Front and Center

Ensuring That Health Reform Puts People First

June 2009

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Front and Center

Ensuring That Health Reform Puts People First

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ABSTRACT: A comprehensive health care reform strategy proposed by the Commonwealth Fund Commission on a High Performance Health System could improve health and health care experiences for many people in the United States. This report focuses on those who would benefit from such health reforms, including the estimated 116 million working-age adults—two-thirds of all adults—who report that they are uninsured or underinsured, have medical bill or debt problems, or experience difficulties obtaining needed care. A national health insurance exchange with competing private plans and a new public plan has the potential to provide greater choices, better benefits, and more affordable premiums. If coupled with broad system reforms, the average family could save $2,314 a year by 2020, as the annual increase in health costs slowed from 6.7 percent to 5.5 percent. Cumulative national savings over the period 2010 to 2020 would be $3 trillion, compared with projected trends.

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Executive Summary

The stakes are high for U.S. families as the nation considers health system reforms. The major beneficiaries of reform would be people who do not fare well in our current systems for financing and delivering health care services, including those at risk for losing their health insurance or affordable access to care when they get sick.

In a nation replete with modern medical centers, there are countless stories of Americans whose lives could have been saved or disabilities averted if they had been able to afford medical care or had timely access to high-quality, safe care. In today's health system both the insured and the uninsured are at risk. Even families whose incomes place them solidly in the middle class worry that they will not be able to afford to get sick, that they will see their children lose the protection of family coverage, or that they will exhaust a lifetime of savings paying off medical debt.

This report examines the multiple ways in which the current health insurance and care delivery systems fail people when they need it. And it describes the people who would benefit from health reforms aimed at providing secure, comprehensive coverage and enabling the delivery of accessible, safe, patient-centered health care.

A Health System in Crisis

Health reform in many nations has been triggered by tragic incidents caused by dysfunctional health care systems. In the United States, 18,000 people die every year as a result of being uninsured—and these preventable deaths are only the tip of the iceberg of missed opportunities to improve health. The U.S. remains the only wealthy country where a serious illness could bankrupt an otherwise well-off family. We may have reached the point where Americans can no longer tolerate the human toll of delayed or inadequate care for those who are sick and unable to pay for care, or the fear of knowing that none of us is truly secure.

The current economic crisis only intensifies the crisis in our health care system, as millions more lose their jobs and enter the ranks of the uninsured. The two purposes of insurance are to ensure access to essential health care and protect against financial hardship of medical bills, yet we have increasingly designed insurance that does neither. With the comprehensiveness and adequacy of insurance eroding, medical bills are often beyond families' ability to pay. Health insurance premiums now exceed a year's pay for minimum wage workers—making them unaffordable for employees and employers alike.

In this report, we focus on the people who would benefit most from health care reform: the uninsured; the underinsured; those with unstable coverage who lose and gain insurance; those who lose their coverage when their life circumstances change; those entering the labor market who cannot find a job with coverage; those who must wait to qualify for coverage until they have worked long enough or been disabled long enough; those who cannot afford their out-of-pocket costs or health insurance premiums; those who are discriminated against because they are sick, older, or female; those who spend hours with hassles over medical bills; and those who cannot find a doctor who provides easy access and helps coordinate their care.

Most people in the U.S. fall into one of these categories and have personally experienced the shortcomings of our current system. Even before the severe recession, an estimated 116 million working-age adults—two-thirds of all adults—reported they were uninsured or underinsured, had medical bill or debt problems, or experienced difficulties obtaining needed care. The beneficiaries of reforms that ensure

affordable health insurance and access to high-quality care would include:

- 46 million who were uninsured at the start of the recession, and 55 million who were uninsured at some point during the past year;
- 25 million working-age adults who are underinsured;
- 72 million working-age adults who have difficulty paying medical bills;
- 49 million small business employees who now pay higher premiums than employees in larger businesses;
- 4 million adults under age 65 with individual coverage whose premiums go toward high overhead costs, leaving less room for benefits;
- one-third of insured people who change plans frequently, often not by choice;
- 46 percent of workers with employer coverage who do not have a choice of plans;
- Medicaid beneficiaries, who would have expanded choices and better access to care if Medicaid provider payments were increased;
- women, who as a group carry greater financial burdens from health care expenses;
- 13 million young adults without coverage;
- older adults and early retirees, who have few affordable insurance options;
- 2 million disabled individuals in the waiting period for Medicare coverage;
- any Medicare beneficiary who now pays high premiums for supplemental coverage; and
- 37 million adults and 10 million children who lack easy access to a regular source of care.

The Benefits of Comprehensive Reform

This report examines how a comprehensive, integrated strategy for health care reform could improve the health and health care experiences for these diverse groups. It is based on a framework previously set forth in *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way*, a report of the Commonwealth Fund Commission on a High Performance Health System that outlined ways to ensure health insurance coverage for all and eliminate the financial burdens that now undermine personal economic security (referred to here as the "Path report" or "Path framework").

Building on current job-based health insurance while expanding the coverage choices available, the reforms would ensure affordable coverage to everyone—covering the uninsured and improving coverage for those who are underinsured. A national health insurance exchange would offer an array of competing private plans and a new public health insurance plan, helping to improve coverage for 138 million currently insured individuals through more choices, better benefits, and/or more affordable premiums, which would be 20 percent to 30 percent lower than those now charged in the individual and small-business markets for comparable benefits and enrollees. Savings would be realized by employers and households at every income level.

If coupled with broad health system reforms, the average family would save $2,314 a year by 2020, as the annual increase in health care costs slowed from 6.7 percent to 5.5 percent. Cumulative national savings to the health system over the period 2010 to 2020 would be $3 trillion, compared with projected trends. While the federal government would need to make upfront investments, the benefits would accrue over time to all of those who finance the health system.

The most important outcome of health system reform that puts people first would be the health benefits to the American people. If the achievable targets included in the Path framework are reached, by the year 2020 an estimated 100,000 lives per year would be saved, 68 million more adults would receive recommended preventive care, and 37 million more adults and 10 million more children would receive care from physician practices that ensure easy access to care and are accountable for providing patients all essential health services. Avoidable hospitalizations would decline each year as well: 640,000 fewer Medicare beneficiaries would be hospitalized for ambulatory care–sensitive conditions, and 180,000 fewer Medicare beneficiaries would be readmitted within 30 days following their initial hospital discharge. In addition, there would be 70,000 fewer children hospitalized for asthma-related complications each year, and 250,000 fewer adults hospitalized for diabetes-related complications.

Payment and system reforms would make the organization and delivery of health care services more responsive to peoples' needs and preferences. In a 2008 survey, three-quarters of all adults reported difficulty accessing care, half reported problems with care coordination, and one-quarter reported serious problems related to time spent on paperwork or disputes about medical bills or health insurance in the previous two years. Reforms that promote accessible, coordinated, patient-centered primary care would be of particular benefit to individuals with chronic illnesses. To ensure that people get the right care, at the right time, and in the right way—and to avoid waste and duplication—it will be necessary to invest in health information technologies. By 2020, 98 percent of physicians should have electronic information systems that meet national standards, up from only about one-fourth of primary care physicians today. Payment systems that enable providers to spend time with their patients and reward excellent results would

Exhibit ES-1. A Health System That Works for People

- ✓ Extends affordable health insurance coverage to everyone
- ✓ Prohibits exclusion and risk-rating based on health status or gender
- ✓ Covers preventive care
- ✓ Ensures that premiums are affordable and medical bills are manageable
- ✓ Allows individuals to keep the coverage they have while providing more insurance plan choices for all
- ✓ Eliminates the need to forgo coverage or switch plans as job or family circumstances change
- ✓ Gives every patient the option to enroll in a medical home, ensuring that they receive all recommended preventive care, help controlling chronic conditions, and assistance navigating the health care system
- ✓ Enables patients to get care when it is needed, including on nights and weekends, and to get questions answered promptly by doctors or nurses by phone or e-mail
- ✓ Reduces the hassle of filing insurance claims and getting bills paid
- ✓ Makes health information such as medical records and test results available to patients on a timely basis

raise the standards of care. There also should be incentives for providers to innovate and improve.

As the political deliberations over health reform increasingly center on how those who provide care or insurance would be affected by various reform options, it is important to focus on the core purpose of reform: ensuring affordable health coverage and health care for all. Putting people first is a shared goal of health professionals, and it is one that needs to guide health reform deliberations. This strategy enjoys widespread support among the public across income groups, geographic regions, and political affiliation. Nine of 10 people believe that health reform should improve the quality of care, ensure that care and insurance are affordable to all, and reduce the numbers of uninsured.

The political challenges to doing so are formidable, but the expectations for our political leaders are also high. Too often, the voices heard in the halls of Congress speak for those who have a strong financial stake in the $2.5 trillion now spent on the health care system. At a time of severe economic crisis, now is the time to listen to the concerns of individuals and families. Designing health reforms that put peoples' interests first should go a long way to forging consensus and enacting legislation during this historic window of opportunity.

Introduction

In the political fray over health reform, it is important to keep sight of a key question: What is best for people? Putting people first is a shared goal of health care professionals, and one that needs to guide health reform deliberations. Keeping this goal at the forefront will make it easier to enact reform that achieves health insurance coverage for all and improves the quality, affordability, and value of care.

The Commonwealth Fund Commission on a High Performance Health System has set forth a framework and a path to reach this goal. The strategy is a comprehensive, integrated one that ensures affordable health insurance for all while improving the quality and efficiency of the health care delivery system and investing in measures, such as health promotion and chronic disease control, that yield long-term payoffs. Described in the recent report, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (hereinafter referred to as the "Path report" or "Path framework"), the strategy calls for a transformation of the health care system to ensure that it centers on peoples' needs and that everyone has the opportunity to attain the best possible health outcomes.[1] Most important, these reforms would make the health care system work better for individuals and families.

The Path framework outlines a set of insurance reforms that together provide a foundation for broad health system reform (Exhibit 1). These include:

- Creating a new insurance exchange that would offer everyone a choice of private insurance plans and a new public insurance option. The exchange would make it easy for people to compare plans and to enroll and keep insurance as their circumstances change.
- Establishing a health insurance standard with comprehensive benefits and financial protection that all insurance plans would have to meet.
- Making sure insurance is affordable relative to income and, with this protection in place, requiring everyone to have health coverage.

Exhibit 1. Affordable Coverage for All: Foundation for Reform Policies in Path Report

- Builds on employer coverage and public programs
- New national insurance exchange
  - Offers private plans and new public health insurance option
  - Makes it easy to choose and stay covered
  - Public plan: comprehensive benefits and low administrative overhead
- All required to have coverage, with provisions for affordability
  - Low-income programs expanded
  - Income-related premium assistance to make coverage affordable
- Shared responsibility for financing: all employers share
- Insurance market reforms
  - Minimum national benefit standard
  - Guaranteed issue, renewal, and community rating (no underwriting)
  - Public comparisons; standardized format
- Insurers compete on basis of added value

Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

- Opening up Medicaid and the Children's Health Insurance Program (CHIP) to people with incomes below 150 percent of the federal poverty level (under $33,000 for a family of four), providing full premiums and low cost-sharing, and raising Medicaid provider payment rates to Medicare levels.
- Sharing responsibility for health care by requiring all employers to offer coverage or contribute to a national health insurance trust fund.
- Requiring all health insurers to offer coverage to anyone wishing to enroll and to charge the same premium, regardless of health status.

This report focuses on the beneficiaries of such health reforms: the uninsured; the underinsured; those with unstable coverage who move in and out of coverage; those who lose their coverage when their life circumstances change; those entering the labor market who have cannot find a job with coverage; those who must wait to qualify for coverage until they have worked long enough or been disabled long enough; those who cannot afford their out-of-pocket costs or health insurance premiums; those who are discriminated against because they are sick, older, or female; those who spend hours dealing with medical bills; and those who cannot find a doctor who provides easy access and helps coordinate their care. Most Americans fall into one of these categories and have personally experienced the shortcomings of our current system. An estimated 116 million working-age adults—two-thirds of all adults—report being uninsured or underinsured, medical bill or debt problems, or difficulties obtaining needed care.[2] First and foremost, health reform must be designed in a way that works for these individuals.

A Health System in Crisis

Forty-Six Million Are Uninsured, Millions More Have Coverage Gaps

The major goal of health care reform in the United States should be to guarantee the availability of affordable health insurance for all. An estimated 46 million Americans were uninsured in 2007, up from 38 million in 2000.[3] Even before the economic downturn, their numbers were projected to grow to 61 million in 2020 (Exhibit 2). Millions more lose coverage for a period as a result of becoming ill, changing jobs, or other circumstances. In 2006, 75 million people were uninsured for all or part of the year, representing 25 percent of the total population and 27 percent of those under 65.[4] Notably, this was before the severe economic downturn and subsequent loss of some 5 million jobs.

Uninsured rates are particularly high among low-income individuals. Half of those with family income under $20,000 were uninsured at some point during 2007. But over the last decade, more and more middle-class families have joined the ranks of the uninsured. Two-fifths (41%) of those with moderate incomes ($20,000 to $39,999) were uninsured at some point during 2007, up from 28 percent in 2001.[5]

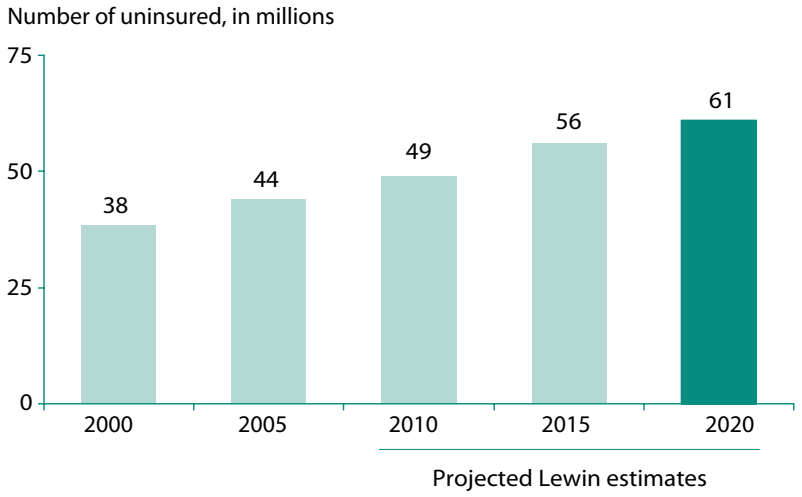
The projected rise in unemployment endangers the health coverage of many more working Americans. Since employer-sponsored insurance is the major source of coverage for working families, loss of a job often means loss of insurance. A recent study found that for every percentage-point increase in the unemployment rate, the number of uninsured increases by approximately 1 million. If unemployment were to rise to 10 percent, 6 million more people would be uninsured than in 2007.[6]

The economic and health consequences of being uninsured and lacking access to affordable care are stark. In a nation replete with modern medical centers, there are countless stories of Americans whose lives could have been saved or whose disabilities could have been averted if they had timely access to affordable, high-quality care.[7] The Institute of Medicine estimates that 18,000 people die each year as a direct consequence of being uninsured, and analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey shows that 68 percent of the uninsured went without needed care because of cost.[8,9] Those with chronic conditions, for example, are less likely than the insured to report managing their conditions, more likely to report not filling prescriptions or skipping doses of drugs, and more likely to use emergency rooms and be hospitalized.[10]

The uninsured are also less likely than the insured to receive preventive care, including immunizations, Pap tests, mammograms, and colon cancer screening. People without health insurance who have life-threatening conditions can die from delays in early detection as well as a lack of adequate treatment.[11] In many nations, major health reform has been triggered by tragedies like these that were the result of dysfunctional health care systems.[12]

Recently, Congress enacted some modest measures to assist the uninsured. Reauthorization of CHIP will cover an estimated additional 4 million uninsured children.[13] Provisions in the American Recovery and Reinvestment Act of 2009 will offset 65 percent of health insurance premiums for recently unemployed workers who are able to retain their employer-based coverage under COBRA.[14] However, many unemployed individuals and families will still find coverage unaffordable even with this assistance.[15] Moreover, Commonwealth Fund analysis suggests that many low-income individuals and families are not eligible for COBRA because they either worked in small firms or did not have health benefits in their former job.[16]

Exhibit 2. Uninsured Projected to Rise to 61 Million by 2020, Not Counting Underinsured or Part-Year Uninsured



Data: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2001 and 2006; Projections to 2020 based on estimates by The Lewin Group.

The Path framework would extend affordable coverage to everyone, ensuring access to needed care and financial protection to individuals and families while providing a foundation for long-term reforms to improve the quality and efficiency of care. The number of uninsured—projected to rise to 61 million in 2020 absent significant reform—would instead fall to an estimated 4 million, or about 1 percent of the U.S. population (Exhibit 3). Even hard-to-reach individuals would qualify for free or low-cost coverage if they became ill and sought care.

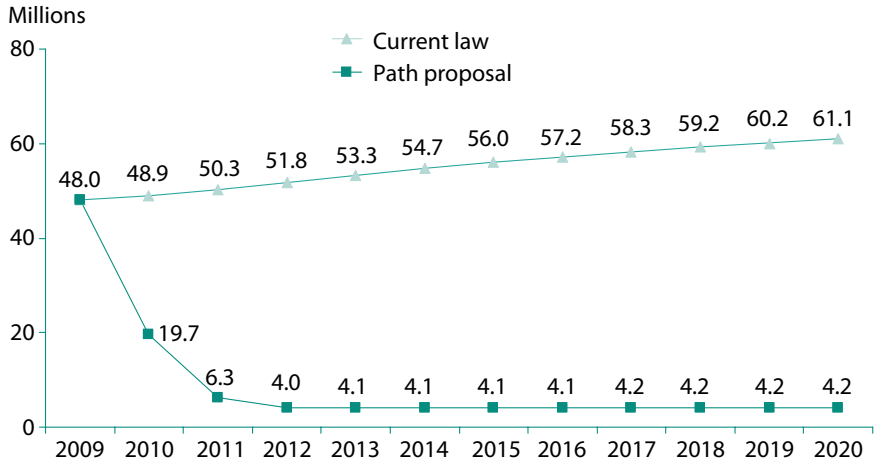
Twenty-Five Million Are Underinsured

Under the current health care system, even those with coverage often have inadequate financial protection and access to care. Individuals with insurance coverage are increasingly at risk of being underinsured or spending a high percentage of their income on medical care, despite having continuous coverage. A recent study defined insured adults as being underinsured if they spent 10 percent or more of their income (5 percent for low-income individuals) on out-of-pocket health care costs, or had deductibles equivalent to 5 percent or more of income.[17] As of 2007, there were an estimated 25 million underinsured adults in the U.S., up 60 percent from 2003. While low-income individuals and families are hit the hardest, the problem has moved up the income ladder and taken hold in the middle class. Between 2003 and 2007, the underinsured rate nearly tripled among adults with incomes above 200 percent of the federal poverty level.

Even though they have coverage all year, the underinsured experience problems accessing care and paying medical bills at rates similar to those seen for the uninsured (Exhibit 4). In a Commonwealth Fund survey, 53 percent of adults who were underinsured reported one of four instances of going without needed care because of costs: not filling a prescription; skipping a recommended medical test, treatment, or follow-up; having a medical problem but not visiting a doctor; or not getting needed specialist care because of costs.[18] Forty-five percent of the underinsured reported one of three medical debt or bill problems: having problems paying medical bills; changing their way of life to pay medical bills; or being contacted by a collection agency for inability to pay medical bills. Rising health care costs have fueled erosion in insurance benefits and shifted financial risk onto individuals and families.[19]

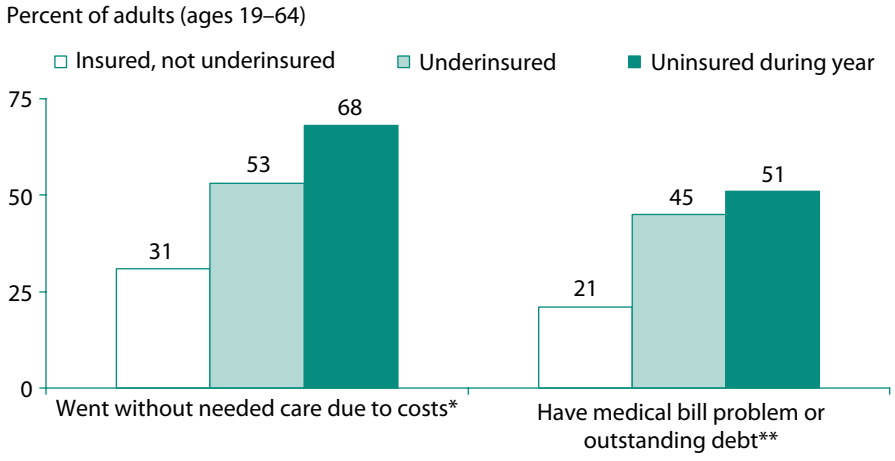
The design of health insurance benefits clearly matters.[20] Yet the nation lacks a standard for coverage that ensures health care access and adequate financial protection, and prevents "surprises" resulting from arbitrary limits or holes in benefits. The Path framework features a public health insurance plan within a national health insurance exchange that would establish a minimum standard benefit package, based on the Blue Cross Blue Shield option available to members of Congress and federal employees. All health plans, including employer-sponsored plans, would be required to meet a minimum coverage standard under the framework. Deductibles in the public insurance standard plan would be $250 per person or $500 per family, rather than the $2,000 to $10,000 deductibles found in some insurance policies today. Even the average deductible for single coverage offered by companies employing fewer than 200 workers approached $1,000 in 2008.[21] Preventive services and services required for treatment of chronic conditions would be covered in full.

Exhibit 3. Trend in the Number of Uninsured, 2009–2020, Under Current Law and with Insurance Reforms and Exchange



Note: Assumes insurance exchange opens in 2010 and take-up by uninsured occurs over two years. Remaining uninsured are mainly those who do not file taxes.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Exhibit 4. Underinsured and Uninsured Adults at High Risk of Going Without Needed Care and Financial Stress



* Did not fill prescription; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor; or did not get needed specialist care because of costs. **Had problems paying medical bills; changed way of life to pay medical bills; or contacted by a collection agency for inability to pay medical bills.
Source: C. Schoen, S. Collins, J. Kriss, M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008. Data: 2007 Commonwealth Fund Biennial Health Insurance Survey.

Seventy-Two Million Struggle to Pay Medical Bills or Have Medical Debt

Rapidly rising health care costs and erosion in the adequacy of health insurance coverage have serious economic consequences for a growing number of individuals and families. Analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey shows that 72 million adults under age 65 have problems paying medical bills or are paying off accumulated medical debt; about 60 percent of these adults were insured at the time the expenses were incurred (Exhibit 5).[22] Adults with medical bill problems face dire financial tradeoffs: 29 percent are unable to pay for basic necessities—food, heat, rent—because of their bills. Meanwhile, 39 percent use their savings to pay bills, and 30 percent take on credit card debt.

Establishing a standard benefit floor and income-related premium assistance is essential to stemming the rise in ruinous medical bills and medical debt. Under the Path framework, no family with income below twice the poverty level would pay more than 5 percent of their income for standard coverage, and, above that level, no family would pay more than 10 percent of their income.

One-Third Frequently Change Health Plans

Linking health insurance to employment, without a mechanism that enables people to keep their coverage as their circumstances change, undermines the continuity of care and endangers health. A change in job, marital, or dependent status typically triggers a change—and often a gap—in coverage. One-third of adults changed insurance plans during the past three years, including 14 percent who have changed more than once (Exhibit 6). This pattern persists even for adults with chronic illness.[23] Studies indicate that changing plans is typically not a matter of choice but rather is necessitated by a change in life circumstances.[24] Volatility in enrollment, including short-term enrollment, erodes incentives for insurance plans to invest in population health and disease prevention, drives up overhead costs, and undermines the stability of patient–provider relationships.

Exhibit 5. Seventy-Two Million Americans Have Problems with Medical Bills or Accrued Medical Debt, 2007

Percent of adults ages 19–64

	2005	2007
In the past 12 months:		
Had problems paying or unable to pay medical bills	23% 39 million	27% 48 million
Contacted by collection agency for unpaid medical bills	13% 22 million	16% 28 million
Had to change way of life to pay bills	14% 24 million	18% 32 million
Any of the above bill problems	28% 48 million	33% 59 million
Medical bills being paid off over time	21% 37 million	28% 49 million
Any bill problems or medical debt	34% 58 million	41% 72 million

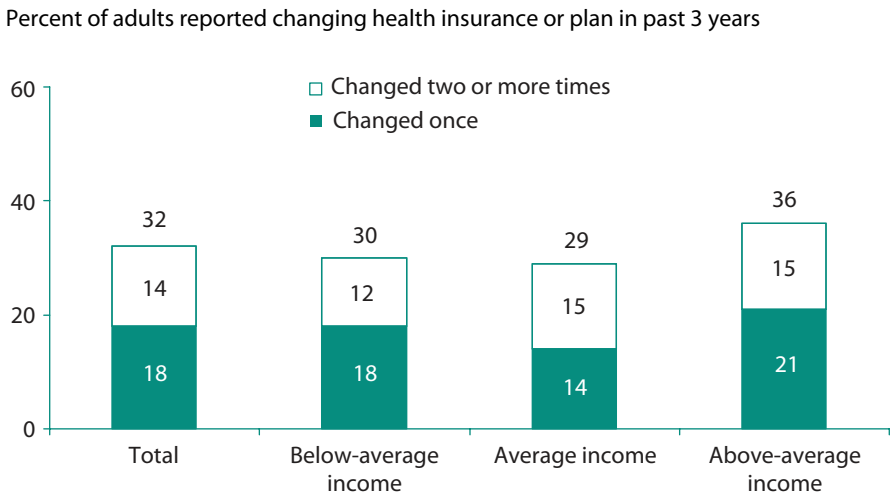
Source: M. M. Doty, S. R. Collins, S. D. Rustgi, and J. L. Kriss, *Seeing Red: The Growing Burden of Medical Bills and Debt Faced by U.S. Families* (New York: The Commonwealth Fund, Aug. 2008).

Commonwealth Fund–sponsored analysis of Medical Expenditure Panel Survey data shows that people with coverage obtained in the individual insurance market are more likely than those with employer-based coverage to switch insurance plans or carriers or undergo periods without coverage (Exhibit 7).[25] Twenty-one percent of people with nongroup coverage reported having one or more spells without insurance over a two-year period, compared with 12 percent of those with employer-sponsored coverage. Meanwhile, an additional 26 percent of those with individual market coverage underwent an insurance transition; by contrast, only an additional 2 percent of those with employer-based insurance experienced churning, such as changing plans or carriers, or gaining and losing coverage.

For those with chronic conditions, churning in insurance program enrollment and gaps in coverage introduce a high risk of complications that result in preventable admissions to hospitals or emergency care. For example, a recent study of Medicaid beneficiaries found that among those with interrupted coverage, there was a fourfold increase in the probability of hospitalization for diabetes, asthma, urinary tract infections, ruptured appendicitis, and other conditions for which timely, appropriate care make a difference.[26] More than 60 percent of enrollees experienced such gaps in coverage. With low-income families forced to demonstrate eligibility as often as every three months, the way that public insurance program criteria are designed frequently leads to discontinuous coverage.

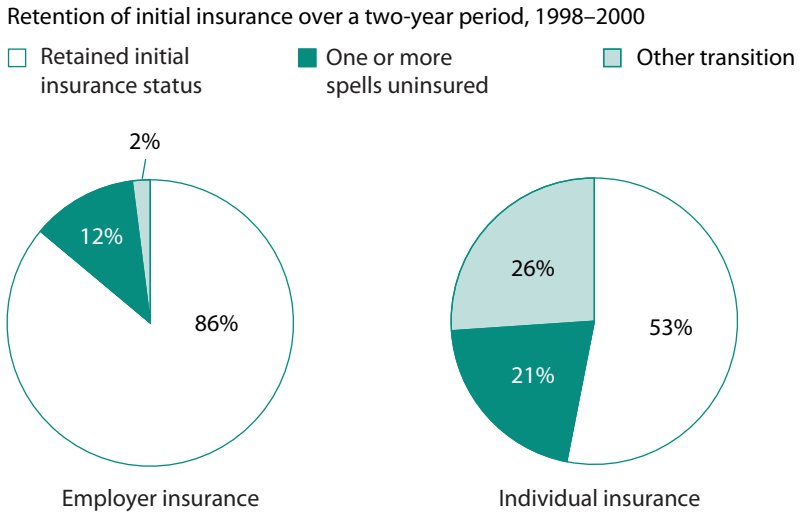
The Path report calls for the creation of a national health insurance exchange offering a variety of private plans and a public health insurance plan. This would give people greater choices among plans, as well as the option to keep continuous coverage that would follow them during life's transitions—thus enhancing population health by ensuring uninterrupted access to preventive and primary care services. Reducing the frequency of coverage interruptions could prevent hospitalizations and other events that trigger negative health consequences for individuals and high costs for families.[27]

Exhibit 6. Switching Health Plans Is a Common Experience Across Incomes, 2007



Data: 2007 Commonwealth Fund International Health Policy Survey of Adults.

Exhibit 7. People with Employer Insurance Have More-Stable Coverage Than Those with Individual Market Insurance



Source: K. Klein, S. A. Glied, and D. Ferry, *Entrances and Exits: Health Insurance Churning, 1998–2000* (New York: The Commonwealth Fund, Sept. 2005). Authors' analysis of the 1998–2000 Medical Expenditure Panel Survey.

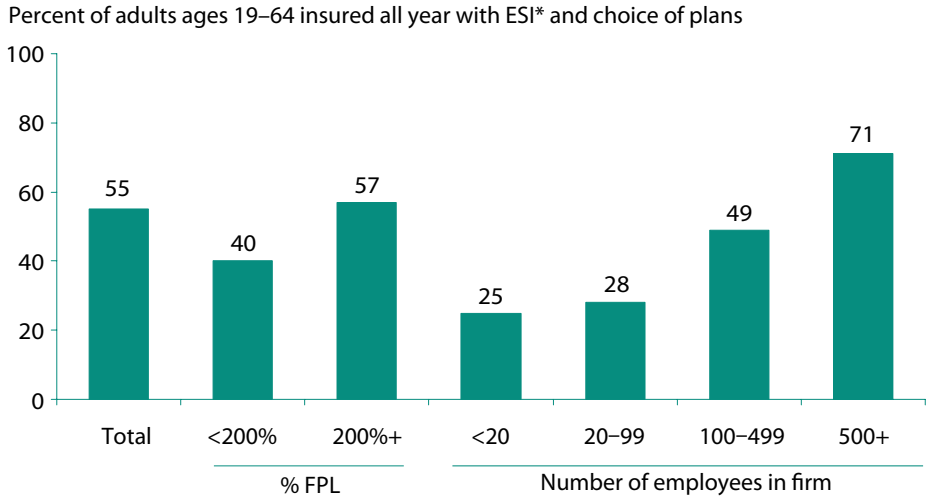
Nearly Half of Workers with Employer Coverage Have No Choice of Plan

Insurance companies increasingly require that small businesses offer their employees only one plan to guard against adverse selection and keep risk pools intact. This has meant that firms with employees spread across multiple locations often do not offer high-quality, regional health plans. Except for some large employers, including the federal government, large businesses also have moved away from sponsoring multiple coverage options. As of 2008, only 14 percent of small firms (those with fewer than 100 workers) and 44 percent of large firms (those with 200 or more workers) offered their employees a choice among different types of health plans.[28] Analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey shows that 42 percent of workers with employer coverage had only one choice; those in firms with more than 500 employees were much more likely than those in firms with fewer than 20 employees to have a choice of plans (71% vs. 25%) (Exhibit 8). Even when workers have plan choice, the plans are often different products offered by the same insurer.

The decline in coverage choices presented to working families has coincided with a nationwide trend toward increasing insurance market consolidation and decreasing competition.[29] Currently, the top two private plans account for 50 percent or more of enrollment in all but three states and 70 percent or more of enrollment in 21 states. Increasing dominance by national insurance companies is making it difficult for regional health plans—including high-quality, efficient plans partnered with integrated health systems—to gain access to group markets.

Setting up a national health insurance exchange that would operate at the state or regional levels would offset the trend toward market concentration, provide multiple health plan choices, including regional plans, and ensure that at least one insurance option would be available to everyone. While employers would be free to contract directly for

Exhibit 8. Employees in Large Firms Are Most Likely to Have Two or More Health Plan Choices



* ESI = employer-sponsored insurance.
Based on adults 19–64 who were who were insured all year through their own employer.
Source: 2007 Commonwealth Fund Biennial Health Insurance Survey.

coverage, the exchange would be open to employer groups as well as individuals. An estimated 70 percent of employers would elect to purchase coverage through the exchange. The exchange would stimulate a new competitive dynamic in insurance markets, making it easy to compare and assess insurance plans by the quality and cost of care provided, generosity of benefits, and beneficiary experiences. Competition among health plans based on performance—rather than health risks—has the potential to improve efficiency and return value to workers and employers.

Under the Path framework, employment-based insurance would remain the mainstay of coverage for many working families, with the number of Americans receiving employer payments toward premiums projected to increase from 164 million to 196 million. By building on our mixed private–public coverage system and creating a new insurance exchange that enables workers and their families to keep their coverage as they move from job to job would make affordable coverage options available to all, while ensuring continuity and stability. It would offer a pathway to more secure coverage within our uniquely American insurance system.

Nearly Half of Small Business Employees Are at Risk

While all working families are at risk of losing health insurance coverage, employees of small businesses are particularly vulnerable. Many are simply not offered insurance. Only 49 percent of those working for firms with fewer than 10 employees had the option to purchase job-based coverage (Exhibit 9).[30] This rate has declined eight percentage points over the previous decade, from 57 percent in 2000. The White House Office of Health Reform notes that small business workers who are not offered coverage often end up uninsured.[31] According to a recent Commonwealth Fund study, three of five uninsured workers are self-employed or working for a firm with fewer than 100 employees.[32]

Employees of small firms receive fewer benefits, pay higher premiums, and often face larger deductibles compared with those working for larger businesses. In

2002, a firm with more than 1,000 employees paid an estimated premium of $3,134 for single-person coverage, while employers with fewer than 10 employees paid $3,579 for the same benefit package.[33] Smaller businesses also pick up a smaller share of premiums, further increasing costs to their workers. Finally, deductibles have risen sharply in smaller firms (with three to 199 employees), with the mean deductible for single coverage rising from $210 in 2000 to $917 in 2008. For larger firms, deductibles increased from $157 to $413 over this period.

The Path framework would pool risk across small and large employers in order to provide equitable and affordable insurance options to all employees. By bringing risk pools together and reducing churning and marketing costs, the health insurance exchange would dramatically improve the efficiency of coverage. Administrative costs as a percentage of medical claims are now estimated to run between 31 percent and 41 percent for the self-employed and businesses with fewer than 10 employees. The economies achieved in the exchange are projected to lower administrative costs to between 13 percent and 15 percent of claims for very small groups.

In addition, under the Path framework, millions of small business employees will gain access to coverage. Historically, employers have invested in the health and well-being of their employees by sharing responsibility for financing their coverage. The framework would build on this foundation by requiring all businesses to offer insurance or contribute to a national health insurance trust fund. Within the context of ambitious payment and system reforms, this would extend affordable health insurance to all and return significant savings to employees and employers alike.

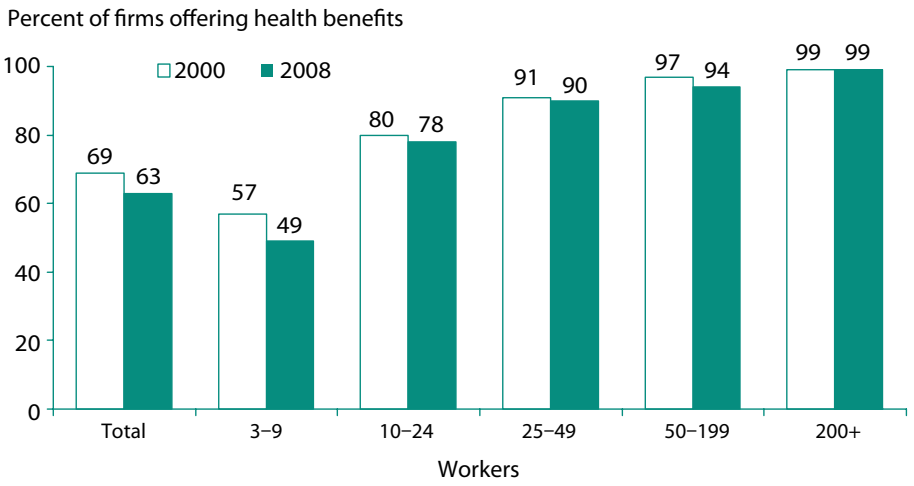
Many in Individual Insurance Market Face High Costs, Limited Benefits

The individual health insurance market does not work well in terms of providing high-value plans or affordable choices. Those covered by individual health insurance plans are much less satisfied with their coverage than those covered by job-based plans. In fact, they are likely to drop individual coverage if an alternative source becomes available from employers or public programs.[34] A majority of those seeking insurance on the individual market found it very difficult or impossible to find affordable coverage: nearly nine of 10 who tried to purchase it within the past three years never bought a plan (Exhibit 10).

Except in a few states that require insurers to have open enrollment and community-rated premiums, insurers in the individual market typically screen applicants for health risks and either exclude high-risk individuals from coverage or charge them higher premiums.[35] By design, such underwriting practices discriminate against the sick and disabled. Nongroup premiums are 20 percent to 50 percent higher than employer plan premiums, and an estimated 40 percent of the premiums go toward administration, marketing, sales commissions, underwriting, and profits.[36] The costs of individual plan premiums typically climb steeply with age.[37] Individual plan benefits are often limited and cost-sharing is typically much higher than that found in group markets. Premium costs and risk selection practices in the individual market are difficult for states to regulate.[38]

The establishment of a national health insurance exchange offering a variety of private plans and a public health insurance plan would ensure that everyone has access to affordable coverage. Requiring everyone to have health coverage would make it possible to pool risks among millions of individuals and

Exhibit 9. Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms But Has Declined Among Small Firms



Source: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2008 Annual Surveys.

Exhibit 10. Individual Market Is Unaffordable for Many Adults

Adults ages 19–64 with individual coverage or who thought about/ tried to buy it in past three years who:	Total	Health problem	No health problem	<200% poverty	200%+ poverty
Found it very difficult or impossible to find coverage they needed	34%	48%	24%	43%	29%
Found it very difficult or impossible to find affordable coverage	58	71	48	72	50
Were turned down or charged a higher price because of a preexisting condition	21	33	12	26	18
Never bought a plan	89	92	86	93	86

Source: S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

achieve substantial economies. Eliminating medical underwriting, establishing open enrollment, and enabling consumers to compare plans online would achieve a marked reduction in administrative costs. Within the insurance exchange, individual coverage is projected to incur administrative costs that are at least 26 percentage points lower than in our current system, resulting in dramatically lower premium costs for enrollees. Ninety-two percent of those who currently hold private, nonemployer coverage would enjoy better and more affordable insurance under the Path framework.

Forty-Two Million Medicaid Beneficiaries Lack Stable Coverage

Medicaid is the workhorse of the U.S. health insurance system, covering low-income people with HIV/AIDS, the homeless, those with serious mental illnesses, and children with developmental disabilities. While millions of vulnerable people rely on the program for access to care, eligibility varies widely from state to state, with 14 states covering parents only if their incomes are below 50 percent of the poverty level.[39] Thirty-five states set thresholds for parents below the poverty level, while 34 states provide no Medicaid coverage for nondisabled adults who do not have children. As a result, in the vast majority of states, an adult who works full time at the minimum wage is ineligible for coverage.

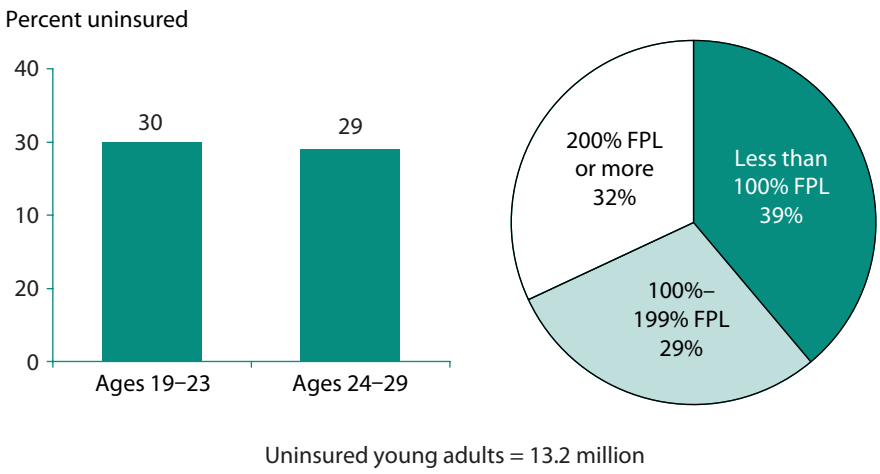
Administrative barriers to Medicaid enrollment and reenrollment often interrupt coverage for some of the country's most vulnerable individuals. These interruptions are widespread and have serious consequences: in a recent study, more than 60 percent of Medicaid enrollees experienced gaps in coverage, putting them at risk for complications that result in preventable admissions to hospitals or emergency care.[40] Medicaid pays providers at substantially lower rates than do private health insurance plans and Medicare, causing fewer providers to accept Medicaid patients and limiting access to care for low-income individuals.[41]

The Path framework calls for opening up Medicaid and CHIP to people with incomes below 150 percent of the federal poverty level (under $33,000 for a family of four), providing full premium subsidies and low cost-sharing and raising Medicaid payment rates to Medicare levels. Enhancing federal matching funds to finance coverage expansions and offset state costs will provide relief to states that face significant budgetary pressures during economic downturns. Together with the ambitious payment and system reforms, the enhanced funding proposed under the Path framework is projected to save state and local governments $1 trillion by 2020. More important, providing adequate and dedicated financing will bring continuous, stable coverage to the 42 million vulnerable individuals who rely on the Medicaid program for their health care needs.

Thirteen Million Young Adults Lack Insurance Coverage

Young adults are a large and rapidly rising proportion of the nation's uninsured population: more than 13 million adults between the ages of 19 and 29 lacked insurance coverage in 2007.[42] Commonwealth Fund analysis shows that young adults now comprise nearly 30 percent of the nonelderly uninsured, including a substantial number of low-income and minority populations (Exhibit 11).[43] Those in low-income households are more likely to go without insurance for both short and long periods: approximately 80 percent of young adults with incomes less than 200 percent of the federal poverty level were uninsured at some point during a four-year period, while 52 percent did not have health insurance for 13 months or more.[44]

Exhibit 11. Uninsured Young Adults Ages 19–29 by Poverty Status and Race/Ethnicity, 2007



Uninsured young adults = 13.2 million

Data: Analysis of the March 2008 Current Population Survey by S. Glied and B. Mahato of Columbia University for The Commonwealth Fund.
Source: J. L. Kriss, S. R. Collins, B. Mahato, E. Gould, and C. Schoen, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2009 Update* (New York: The Commonwealth Fund, forthcoming).

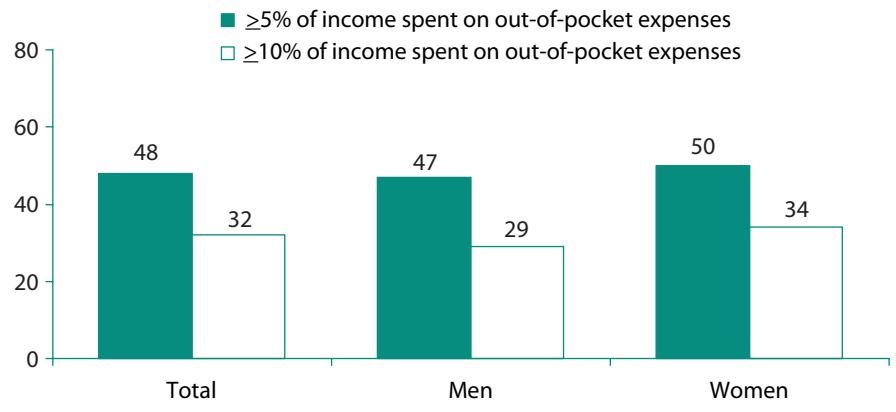
These problems arise in part because young adults do not fare well in our predominantly employment-based insurance system, as they often hold temporary positions or low-wage jobs that do not include benefits. Moreover, transitions in employment during the early working years can translate into time spent without coverage or waiting periods before receiving coverage. Commonwealth Fund research shows that gaps in coverage have important health and economic consequences for young adults and their families. Compared with those who have coverage all year, those spending at least part of the year without coverage are more likely to experience barriers to care and more likely to report problems related to medical bills and debt.[45]

The policy framework put forth in the Path report would extend affordable health coverage to the 13 million young adults who lack insurance coverage and the millions more who undergo transitions during their early working years. Young adults could remain covered under their parents' policies until age 26. Young adults with income up to 150 percent of the poverty level would be eligible for Medicaid or CHIP, and those with incomes up to 200 percent of the poverty level would be eligible for premium assistance that caps premiums at no more than 5 percent of income. A portable public health insurance plan within a national health insurance exchange would provide a continuous source of coverage for young adults who make frequent job changes.

Women Face Financial Burdens of Health Care Expenses

Recent work by the Commonwealth Fund shows that women face particular problems in securing affordable health coverage and care.[46] Steep rises in the cost of private health insurance have led to declining rates of coverage for working-age women (ages 25 to 64) over the past 25 years.[47] Compared with men, women are less likely to have access to their own employer-sponsored insurance and more likely to purchase coverage in the individual market, which is more expensive than the group market. Women also are more likely than men to have high

Exhibit 12. Percent of Income Spent on Family Out-of-Pocket Costs and Premiums

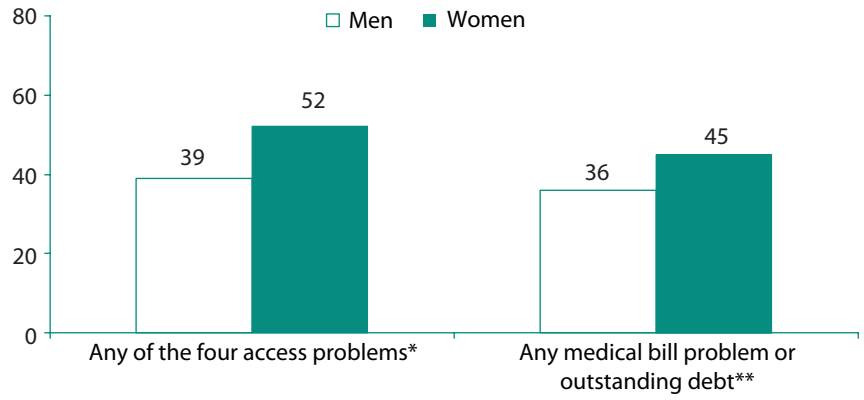


* Employer-sponsored or individual insurance.
Source: S. D. Rustgi, M. M. Doty, and S. R. Collins, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* (New York: The Commonwealth Fund, May 2009).

out-of-pocket costs as a share of income, avoid needed care because of cost, and have medical bill and debt problems (Exhibits 12 and 13).

Women face many obstacles when attempting to secure coverage on the individual market. Thirty-eight states do not prohibit or limit underwriting by gender, a practice by which insurers charge women more than men on the basis of larger expected claims costs. A recent study found that many differentials were arbitrary and not "justified by actuarial statistics."[48] Meanwhile, underwriting by health status and age disproportionately affects women, who are more

Exhibit 13. Women Are More Likely to Have Access Problems and Medical Bill Problems in Past Year, 2007



* Includes those individuals who did not fill a prescription because of cost, did not see a specialist when needed, skipped a medical test, treatment, or follow-up, or had a medical problem but did not see a doctor or go to a clinic.
** Includes those individuals not able to pay medical bills, having a bill sent to a collection agency when they were unable to pay it, changing way to life to pay medical bills, and having medical bills or medical debt being paid off over time.
Source: S. D. Rustgi, M. M. Doty, and S. R. Collins, *Women at Risk: Why Many Women Are Forgoing Needed Health Care* (New York: The Commonwealth Fund, May 2009).

likely than men to need health care services throughout their lifetimes and have chronic conditions requiring ongoing treatment. Finally, older women are more likely than older men to turn to the individual market after their spouses qualify for Medicare.

The Path framework would limit health insurance rating by gender, age, and health status, helping make individual and group coverage more affordable for working-age women. Given their lower incomes relative to men, women would disproportionately benefit from provisions that provide premium assistance based on income. Under the framework, those with incomes up to 150 percent of the poverty level would be eligible for Medicaid and those with incomes below 200 percent of the poverty level would be eligible for premium assistance that caps the proportion of premiums paid by individuals at 5 percent of income.

Older Adults and Early Retirees Face High Costs

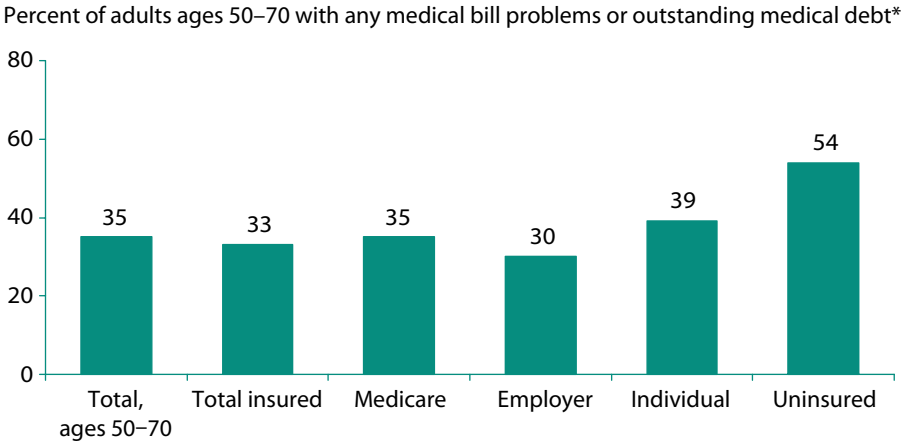
Older adults seeking health insurance coverage typically face prohibitively high premiums, large deductibles, and troubling exclusions. Such problems are particularly prevalent among those without access to a large group plan. A 2005 Commonwealth Fund survey of older adults showed that more than half of respondents who secured coverage on the individual market spent $3,600 or more annually on their health insurance premiums and a quarter spent $6,000 or more.[49] Meanwhile, 42 percent of older adults with individual coverage had deductibles higher than $1,000.

Twenty-four percent of the near-elderly (ages 50 to 70) failed to get health care services because of cost, including not filling a prescription, not seeing a doctor or specialist when needed, or skipping a medical test or follow-up treatment. Fifty-seven percent of uninsured older adults and nearly a third (32%) of those with individual coverage reported at least one of these problems. More than one-third (35%) had a problem paying their medical bills in the last 12 months or were paying off medical debt they had accrued over the last three years (Exhibit 14). Those who were uninsured or purchased coverage on the individual market reported such problems at the highest rates.

Given the relatively large proportions of older Americans who report problems in accessing care and paying medical bills, it is not surprising that nearly three-fourths (73%) said they would be very or somewhat interested in receiving Medicare before age 65. Support for this is particularly high among the uninsured (94%) and those with individual coverage (84%), as well as those with very low incomes (86%). Commonwealth Fund–supported work suggests that in addition to being popular, this would be sound public policy: increasing health coverage among older adults may not only improve health outcomes but also reduce future health care use and Medicare expenditures by providing recommended preventive care and lowering hospital admissions.[50]

Under the Path framework, insurance plans could no longer turn people away or charge exorbitant premiums and deductibles because people have an existing medical condition or are considered to be at high risk for developing one. Nor would individuals with health conditions be charged higher premiums than healthy people. Providing a public health insurance plan option with community-rated premiums using broad age bands would give older Americans access to coverage and care that enables them to lead longer, healthier lives. It also would lower costs to the Medicare program in the long run.

Exhibit 14. More Than One-Third of Older Adults Report Medical Bill Problems



* Problems paying/not able to pay medical bills, contacted by a collection agency for medical bills, had to change way of life to pay bills, or has medical debt being paid off over time.
Source: S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, and A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: The Commonwealth Fund, June 2005).

Two Million Disabled Individuals Wait Two Years for Medicare

Newly disabled adults face innumerable challenges, not the least of which is securing affordable health insurance coverage. After waiting five months to begin receiving cash benefits from the Social Security Disability Insurance (SSDI) program, such adults must wait an additional two years to begin receiving Medicare benefits. Even after qualifying for coverage, the disabled Medicare population faces a daunting combination of low income, poor health status, heavy prescription use, and high medication bills.[51]

A recent Commonwealth Fund–supported study found that inability to get needed care is a serious problem for those caught in the waiting period.[52] The Path framework would end the two-year waiting period for the disabled, benefiting over 1.8 million people, including 20 percent (or approximately 350,000) who are uninsured at a time that is particularly critical for treatment and rehabilitation (Exhibit 15).[53] Many disabled adults have low incomes and would benefit from the premium assistance available to Medicare beneficiaries under the Path framework.

Forty Million Medicare Beneficiaries Face High Premiums

The Medicare program is working for more than 40 million elderly and disabled adults across the country. Compared with those under age 65 with either public or private health coverage, Medicare beneficiaries over age 65 report better access to health care services and superior financial protection from burdensome medical bills (Exhibit 16).[54] Such beneficiaries are less likely to go without needed care because of costs and less likely to report access problems related to cost. Those under age 65 with individual and employer coverage are more likely than Medicare beneficiaries over age 65 to not visit a doctor when sick; not fill a prescription; skip a medical test, treatment, or follow-up visit recommended by a doctor; and not see a specialist when a doctor thought it was needed.

Exhibit 15. Sick, Disabled, and Waiting for Medicare: Source of Insurance During the Long Wait

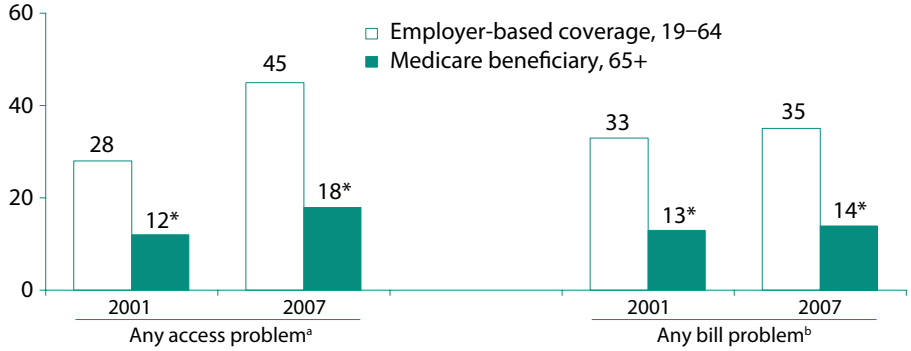
	13–24 mo. before SSDI	1–12 mo. before SSDI	1–12 mo. after SSDI	13–24 mo. after SSDI	25–36 mo. after SSDI
Uninsured (%)	21	23	23	17	4
Private – own employer (%)	41	37	26	21	16
Private – family member employer (%)	37	33	30	35	31
Medicaid (%)	7	8	17	21	29
Medicare (%) (respondent)	3	2	4	11	61

Source: G. Livermore, D. Stapleton, and H. Claypool, *Health Insurance and Health Care Access Before and After SSDI Entry* (New York: The Commonwealth Fund, May 2009).

Medicare's cost-sharing, however, can be a deterrent to care for lower-income beneficiaries or those without supplemental coverage.[55] Meanwhile, elderly beneficiaries spend an average of 22 percent of their income on premiums and out-of-pocket health care costs.[56] This is projected to grow to 30 percent by 2025. Few older adults entering retirement have substantial savings on which to draw to meet these expenses.[57]

To strengthen the program for the future, the Path framework would improve financial protection for Medicare beneficiaries. Premium caps of 5 percent

Exhibit 16. Access and Bill Problems for Elderly Medicare Beneficiaries and Nonelderly Adults Covered by Employer-Based Insurance, 2001–2007



Note: * Differences from employer-based insurance statistically significant, $p < .001$, after adjusting for health status, poverty, and prescription drug coverage.
[a] Any access problem includes: did not fill prescription, get needed specialist care, skipped recommended test or follow-up, had medical problems but did not visit doctor.
[b] Any medical bill problem includes: not able to pay bills, contacted by a collection agency for any medical bill, or had to change way of life significantly because of medical bills. To make 2001 and 2007 data comparable, any bill problem in 2007 includes being contacted by a collection agency about a medical bill regardless if it was for a billing error or unpaid bill.
Source: K. Davis, S. Guterman, M. M. Doty, and K. Stremikis, "Meeting Enrollees' Needs: How Do Medicare and Employer Coverage Stack Up?" *Health Affairs* Web Exclusive, May 12, 2009:w521–w532.

of income for low-income beneficiaries and 10 percent of income for higher-income beneficiaries would provide financial protection to elderly and disabled individuals.

Improved Coverage and Affordability for All

The Path framework offers a comprehensive, integrated strategy to ensure health coverage for all and eliminate the financial burdens that now undermine economic security for U.S. families. The creation of a national health insurance exchange with an array of competing private plans and a public health insurance plan meeting standards for eligibility and benefits would be key to its success.

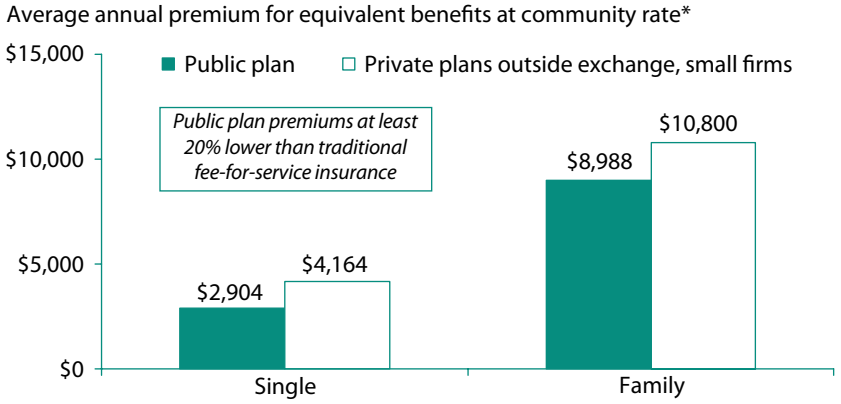
Many sources of waste in our current insurance system would be eliminated. For example, rules requiring insurers to cover everyone regardless of health status would eliminate the cost of medical exams and underwriting to ascertain health risk. Reduced churning would lower the administrative costs associated with disenrollment and reenrollment. Enrollment through the national health insurance exchange's Web-based system would reduce the need for brokers and brokers' fees.

Requiring everyone to have health insurance would broaden the risk pool, incorporating many relatively healthy uninsured individuals. Paying physicians, hospitals, and health systems through innovative methods that reward better health outcomes and provide incentives to avoid complications requiring hospitalization or emergency room use would further lower costs. The combination of savings from reduced health care utilization, prices, and administrative costs would be shared with families and employers. Premiums would be an estimated 20 percent to 30 percent lower than current premiums in the individual and small business markets (Exhibit 17).

The requirement for everyone to obtain health insurance and the standards on covered benefits would ensure that everyone has affordable, comprehensive coverage. It would assist 116 million working-age adults who are underinsured or uninsured at some point during the year, face problems obtaining needed care, or have problems paying medical bills or medical debt. The requirement to have health coverage would be coupled with shared financial responsibility among individuals, employers, and government. Under the Path framework, employers would have to pay at least 75 percent of employee premiums or contribute to a health insurance trust fund and the federal government would provide premium assistance guaranteeing that no one with income below twice the poverty level would pay more than 5 percent of their income for a standard benchmark plan. Those with higher incomes would pay no more than 10 percent of their income for such a plan.

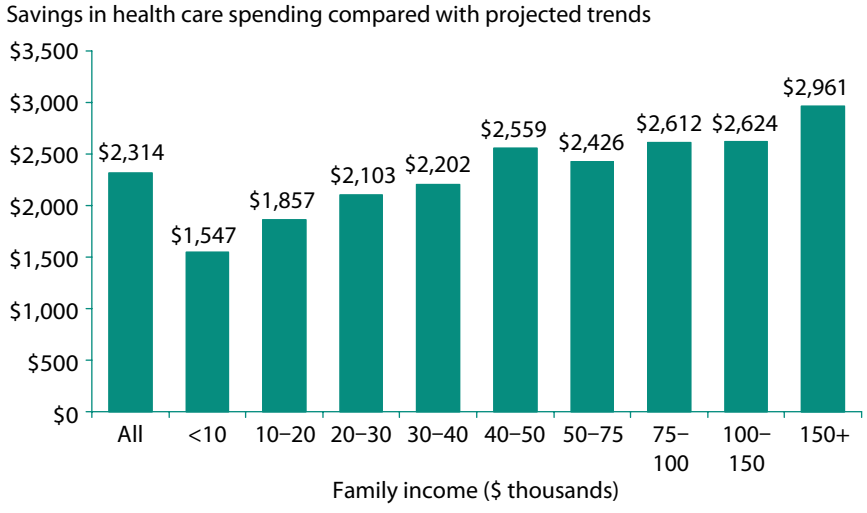
The savings from insurance, payment, and system reforms would be shared with employers and households. Under the Path framework, employers would save $231 billion over the period 2010–2020.[58] By 2020, the average household would save $2,314 (Exhibit 18). Slowing the growth in health care outlays from 6.7 percent annually to 5.5 percent annually—while seemingly a modest target—would result in significant savings to all health care payers and a total cumulative savings over 2010–2020 of $3 trillion (Exhibit 19). While the federal government would need to make upfront investments in an improved coverage and care system, the benefits and savings would accrue over time to all those who currently help finance the health system.

Exhibit 17. Estimated Premiums for New Public Plan Compared with Average Current Premiums, Individual/Small Employer Private Market, 2010



* Benefits used for modeling include full scope of acute care medical benefits; $250 individual/$500 family deductible; 10% coinsurance for physician service; 25% coinsurance and no deductible for prescription drugs; reduced for high-value medications; full coverage checkups/preventive care. $5,000 individual/$7,000 family out-of-pocket limit.
Note: Premiums include administrative load.
Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Exhibit 18. Average Annual Savings per Family Under Path Reforms, 2020



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Putting People First: Making Health Reform Work for Individuals and Families

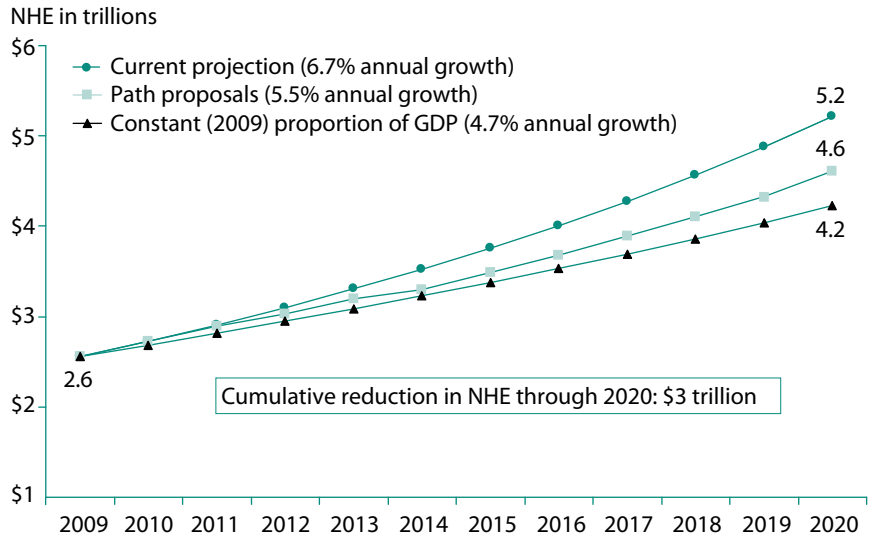
Given the widespread problems documented here, it is not surprising that half of U.S. adults think the health system needs fundamental change, while another 32 percent believe it needs to be rebuilt completely.[59] It is a system that is not working for people. The problems go beyond coverage and affordability to the organization and delivery of care. Health reform not only must ensure affordable coverage for all but also improve the accessibility, coordination, and quality of care.

Nearly three-fourths (73%) of Americans say they experience difficulty accessing care. Thirty percent of adults experience problems getting an appointment with their doctor on the same or next day. Forty-one percent report problems getting advice by phone from their physician during office hours. Sixty percent experience problems getting care on nights, weekends, and holidays without having to go to the emergency room. Access to care means more than being able to afford care; it requires having a patient-centered medical home that ensures access to care and information 24 hours a day, seven days a week.

There are also problems in the coordination of care. Nearly half (47%) of adults report having experienced some type of care coordination problem, with patients requiring care from multiple physicians more likely to experience such problems. One-fourth (25%) of adults report not getting test results or having to call repeatedly for results. One-fifth (19%) report not having test results available at the time of a scheduled appointment, and one-fifth (21%) report that their doctors failed to provide important information or test results to other doctors and nurses involved in their care. Breakdowns in the flow of information between primary care physicians and specialists are especially common.

The health system is not designed to be convenient for patients. Americans spend considerable time navigating a complex insurance system and a fragmented care delivery system. Nearly one of three

Exhibit 19. Total National Health Expenditures (NHE), 2009–2020
Current Projection and Alternative Scenarios



Note: GDP = Gross Domestic Product. Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Exhibit 20. Potential Impact on Patients if the United States Improved National Performance to Benchmark Levels

	Current national average	2020 target*	Impact on number of people
Percent of adults (ages 19–64) insured, not underinsured	58%	99%	73 million increase
Percent of adults (age 18 and older) receiving all recommended preventive care	50%	80%	68 million increase
Percent of adults (ages 19–64) with an accessible primary care provider	65%	85%	37 million increase
Percent of children (ages 0–17) with a medical home	46%	60%	10 million increase
Percent of adult hospital stays (age 18 and older) in which hospital staff always explained medicines and side effects	58%	70%	5 million increase
Percent of Medicare beneficiaries (age 65 and older) readmitted to hospital within 30 days	18%	14%	180,000 decrease
Admissions to hospital for diabetes complications, per 100,000 adults (age 18 and older)	240	126	250,000 decrease
Pediatric admissions to hospital for asthma, per 100,000 children (ages 2–17)	156	49	70,000 decrease
Medicare admissions to hospital for ambulatory care–sensitive conditions, per 100,000 beneficiaries (age 65 and older)	700	465	640,000 decrease
Deaths before age 75 from conditions amenable to health care, per 100,000 population	110	69	100,000 decrease
Percent of primary care doctors with electronic medical records	28%	98%	180,000 increase

* Targets are benchmarks of top 10% performance within the U.S. or top countries.
Source: Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2008* (New York: The Commonwealth Fund, July 2008).

(28%) patients reports serious problems in terms of the time spent on paperwork or disputes related to medical bills and health insurance in the past two years. For those in fair or poor health, two of five (40%) report such problems.

There is a better way. A patient-centered health system would ensure that people get the care they need, when they need it. The Path framework encourages all individuals to enroll in a patient-centered medical home, or a physician practice that

Exhibit 21. A Health System That Works for People

- ✓ Extends affordable health insurance coverage to everyone
- ✓ Prohibits exclusion and risk-rating based on health status or gender
- ✓ Covers preventive care
- ✓ Ensures that premiums are affordable and medical bills are manageable
- ✓ Allows individuals to keep the coverage they have while providing more insurance plan choices for all
- ✓ Eliminates the need to forgo coverage or switch plans as job or family circumstances change
- ✓ Gives every patient the option to enroll in a medical home, ensuring that they receive all recommended preventive care, help controlling chronic conditions, and assistance navigating the health care system
- ✓ Enables patients to get care when it is needed, including on nights and weekends, and to get questions answered promptly by doctors or nurses by phone or e-mail
- ✓ Reduces the hassle of filing insurance claims and getting bills paid
- ✓ Makes health information such as medical records and test results available to patients on a timely basis

is held accountable for ensuring that care is accessible when needed, reminding patients about preventive services, maintaining a registry of individuals with chronic conditions, and working with patients to control their conditions and prevent avoidable hospitalizations. Patient-centered medical homes would use information systems that, with patients' permission, make medical records easily accessible to all of the doctors and nurses involved in an individual's care. They would take responsibility for coordinating care, helping patients get appointments with specialists and providing information and follow-up care after specialist consultations or hospitalizations. Most important, patient-centered medical homes would be rewarded for achieving excellent results—ensuring that people are satisfied with their care, receive recommended preventive services, have their chronic conditions controlled, and avoid use of emergency rooms and hospitalizations when possible.[60]

The most important outcome of health system reform that puts people first would be the health benefits to the American people. If the achievable targets included in the Path framework are reached, by the year 2020 an estimated 100,000 lives per year would be saved, 68 million more adults would be up-to-date with preventive care, and 37 million more adults and 10 million more children would receive care from accessible physician practices accountable for ensuring they receive all essential care (Exhibit 20). Avoidable hospitalizations would decline each year, including 640,000 fewer Medicare beneficiaries hospitalized for ambulatory care–sensitive conditions and 180,000 fewer Medicare beneficiaries readmitted within 30 days following their initial hospital discharge. There would be 70,000 fewer children hospitalized with asthma complications each year, and 250,000 fewer adults hospitalized with diabetes complications. Keeping people healthy and out of hospitals would be a major benefit to individuals and families, as well as a significant source of savings to the health system.

To ensure that people get the right care, at the right time, and in the right way—and to avoid waste and duplication—it will be necessary to invest in health information technologies. By 2020, 98 percent of physicians should have electronic information systems that meet national standards, up from only about one-fourth of primary care physicians today.

Achieving a high performance health system that provides benefits commensurate with our investment in health care requires multipronged strategies. By extending affordable health insurance to all, aligning financial incentives to enhance value and achieve savings, organizing the health care system around the patient to ensure that care is accessible and coordinated, meeting and raising benchmarks for high-quality, efficient care, and ensuring accountable national leadership and public–private collaboration, the United States could build on examples of excellence from around the nation, and provide what everyone wants: the best health care in the world and the best health outcomes.

Such a strategy enjoys widespread support among the public across income groups, geographic regions, and political affiliation. About nine of 10 Americans believe that health reform should improve the quality of care, ensure that care and insurance are affordable to all, and reduce the numbers of uninsured.[61] The political challenges to doing so are formidable, but the expectations for our political leaders are also high. Designing health system reform that puts people's interests first should go a long way to forging consensus and enacting needed changes during this historic window of opportunity.

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