



COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

A ROADMAP TO HEALTH INSURANCE FOR ALL: PRINCIPLES FOR REFORM

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ABSTRACT: Presidential candidates, governors, and members of Congress are advancing proposals to expand health insurance coverage to all Americans—the most important step in improving access to quality health care. This report, prepared for The Commonwealth Fund Commission on a High Performance Health System, explores the different options and how each may not only increase coverage for the uninsured, but also improve quality and efficiency and gain control over spiraling health care costs. Proposals are grouped into three approaches: tax incentives and the individual insurance market; mixed private–public group insurance with shared responsibility for financing; and public insurance. The Commission believes the most pragmatic approach to coverage for all is mixed private–public group insurance that builds on the best features of our current system with shared responsibility for financing from individuals, employers, and government that minimizes dislocation for the millions of Americans who currently have good coverage.

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PREFACE

We are pleased to present *A Roadmap to Health Insurance for All: Principles for Reform*, authored by The Commonwealth Fund's Sara Collins and colleagues, and endorsed by The Commonwealth Fund Commission on A High Performance Health System. In August 2006, the Commission, in its first publication, *Framework for a High Performance Health System for the United States*, identified access to care as the cornerstone of a high performance health system. The Commission defined the components of access to include: universal participation; a minimum level of financial protection and established benefits for all; affordable care; and equitable care. In a subsequent report, which presented findings from a scorecard of health system performance by state, the Commission found that quality of care is directly related to access to care.

Since the Commission began its work more than two years ago, Americans have begun to realize that U.S. health care system performance is not as good as it could be. Despite spending more on health care than any other country in the world, our system could be more effective, efficient, and equitable, and could enable us to lead longer, healthier, and more productive lives. Many health care reform plans begin with a proposal for expansion of health insurance coverage. The need for such coverage expansion is considered an essential component for many of these plans. *A Roadmap to Health Insurance for All* makes a compelling case that, unless there is coverage for everyone, the United States cannot have a high performance health system associated with more effective and efficient care and longer, healthier, and more productive lives. If our society is to continue to prosper, we must ensure coverage for all Americans. Yet, the report makes clear that the reform strategies will have an impact both on coverage and on the prospects for improving quality and efficiency.

The *Roadmap* presents a set of principles endorsed by the Commission that Americans can use to evaluate proposals for health insurance reform. It frames the evaluation of these proposals around three different approaches: tax incentives and individual insurance market; mixed private–public group insurance with shared responsibility for financing; and public insurance. The Commission believes that the most pragmatic approach to coverage for all is mixed private–public group insurance, an approach that builds on our current system of health insurance with shared responsibility for financing from individuals, employers, and government that minimizes dislocation for the millions of Americans who currently have good coverage. The Commission also believes that reforms to improve quality and efficiency should be pursued at the same time as reforms that provide coverage expansion. In November 2007, we will issue recommendations for moving forward in these areas, with future reports providing specific policy guidance to achieve a high performance health system. It is our hope that these reports will help national and state leaders grappling with these difficult issues and contribute to informed debate and discussion about the future direction of the U.S. health system.

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EXECUTIVE SUMMARY

Presidential candidates, governors, and members of Congress are advancing proposals to address the nation's most important health policy issue: the steady increase in the number of uninsured individuals. This is a welcome development, and augurs well for reversing the steady climb in the numbers of uninsured. Since 2000, the number of uninsured has increased by more than 20 percent, reaching 47 million in 2006. In addition, rising health care costs are squeezing many middle-income Americans with insurance, who report difficulties paying medical bills due to a lack of adequate coverage.

Extending health insurance coverage to all Americans is the most important step in improving access to quality health care. However, there is also an opportunity to achieve this goal in a way that helps the United States achieve a high performance health system that simultaneously yields better access, higher quality, and greater efficiency. This report, prepared for The Commonwealth Fund Commission on a High Performance Health System, investigates the ways in which our current health insurance system fails to promote high performance in the areas of access, equity, quality, efficiency, and cost control. It explains why universal coverage is essential to improving performance measures in each of these core areas. The report also describes the different ways in which policymakers may design universal coverage and how each option will have long-range implications for the system's ability to consistently achieve higher-quality and more efficiently delivered care, as well as its ability to gain control over health care cost growth.

The report presents principles for health insurance reform to help the public assess proposals based not only on their ability to achieve universal coverage, but also on their potential to move the nation's health care system toward high performance. It outlines the questions that all Americans should consider in evaluating the reform proposals suggested by federal and state policy leaders, and it contrasts proposals built around three distinct philosophies:

1. **Tax incentives for individual market insurance.** Proposals that rely primarily on individuals' responsibility for obtaining coverage, with tax incentives to subsidize purchase of insurance in the individual insurance market.
2. **Mixed private–public group insurance with shared responsibility for financing.** Proposals that build on our current mixed private–public system of health insurance with shared responsibility for financing coverage by government, employers, and households.

3. **Public insurance.** Proposals that would cover nearly all Americans under public insurance programs, such as Medicare, with everyone covered through the same public system.

In the Commission's view, both the mixed private–public group insurance and the public insurance reform proposals have the greater potential to move the health care system toward high performance. Both approaches have the potential to provide everyone with comprehensive and affordable health insurance, achieve greater equity in access to care, realize efficiencies and cost savings in the provision of coverage and delivery of care, and redirect incentives to improve quality. From a pragmatic perspective, however, the mixed private–public approach would cause far less dislocation by allowing the more than 160 million people who now have employer-based health coverage to retain it, instead of asking them to enroll in a new program. This approach would build on the best features of our current system while addressing its most serious shortcomings: gaps in coverage and the absence of the incentives, organization, and infrastructure required for a high performance health system.

WHY DOES THE CURRENT HEALTH INSURANCE SYSTEM FAIL TO PROMOTE HIGH PERFORMANCE?

Access to Care Is Unequal. The most important determinant of access to health care is adequate health insurance coverage. People with low and moderate incomes are most at risk of lacking coverage through an employer and most at risk of being uninsured. They also spend the largest share of their incomes on premiums and out-of-pocket health care costs.

Poor Access to Care Is Linked to Poor Quality. People who lack health insurance are much less likely to have a regular source of care, use fewer and less appropriate health services, are less likely to receive timely preventive and screening services, are less likely to receive appropriate care for management of their conditions, and have worse clinical outcomes. People without coverage have both poorer health status and shorter life expectancies.

Care Delivery Is Inefficient. Lacking adequate coverage impedes the delivery of efficient care once a person without coverage enters the health care system. Uninsured adults report the highest rates of test results or records not being available at the time of their appointment, as well as the highest rates of receiving duplicate tests. Physicians also report inefficiencies in securing pharmaceuticals and follow-up medical care for uninsured patients.

A Fragmented Health Insurance System Makes It Difficult to Control Costs.

The U.S. spends a far greater share of its gross domestic product on health care and its citizens spend more out-of-pocket than other industrialized countries, which all have universal health insurance. The highly fragmented way in which we purchase health services in the U.S. allows prices to climb above those in other industrialized nations. In addition, a significant percentage of the cost of health insurance goes toward administrative activities. An estimated 10 percent to 40 percent of premiums is consumed by claims administration, underwriting, marketing, profits, and other administrative costs. Costs of insurance administration are the fastest-growing component of U.S. national health expenditures.

Financing of Care for Uninsured and Underinsured Families Is Inefficient.

The total costs of uncompensated care in the United States were nearly \$41 billion in 2004. This figure would be far higher if uninsured people received as much health care as insured people do. Uninsured adults and children receive just 55 percent of the medical care that those who are insured for the full year receive. Research suggests that private payers finance uncompensated care costs that are not covered by public funds through surcharges to private payers, ultimately resulting in higher private insurance premiums. Estimates of this “hidden tax” range from 8.5 percent of premiums nationally to up to 10.6 percent in California.

Positive Incentives in Benefit Design and Insurance Markets Are Lacking.

Incentives in benefit design and in provider reimbursement are not consistently aligned to encourage the use of effective services, discourage the use of ineffective services, and reduce over-utilization, duplication, and waste. Adverse selection encourages insurance companies to expend considerable resources avoiding health risks in the small group and individual insurance markets.

DESIGN MATTERS: KEY PRINCIPLES TO CONSIDER IN DEVELOPING AND EVALUATING HEALTH REFORM PROPOSALS

Extending health insurance coverage to people who currently lack it is a necessary, but not sufficient, condition for achieving high performance. The way in which a universal coverage system is designed will have a deep impact on its ability to make sustainable and systematic improvements in access to care, equity, quality of care, efficiency, and cost control. With these goals in mind, the following are some key principles policymakers and the public should consider in developing or evaluating health reform proposals:

Access to Care

- Provides equitable and comprehensive insurance for all.
- Insures the population in a way that leads to full and equitable participation.
- Provides a minimum, standard benefit floor for essential coverage with financial protection.
- Premiums, deductibles, and out-of-pocket costs are affordable relative to family income.
- Coverage is automatic and stable with seamless transitions to maintain enrollment.
- Provides a choice of health plans or care systems.

Quality, Efficiency, and Cost Control

- Health risks are pooled across broad groups and over lifespans; insurance practices designed to avoid poor health risks are eliminated.
- Fosters efficiency by reducing complexity for patients and providers, and reducing transaction and administrative costs as a share of premiums.
- Works to improve health care quality and efficiency through administrative reforms, provider profiling and network design, utilization management, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.
- Minimizes dislocation; people can maintain current coverage if desired.
- Simple to administer.
- Has the potential to lower overall health care cost growth.

Financing

- Financial commitment to achieve these principles.
- Financing should be adequate and fair, based on ability to pay, and is a shared responsibility of federal and state governments, employers, individual households, and other stakeholders.

CURRENT PROPOSALS FOR HEALTH INSURANCE REFORM

Current proposals to reform the health insurance system include: strategies that emphasize tax incentives for obtaining insurance through the individual market; proposals that build on existing private–public group insurance with a shared responsibility for financing coverage; and proposals to cover everyone through public forms of insurance, like Medicare.

Tax Incentives for Individual Market Insurance. Proposals by President George W. Bush, former New York City mayor Rudy Giuliani, Senator John McCain (R–Ariz.), and former Massachusetts governor Mitt Romney would create tax incentives for people to gain coverage through the individual insurance market.

Mixed Private–Public Group Insurance with Shared Responsibility for Financing. The state of Massachusetts, Governor Arnold Schwarzenegger of California, and five Democratic presidential candidates (Senators Hillary Clinton (D–N.Y.), Christopher Dodd (D–Conn.), and Barack Obama (D–Ill.), former North Carolina Senator John Edwards (D–N.C.) and New Mexico Governor Bill Richardson) have either proposed plans or passed laws—in the case of Massachusetts—for universal coverage that maintain and build on the current mixed private and public insurance system. Most include requirements for individuals to purchase coverage and for employers to offer or help pay for coverage, expansions in Medicaid and State Children’s Health Insurance Program (SCHIP), and new group insurance options with financial support for premiums and out-of-pocket expenses for lower- and middle-income households.

Public Insurance. Representative Pete Stark (D–Calif.), Senator Edward Kennedy (D–Mass.), Representative John Dingell, (D–Mich.), Representative John Conyers (D–Mich.), and Representative (and presidential candidate) Dennis Kucinich (D–Ohio) have proposed universal coverage plans in which Medicare or a new government plan plays a central role.

WHICH STRATEGIES HAVE THE GREATEST PROMISE TO MOVE THE SYSTEM TO HIGH PERFORMANCE?

Assessing the health insurance reform proposals against the key principles described earlier helps to illustrate each proposal’s strengths and weaknesses (Figure ES-1). The proposals, which reflect different philosophical strategies and values, use a range of mechanisms to address health system issues of inadequate access to care, variable quality, and high cost. Design features of the three different approaches have significant implications for each of these issues, including the number of people covered, the cost to stakeholders and the overall health system, equity in access and financing, and improvements in efficiency and quality. Raising the right questions and weighing the evidence will help shape consensus.

Figure ES-1. How Well Do Different Strategies Meet Principles for Health Insurance Reform?

Principles for Reform	Tax Incentives and Individual Insurance Markets	Mixed Private–Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum Standard Benefit Floor	–	+	+
Premium/Deductible/Out-of-Pocket Costs Affordable Relative to Income	–	+	+
Easy, Seamless Enrollment	0	+	++
Choice	+	+	+
Pool Health Care Risks Broadly	–	+	++
Minimize Dislocation, Ability to Keep Current Coverage	+	++	–
Administratively Simple	–	+	++
Work to Improve Health Care Quality and Efficiency	0	+	+

0 = Minimal or no change from current system; – = Worse than current system;
 + = Better than current system; ++ = Much better than current system

Tax Incentives for Individual Market Insurance

Reform proposals that rely on tax incentives and voluntary purchase of coverage in the individual insurance market are, on their own, unlikely to achieve universal coverage (Figure ES-1). Buying coverage in the individual market will continue to be challenging if tax incentives are not coupled with an individual mandate, minimum benefit standards, regulations against risk selection, and premium and out-of-pocket spending limits as a share of income. Providing incentives for coverage in the individual market without an individual mandate or regulations against risk selection would not pool risks. Insurers would still write individual policies rather than policies for a broad group of people. With administrative costs in the individual market running from 25 percent to 40 percent of premium dollars compared with 10 percent in employer group markets and 2 percent in Medicare, covering more people through this market would only fuel growth in annual administration costs.

Supporters of these proposals argue that consumers spending their own money on health insurance and health care would be more cost-conscious, seek out lower cost providers, and avoid marginal or unnecessary care. These proposals would allow substantial choice of covered benefits and financial protection within the limits of people’s budgets. However, they could limit options and increase costs for those with health risks, depending on existing consumer protections, which vary by state. People with preexisting conditions might face very high premiums, might be unable to get their health needs

covered, or might not be offered a policy at all. If designed to avoid undermining employer-based coverage, the proposals would cause minimal dislocation with the ability to maintain current health insurance coverage.

These proposals would do little to alter incentives to improve health care quality and efficiency. From a financing perspective, the lack of risk pooling and higher administrative costs would inflate the size of tax credits necessary for making premiums affordable for lower-income people.

Mixed Private–Public Group Insurance with a Shared Responsibility for Financing

Most proposals that build on the current system would ensure universal coverage by requiring that all individuals purchase coverage and that employers either provide coverage to employees or contribute to premiums. Such mandates would be critical to ensure everyone is covered (Figure ES-1). Most proposals would also create new group insurance options, sometimes referred to as “exchanges” or “connectors” for people without access to employer coverage and for small businesses. These new health insurance exchanges would allow consumers a choice of private and public plans. Offering a public plan option like Medicare in these new health insurance exchanges would give individuals and businesses the ability to choose between private and public health plans. Most proposals specify a minimum standard benefit package for plans offered by employers and through the health insurance exchange.

Affordability of coverage would be assured through expansion of Medicaid and SCHIP for lower-income families and provision of premium assistance for lower- and middle-income people buying coverage in the new health insurance exchange. However, it is important that potential out-of-pocket costs also be taken into consideration when defining affordability under a mandate.

By building on multiple forms of existing group coverage and adding a new group insurance option, these proposals, on their own, would not make enrollment easier or more seamless. They would also retain much of the complexity of the current system. Automatically enrolling people through the tax system under an individual mandate would help ensure that people become and remain enrolled. The income tax system can also provide an administrative mechanism for income-related premium assistance and ceilings on out-of-pocket costs as a percentage of income.

These approaches would pool risk by building on the large risk pools of the employer market and public programs and create new health insurance exchanges with regulations against risk selection. The actual design of the new health insurance exchanges

will be important, however, with respect to the restrictions against risk selection, the type of plans available for consumers, the extent of income-related subsidies and whether both out-of-pocket costs and premiums are taken into consideration when determining the amount a family pays.

By building on the current system, these proposals would cause minimal dislocation. People could keep their employer coverage as long as it met minimum benefit and affordability standards. By replacing small group or individual market coverage with coverage through health insurance exchanges or public programs, administrative savings could be achieved. If Medicare, Medicaid/SCHIP, and employer coverage were redesigned to reward health care providers for higher quality or more efficient care, even further savings are possible. Success will depend on effective national leadership, collaboration between the public and private sectors, and the creation of the information and infrastructure including information technology.

Financing would be a mix of federal and state general revenue taxation, employer and individual premium contributions, and modest cost-sharing. Subsidies for low-income families would offset all or part of their premium and out-of-pocket costs; broad risk pooling would help keep the size of subsidies low. The financial distribution of costs is likely to be closely proportional to earnings, and more progressively shared than financing under most approaches that provide tax incentives for coverage through the individual market. Some proposals would fund the federal portion of costs by repealing or not renewing tax cuts for higher-income households, thereby increasing the progressive nature of the overall financing.

Public Insurance

Public insurance programs offer the greatest potential for automatic and continuous enrollment and the ability to cover everyone (Figure ES-1). Enrollment could be facilitated through local Medicare or Social Security offices. Those failing to enroll could be signed up when they seek health care services or coverage could be verified as part of income tax filing. With everyone eventually enrolled at birth in an expanded Medicare, people would automatically be enrolled and stay enrolled across their lifespans. Most proposals would establish a minimum standard benefit package modeled on the typical plan offered to members of Congress or to employees of large firms. For those proposals requiring enrollees to pay cost-sharing or a portion of premiums, a ceiling on out-of-pocket costs and premiums as a percentage of income would be established to ensure affordability. Some proposals modeled, for example, on the Canadian health system would not include patient cost-sharing for basic services and would be financed by federal and state taxes.

Given Medicare's low administrative costs and broad risk pooling, substantial savings could accrue in an expanded Medicare approach through a reduction in administrative costs. Other sources of savings would likely arise from paying providers Medicare rates that are lower, on average, than private rates.

The proposals modeled on the current Medicare program would provide choice of plans, including the private plan options currently available to Medicare beneficiaries and the program's self-insured plan.

The public insurance approaches to health insurance reform would create dislocation, with people moving from their current coverage to coverage through Medicare or another public plan. However, people would still likely keep their same set of providers. Proposals that would allow employers to continue offering coverage would be less disruptive initially, although it is anticipated that most employers would ultimately prefer to pay a part of the Medicare premium rather than private coverage premiums, which would probably be higher.

These proposals would allow the nation to develop and utilize common quality metrics, gather data on the health care outcomes of the full population, and evaluate and improve the performance of providers based on a large pool of patients not fragmented by insurance type. They also would allow for the creation of uniform provider payment systems that reward high-quality care, standardization in health information technology, and the creation of universal processes to improve safety systematically across health care institutions.

Financing is likely to come largely from federal income and payroll taxes or new taxes, such as a value-added tax or consumption tax. This would be less administratively complex than providing premium subsidies based on income. The distribution of financing is most likely to be more progressively related to income than either individual insurance market or mixed private-public group insurance proposals.

CONCLUSION

Ultimately, we must move the health care system to high performance using goals and properly aligned incentives that orient all participants in the same direction: toward improved access, quality, equity, and efficiency. The most important feature of any health insurance reform proposal is whether it can succeed in providing health insurance and access to care to all. In addition, proposals should be examined for their ability to produce better access, higher quality, and greater efficiency. Whenever possible, we must seek

synergy between coverage expansion and reform that will move the U.S. to a high performance health system.

Achieving universal coverage will require engaging everyone in a debate on values, our commitment to a healthy and productive life for all, and the merits of different strategies for achieving improved coverage and better performance from our health system. This guide is offered to both underscore the importance of such reforms and to help shape the debate and emerging consensus on future directions for the U.S.

Serious reform will require broad consensus and a significant financial investment by federal and state governments, employers, households, and other stakeholders. A shared responsibility among all stakeholders will be needed to achieve the goals of reform in a way that is effective and fair.

A ROADMAP TO HEALTH INSURANCE FOR ALL: PRINCIPLES FOR REFORM

INTRODUCTION

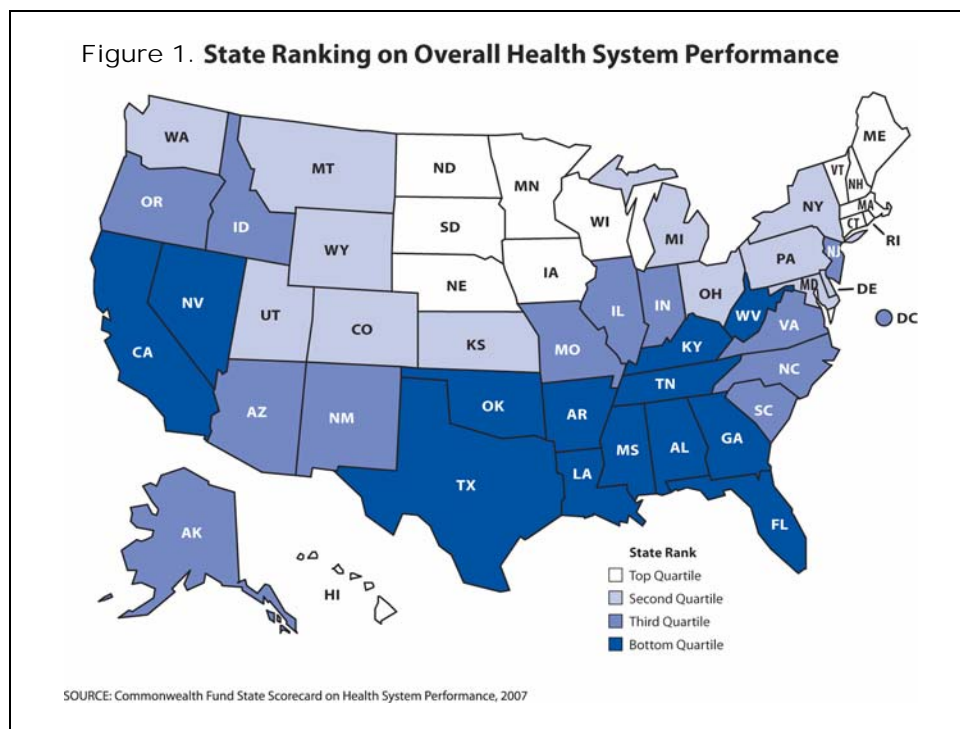
It is well-documented that the U.S. health care system performs poorly relative to other industrialized nations, as well as relative to achievable benchmarks for health outcomes, quality, access, efficiency, and equity. In addition, geographic location within the United States plays a role in terms of an individual's access to care, quality of care, and opportunity to lead a healthy life. A major culprit in this inconsistent performance is our system's failure to provide health insurance to 47 million people and adequate coverage for 16 million more. Universal coverage is essential to placing the health care system on a path to high performance. The way in which a universal coverage system is designed will be critical to the health care system's ability to make sustainable and systematic improvements on key performance measures.

This report, prepared for The Commonwealth Fund Commission on a High Performance Health System, investigates the ways in which the current health insurance system fails to promote high performance in the areas of access, equity, quality, efficiency, and cost control, and explains why universal coverage is essential to improving performance in each of those areas. The report also describes the ways in which policymakers may design universal coverage and how each option will have long-range implications for the system's ability to consistently achieve higher-quality and more efficiently delivered care, and its ability to gain control over health care cost growth. Finally, this report proposes a set of principles for health insurance reform to help policymakers craft proposals that not only hold promise in achieving universal coverage, but also have the potential to place the nation's health care system on a path to high performance.

WHY DOES THE CURRENT HEALTH INSURANCE SYSTEM FAIL TO PROMOTE HIGH PERFORMANCE?

The Commonwealth Fund Commission on a High Performance Health System's National Scorecard on U.S. Health System Performance finds that the U.S. health system falls far short of achievable benchmarks for health outcomes, quality, access, efficiency, and equity.¹ Out of a possible 100 points—based mostly on benchmarks that have been achieved within the United States or other countries—the U.S. received a score of 66, or one-third below benchmark levels of performance. The U.S. ranks at the bottom of industrialized countries on healthy life expectancy at birth or at age 60. In addition, out of 23 countries, the U.S. ranked last on infant mortality, with a rate of seven infant deaths per 1,000 births, more than double the rates of the top three countries.

Health system performance also varies dramatically within the U.S. The Commission’s State Scorecard on Health System Performance found substantial state-by-state variation on 32 measures of performance in five broad dimensions: access to care, quality of care, avoidable hospital use and costs, equity, and healthy lives.² States in the Northeast and upper Midwest rank high on many of these measures; states with the lowest rankings tend to be concentrated in the South (Figure 1). For example, the Scorecard finds a twofold difference across states in the rate of death amenable to health care (that is, deaths before age 75 that are potentially preventable with timely, effective care). If all states reduced their rates of avoidable death to that of the highest performing state (Minnesota with 70.2 deaths per 100,000), we could avoid an estimated 90,000 premature deaths each year.

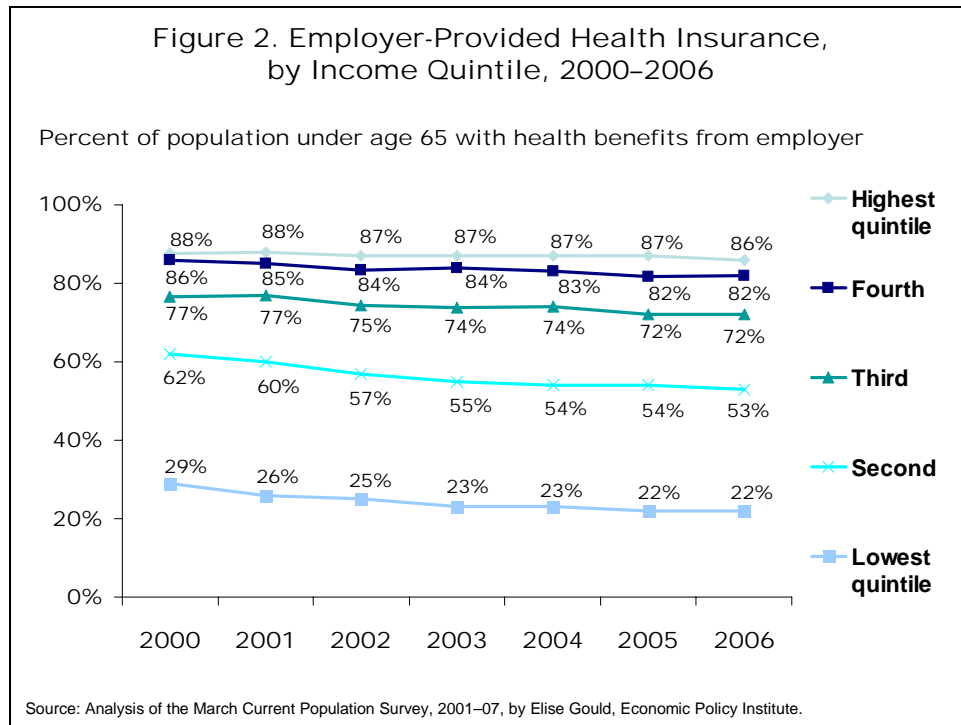


ACCESS TO CARE IS UNEQUAL

Access to care is a crucial component of high-performing health systems. In a literature review conducted in 2003 on the consequences of being uninsured, the Institute of Medicine (IOM) concluded that the most important determinant of access to health care is adequate health insurance coverage.³

Though employer coverage remains the predominant form of health insurance coverage for U.S. workers and their families, rising premiums have weakened the ability of some firms to offer comprehensive coverage and led many to share more of their costs with employees in the form of higher deductibles and other cost-sharing measures. In

2006, 47 million people were uninsured, an increase of 8.6 million from 2000.⁴ People with low and moderate incomes are most at risk of lacking coverage through an employer and are the most at risk of being uninsured. Only 22 percent of adults under age 65 in families with incomes of \$20,000 or less had coverage through an employer in 2006, down from 29 percent in 2000. Employer-based coverage in the next-higher income category—under \$37,800 annually—declined from 62 percent in 2000 to 53 percent in 2006 (Figure 2).



Although the individual insurance market provides coverage to approximately 16 million adults and children or about 6 percent of the under-65 population, numerous studies have found that the individual insurance market presents challenges for families seeking coverage due to high premiums and the difficulty of gaining coverage when individuals have preexisting health problems.⁵ Of 58 million adults under age 65 who sought coverage in the individual insurance market in the last three years, 90 percent never purchased a plan.⁶ Although increasing numbers of adults have lost access to employer-based coverage over the past five years, there has been virtually no change in the number of people covered by individual market insurance. Loss of employer coverage has led to higher levels of uninsured individuals, not to higher levels of individual coverage.⁷

If not for state expansions in eligibility in Medicaid and the State Children’s Health Insurance Program (SCHIP) over the last decade, this trend would have extended to

children also. The State Scorecard found that the number of states where 16 percent or more of children under age 18 were uninsured fell from nine in 1999–2000 to five in 2005–2006 (Figure 3). In contrast, the number of states where 23 percent or more of the adult population under age 65 was uninsured jumped from two in 1999–2000 to nine in 2005–2006 (Figure 4).⁸ Coverage eligibility for parents and adults without children in Medicaid and SCHIP varies greatly across states: 14 states cover parents with incomes up to 50 percent of poverty, approximately equivalent to an annual income of just over \$10,000 for a family of four.⁹ Thirty-four states provide no Medicaid coverage at all for adults who do not have children.

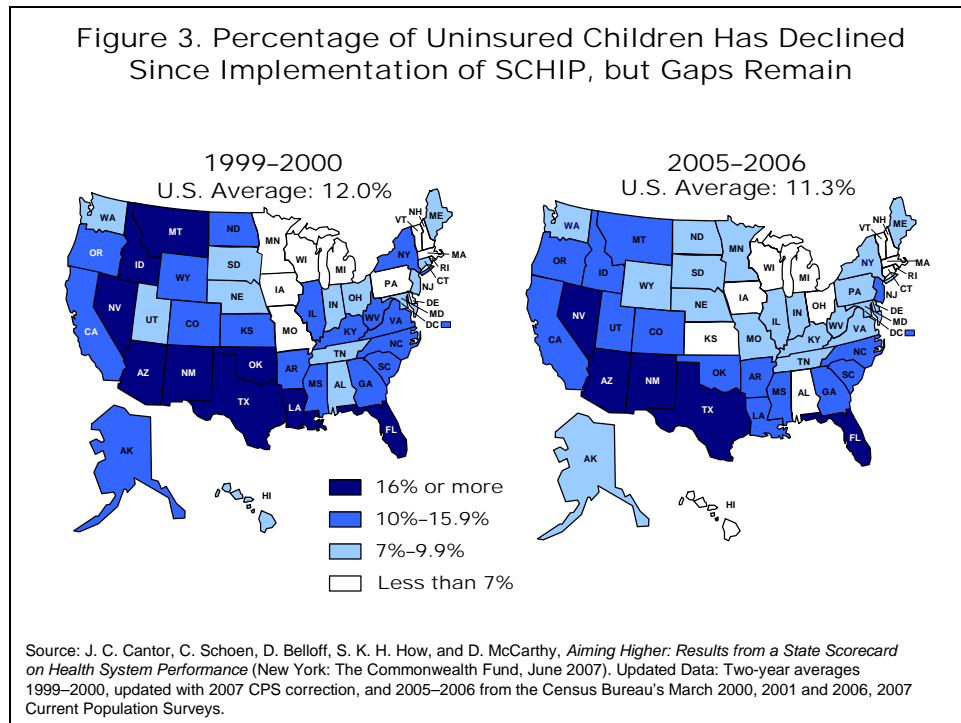
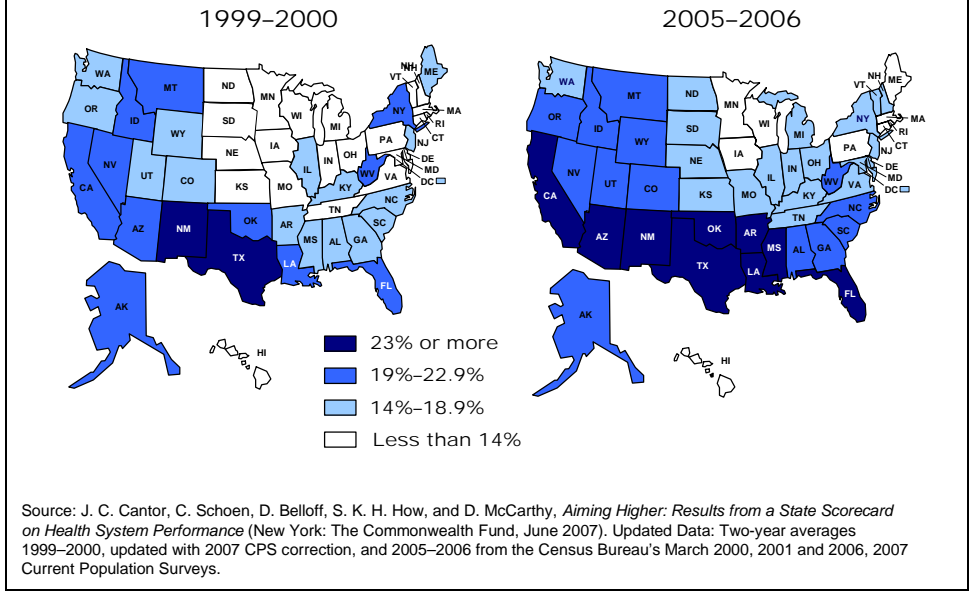


Figure 4. Uninsured Nonelderly Adult Rate Has Increased from 17.3 Percent to 20.0 Percent in Last Five Years

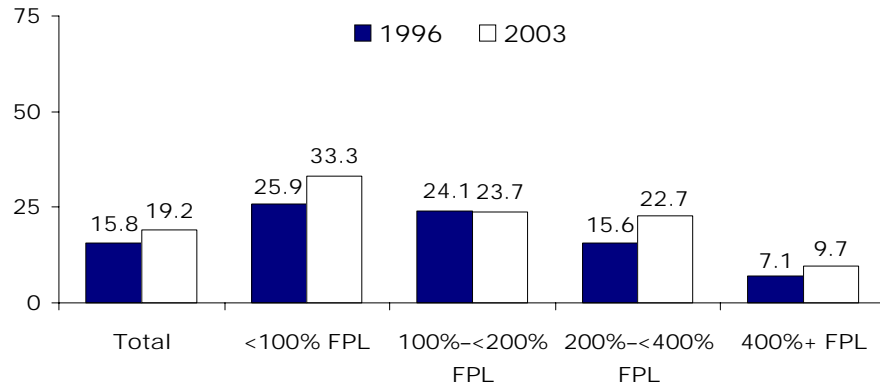


Source: J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007). Updated Data: Two-year averages 1999-2000, updated with 2007 CPS correction, and 2005-2006 from the Census Bureau's March 2000, 2001 and 2006, 2007 Current Population Surveys.

The effect of rising cost-sharing on families has become apparent during a period in which incomes grew at a much slower rate than did health care costs. Between 1996 and 2003, the share of families spending more than 10 percent of their disposable income on premiums and out-of-pocket health care costs climbed from 15.8 percent to 19.2 percent (Figure 5).¹⁰ Those in low- and moderate-income families were the most affected: one-third of families with incomes under 100 percent of poverty spent more than 10 percent of their disposable income on premiums and out-of-pocket costs, up from 26 percent in 1996. Using a measure of underinsurance that defines inadequate coverage as having out-of-pocket medical expenses that exceed 10 percent of family income (5 percent for those with incomes under 200 percent of poverty) or having deductibles of 5 percent or more of income, Schoen and colleagues estimate that 16 million adults under age 65 were effectively underinsured in 2003.¹¹

Figure 5. Prevalence of High Family Out-of-Pocket Cost Burdens by Poverty Status Among the Nonelderly Population, 1996 and 2003

Percent of nonelderly adults who spend >10% of disposable household income on out-of-pocket premiums and expenditures on health care services



Source: J. S. Banthin and D. M. Bernard, "Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003," *Journal of the American Medical Association*, Dec. 13, 2006 296(22):2712-19.

POOR ACCESS TO CARE IS LINKED TO POOR QUALITY CARE

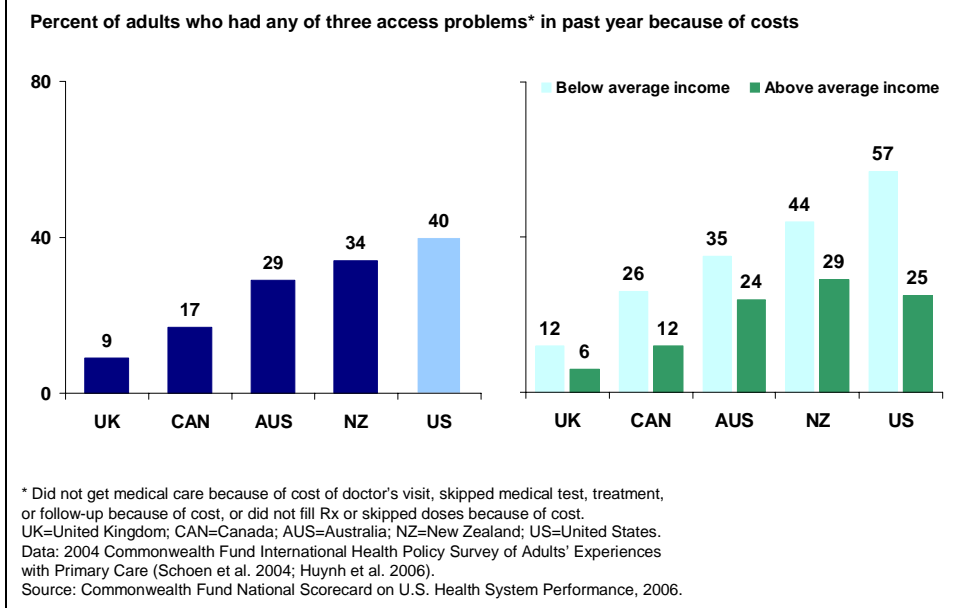
According to the IOM's 2003 study on the importance of health insurance, people who lack health insurance have fundamentally different life experiences than do those who are insured.¹² For instance, they are much less likely to have a regular source of care and use fewer health services and less appropriate services for their particular conditions. They are less likely than adults with any type of health insurance to receive timely preventive and screening services. In five chronic disease categories that the IOM studied, uninsured adults were less likely to receive appropriate care for management of their conditions and had worse clinical outcomes than insured adults with chronic illness.¹³ What are the consequences of such poor quality care? People without coverage have both poorer health status and shorter life expectancies. The IOM estimates that 18,000 avoidable deaths occur each year in the U.S. as a direct result of individuals being uninsured. In a review of the literature in 2003, Hadley concluded that lacking health insurance negatively affects health, reduces labor force participation, and lowers incomes.¹⁴ He estimated that up to 17,200 preventable deaths occur each year as a result of being uninsured.

In an extensive analysis performed for the IOM, Vigdor estimated the personal economic loss of diminished health and longevity in the U.S. as a result of lack of coverage.¹⁵ Using information on the longevity, prevalence of health conditions, and health-related quality of life of uninsured people, Vigdor estimated that the lost "health capital" of going without coverage ranges between \$1,645 and \$3,280 for each additional

year without health insurance. Based on this estimate, the IOM projected that the aggregate, annualized cost of uninsured people's lost capital and earnings from poor health and shorter lifespans falls between \$65 billion and \$130 billion for each year without coverage. Considered another way, the nation stands to gain \$65 billion to \$130 billion in potential economic value if it provided insurance coverage to the approximately 40 million uninsured people at the time of the IOM study.

Since the time of the IOM and Hadley studies, evidence linking lack of insurance with poor quality care has continued to mount. In a survey of five countries, Schoen and colleagues found that the U.S. had the highest share of adults reporting cost-related problems accessing needed health care (Figure 6). In 2004, 40 percent of U.S. adults and 57 percent of adults with below-average incomes reported they went without care during the year because of cost—four times higher than in the United Kingdom, a country with universal health insurance coverage and other protective policies.¹⁶ In 2005, more than one-quarter (26%) of U.S. adults and more than one-third (36%) of uninsured U.S. adults went to an emergency room for a condition that could have been treated by a regular doctor. This is two and three times the rate reported by British respondents (12%) and four and six times the rate reported by Germans (6%). In three nationally representative telephone surveys of U.S. adults conducted in 2001, 2003, and 2005, the Commonwealth Fund found that people who spend anytime without coverage over a 12-month period report significantly higher rates of cost-related access problems.¹⁷ Using data from the Commonwealth Fund 2006 Quality of Care Survey, Beal and colleagues found that adults who spent any time uninsured in the prior year were significantly less likely to have a regular doctor or medical home—defined as having a regular doctor or nurse from whom they receive accessible and coordinated care—and significantly less likely to say that they always or often receive the health care they need when they need it.¹⁸

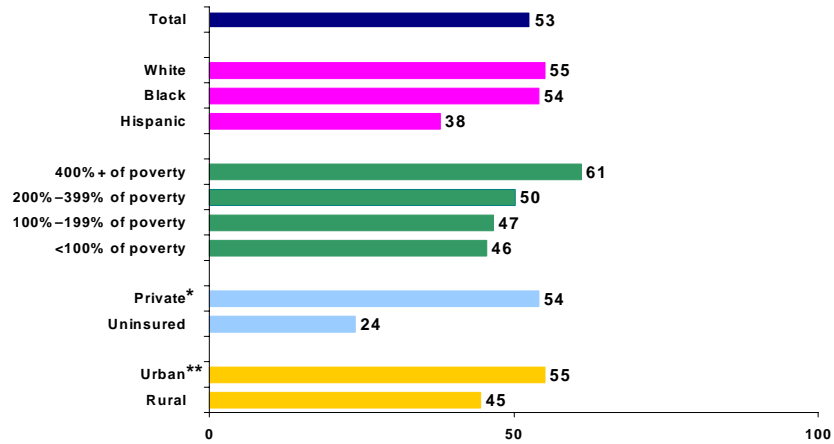
Figure 6. Access Problems Because of Costs in Five Countries, Total and by Income, 2004



Poor quality health care is particularly devastating and can have long-term implications for uninsured adults with chronic health problems. In a recent article in the *Journal of the American Medical Association*, Hadley found that uninsured patients who experienced an injury or were newly diagnosed with a chronic health condition received less medical care, were more likely to report not being fully recovered but no longer receiving care, and were more likely to report lower health status seven months after the event than were insured patients who experienced a similar medical event.¹⁹ The National Scorecard found that only one-quarter (24%) of uninsured adults with diabetes had received all three recommended services for diabetes in the last year (i.e., HbA1c test, retinal exam, and foot exam), less than half the rate of privately insured adults with diabetes (54%) (Figure 7). Collins and colleagues found that nearly 60 percent of nonelderly adults with a chronic health condition who had been uninsured for some time in 2005 did not fill a prescription or skipped a dose of their medication for their condition because of cost, compared with 18 percent of those who had coverage all year (Figure 8).²⁰ The authors also found that more than one-third (35%) of uninsured adults with a chronic condition went to an emergency room or stayed overnight in a hospital for their condition, compared with 16 percent of those who were insured all year.

Figure 7. Receipt of All Three Recommended Services for Diabetics, by Race/Ethnicity, Family Income, Insurance, and Residence, 2002

Percent of diabetics (ages 18+) who received HbA1c test, retinal exam, and foot exam in past year



* Insurance for people ages 18–64.

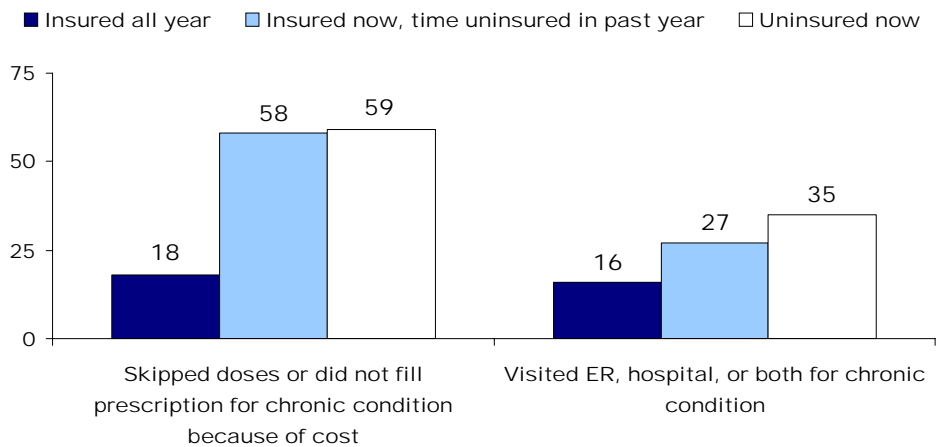
** Urban refers to metropolitan area ≥ 1 million inhabitants; Rural refers to noncore area $< 10,000$ inhabitants.

Data: 2002 Medical Expenditure Panel Survey (AHRQ 2005a).

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 8. Adults Without Insurance Are Less Likely to Be Able to Manage Chronic Conditions

Percent of adults ages 19–64 with at least one chronic condition*



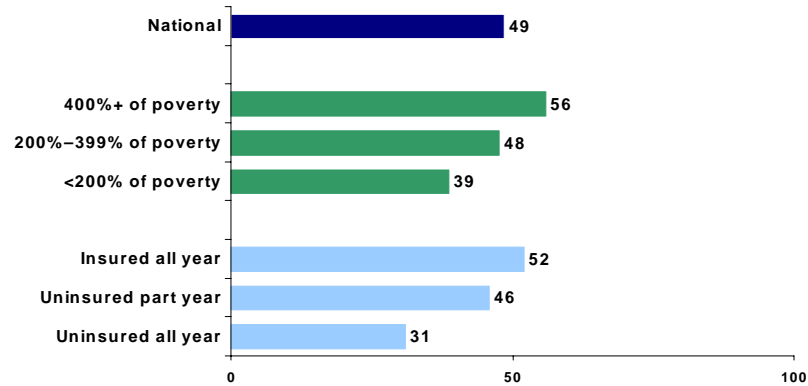
* Hypertension, high blood pressure, or stroke; heart attack or heart disease; diabetes; asthma, emphysema, or lung disease.

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Apr. 2006).

The proportion of adults and children who receive recommended screening tests and preventive care is quite low overall, with rates particularly low among those lacking insurance coverage. The National Scorecard found that just 31 percent of adults who were uninsured all year received recommended screening tests and preventive care appropriate to their age and gender, compared with more than half of adults with coverage all year (Figure 9). One-third (35%) of uninsured children received both a medical and a dental preventive care visit in the last year, compared with 63 percent of insured children (Figure 10). Similarly, fewer than one-quarter (23%) of uninsured children have a medical home compared with more than half (53%) of privately insured children (Figure 11).

Figure 9. Receipt of Recommended Screening and Preventive Care for Adults, by Family Income and Insurance Status, 2002

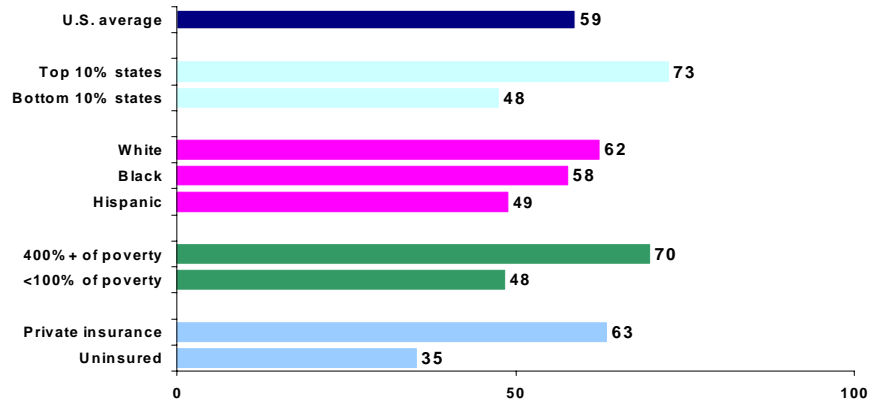
Percent of adults (ages 18+) who received all recommended screening and preventive care within a specific time frame given their age and sex*



* Recommended care includes seven key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot. Data: B. Mahato, Columbia University analysis of 2002 Medical Expenditure Panel Survey. Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

Figure 10. Preventive Care Visits for Children, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

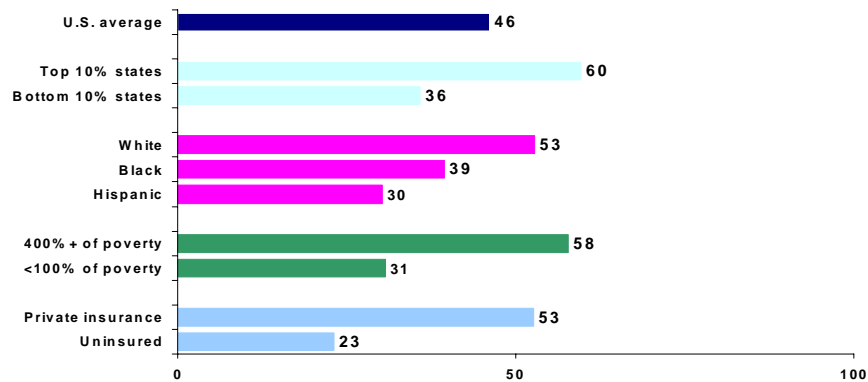
Percent of children (ages <18) received BOTH a medical and dental preventive care visit in past year



Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at <http://www.nschdata.org>).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

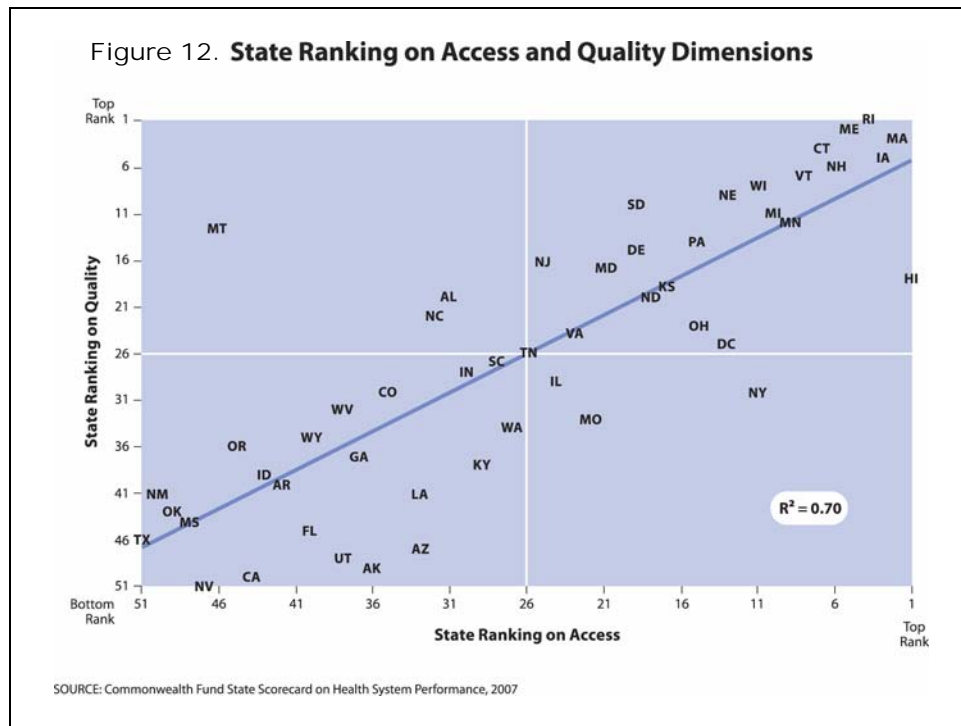
Figure 11. Children with a Medical Home, by Top and Bottom States, Race/Ethnicity, Family Income, and Insurance, 2003

Percent of children who have a personal doctor or nurse and receive care that is accessible, comprehensive, culturally sensitive, and coordinated*

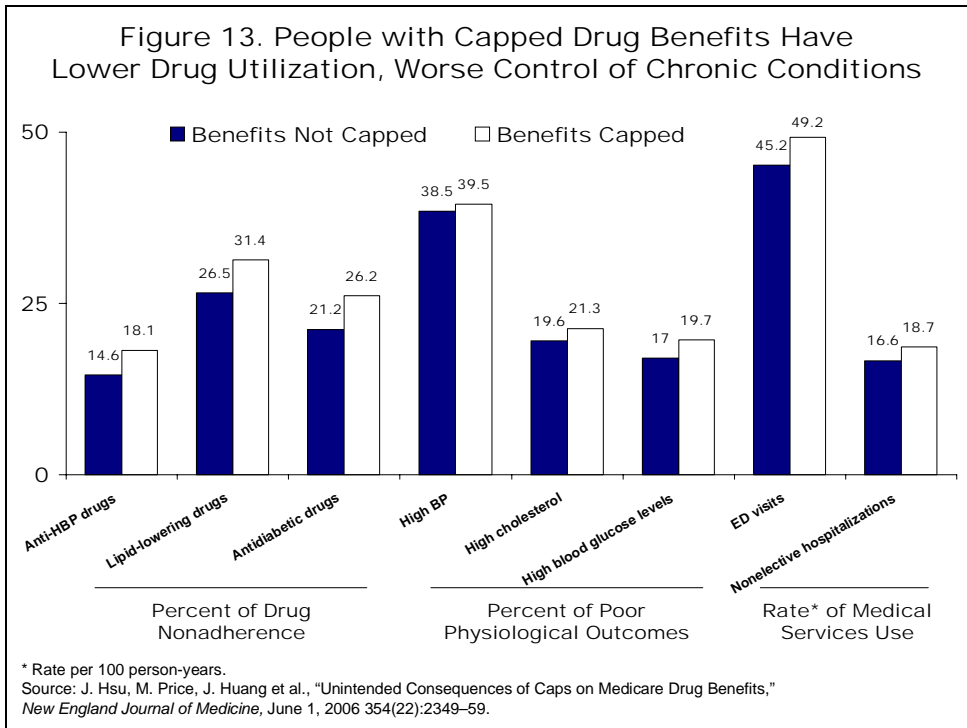


* Child had 1+ preventive visit in past year; access to specialty care; personal doctor/nurse who usually/always spent enough time and communicated clearly, provided telephone advice or urgent care and followed up after the child's specialty care visits.
Data: 2003 National Survey of Children's Health (HRSA 2005; retrieved from Data Resource Center for Child and Adolescent Health database at <http://www.nschdata.org>).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

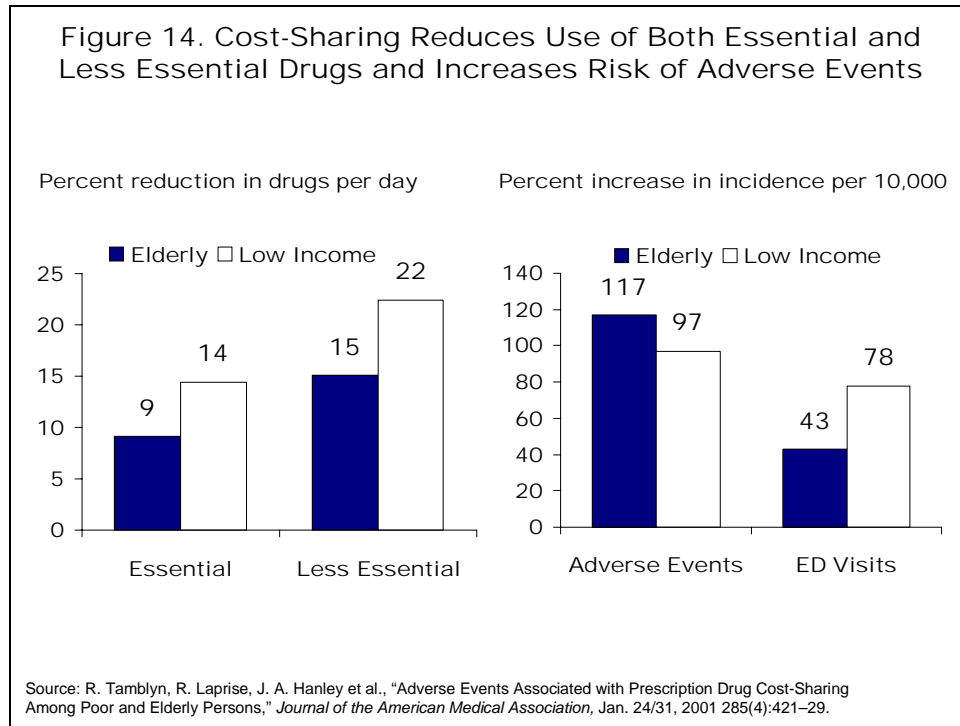
The State Scorecard finds that across states, better access to care and higher rates of insurance are closely associated with better quality (Figure 12).²¹ States with the lowest rates of uninsured residents tend to score highest on measures of preventive and chronic disease care, as well as other quality indicators. Four of the five states with the best access-to-care rankings (Massachusetts, Iowa, Rhode Island, and Maine) also rank among the highest on quality of care. States with low-quality rankings tend to have high rates of uninsured residents. Indeed, the five top-ranked states overall (Hawaii, Iowa, New Hampshire, Vermont, and Maine) all have high rates of insurance coverage, with nearly 90 percent of working-age adults insured. In contrast, in the five lowest-ranked states (Nevada, Arkansas, Texas, Mississippi, and Oklahoma), the share of insured adults ranges between 70 percent and 78 percent.



There is considerable evidence that high out-of-pocket costs lead insured patients to go without needed health care. The RAND Health Insurance Experiment found that greater cost-sharing reduced the use of both essential and less-essential health care.²² A study of Medicare beneficiaries by John Hsu and colleagues found that people with capped drug benefits had lower drug utilization than those without capped benefits; consequences included poorer adherence to drug therapy and worse control of blood pressure, lipid levels, and glucose levels (Figure 13).²³ Moreover, cost savings from the cap were offset by increases in the costs of hospitalization and emergency room use.



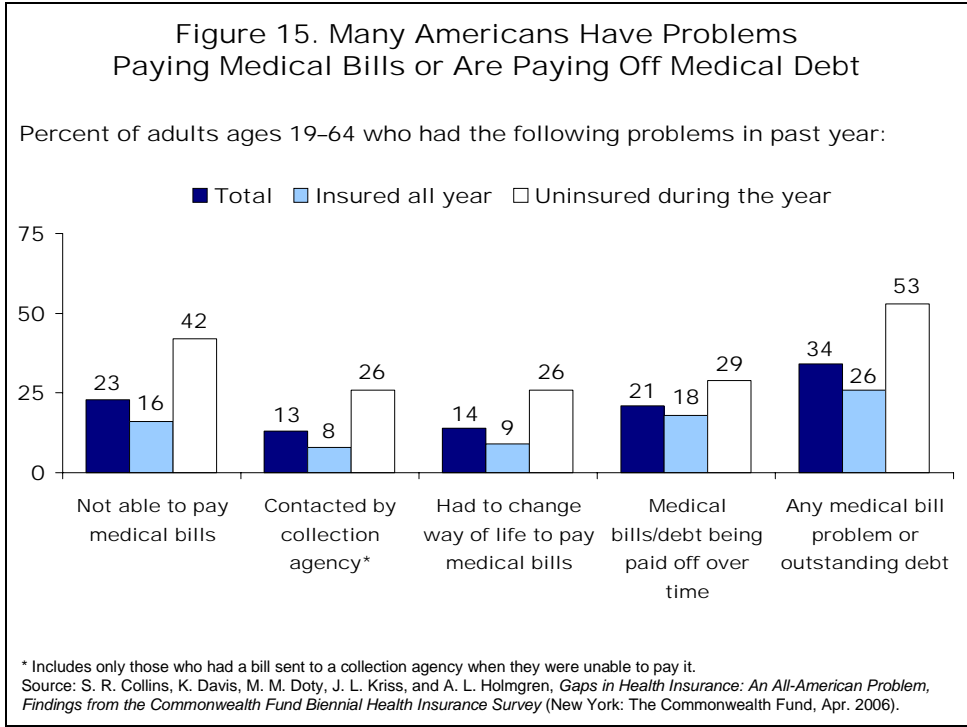
Similarly, a study by Tamblyn and colleagues found that increased cost-sharing reduced the use of both essential and nonessential drugs among elderly and poor patients, and it increased the risk of adverse health events like hospitalizations and admissions to the emergency room (Figure 14).²⁴ In two consecutive annual surveys of people in consumer-directed health plans, Fronstin and Collins found that adults in health plans with greater than \$1,000 deductibles were more likely to report avoiding or delaying needed health care or not filling a prescription because of cost than were those in health plans with lower or no deductibles.²⁵ A review by Rice and Matsuoka of more than 20 studies examining the impact of cost-sharing on health care use and the health status of people age 65 and older found that increases in cost-sharing nearly always reduced the health care use and/or the health status of this population.²⁶ Finally, research by Schoen and colleagues, using data from the Commonwealth Fund Biennial Health Insurance Survey, revealed that insured people with out-of-pocket costs high relative to income were nearly as likely to report not accessing needed health care because of costs as were people without any coverage at all.²⁷



Hurley and colleagues suggest that persistent differences in the comprehensiveness of coverage across the United States are creating a multitiered system of access in which families with the best benefits have financial access to the latest technologies and state-of-the-art facilities, while those with less comprehensive coverage or with coverage characterized by low provider reimbursement rates have far less access to emerging treatments and new facilities.²⁸

Being uninsured or underinsured can have minor to catastrophic financial consequences for families. In recent years, hospitals have become increasingly aggressive in obtaining payment from uninsured patients, charging self-pay patients much higher rates than those negotiated by private insurers. In 2004, Anderson found that hospitals charged self-pay patients rates that were often 2.5 times those paid by most insurers and greater than three times hospitals' Medicare-allowable costs.²⁹

Using the Commonwealth Fund Biennial Health Insurance Survey, Collins and colleagues found that more than half of working-age adults who had been uninsured during 2005 reported problems with medical bills during that time or were paying off accrued medical debt (Figure 15).³⁰ They also found high rates of medical bill problems among those with coverage. About one-quarter (26%) of privately insured adults either had a problem paying a medical bill in the past 12 months or were paying off accrued medical debt.³¹ Those with annual deductibles of \$1,000 or higher were particularly affected by bills and debt: more than two of five (41%) reported bill problems or accrued debt.³²



Confronted with medical bills and debt, many people are forced to make trade-offs between spending and saving priorities. In the Commonwealth Fund survey, 40 percent of uninsured adults with medical bill problems were unable to pay for basic necessities like food, heat, or rent, and nearly 50 percent had used all their savings to pay their bills (Figure 16).³³ People with insurance coverage are also feeling the pinch, with growing implications for their savings. The Employee Benefit Research Institute found that the share of insured adults who reported reducing their retirement contributions as a result of higher health care spending climbed from 26 percent in 2005 to 36 percent in 2006 (Figure 17).³⁴ More than half (53%) reported they had decreased contributions to other saving accounts, up from 45 percent in 2005.

Figure 16. One-Quarter of Adults with Medical Bill Burdens and Debt Were Unable to Pay for Basic Necessities

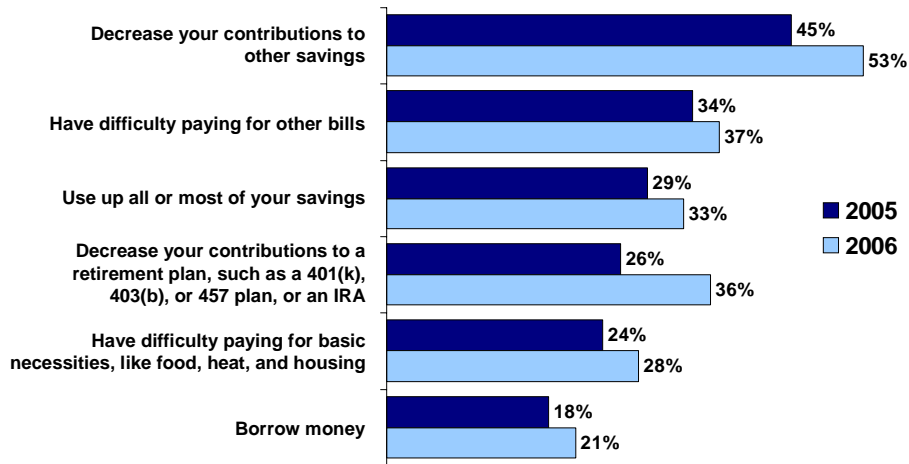
Percent of adults ages 19–64 with medical bill problems or accrued medical debt

Percent of adults reporting:	Total	Insured all year	Insured now, time uninsured during year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	26%	19%	28%	40%
Used up all of savings	39	33	42	49
Took out a mortgage against home or took out a loan	11	10	12	11
Took on credit card debt	26	27	31	23

Source: S. R. Collins, K. Davis, M. M. Doty, J. L. Kriss, and A. L. Holmgren, *Gaps in Health Insurance: An All-American Problem, Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, Apr. 2006).

Figure 17. Increased Health Care Costs Associated with Reduced Savings

Has increased spending on health care expenses in the past year caused you to do any of the following? Among those with health insurance coverage who had increases in health care costs in the last year (percentage saying “yes”)



Source: EBRI Health Confidence Survey, 2005 and 2006.

CARE DELIVERY IS INEFFICIENT

Not only does lacking adequate coverage increase the potential for costly care down the road, it also impedes the delivery of efficient care once a person without coverage enters the health care system. This problem is not limited to individuals without insurance coverage. People with and without health insurance may see multiple physicians in multiple institutions and face the inherent difficulties of transferring information and medical records among the providers involved.³⁵ Breakdowns in the coordination of care can lead to inefficient care, such as the duplication of tests when records become lost. Having gaps in health insurance coverage can exacerbate such coordination problems, particularly when individuals have multiple chronic conditions. The U.S. scores poorly on care coordination compared with other countries. The National Scorecard found that among adults in poor health, the U.S. had the highest rates of test results or records not being available at the time of their appointment in the last two years, and the second-highest rates of receiving a duplicate test.³⁶ On both measures, people without insurance reported the highest rates of problems.

Physicians also report inefficiencies in securing pharmaceuticals, as well as follow-up medical care, for uninsured patients. In a study of 12 cities across the country, Hurley and colleagues found that community health centers carefully guarded limited drug supplies because only a few patients with chronic conditions could quickly exhaust supplies.³⁷ Gusmano and colleagues found that physicians practicing in community health centers often encounter difficulties obtaining specialized services for their uninsured patients.³⁸ According to the Hurley study, physicians in community health centers often cope with this limitation by sending patients to emergency departments, which are required by law to provide emergency care regardless of ability to pay, and which maintain call lists of specialists. Yet the researchers found that specialty call lists have become weakened by the opportunities increasingly available to specialists for lucrative practices in freestanding facilities. Moreover, even when specialty care can be secured in emergency departments it is very difficult for uninsured patients to gain access to follow-up care.

FRAGMENTED HEALTH INSURANCE SYSTEM MAKES CONTROLLING COSTS DIFFICULT

Spending on health care in the U.S. continues to climb apace. In 2005, national health expenditures rose at a rate of nearly 7 percent, more than twice the rate of growth in the economy.³⁹ Similar annual rates of growth are projected through 2016.⁴⁰ U.S. spending on health care constituted 15.3 percent of gross domestic product in 2005, compared with 9.1 percent in the median Organization for Economic Cooperation and Development

(OECD) country (Figure 18). Per-capita spending on health care in the U.S. totaled \$6,401 in 2005, twice the median for all 30 OECD countries, at \$2,922 (Figure 19).⁴¹ Americans also spend twice as much on out-of-pocket expenses as do residents of other industrialized countries (Figure 20). Steady increases in health care costs also place upward pressure on the cost of health insurance: premiums are growing at rates more than twice those of other indicators such as wages and consumer price inflation. The average annual cost of family coverage in employer-based health plans, including employer and employee contributions, topped \$12,106 in 2007—more than the average yearly earnings of a full-time worker earning the minimum wage (Figure 21).⁴²

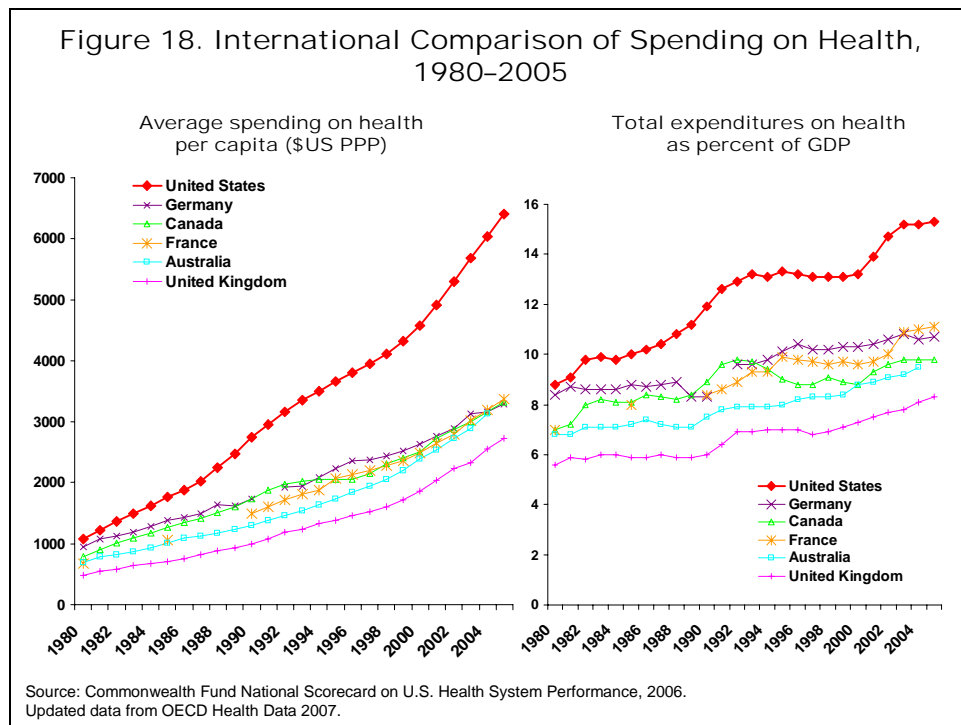
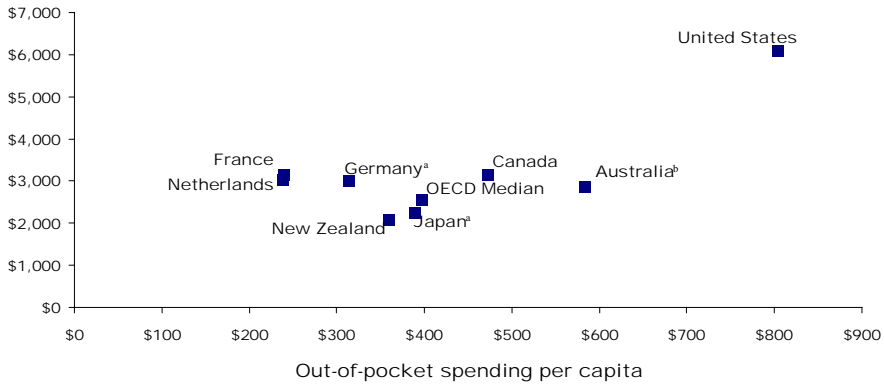


Figure 19. Americans Spend More Out-of-Pocket on Health Care Expenses

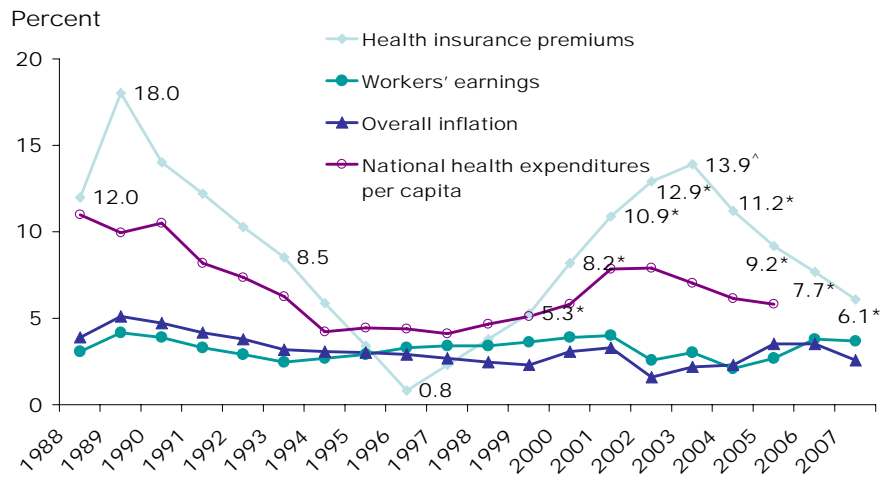
Total health care spending per capita



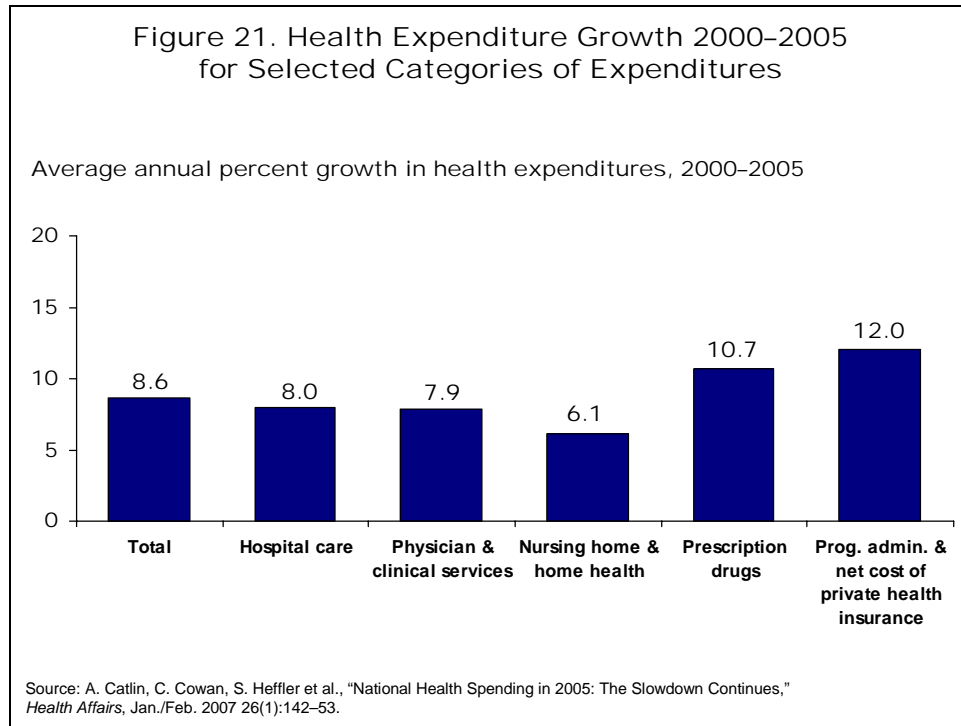
^a2003
^b2003 Total Health Care Spending, 2002 OOP Spending

Source: The Commonwealth Fund, calculated from OECD Health Data 2006.

Figure 20. Increases in Health Insurance Premiums Compared with Other Indicators, 1988-2007



* Estimate is statistically different from the previous year shown at p<0.05.
 ^ Estimate is statistically different from the previous year shown at p<0.1.
 Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates of workers' earnings have been updated to reflect new industry classifications (NAICS).
 Source: G. Claxton, J. Gabel et al., "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs*, Sept./Oct. 2007 26(5):1407-16. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007, and Commonwealth Fund analysis of National Health Expenditures data.



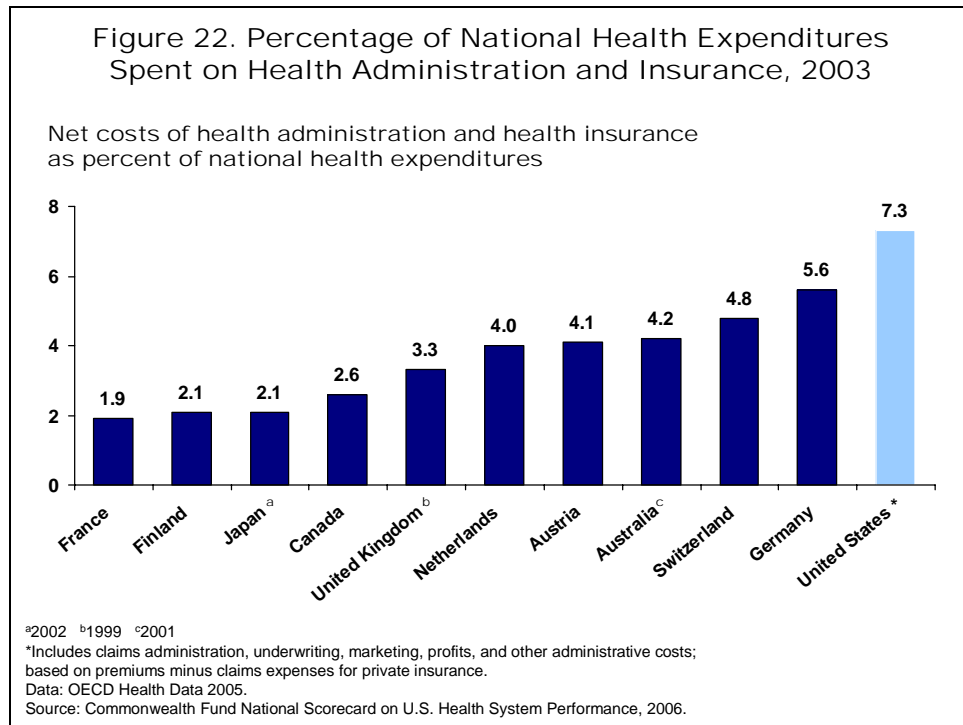
Higher Prices

Despite the large differences in per-capita spending between the U. S. and other OECD countries, Anderson and colleagues have pointed out that the U.S. has fewer physicians, nurses, and hospital beds per capita than other industrialized countries.⁴³ U.S. residents also go to the doctor less often, are admitted to the hospital less frequently, and have shorter lengths of stay when they are admitted than residents of other OECD countries. The authors suggest that people in the U.S. are paying much more for their health care services than are those in other countries, and cite evidence in prices for physician visits, hospital stays, and pharmaceuticals.⁴⁴ Higher overall compensation for professionals in U.S. industries probably explains part of the price differential. But Anderson and colleagues also argue that the highly fragmented nature of the demand side of health care markets (i.e., multiple purchasers of health care) allow prices to climb above those in other industrialized nations. Canada, for example, is characterized by single-buyer purchasing power on the part of the provincial health plans on behalf of Canadians. But even in countries without a single-buyer system, like Germany, purchasing power can be far more concentrated than in the U.S., with multiple payers allowed to collectively negotiate prices with health care providers, within global health care budgets.

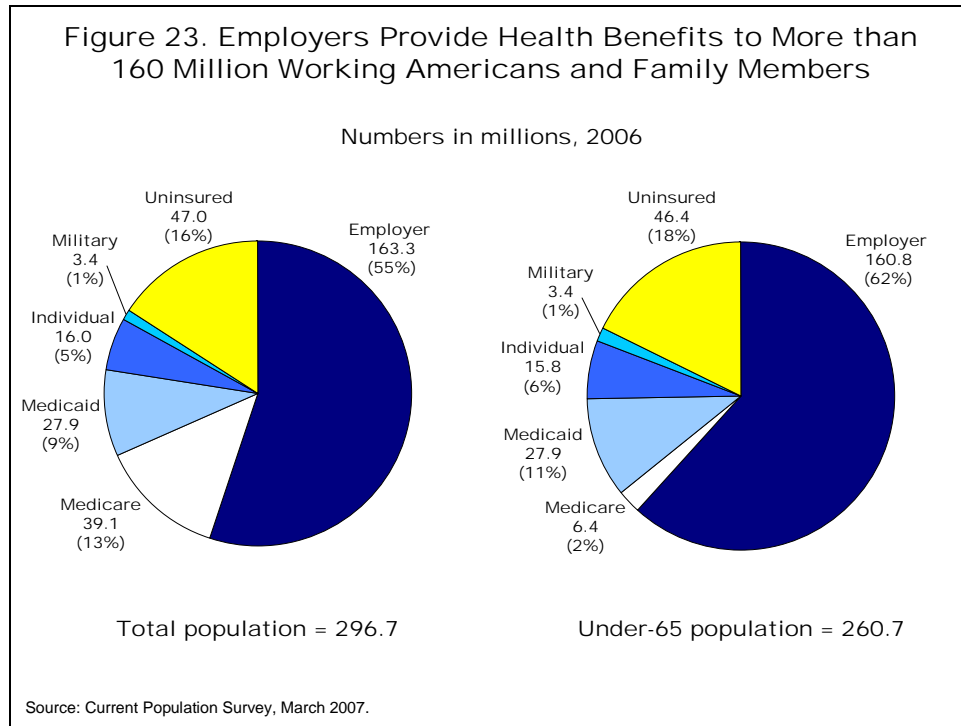
High Costs of Insurance Administration

The fractured and disorganized nature of health care financing in the U.S. creates other excess costs. The U.S. is unique in that a significant percentage of the cost of health

insurance goes toward administrative activities: an estimated 10 percent to 40 percent of premiums, depending on the market and state, is consumed by claims administration, underwriting, marketing, profits, and other administrative costs.⁴⁵ In fact, the cost of insurance administration is the fastest-growing component of national health expenditures. Between 2000 and 2005, net insurance administrative overhead, including administrative expenses and insurance industry profits, as well as public insurance program costs, rose by 12 percent per year compared with an average of 8.6 percent for overall spending (Figure 22).⁴⁶



Indeed, the U.S. leads all other industrialized countries in its share of national health expenditures devoted to health care administration. In 2003, spending on health and insurance administration commanded 7.3 percent of national health spending. Similar spending in other industrialized countries ranged from 5.6 percent of national health expenditures in Germany to around 2 percent in France, Finland, and Japan (Figure 23).⁴⁷ Davis and colleagues estimate that if the U.S. had a level of administrative spending similar to that of France, Finland, and Japan, it would have saved \$97 billion on health care costs in 2004.⁴⁸ Even reducing spending closer to the rate of countries with mixed public and private insurance systems, like Germany and Switzerland, would have saved an estimated \$32 billion to \$46 billion in that year.



Inefficient Financing of Care for Uninsured and Underinsured Families

Hadley and Holahan estimate that the total costs of uncompensated care in the U.S. were \$40.7 billion in 2004.⁴⁹ Hospitals incurred about 63 percent of the uncompensated care costs, physicians about 18 percent, and clinics and direct care programs, like Veterans Affairs and the Indian Health Service, 19 percent. Federal, state, and local funding available in 2004 to reimburse uncompensated care costs amounted to \$34.6 billion, or 85 percent of the total. More than two-thirds of that funding is provided through the federal government, primarily in the form of payments to hospitals through disproportionate share hospital payments. Physicians are unlikely to receive government funds for providing uncompensated care unless they practice in community health centers or direct service programs. Some researchers have argued that private payers finance uncompensated care costs that are not covered by public funds through surcharges to private payers, with these higher costs ultimately leading to higher private insurance premiums. Estimates of this “hidden tax” range from 8.5 percent of premiums nationally and 10.6 percent in California.⁵⁰

Uncompensated care costs might be far higher if uninsured people used as much health care as insured people do. Hadley and Holahan estimate that adults and children without health insurance for a full year receive just 55 percent of the medical care that those who are insured for the full year receive.⁵¹ Based on the health care behavior of people with low and moderate incomes with insurance, the authors project that in 2004, covering all people in the United States would increase health care spending by \$48 billion.

When this amount is added to current uncompensated care spending, out-of-pocket spending by uninsured families, and part-year premium payments for those who are insured less than the full year, total spending for those currently uninsured would amount to \$173 billion.

What is not included in the Hadley and Holahan estimate are the potential long-term cost savings that might accrue by correcting—through the mechanism of continuous and comprehensive universal coverage—the inefficient and ultimately costly health care behavior that currently characterizes uninsured or intermittently insured families along with the providers who care for them. The health care incentives uninsured families face—to delay or avoid care when conditions are relatively inexpensive to treat, before they become serious and costly—run counter to long-held notions of the need for chronic care management and preventive care to promote healthy and productive lives, as well as to control long-term costs. McWilliams and colleagues found that among adults with chronic conditions, previously uninsured adults who acquired Medicare coverage at age 65 reported significantly greater increases in the number of doctor visits and hospitalizations and in total medical expenditures than did previously insured adults, with the difference persisting through age 72.⁵² The findings suggest that the costs of providing health insurance for uninsured near-elderly adults may be partially offset by subsequent reductions in health care use and spending once they enter Medicare.

LACK OF POSITIVE INCENTIVES FOR HEALTH IN BENEFIT DESIGN AND INSURANCE MARKETS

The existing incentives in benefit design and plan reimbursement of providers are not consistently aligned in ways that encourage use of effective services. They also do not discourage use of ineffective services or reduce over-utilization, duplication, and waste. Despite the fact that 70 percent to 80 percent of health care costs are related to chronic illnesses, incentives are not consistently directed toward improving the management of such illnesses before they become serious and expensive. Gabel and colleagues recently found, for example, that substance abuse benefits in employer-based health plans are, on average, much more limited than medical-surgical benefits, thereby discouraging initiation of treatment as well as monitoring and follow-up treatment through limits on office visits, hospital days, and higher co-pays relative to medical-surgical benefits.⁵³ The collective incentives with respect to substance abuse thus discourage early intervention that might prevent the development of costly chronic illnesses linked to alcohol and substance abuse.

Complex benefit and cost-sharing designs appear to leave many patients confused about covered and uncovered services. Recently, this has been particularly true with high

deductible health plans. In a survey of people with high deductible health plans with health savings accounts (HSAs), Fronstin and Collins found that the share of adults in such plans who reported that their plans were easy to understand actually fell from 54 percent in 2005 to 45 percent in 2006.⁵⁴ In contrast, 65 percent of adults in health plans with lower deductibles and no savings accounts said their plans were easy to understand. By law, employers can exclude preventive care from the deductible in HSA-eligible high-deductible health plans. Claxton and colleagues found that 82 percent of workers enrolled in the plans have employers who do this.⁵⁵ But Fronstin and Collins found that more than half of adults in these plans said their deductibles applied to all health care services, including preventive care.⁵⁶ In addition, a 2006 report by the General Accountability Office found that many participants in the plans had difficulty distinguishing between preventive services and other services provided during a physician office visit.⁵⁷ Some participants explained that, in their experience, certain laboratory tests performed during a preventive care visit were not considered preventive services and therefore, not excluded from the deductible.

Value-based insurance design (VBID) is a recent innovation in which copays vary by the expected value (i.e., benefits and costs) of clinical services either for all patients or for targeted groups of patients with chronic illness.⁵⁸ VBID lowers copayments for services of high clinical value such as medications for asthma. A handful of companies are experimenting with VBID. Pitney Bowes, for example, lowered copayments for all patients who use drugs for diabetes, asthma, and hypertension. Other employers have attempted the design with targeted patient groups, such as workers with diabetes. Some companies that have experimented with VBID found that decreasing copayments on key services led to significant increases in drug therapy adherence, a decrease in sick leave, and overall cost savings.⁵⁹

Health plans have not traditionally rewarded or penalized providers to encourage delivery of high-quality preventive care and chronic care management. Payers typically pay physicians and hospitals a negotiated price that has no relationship to the quality or efficiency of the care they provide. However, recent disease management programs and pay-for-performance approaches are aimed at redirecting current incentives. There has been a rapid growth in the number of pay-for-performance programs over the past five years in both the public and private sectors. More than half of commercial health plans and state Medicaid agencies have pay-for-performance programs in place; within five years, nearly 85 percent of states will be operating Medicaid pay-for-performance programs.⁶⁰ The largest hospital pay-for-performance program—the CMS/Premier Hospital Quality Incentive Demonstration—was initially scheduled for three years, but has been extended

an additional three years. To increase the effectiveness of pay-for-performance programs, multiple payers must come together and agree on a common set of quality metrics. Examples of collaborations among public and private payers to produce more accurate measures of quality at the provider level include the Integrated Healthcare Association pay-for-performance program in California, and Medicare's Better Quality Information Pilots.⁶¹

Adverse Selection Encourages Risk Avoidance in Small Group and Individual Markets

Insurance carriers sell policies in three different markets—large employer group, small employer group (i.e., firms of fewer than 50 employees), and individual—in each of the 50 states and the District of Columbia.⁶² Because of the voluntary nature of health insurance in the U.S., people who are not covered through the broad risk pools of large companies must buy coverage, either as small businesses or individuals. Because of the expense of health insurance, small businesses or individuals may wait until they are more likely to need insurance, such as when an employee or family member develops a health problem or plans on becoming pregnant. This is known as adverse selection and is a serious threat to the viability of carriers selling in the small and individual markets; the incentive to protect against it is the overriding dynamic in those markets. Given the challenge of selling policies in the small group and individual insurance markets, many carriers simply choose to avoid the markets—particularly the individual market—altogether unless state regulations require carriers that sell in the large group market to also sell in the small and individual markets. Swartz reports that in 1997, merely 700 carriers sold individual policies in the U.S., compared with 2,450 carriers that sold in the small- and large-group markets.⁶³

Some states have implemented regulations to help maintain access to insurance for older people or those in poor health, while other states have left their markets largely unregulated. The wide variation in these markets has had a significant impact on the states in which insurers choose to sell their products, the prices of those products, the associated cost-sharing features, and the covered services. Such variation has also had a significant impact on the types of individuals and businesses able to gain coverage and the premiums they are charged. Gabel found that employees in companies with fewer than 10 employees pay an average of 18 percent more in health insurance premiums than those in the largest firms, after taking into account the actuarial value of their plans, but that such prices vary widely across the country.⁶⁴

Because carriers selling policies in the small group and individual insurance markets do not have complete information about their potential customers' health, they invest

significant capital in attempting to identify risk and in designing underwriting models to determine whether premium revenues will exceed expected costs.⁶⁵ In states that have prohibited or limited underwriting through community rating or adjusted community rating laws, carriers have developed several different selection mechanisms to weed out potential costly applicants. As Swartz points out, these strategies include the refusal to write a policy; selling to niche markets that are potentially profitable, such as small firms of lawyers and other professionals; avoiding or “redlining” industries that carry higher health risks such as taxi drivers; excluding coverage for individuals with preexisting conditions; and offering policies with differentiated benefits as a way of eliciting information about the health status of potential clients. According to Swartz, the practice of selling policies with differentiated benefits has become a sophisticated, and administratively costly, way to determine whether clients are low risk or high risk. In states that have attempted to prevent carriers from practicing these methods, insurers have developed other strategies.

UNIVERSAL COVERAGE IS INTEGRAL TO ACHIEVING A HIGH PERFORMANCE HEALTH SYSTEM

The findings of the National Scorecard and State Scorecard strongly suggest that the U.S. must insure all residents to move effectively to a higher level of overall health system performance. The U.S. consistently ranks poorly among industrialized nations—all of which have varying forms of universal health insurance—on key measures of performance, including preventable mortality, life expectancy, and infant mortality.

Similarly, the top-ranking states in the State Scorecard have the lowest rates of uninsurance among adults and children. Moreover, many have extensive publicly sponsored insurance programs, with income thresholds that support low- and modest-wage workers and their families. For example, only eight states in the country have SCHIP and Medicaid programs that cover children up to 300 percent of the poverty level. Five of those states rank among the top 10 overall in the State Scorecard.

In addition, two states among the top 10 overall leaders, Hawaii and Maine, have attempted to extend health insurance to most of their residents. Hawaii, which ranks first in the State Scorecard, mandated in 1974 that employers—with a few exceptions, such as seasonal employers and government services—provide insurance to all employees who work more than 20 hours per week.⁶⁶ In Maine, Governor John Baldacci signed the Dirigo Health Reform Act into law in June 2003. Dirigo aims to make quality, affordable health care available to every citizen in the state within five years and to initiate new processes for containing costs and improving health care quality.

Millions of families lack the financial means to regularly access preventive care and chronic disease management, allowing chronic conditions to become serious and expensive to treat. For the U.S. to gain control of health care cost inflation associated with such illness, it is critical that the entire population be brought into the health care system.

DESIGN MATTERS: KEY PRINCIPLES TO CONSIDER IN DEVELOPING AND EVALUATING HEALTH REFORM PROPOSALS

Extending health insurance coverage to people who currently lack it is necessary, but not a sufficient condition for achieving high performance. The way in which a universal coverage system is designed will have a deep impact on its ability to make sustainable and systematic improvements on the dimensions measured in the National Scorecard and State Scorecard: access to care, equity, quality of care, efficiency, and cost control. With these goals in mind, the following are some key principles policymakers and the public should consider in developing or evaluating health reform proposals:

Access to Care

- Provides equitable and comprehensive insurance for all.
- Insures the population in a way that leads to full and equitable participation.
- Provides a minimum, standard benefit floor for essential coverage with financial protection.
- Premiums, deductibles, and out-of-pocket costs are affordable relative to family income.
- Coverage is automatic and stable with seamless transitions to maintain enrollment.
- Provides a choice of health plans or care systems.

Quality, Efficiency, and Cost Control

- Health risks are pooled across broad groups and lifespans; insurance practices designed to avoid poor health risks are eliminated.
- Fosters efficiency by reducing complexity for patients and providers, and reducing transaction and administrative costs as a share of premiums.
- Works to improve health care quality and efficiency through administrative reforms, provider profiling and network design, utilization management, pay-for-performance payment models, and structures that encourage adherence to clinical guidelines.

- Minimizes dislocation; people can maintain current coverage if desired.
- Simple to administer.
- Has the potential to lower overall health care cost growth.

Financing

- Financial commitment to achieve these principles.
- Financing should be adequate and fair, based on ability to pay, and is a shared responsibility of federal and state governments, employers, individual households, and other stakeholders.

CURRENT PROPOSALS FOR EXPANDING HEALTH INSURANCE

Current proposals to reform the health insurance system include: strategies that emphasize tax incentives for obtaining insurance through the individual market; proposals that build on existing private–public group insurance with a shared responsibility for financing coverage; and proposals to cover everyone through public forms of insurance, like Medicare.

Tax Incentives for Individual Market Insurance

President George W. Bush, former New York City mayor Rudy Giuliani, Senator John McCain (R–Ariz.), and former Massachusetts governor Mitt Romney support proposals that would create tax incentives for people to gain coverage through the individual insurance market.⁶⁷ In his 2008 budget, President Bush proposed to end the current tax exemption for employer-provided health benefits, and instead provide personal income tax deductions for those who buy insurance coverage. Under this proposal, people could continue to receive coverage through their employers or buy coverage on the individual insurance market. For the first time, health benefits offered through an employer would be counted as taxable income and those purchasing coverage through the individual insurance market would also receive a tax deduction.

In public remarks, Giuliani has embraced the Bush Administration’s approach, though he has not released a formal proposal. In speeches on this issue, McCain and Romney favor purchasing health insurance through the individual market. Some proposals of this nature would urge states to relax individual market regulations such as community rating (i.e., limits on the degree that health risk influences premiums) or guaranteed issue (i.e., requiring insurers to offer policies to everyone who would like to buy one).

Mixed Private–Public Group Insurance with Shared Responsibility for Financing

The state of Massachusetts, Governor Arnold Schwarzenegger of California, and five Democratic presidential candidates (Senators Hillary Clinton (D–N.Y.), Christopher Dodd (D–Conn.), and Barack Obama (D–Ill.), former North Carolina Senator John Edwards and New Mexico Governor Bill Richardson) have proposed plans—or, in the case of Massachusetts, passed laws—for universal coverage that would maintain and build on the current mixed private and public insurance system.⁶⁸ Most proposals include requirements for individuals to purchase coverage and for employers to offer or help pay for coverage, expansions in state Medicaid and SCHIP, and new group insurance options with financial support for premiums and out-of-pocket expenses for lower and middle-income households.

More than 160 million people—or 62 percent of the under-65 population—receive coverage through an employer. Proposals that build on the current system would retain and strengthen the employer role in the system by requiring that all large employers offer coverage or pay part of the coverage costs of their employees (Figure 23). The plans would also build on existing public insurance programs by expanding Medicaid and SCHIP, which currently cover 32.6 million adults and children, or 13 percent of the under-65 population, and leave Medicare intact for people over age 65.

The most gaping hole in the current system occurs when people under age 65 do not have access to employer coverage and are not eligible for Medicaid or SCHIP. The individual insurance market—where just 6 percent of the under-65 population buys coverage—has proven inadequate to stem the rising tide of uninsured people. The new plans propose to fill this gap with new group insurance options sometimes referred to as “exchanges” or “connectors.” These options include merging the individual and small group markets, like Massachusetts’s Commonwealth Care Connector; a new menu of private and public insurance plan options such as Medicare within the Federal Employees Health Benefits Program (FEHBP), as in Senator Clinton’s health reform proposal; regional markets with both private and public plan options including Medicare, as in Edwards’s proposal; and a national insurance exchange with both private and public plan options, as in Senator Obama’s proposal. Offering a public plan like Medicare in these new health insurance exchanges would give individuals and businesses a choice between private and public health plans.

The Massachusetts law and the similar proposals made by Governor Schwarzenegger and the presidential candidates would provide subsidies for lower-income households to offset the cost of insurance purchased in the new group options. All proposals would require a minimum standard benefit package and would prevent insurers from writing—or denying—policies based on health risk. Some plans would allow

businesses of all sizes to buy coverage for their employees through this new group pool, while others would allow only small businesses to do this. Finally, most of the plans would require that all U.S. residents have health insurance.

Public Insurance

Representative Pete Stark (D–Calif.), Senator Edward Kennedy (D–Mass.), Representative John Dingell (D–Mich.), Representative John Conyers (D–Mich.), and Representative (and presidential candidate) Dennis Kucinich (D–Ohio) have proposed universal coverage plans in which Medicare or a new government plan plays a central role.⁶⁹ In these proposals, people of all ages would become eligible for Medicare with a benefit package that improves on current Medicare benefits and resembles that of public employees and members of Congress. The Stark bill would allow large employers to continue to offer coverage or pay a portion of the Medicare premium for their employees. The Kennedy/Dingell bills and the Conyers/Kucinich bills would finance an expanded Medicare program with a payroll tax for employers and a wage tax for employees. In all proposals, including those that allow employers to continue offering their own coverage, most people are expected eventually to be covered through Medicare or other public plan.⁷⁰

HOW WELL DO DIFFERENT STRATEGIES MEET PRINCIPLES FOR HEALTH INSURANCE REFORM?

Assessing the health insurance reform proposals against the key principles described earlier helps to illustrate each proposal’s strengths and weaknesses. The proposals, which reflect different philosophical strategies and values, use a range of mechanisms to address health system issues of inadequate access to care, variable quality, and high cost. Design features of the three different approaches affect each of these issues. In particular, the inclusion or omission of key features has significant implications for the number of people covered, the cost to stakeholders and the overall health system, equity in access and financing, and improvements in efficiency and quality. Raising the right questions and weighing the evidence will help shape consensus.

Access to Care

Does the proposal cover everyone? Health insurance reform proposals vary in their effectiveness at providing coverage to all, determining which previously uninsured people gain coverage, and determining the source of that coverage (Figure 24). Jeanne Lambrew and Jonathan Gruber argue that the most important features in mixed private–public group insurance approaches that will affect coverage are: 1) whether employers are required to offer and contribute to coverage; 2) whether individuals are required to obtain

coverage; and 3) the structure and generosity of public subsidies, including expansions of public programs.⁷¹ Other key features include the degree of risk pooling and the decision to include an autoenrollment mechanism.

Figure 24. How Well Do Different Strategies Meet Principles for Health Insurance Reform?

Principles for Reform	Tax Incentives and Individual Insurance Markets	Mixed Private–Public Group Insurance with Shared Responsibility for Financing	Public Insurance
Covers Everyone	0	+	+
Minimum Standard Benefit Floor	–	+	+
Premium/Deductible/ Out-of-Pocket Costs Affordable Relative to Income	–	+	+
Easy, Seamless Enrollment	0	+	++
Choice	+	+	+
Pool Health Care Risks Broadly	–	+	++
Minimize Dislocation, Ability to Keep Current Coverage	+	++	–
Administratively Simple	–	+	++
Work to Improve Health Care Quality and Efficiency	0	+	+

0 = Minimal or no change from current system; – = Worse than current system;
+ = Better than current system; ++ = Much better than current system

In simulation exercises, Lambrew and Gruber found that the inclusion of an individual mandate in mixed private–public approaches is critical to achieving universal coverage. An employer mandate alone, even with generous subsidies, falls short of universal coverage, since it fails to reach those with weak connections to the labor force and those for whom the subsidies are not sufficient incentive to enroll. Employer mandates that exclude small firms would cover even fewer uninsured people.⁷²

In addition, subsidies provided to individuals and small firms to help them voluntarily buy into a new group option will—in the absence of an employer or individual mandate—fall far short of universal coverage. Moreover, this may contribute to individuals with employer-based coverage becoming uninsured. Lambrew and Gruber find that a proposal that combined a new group option, Medicaid expansion, along with generous subsidies to firms and individuals, would cover only about 20 percent of the uninsured. This is partly because some small firms with lower-wage workers might drop coverage if they knew their employees had a new option. In addition, the voluntary nature of individual enrollment would result in large numbers of people continuing to go without coverage.

Another important feature is the structure of subsidies in all approaches and whether they would keep pace with inflation of medical costs, over time. Subsidies that cap premiums and out-of-pocket spending as a share of income would maintain their value over time. Other approaches, such as a fixed tax deduction for those enrolling in employer coverage or individual coverage, would have to be structured to maintain their value in the face of rising costs and premiums. For example, income tax deductions that rise at a slower rate than premiums would have the potential to cover more uninsured people in the first years of the proposal than in subsequent years, when premiums are more likely to exceed the cap and thus be more expensive to taxpayers.

Under a mixed private–public approach with employer and individual mandates, most people would maintain their current source of coverage, either through an employer plan or a public program.⁷³ There would be a large shift to the new group option from the current individual market, an increase in public coverage, and an increase in employer coverage as a result of the employer and individual mandates.⁷⁴

A public insurance approach, such as proposals to expand Medicare to the full population, would likely cover everyone. Individuals could not opt out. Prior analyses of approaches that would allow employers to opt out, such as Representative Stark’s AmeriCare bill, find that most employers would not elect to opt out, as it is unlikely that firms could negotiate premiums with rates more favorable than those the government could offer in Medicare’s fee-for-service plan, its self-insured product.⁷⁵ Thus, it is anticipated that most people would have coverage through Medicare, even with an employer opt-out.

Proposals that would expand coverage through the individual insurance market are unlikely to achieve universal coverage. Prior analysis of President Bush’s proposal to equalize the tax treatment of employer and individual coverage finds that it would cover only about one of five previously uninsured people in the first year.⁷⁶ The new tax deduction would be a capped amount that would rise annually by the rate of consumer price inflation, which is projected to rise more slowly than premiums. The proposal is therefore likely to cover more uninsured people in the first years of the proposal than in later years, when premiums are more likely to exceed the cap. In addition, providing an equivalent capped income tax deduction for insurance gained through the individual market would provide some employers—particularly small employers—with an incentive to drop coverage, since employees would receive the same tax deduction for coverage in the individual market. The number of people with employer-based coverage might fall as a result, and the number covered in the individual insurance market would rise.

Does the proposal provide a minimum, standard benefit floor for essential coverage with financial protection? Proposals that define a minimum health benefit package including cost-sharing would improve coverage for millions whose current health insurance provides inadequate protection leaving them underinsured and would provide comprehensive access to care for people who become newly insured. Standard benefit packages could ensure that people have access to essential preventive services like vaccines for children and adults—perhaps modeled on the Center for Disease Control’s Vaccines for Children program—and an emphasis on prevention and control of chronic health conditions. Many recent proposals have required that qualifying health plans in new group insurance exchanges or public insurance strategies be equivalent in value to the Blue Cross/Blue Shield Standard Plan offered to federal employees and members of Congress under FEHBP (Figure 24). In addition, many proposals would also cap out-of-pocket costs as a share of income or subsidize premiums.

By expanding access to Medicaid and SCHIP, some proposals would improve existing benefits and lower premiums and out-of-pocket costs for many currently underinsured children and adults with low-to-moderate incomes. In the case of both the mixed private–public group insurance and the public insurance proposals, requiring a comprehensive set of benefits and lower cost-sharing would improve coverage for existing Medicare beneficiaries who face substantial cost-sharing.

In contrast, proposals that provide tax incentives for coverage in the individual insurance market would move some people into plans with more limited benefits or higher deductibles. In states that allow underwriting, people with health problems would be at risk of being charged a much higher premium for their coverage, having their health problem excluded, or being denied coverage altogether. Collins and colleagues found that 71 percent of adults with health problems who tried to buy a plan in the individual market in the past three years found it very difficult or impossible to find a plan they could afford; one-third said they were turned down or charged a higher price because of a preexisting condition.⁷⁷ Ninety-two percent said they never bought a plan.

Are premiums, deductibles, and out-of-pocket costs affordable relative to family income? The design of new premium subsidies, tax credits, or tax deductions has significant implications for how costs or savings accrue across households. Recent mixed private–public group insurance proposals and public insurance proposals have significant premium and cost protections for consumers to ensure that lower-income families would pay less than higher-income families (Figure 24). Cost savings to households would also arise from people gaining insurance coverage, as well as from the new protections that

would benefit currently insured families with high out-of-pocket costs and premiums relative to their incomes.

By requiring all individuals to have health insurance if an affordable option is available, Massachusetts has directly confronted the issue of affordable health insurance. Blumberg and colleagues examined the affordability issue in the context of the Massachusetts law through a national analysis of premiums and out-of-pocket health care expenses for people in different income groups with both individual and employer coverage.⁷⁸ People in low- and moderate-income households with individual market coverage spend a large percentage of their income on premiums and out of pocket costs, making it unfeasible to define affordability based on current expenditures as a share of income. A more appropriate standard, they argue, is the share of income currently spent by higher-income households on both premiums and out-of-pocket spending. Including out-of-pocket spending in addition to premiums reflects the fact that plans purchased in the individual insurance market can have low premiums but high deductibles or other cost-sharing that can lead to high out-of-pocket spending.

Mandating coverage without taking into account out-of-pocket spending could prove burdensome for people with lower incomes or poor health. Massachusetts ultimately settled on using premiums alone in defining affordable plans and determined that people with incomes under 150 percent of the poverty level would pay no premiums; those with incomes up to 200 percent of poverty would pay on average 2.4 percent of income on premiums; those with incomes up to 300 percent would pay on average 4.5 percent; and those with incomes up to 500 percent of poverty would pay on average 8 percent.⁷⁹ Blumberg and colleagues point out that these standards are in the range that people with incomes of 300 percent to 500 percent of poverty spend on employer and individual market premiums: 2.1 percent for employer and 7.9 percent for individual market.

Standard income tax deductions for private insurance in various new proposals differ considerably in how progressively the deduction is structured and whether there are additional premium subsidies for lower-income families. In early 2007, Senator Ron Wyden (D-Ore.) introduced the Healthy Americans Act to end the tax exemption for employer-provided health benefits and replace it with a standard personal income tax deduction, as in President Bush's proposal.⁸⁰ But the Wyden bill differs from the President's proposal in several ways, including: creating large regional purchasing pools where people would buy coverage, ending employer-based coverage altogether, and progressively structuring a new personal income tax deduction and combining it with premium subsidies for lower-income households. A prior analysis of the Wyden bill

estimates it would result in a decline in household spending on health care for lower-income families and increases for higher-income families.⁸¹ In contrast, because the Bush Administration's proposal would create a standard income tax deduction that does not vary by income and does not include additional premium support, higher-income families would realize significantly higher savings in health spending than lower-income families.

Does the proposal make it easy and seamless to get and stay enrolled? Proposals that would enroll people automatically through the tax system or at birth are the most likely to ensure that people become and remain enrolled. Under a public insurance approach, most people would be covered under one system, which would also help ensure that people remain enrolled, regardless of changes in income, age, health status, or employment status (Figure 24). Enrolling people through the tax system in the mixed private–public approaches would help reduce the churning in and out of coverage that now characterizes the current system. Approaches that would provide tax incentives for individual market coverage would not make enrollment easier or more seamless.

Incremental proposals targeted at certain groups of people or income groups face the inherent challenge of enrolling all those who are eligible. This has plagued both Medicaid and SCHIP, resulting in substantial churning when people fail to re-enroll in six or 12 months. The programs also fail to reach millions of adults and children who are eligible but not enrolled. Prior analyses have found that adding provisions to increase enrollment and retention in targeted programs do increase enrollment, but, even with such provisions, many eligible adults and children eligible would remain uninsured.⁸² Targeted expansions to increase coverage are limited by eligibility standards determined by income, as opposed to a more comprehensive national system that would automatically enroll eligible individuals.

Do people have a choice of health plans or care systems? Although many Americans have little choice in their health plan or provider, surveys show they highly value having such choices and are more satisfied with their health care when they have more choices. Just over half of adults under age 65 with employer-based health insurance currently have a choice of two or more health plans. Choice varies widely by firm size: only one-quarter of workers in firms of fewer than 20 employees have a choice of plan compared with 71 percent of those in firms with more than 500 workers.⁸³ Lambrew found that nearly three of five adults under age 65 with employer-based coverage surveyed in the Commonwealth Fund Biennial Health Insurance Survey said it was very important that their employer offer a choice of health plans.⁸⁴ In terms of choice of provider, 30 percent of nonelderly adults report having a great deal of choice and

43 percent have a fair amount of choice.⁸⁵ Adults in employer plans and in higher-income households have the greatest choice of providers; those in individual market or state public insurance plans like Medicaid and in lower-income households have the least choice. Lambrew concluded that having a choice of provider was a more important factor in overall satisfaction with health care than having a choice of health plan.

Reflecting public opinion, most current coverage proposals emphasize a choice of health plans and providers (Figure 24). The new health insurance exchanges in the mixed private–public group insurance proposals would allow enrollees a choice of private and public plans. The public insurance proposals would be modeled on the current Medicare program and FEHBP, where most beneficiaries can choose from a range of health plans. The proposals that would provide tax incentives for people to gain coverage through the individual market would allow people more choice of plans and benefit combinations. However, older people or those in poor health might have less choice in the individual market than those who are young and in good health, depending on the specifics of the proposal.

Quality, Efficiency, and Cost Control

Do proposals pool health care risks broadly? How proposals are structured and how broadly risks are pooled have a fundamental impact on both costs and equity. Proposals that would provide an equivalent capped income tax deduction for insurance gained through employers or through the individual market would have the effect of moving more people into the individual market. Senator Wyden’s bill would also encourage nonemployer coverage, but would create new group insurance options and impose restrictions on individual underwriting. Mixed private–public group insurance models would create new group insurance options and maintain the risk pooling that exists in the employer group market and existing public programs (Figure 24). Public insurance approaches would pool most people into a single group. Prior estimates have shown the differential impact on the costs of insurance administration, depending on the size of the risk pool, to be substantial. Proposals that increase coverage through the individual market have the potential to increase administrative costs, while those that provide group coverage—especially through the Medicare program—have the potential to significantly lower overall administrative costs.⁸⁶

Policy reforms focused on the individual or small group insurance markets to increase access are significantly challenged by the perverse dynamic of adverse selection.⁸⁷ Proposals that would allow individuals or small businesses to purchase coverage in states where they do not live—thereby bypassing existing state insurance regulations, such as

community rating—are estimated to make small group and individual market coverage more affordable for the young and healthy, but they are also expected to significantly increase premiums for less-healthy consumers or companies with older or less-healthy workers who remain in markets with consumer protections. Alternatively, proposals that establish pools for individuals or small businesses with premium protections, federal reinsurance, and tax credits without imposing similar regulations on existing small group and individual insurance markets could have the unintended effect of attracting older or less-healthy consumers, while those who are healthier or younger shop elsewhere for cheaper policies. It is important that proposals attempt to broadly pool people to avoid the dysfunctional dynamic that occurs in the small group and individual insurance markets when groups of people are divided according to age or health risk.

Broad risk pooling is also critical on equity grounds. The proposals that attempt to increase coverage through existing small group or individual insurance markets ultimately confront the central dynamic governing those markets—the powerful incentive on the part of carriers to protect against health risk. Proposals that would increase incentives for people to gain coverage through the individual insurance market must address the significant variation in premiums and in the value of benefits that characterize that market. The value of tax credits or tax deductions would probably vary according to geographic location, age, health status, and gender. In addition, there is the issue of people with severe health problems for whom no insurer will write a policy. In general, proposals built on existing and new group insurance options would avoid these problems, particularly with the addition of an individual mandate, as would public insurance approaches. The new group insurance market exchanges in the mixed private–public proposals and the Commonwealth Connector in Massachusetts might, without proper safeguards, be at risk for adverse selection and premium escalation. Protections for these group insurance exchanges would include mandatory participation, community rating for the full state market and the insurance connectors, and adequate federal reinsurance.

Does the proposal minimize dislocation? Could people maintain their current coverage? A factor contributing to the defeat of the Clinton Administration’s health care reform plan in 1993 was the exploitation of the public’s fear of moving from coverage it was familiar with—mostly employment-based—to a new approach. Recent surveys by the Employee Benefit Research Institute show that Americans continue to place a high value on employer-based coverage. More than three-quarters of employees enrolled in employer-based insurance said they would prefer to receive employer coverage rather than an increase in taxable income equivalent to their premium.⁸⁸

In addition, from a pragmatic perspective, allowing people to remain with their current coverage as long as it met minimum benefit and affordability standards might be simpler than moving everyone to new forms of coverage at the outset of a newly reformed system. With more than 60 percent of the under-65 population enrolled in employer-based plans, it would be far less disruptive to allow people to stay in their plans. Moreover, by maintaining employer coverage, the system would continue to reap the efficiency benefits of the large employer risk pools.

Depending on their details, the proposals that would cause the least dislocation are the individual insurance market approaches and the mixed private–public group insurance proposals. Each would allow people with employer-based health insurance to retain their coverage if desired. In contrast, public insurance approaches would involve most people gaining coverage through a new public insurance plan like Medicare, although some—like Representative Stark’s AmeriCare proposal—would allow employers to continue offering coverage. It is unlikely that people would have to change their current providers under public insurance approaches.

Is the program simple to administer? The current insurance system is highly fragmented and complex, with people receiving coverage through multiple, competing insurance carriers. Covering everyone under Medicare or another public plan would substantially reduce this complexity. The mixed private–public group insurance approaches would retain much of the complexity of the current system. Yet, replacing the individual market with new forms of group coverage in the mixed private–public approaches, and expanding public insurance programs and employer group coverage could also lead to substantial savings. As a share of premiums, insurance administrative costs range from 2 percent under Medicare to 10 percent for employer group coverage, and to 25 percent to 40 percent for coverage purchased in the individual insurance market.⁸⁹ Covering more people through the individual insurance market would further fragment risk pools and exacerbate administrative complexity.

Does the system focus on improving health care quality and efficiency? A significant barrier to improving the quality and efficiency of health care nationally is the substantial number of people who lack health insurance coverage and are therefore largely outside the system. Proposals that would cover the most people would help ensure the population as a whole has access to preventive care and timely, essential medical care across lifespans.

But the ways in which people are insured, the comprehensiveness of the benefit package and cost-sharing provisions, and the incentives facing payers and providers will also be important determinants of whether significant and systematic improvements in quality and efficiency can be achieved. Proposals that would reform the health insurance system with a continuing role for private insurance carriers must address how to encourage or require insurers to compete on the basis of increasing quality of care and lowering administrative and transaction costs, rather than on the basis of risk or paying claims. How would the proposals foster innovation among competing plans in provider profiling, network design, utilization management, pay-for-performance, and evidence-based medicine? How would the proposals encourage carriers to simplify the complex payment arrangements that currently exist between payers and providers? Would the proposals require insurers to spend a certain percentage of premiums for medical care, while limiting the share allocated to administration and profit? In mixed private-public group insurance models, how would private and public carriers be integrated to allow for shared information and uniform measurement of provider quality and costs, interoperable health information technology, and uniform provider payment?

Does the proposal have the potential to achieve overall system savings? Insuring everyone has the potential to generate substantial savings to the overall health system.⁹⁰ Primarily, this reflects the significant potential savings in the cost of insurance administration, particularly in the case of the public insurance approaches, but also in the mixed private-public group insurance approaches where group coverage replaces the individual insurance market. Universal coverage would also reduce cost-shifting to private payers as a result of uncompensated care by providers and potentially lead to lower premiums. Another substantial source of savings in the public insurance proposals would be changes in provider payment from current private reimbursement rates to Medicare rates.

Financing

Is financing adequate, shared across stakeholders, and fair, based on ability to pay? Achieving universal coverage that meets these key principles will require a serious financial investment by federal and state governments, employers, households, and other stakeholders in the health care system. Such a shared responsibility among stakeholders should be fair, based on ability to pay.

Broad risk pooling will have significant implications for financing. For example, if tax credits for coverage in the individual insurance market were directed toward making coverage affordable for lower-income families, the lack of risk pooling and high per-person administrative costs would make them relatively more expensive than tax credits or

subsidies for people to buy coverage through large risk pools. This is another reason why the design of the new health insurance exchanges in the mixed private–public proposals will be important. Broader risk pooling will keep plans affordable for families and lower the amount of federal or state subsidies required. Public insurance approaches would achieve the broadest risk pooling.

WHICH STRATEGIES HAVE THE GREATEST PROMISE TO MOVE THE SYSTEM TO HIGH PERFORMANCE?

After examining how the strategies compare, which approach has the greatest promise to help move the health care system toward high performance?

Tax Incentives for Individual Market Insurance

Proposals that would reform the health insurance system by relying on tax incentives and voluntary purchase of coverage in the individual insurance market are, by themselves, unlikely to achieve universal coverage. Buying coverage in the individual market will continue to be challenging if tax incentives are not coupled with an individual mandate, minimum benefit standards, regulations against risk selection, and premium and out-of-pocket spending limits as a share of income. Providing incentives for coverage in the individual market without an individual mandate or regulations against risk selection would not pool risks. Insurers would still write individual policies rather than policies for a broad group of people.

With administrative costs in the individual market running from 25 percent to 40 percent of premium dollars compared with 10 percent in employer group markets and 2 percent in Medicare, covering more people through this market will only increase U.S. annual spending on insurance administration. Supporters of these proposals, however, argue that when consumers spend their own money on health insurance and health care they will be more cost-conscious, seek out lower-cost providers, and avoid marginal or unnecessary care. These proposals would allow substantial choice of covered benefits and financial protection, within the limits of people’s budgets. However, they could limit options and increase costs for those with health risks depending on existing consumer protections, which vary by state. People with preexisting conditions might face very high premiums, might be unable to get their health needs covered, or might not be offered a policy at all.

If designed to avoid undermining employer-based coverage, the proposals would cause minimal dislocation, with the ability to maintain current health insurance coverage. But if the existing tax exemption for employer-based health benefits is replaced with a

new standard personal income tax deduction or tax credit, increasing numbers of families may pay taxes on their employer-provided health benefits if premium inflation exceeds the growth in the standard tax deduction or tax credits. In addition, if the new income tax deductions or tax credits do not vary by income, they would benefit higher-income families more than lower-income families. If restructured as refundable tax credits, they would provide greater assistance to lower-income families. From a financing perspective, the lack of risk pooling and higher administrative costs would inflate the size of tax credits necessary for making premiums affordable for lower-income people. These proposals would do little to alter incentives to improve health care quality and efficiency.

Mixed Private–Public Group Insurance with a Shared Responsibility for Financing

Most proposals that build on the current system would ensure universal coverage by requiring that all individuals purchase coverage and that employers either offer coverage to employees or contribute to premiums. Such mandates would be critical to ensuring that everyone is covered. Most proposals would also create new group insurance exchanges for people without access to employer coverage and for small businesses. These new health insurance exchanges would allow consumers choices of private and public plans. Offering a public plan option like Medicare in these new health insurance exchanges would give individuals and businesses the option to choose between private and public health plans. Most proposals specify a minimum standard benefit package for plans offered by employers and through the health insurance exchange.

Affordability would be assured through expansion of Medicaid and SCHIP for lower-income families and provision of premium assistance for lower- and middle-income individuals buying coverage in the new health insurance exchanges. The new Massachusetts law, for example, mandates that state residents have coverage where an affordable plan is available and defines affordable as a premium that costs an average of 2.4 percent of income up to 200 percent of the poverty level; 4.5 percent of income up to 300 percent of poverty; and 8 percent up to 500 percent of poverty. However, it is important that potential out-of-pocket costs also be taken into consideration when defining affordable coverage under a mandate

By building on multiple forms of existing group coverage and adding a new group insurance option, these proposals on their own would not make enrollment easier or more seamless. They would also retain much of the complexity of the current system. Automatically enrolling people through the tax system with an individual mandate would help ensure that people become and remain enrolled. The income tax system can also

provide an administrative mechanism for income-related premium assistance and ceilings on out-of-pocket costs as a percentage of income.

These approaches would pool risk by building on the large risk pools of the employer market and public programs and create new health insurance exchanges with regulations against risk selection. The actual design of the new health insurance exchanges will be important, however, with respect to the restrictions against risk selection in both the exchanges and existing markets, the type of plans available for consumers, the extent of income-related subsidies, and whether both out-of-pocket costs and premiums are taken into consideration when determining the amount that a family can pay.

By building on the current system, these proposals would cause minimal dislocation—individuals with employer coverage that met minimum benefit and affordability standards could keep their coverage. Replacing small group or individual market coverage with coverage through health insurance exchanges or public programs would also save administrative costs. If Medicare, Medicaid/SCHIP, and employer coverage were redesigned to reward health care providers for higher-quality or more efficient care, even further savings would be possible. Success will depend on effective national leadership, collaboration between the public and private sectors, and information and infrastructure systems that incorporate information technology.

Financing would be a mix of federal and state general revenue taxation, employer and individual premium contributions, and modest cost-sharing. Subsidies for low-income families would offset all or part of premiums and out-of-pocket costs; broad risk pooling would help keep the size of subsidies low. The financial distribution of costs is likely to be closely proportional to earnings, and more progressively shared than financing under most approaches that provide tax incentives for coverage through the individual market. Some proposals would fund the federal portion of costs by repealing or not renewing tax cuts for higher-income households, thereby increasing the progressive nature of the overall financing.

Public Insurance

Public insurance programs offer the greatest potential for automatic and continuous enrollment and the ability to cover everyone. Enrollment could be facilitated through local Medicare or Social Security offices. Those failing to enroll could be signed up when they seek health care services, or coverage could be verified as part of income tax filing. With everyone eventually enrolled at birth in an expanded Medicare program, people would automatically be enrolled and stay enrolled across their lifespans. Most proposals would establish a minimum standard benefit package—modeled on the typical plan offered

to members of Congress or to employees of large firms—for all those in the newly expanded Medicare program, including those over age 65. For those proposals requiring enrollees to pay cost-sharing or a portion of premiums, a ceiling on out-of-pocket costs and premiums as a percentage of income would be established to ensure affordability. Some proposals modeled, for example, on the Canadian health system would not include patient cost-sharing for basic services and would be financed by federal and state taxes. Given Medicare's low administrative costs and broad risk pooling, substantial savings could accrue in an expanded Medicare approach through a reduction in administrative costs. Other sources of savings would likely arise from paying providers Medicare rates that are lower, on average, than private rates.

The proposals modeled on the current Medicare program would provide choice of private plan options currently available to Medicare beneficiaries, as well as the program's own self-insured plan.

The public insurance approaches to health insurance reform would create dislocation as people would move from their current source of coverage to coverage through Medicare or another public plan. However, people would still likely keep their same set of providers. Proposals that would allow employers to continue offering coverage would be less disruptive. It is anticipated, however, that most employers would ultimately prefer to pay a part of the Medicare premium rather than private coverage premiums, which would probably be higher.

These proposals would enable the nation to develop and utilize common quality metrics, gather data on the health care outcomes of the full population, and evaluate and improve the performance of providers based on a large pool of patients not fragmented by insurance type. They also would allow for the creation of uniform provider payment systems that reward high-quality care and standardization in health information technology, and help create universal processes to improve safety systematically across health care institutions.

Financing is likely to come largely from federal income and payroll taxes or new taxes, such as a value-added tax or consumption tax. This mechanism would be less administratively complex than providing premium subsidies based on income. The distribution of financing is more likely to be progressively related to income in public insurance proposals than in either individual insurance market or mixed private-public group insurance proposals.

THE VIEW OF THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

In the Commission's view, both the mixed private–public group insurance with a shared responsibility for financing and the public insurance reform proposals have the greatest potential to move the health care system toward high performance. Depending on the specifics of proposals, both approaches have the potential to provide everyone with comprehensive and affordable health insurance, achieve greater equity in access to care, realize efficiencies and cost-savings in the provision of coverage and delivery of care, and redirect incentives to improve quality. However, from a pragmatic perspective, allowing the more than 160 million people who now have employer-based health coverage to retain it as in the mixed public–private approach—and not asking them to enroll in a new program as in the public insurance models—would cause far less dislocation.

Many mixed private–public group insurance proposals would provide people without access to employer coverage public plan options, like Medicare. Allowing Medicare to compete on an equal basis with private plans offering the same benefit packages would ultimately allow individuals and businesses the option to choose between private and public plan options. The mixed private–public approaches would build on the broadest risk pools in the current system—employer and public plans—and create new group insurance exchanges for people without access to employer or public plans. The new group insurance exchanges coupled with income-based subsidies would replace the individual insurance market—currently the least efficient and least equitable type of health insurance in the system.

CONCLUSION

Ultimately, we must move the health care system to high performance using goals and properly aligned incentives that orient all participants in the same direction: toward improved access, quality, equity, and efficiency. The most important feature of any health insurance reform proposal is whether it can succeed in providing health insurance and access to care to all. In addition, proposals should be examined for their ability to produce better access, higher quality, and greater efficiency. Whenever possible, we must seek synergy between coverage expansion and reforms that encourage high performance. It is critical that all adults and children be able to fully participate in a well-organized, incentive-based system that ensures everyone receive the right care, at the right time, and in the right setting, over their lifespans.

Achieving universal coverage will require serious financial investment by federal and state governments, employers, households, and other stakeholders. This shared responsibility should be fair, based on ability to pay.

Achieving universal coverage will require engaging everyone in a debate about values, our commitment to a healthy and productive life for all, and the merits of different strategies for achieving improved coverage and better performance. Serious reform will require broad consensus.

In our view, a shared responsibility among all stakeholders is needed both to achieve the goals of reform and to do so in a way that is both effective and fair. It is our hope that this guide will help national and state leaders grappling with these difficult issues, and contribute to informed debate and discussion about the future direction of the U.S. health system.

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⁶⁸ For detail on the presidential candidates’ plans, see <http://www.hillaryclinton.com/>; <http://www.chrisdodd.com/>; <http://johnedwards.com/>; <http://www.barackobama.com/index.php>; <http://www.richardsonforpresident.com/>. For detail on the Massachusetts law, see

<http://www.lawlib.state.ma.us/healthinsurance.html>; and for details on Governor Schwarzenegger's proposal see <http://gov.ca.gov/index.php?/press-release/7648/>.

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