer advocate | 4 |
| Lobbyist | 4 |
| Policymaker or policy staff (federal) | 5 |
| Policymaker or policy staff (state) | 3 |
| Other health care provider (not physician) | 2 |
| Regulator | * |
| Other | 4 |
| Retired | 5 |

**TABLE 12**
**PERMISSION TO BE NAMED AS A SURVEY PARTICIPANT**
Base: 255 Respondents

| | % |
|---|---|
| Yes | 87 |
| No | 13 |

Appendix

## Methodology

The online survey was conducted by Harris Interactive with 255 opinion leaders in health policy and innovators in health care delivery and finance between February 3, 2005, and February 15, 2005.

The sample for this survey was developed by using a two-step process. Initially, The Commonwealth Fund and Harris Interactive jointly identified a number of experts across different industries and professional sectors with a range of perspectives, based on their affiliations and involvement in various organizations and institutions. Harris Interactive then conducted an online survey with these experts asking them to nominate others within and outside their own fields whom they consider to be leaders and innovators in the health care industry. Based on the result of the survey and after careful review by Harris Interactive, The Commonwealth Fund, and a selected group of health care experts, the sample for this poll was created. The final list included 1,329 people.

Harris Interactive sent out individual e-mail invitations containing a password-protected link to the survey to the entire sample. Of the 1,329 invitations, 78 were returned as undeliverable. Steps were taken to attempt to correct the e-mail addresses and locate the individuals, however these efforts were unsuccessful. Harris Interactive determined that the undeliverable e-mail addresses appeared to be randomly distributed among the different sectors and affiliations. Data collection took place between February 3, 2005, and February 15, 2005. Two reminders were sent to anyone who had not responded. The response rate was 20 percent. Typically, samples of this size are associated with a sampling error of +/- 6%.