



A New Era in American Health Care: Realizing the Potential of Reform



KAREN DAVIS
June 2010

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ABSTRACT

Through a pragmatic mix of public and private financing, the new Patient Protection and Affordable Care Act will expand health care coverage, establish health insurance exchanges with market rules that protect individuals and families, and begin to transform the health care system by encouraging greater value and efficiency through a series of payment and delivery system initiatives. In this report, Commonwealth Fund president Karen Davis outlines the key features of the new reform law, discusses who will be most helped and how, and describes the ways in which the health care system will begin to provide more patient-centered, accessible, and coordinated care to all Americans. Davis also discusses the challenges that will need to be overcome as the law's provisions are implemented over the coming months and years.

A New Era in American Health Care: Realizing the Potential of Reform

Karen Davis

After a century of trying, the United States has joined the world's other major industrialized nations in providing all its citizens with access to essential health care. When President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010, he delivered on a key promise from his 2008 presidential campaign and succeeded in placing the nation on a path toward a high performance health system that serves everyone. Such change has been a long time coming. Theodore Roosevelt first proposed comprehensive reform in 1912, followed by Presidents Harry Truman, Richard Nixon, Jimmy Carter, George H. W. Bush, and Bill Clinton.¹

Commonwealth Fund analysis shows that the new law will deliver on all three of the goals President Obama set forth when Congress began crafting reform legislation last year:

- Expand access to affordable health insurance for those without coverage;
- Improve the affordability of insurance for those who already have it; and
- Slow the rise in health care costs for individuals, families, and employers while not adding to the federal budget deficit.²

WHAT ARE THE KEY FEATURES OF HEALTH REFORM?

Through a pragmatic mix of public and private financing, the new law will expand health care coverage, establish health insurance exchanges with market rules that protect individuals and families, and begin to transform the health care system by encouraging greater value and efficiency through a series of payment and delivery system initiatives. Exhibit 1 shows how these changes mirror in large part the recommendations outlined in the report *Path to a High Performance Health System*, published by the Commonwealth Fund Commission on a High Performance Health System in February 2009.³

Key features of reform include:

1. **New federal insurance market rules** that prohibit restricting coverage or varying premiums based on health, set limits on the share of private premiums going for non-medical costs, and establish essential standard benefit packages that guarantee beneficiaries a comprehensive array of services with limits on levels of cost-sharing.
2. **New health insurance exchanges** that will more efficiently pool risk, lower administrative costs, and provide eligible individuals and small businesses a choice of affordable health plans.

Exhibit 1. Major Features of Commonwealth Fund Proposals and the New Health Reform Law

	Commonwealth Fund's Path and Fork in the Road reports	Health Reform Law
Individual Mandate	✓	✓
Employer Shared Responsibility	Lower of 7% of earnings or \$2,500 per employee	\$2,000 per employee for employers with 50+ employees not offering coverage
Insurance Market Rules	Rules on enrollment, premiums, and consumer protections	Rules on enrollment, premiums, medical loss, consumer protections
Insurance Exchanges	National, public plan option, start in 2010	State, new nonprofit plan options, start in 2014
Benefit Standard	Comprehensive; 84% actuarial value	Comprehensive; 70% actuarial value
Income-Related Premium and Cost-Sharing; Medicaid Expansions	0–12% of income sliding scale premium caps up to 28% tax bracket; Medicaid to 150% poverty	2%–9.5% of income up to 400% FPL; Medicaid to 133% poverty
Payment Reform	Mandatory Medicare/public payment reform—ACOs, Medical Homes, 5% increase in primary care, 1% productivity improvement, Medicaid at Medicare levels; Rx prices	Voluntary Medicare payment innovations—ACOs, Medical Homes, 10% increase in primary care, 1% productivity improvement, Medicaid primary care at Medicare levels, CMS Innovation Center, Independent Payment Advisory Board
System Reform	Comparative effectiveness tied to benefit design; HIT; Medicare Advantage reform	Comparative effectiveness research; HIT; Medicare Advantage reform

Source: Commonwealth Fund analysis of health reform law; The 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); and C. Schoen, K. Davis, S. Guterman, and K. Stremikis, *Fork In the Road: Alternative Paths to a High Performance U.S. Health System* (New York: The Commonwealth Fund, June 2009).

3. **Affordability provisions for low- and middle-income families** including an essential standard benefit package, premium assistance on a sliding scale up to four times poverty income (about \$88,000 for a family of four), and expansion of Medicaid eligibility up to 133 percent of the federal poverty level (almost \$30,000 for a family of four).
4. **A commitment to shared responsibility** that preserves employer-sponsored insurance, provides health insurance tax credits to small businesses, assesses a contribution from larger businesses whose employees receive government-financed premium subsidies, and requires that individuals have coverage.
5. **Improvements to Medicare prescription drug benefits** including \$250 rebates for seniors falling into the “doughnut hole” in 2010 and elimination of that coverage gap by 2020.
6. **Creation of a new long-term care financing program** to support community living for the disabled.
7. **Investment in a stronger primary care foundation**, one that includes increases in payment for primary care under Medicare and Medicaid, incentives for practices to organize as patient-centered medical homes providing more accessible and coordinated care, and investment in primary care training and expansion of community health centers and the National Health Service Corps.

8. Establishment of an innovation center within the Centers for Medicare and Medicaid Services to rapidly test and spread effective payment methods that reward quality of care, rather than volume of services. Additional payment and system reform provisions encourage accountability for patient outcomes and use of medical resources, and provide incentives for productivity improvement.

9. Creation of an Independent Payment Advisory Board with the authority to make recommendations for reducing cost growth and improving quality in both the Medicare program and the health system as a whole.

10. Investment in the infrastructure required for a high-performance health system, including publicly reported information on quality, cost, and performance of providers and insurers; use of modern information technology in medical care and health insurance; and national strategies and policies on disease prevention, public health, quality, safety, and the health care workforce.

The Commonwealth Fund has published a series of reports detailing the major features of health reform proposals, and timelines for the provisions incorporated into the final law.⁴

WHO IS HELPED BY HEALTH REFORM?

A majority of Americans stand to gain under health reform. Primary beneficiaries include the uninsured and intermittently insured, the underinsured, those who cannot afford their out-of-pocket costs or health insurance premiums, small businesses and their employees, young adults who will be able to stay on their parents' policies until they find a job with health benefits, and those who are denied coverage because they have preexisting conditions or major health problems.

Most Americans fall into one of these categories and have personally experienced the shortcomings of our current system. Two-thirds of all working-age adults report problems with coverage, access to care, or medical bills under the old system.⁵

The following examples illustrate how the new coverage options, benefit standards, and market rules contained in the reform law will benefit different types of people.

Uninsured individuals, whether low- or modest-wage workers or unemployed, will be able to get and afford the care they need.

Currently, almost three-fourths of those who are uninsured at any point during the year report not getting needed care. Sixty percent also report medical debt and bill problems.⁶ The Congressional Budget Office (CBO) estimates that by 2019 health reform will increase the proportion of the insured population from 83 percent to 94 percent⁷ (Exhibit 2).

About half of the 32 million newly insured will be covered by Medicaid, with no financial barriers to care. The other half will receive help in purchasing private coverage. Some will take up employer coverage for the first time, or benefit from new affordable offers for job-based coverage—stimulated, for



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Sandra's Story*

Before: Sandra works part-time as a waitress in a restaurant while she pursues her nursing degree. She does not qualify for benefits through her job, and she can't afford to buy her own health insurance. She receives no preventive or routine care, and tries to avoid going to the doctor when she is sick. The last time she saw a doctor she was diagnosed with hypertension and given a prescription, but she couldn't afford to fill it and hasn't been back since.

After: Sandra's employer might receive new tax credits that make it easier to offer affordable health insurance. Or, she will be eligible for federal premium credits that will help her buy insurance through an insurance exchange. Preventive care will be free. She will not be disqualified because of her hypertension or charged a higher premium.

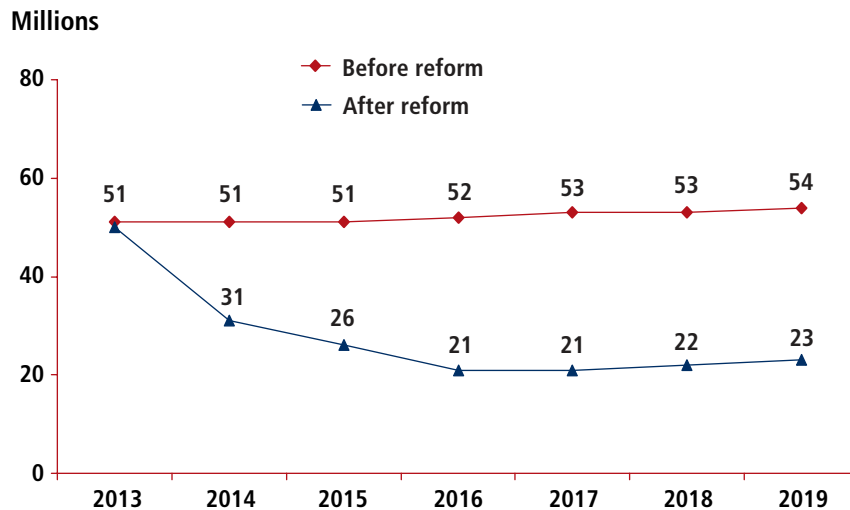
**These and other examples throughout this essay are illustrative and not based on actual individuals.*

example, by new tax credits for small businesses. Those without employer coverage can receive federal assistance to purchase qualified health plans through the insurance exchanges; this applies to individuals and families earning between 133 percent (\$29,327 for a family of four) and 400 percent of poverty (\$88,200 for a family of four). For families in that income range, premium contributions will be limited to between 3.0 and 9.5 percent of income.

Young adults graduating from high school or college will no longer be uninsured and no longer dependent on emergency rooms for care.

Nearly 30 percent of young adults are uninsured, often aging out of their parents' plans and unable to find jobs that offer health insurance benefits.⁸ Fifty-three percent report going without needed care in the last year, and four of 10 report difficulty paying medical bills or accumulated medical debt (Exhibit 3).

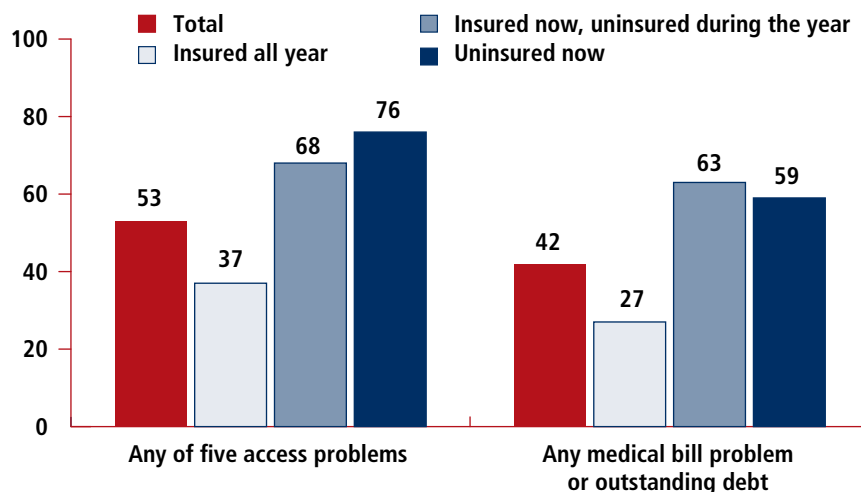
Exhibit 2. Trend in the Number of Uninsured Nonelderly, 2013–2019 Before and After Health Reform



Note: The uninsured includes unauthorized immigrants. With unauthorized immigrants excluded from the calculation, nearly 94% of legal nonelderly residents are projected to have insurance under the new law. Sources: The Congressional Budget Office Cost Estimate of H.R. 4872, Reconciliation Act of 2010, Mar. 20, 2010, <http://www.cbo.gov/doc.cfm?index=11379>.

Exhibit 3. Uninsured Young Adults Most Likely to Have Cost-Related Access Problems and Medical Bill or Debt Problems in the Past Year

Percent of adults ages 19–29 reporting cost-related access problems or medical bill or debt problems:



Notes: Access problems include not filling a prescription; skipping a medical test, treatment, or follow-up; having a medical problem but not seeing a doctor or going to a clinic; not seeing a specialist when needed; and delaying or not getting needed dental care. Medical debt or bill problems include not being able to pay medical bills; being contacted by a collection agency; changing way of life to pay medical bills; and medical bills/debt being paid off over time.
 Source: S. R. Collins and J. L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, May 2010).

One-fourth of young adults use emergency rooms during the year, incurring bad debts that may affect their future credit as well as the financial stability of safety-net institutions serving those who cannot pay.

Effective September 2010, young adults will be permitted to stay on their parents’ insurance policies up to age 26, or until they find a job with health

benefits. In 2014, about 7 million young adults with incomes below 133 percent of the poverty level (\$14,404 for a single adult) will become eligible for Medicaid; states have the option to cover low-income adults beginning in 2010 at the current federal matching rate. In addition, young adults will be able to purchase coverage through health insurance



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Marcus’s Story

Before: When Marcus graduated from college with a business degree, he knew it might take a while to find a job, so he reluctantly moved back home with his parents while he looked. Since he is no longer a student, he is no longer eligible for coverage under his parents’ health plan. He tries to help out around the house, but when he shattered his ankle falling off a ladder, requiring extensive surgery and rehab, his parents had to take out a loan to pay for his care.

After: Marcus will be covered by his parents’ policy until he turns 26. Alternatively, he might be eligible for Medicaid, or he might qualify for help paying for coverage through a health insurance exchange.



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Linda's Story

Before: Linda has decided to go into business for herself and plans to work from home. But now she faces a tough dilemma. While her current employer offers a decent health plan, with her diabetes she can't afford to buy coverage on her own, and the benefits don't cover all the medications and supplies she needs. Starting her own business has been a longstanding dream, but she can't afford to pay for her diabetes care out-of-pocket.

After: Linda will be able to afford coverage through the health insurance exchange, where the premiums will likely be lower for comprehensive coverage than in today's individual insurance market. That's because the exchange will pool risk, her premium won't depend on her health condition, and the government will provide Linda with financial assistance to keep her share of the premium under 9.5 percent of her income. The benefits will be comprehensive, covering what she needs to control her diabetes.

exchanges in 2014; 85 percent of those young adults (those with incomes below four times the poverty level of \$43,320 for a single adult) will be eligible to receive help paying premiums and medical bills.⁹

Workers will no longer lose coverage when changing jobs.

Thirty-two percent of adults report at least one change in their health plan in the past three years.¹⁰ These changes in coverage often result in spells without any insurance, loss of specific benefits, or the need to change doctors. Some people even lose their group coverage altogether, necessitating the purchase of insurance on the more expensive individual market, where enrollees are particularly vulnerable to changes in carriers and gaps in coverage.¹¹ This churning has stark consequences for continuity of care and proper management of chronic conditions.

The new health reform law will help workers at every income level keep their insurance coverage if they already have it, or purchase coverage if they do not. Beginning in 2014, workers in small firms or those buying insurance in the individual market will be able to purchase coverage through insurance exchanges that more efficiently pool risk and reduce administrative costs. Initially, eligibility will be

limited to workers buying coverage in the individual market and workers in firms with 50 or fewer employees, or, at each state's option, firms with 100 or fewer employees. After 2017, states have the option of opening the exchange to firms of any size.

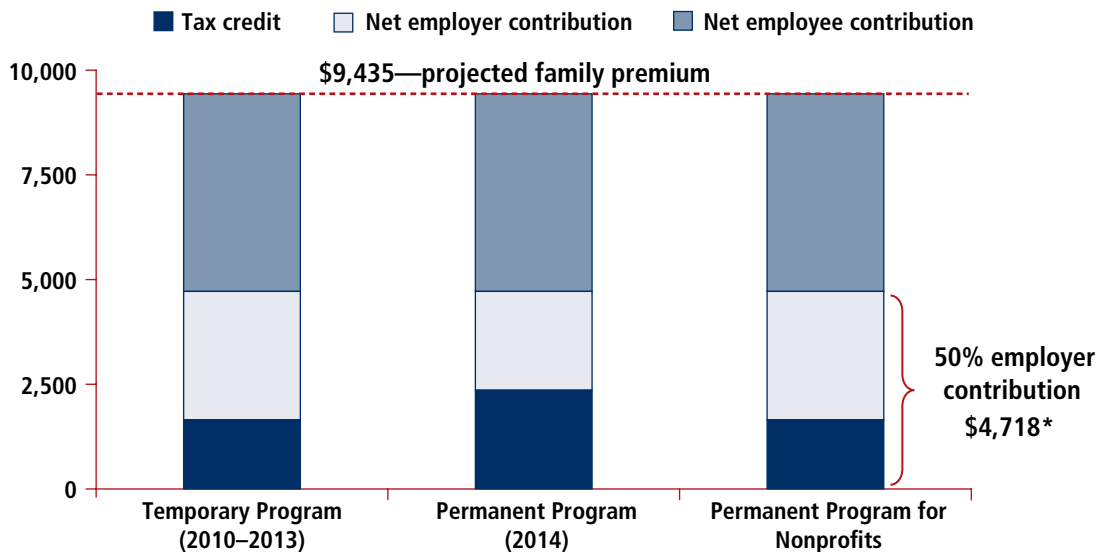
Small business owners will be able to offer health coverage and afford premiums.

About 78 percent of firms with 10 to 24 employees and 49 percent of firms with three to nine employees now offer coverage to their workers—even though insurance premiums for small businesses tend to be higher than premiums for larger businesses for health plans with similar benefits.¹² These percentages may increase as workers seek to fulfill their obligation to carry health insurance. In Massachusetts, for example, the share of workers with employer coverage increased from 80 percent to 84 percent under health reform, as more employers offered coverage and some workers who had been eligible for coverage opted to take it up.¹³

As an added incentive for employers to offer coverage, tax credits will be available to offset up to 35 percent of employers' premium contribution for two years for low-wage firms with fewer than 25 employees. A temporary program is slated to begin in 2010;

Exhibit 4. Small Business Tax Credits Under Affordable Care Act for Family Premiums

Credit per employee




* To be eligible for tax credits, firms must contribute 50% of premiums. Firms receive 35% and later 50% of their contribution in tax credits. Note: Projected premium for a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan. Small businesses are eligible for new tax credits to offset their premium costs in 2010. Tax credits will be available for up to a two-year period, starting in 2010 for small businesses with fewer than 25 employees and with average wages under \$50,000. The full credit will be available to companies with 10 or fewer employees and average wages of \$25,000, phasing out for larger firms. Eligible businesses will have to contribute 50 percent of their employees' premiums. Between 2010–13, the full credit will cover 35 percent of a company's premium contribution. Beginning in 2014, the full credit will cover 50 percent of that contribution. Tax-exempt organizations will be eligible to receive the tax credits, though the credits are somewhat lower: 25 percent of the employer's contribution to premiums in 2010–13 and 35 percent beginning in 2014. Source: Commonwealth Fund analysis of Affordable Care Act (Public Law 111-148 and 111-152). Premium estimates are from the Henry J. Kaiser Family Foundation Health Reform Subsidy Calculator, <http://healthreform.kff.org/SubsidyCalculator.aspx>.

the permanent program, scheduled to start in 2014, will provide up to a 50 percent credit for two years (Exhibit 4).

In 2014, small employers can elect to purchase coverage for their employees through the exchanges, taking advantage of the reduced administrative costs

and lower premiums they will bring. As workers change jobs, they may be able to continue coverage through another participating employer, or, if their new employer does not offer health benefits, purchase subsidized coverage through the exchanges.



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Mark's Story

Before: Mark employs three mechanics in his garage, and business is steady. Mark is lucky, he gets insurance through his wife's employer. So does one of his employees, but the other two are uninsured. He'd like to be able to offer health insurance to his workers, but he just can't swing it financially. He knows that being able to offer benefits is not just good for his workers, it's also good for his business. Whenever he is hiring, he sometimes loses good prospects if they can get health benefits somewhere else.

After: With tax credits to offset some of his costs, and with the ability to buy comprehensive health insurance, likely at a lower cost through the exchanges, small business owners like Mark will be more likely to offer coverage.

Families will face fewer difficulties paying out-of-pocket expenses.

More than 60 percent of individuals who have accumulated medical debt were insured at the time they incurred the expenses.¹⁴ Shrinking coverage—the typical employer plan now covers 80 percent of average medical expenses—and increasing deductibles during the past decade have resulted in a sharp rise in the number of Americans who face substantial out-of-pocket costs, rendering them “underinsured.”¹⁵ One-fourth of insured Americans who have difficulty paying their medical bills report using up all their savings or taking on credit card debt to pay those bills (Exhibit 5).

Beginning in 2014, insurance plans must meet essential benefit standards covering hospital care, physician services, prescription drugs, preventive services without cost-sharing, and pediatric dental and vision care, among other benefits.

Plans will be classified into different “tiers” to allow families to understand their out-of-pocket liability. Actuarial values—the proportion of costs actually covered—will range from 60 percent (bronze tier) to 90 percent (platinum tier). The percentage of expenses covered will vary depending on family income, and out-of-pocket expenses will be limited for individuals and families of all income levels.

Exhibit 5. More Than One-Quarter of Adults Under Age 65 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		Uninsured Anytime During Year	
		No underinsured indicators	Underinsured	Insured now, time uninsured in past year	Uninsured now
Unable to pay for basic necessities (food, heat, or rent) because of medical bills	29%	16%	29%	42%	40%
Used up all of savings	39	26	46	46	47
Took out a mortgage against your home or took out a loan	10	9	12	11	11
Took on credit card debt	30	28	33	34	26
Insured at time care was provided	61	80	82	46	24

Source: S. R. Collins, J. L. Kriss, M. M. Doty, and S. D. Rustgi, *Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007* (New York: The Commonwealth Fund, Aug. 2008).



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Janice's Story

Before: Janice is a self-employed musician. Because she's young and healthy, she figures she will be okay without health insurance for a few years. When she discovers that she's pregnant, and that her husband's employer policy covers only him, she looks for individual coverage that will help her with the expenses of prenatal care and delivery. What she found astonished her: not only was it almost impossible to find insurers who would even offer her coverage, but the few that did would charge her more for basic coverage than they would charge a man, *and* would require an expensive rider to cover the maternity-related costs.

After: Health plans will be prohibited from charging higher premiums due to gender, health status, or family history. In addition, they will provide comprehensive benefits, including maternity care. Janice will be able to obtain affordable coverage on her own through the newly created health insurance exchange.

Low-income mothers will be able to afford prenatal care.

Work by The Commonwealth Fund shows that many women face problems securing affordable health coverage and care.¹⁶ Women are less likely to have employer-sponsored insurance available to them and often must seek coverage in the more expensive individual market. The practice of gender rating means that women pay substantially more than men for similar or worse insurance. Pregnant women without employer coverage face particular difficulty securing adequate individual coverage for prenatal care: a recent study showed that across the country just 13 percent of individual insurance market plans available to a 30-year-old woman provided maternity coverage.¹⁷ While a limited number offered additional

maternity riders, all remained largely unaffordable for low- and middle-income individuals.

Beginning in 2014, insurers will be prohibited from charging higher premiums because of gender, health status, or family history. Pregnant women in the Medicaid program will see new coverage options for freestanding birth centers that allow women to use midwives and birth attendants recognized in each state. Medicaid will also cover free smoking cessation programs for pregnant women. The Department of Health and Human Services, meanwhile, is authorized to make grants to states to promote improvements in maternal, prenatal, and infant health. And states are eligible to receive federal funds to provide home visitation services for maternal health and prenatal care.

Men and women will have access to cancer screening for early detection.

Despite significant strides in improving the delivery of preventive services, many adults still fail to receive recommended preventive care and cancer screening. The Commonwealth Fund's National Scorecard on U.S. Health System Performance finds that only half of all adults, and less than one-third of uninsured adults, are up-to-date with recommended preventive care.¹⁸ Failure to detect colon, breast, and cervical cancer at an early stage contributes to high mortality rates for these diseases.

Beginning in 2010, all recommended preventive services will be covered without cost-sharing under new individual and group plans (for Medicare beneficiaries, this will begin in 2011). States that expand Medicaid coverage to include approved preventive services with no cost-sharing will receive increased federal funding for these services. This will remove financial barriers to care and save lives. The Commonwealth Fund's national scorecard estimates that reaching achievable levels of preventive care would result in 70 million more Americans obtaining timely preventive care.

Older adults will no longer be denied coverage because of health problems and preexisting conditions.

Older adults seeking health insurance coverage typically face prohibitively high premiums, large deductibles, and troubling exclusions for health problems and preexisting conditions. A Commonwealth Fund study found that 24 percent of the near-elderly (ages 50 to 70) failed to get health care services because of the cost.¹⁹ More than one-third (35%) had a problem paying their medical bills in the last year or were paying off medical debt they had accrued over the last three years (Exhibit 6).

Beginning 90 days after enactment of the law, older adults with preexisting conditions who have been uninsured for at least six months will be eligible for subsidized insurance through a national high-risk pool. Premiums will be set for a standard population and cannot vary by more than a factor of four based on age—that is, older adults will pay no more than four times what younger adults pay for coverage.

In 2014, insurance companies will be required to cover all individuals regardless of health status and charge the same premium regardless of preexisting conditions. Premiums may vary based on age, but by no more than a three-to-one ratio. These provisions will greatly increase the affordability and availability of coverage for older adults with health problems.



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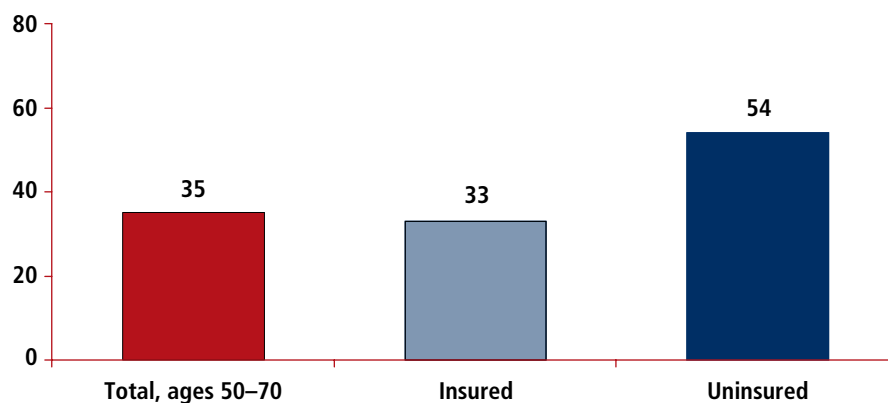
Maria's Story

Before: Maria knows she should have a regular Pap test and mammogram. But her insurance only covers part of the cost and as a single mom she is on a very tight budget. Her mother is still healthy at 84, so she figures her chances of getting cancer are pretty slim, anyway.

After: Since all recommended preventive services will be fully covered, Maria will not have to pay anything for her preventive tests. In addition, states that expand Medicaid coverage in the same way will receive increased federal funding for these services.

Exhibit 6. More Than One-Third of Older Adults Report Medical Bill Problems

Percent of adults ages 50–70 with any medical bill problems or outstanding medical debt*



* 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).

Individuals with functional limitations will be able to afford help to continue living at home.

More than 10 million Americans are estimated to need long-term care assistance and support to perform daily activities. That number is projected to grow substantially as the population ages and more individuals become disabled.²⁰ Long-term care is simply unaffordable for the majority of the population. While Medicare covers some short-term skilled nursing and home

health care, Medicaid is the only program available to finance care for those with long-term disabilities and needs and without significant income or assets. Unfortunately, workers and retirees with functional limitations must “spend down” their savings—essentially impoverishing themselves—before becoming eligible for Medicaid assistance.

The health reform law establishes a national, voluntary insurance program for purchasing community living assistance services and supports in



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Ed's Story

Before: When his wife died unexpectedly, Ed was dropped by the health insurance plan they had gotten through her employer. Self-employed, and too young for Medicare, he is looking for individual coverage. But at 58, the only plans he's being offered come with exorbitant premiums and high deductibles. Even if he were able or willing to pay that much—which he isn't—he wouldn't even get coverage for his depression, because it is a preexisting condition.

After: Ed will be able to get health coverage, regardless of his preexisting condition, through the new high-risk pool. In addition, his premium will be set for a standard population, and will cost no more than four times as much as comparable coverage for a younger adult. Eventually, Ed will be able to buy comprehensive, subsidized coverage through the exchange.



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Esther's Story

Before: If Esther budgets her Social Security payments very carefully, she can make ends meet. Since her small house and car are both paid for, her biggest expense is her prescription drugs. At 70, with a combination of chronic conditions including diabetes, hypertension, and congestive heart failure, she takes a lot of medication. When she reaches a spending threshold of \$2,700—the start of the Medicare “doughnut hole”—she has to pay 100 percent of the cost. Sometimes she takes half-doses or skips a day to make the medication last longer. She also skips her annual wellness visit, including important preventive services, to save on the copayment.

After: Esther will receive a rebate on her doughnut hole spending and discounts on brand-name and generic drugs. She will also be eligible for annual wellness visits and all recommended preventive services without cost sharing.

2012. Known as the Community Living Assistance Services and Supports (CLASS) program, it will provide a cash benefit to individuals with limitations, enabling them to purchase nonmedical services and supports necessary to remain at home. After a five-year vesting period, the program will begin to provide benefits to those who need assistance. The program is financed through voluntary payroll deductions—all working adults will be automatically enrolled in the program unless they opt out.

Medicare beneficiaries will receive free preventive care and no longer face the prescription drug “doughnut hole.”

Medicare prescription drug coverage currently includes a gap—called a “doughnut hole”—where beneficiaries are required to pay 100 percent of their prescription drug costs between \$2,700 and \$6,154. Under health reform, Medicare beneficiaries entering the coverage gap will receive a \$250 rebate in 2010. In 2011, beneficiaries covered by private drug plans (other than those with high incomes) will receive a 50 percent discount on brand-name drugs. Beneficiaries will then receive additional discounts on brand-name and generic drugs, to close the doughnut hole by 2020. Rather than paying 100 percent of prescription costs, beneficiaries will pay 25 percent.

In addition, beginning in 2011, Medicare beneficiaries are eligible for an annual wellness visit and all recommended preventive services, without any cost-sharing.

HOW WILL THE HEALTH CARE SYSTEM CHANGE?

By putting more emphasis on preventive and primary care, and by rewarding quality, the Affordable Care Act not only improves the affordability of health insurance, it also pushes the health care system to deliver more patient-centered, accessible, and coordinated care.

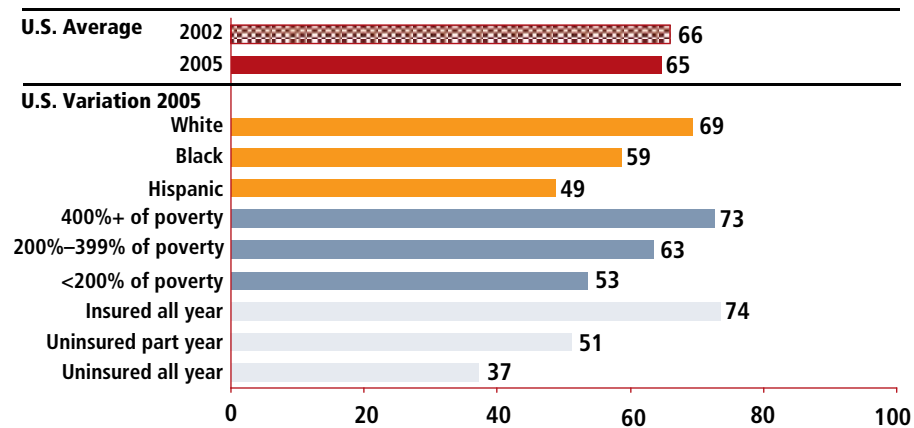
Under the new reforms, patients will be more likely to have:

- **A physician practice that is accessible 24/7 and helps arrange specialist appointments.**

A strong network of primary care physicians is central to a high performance health system that works for everyone.²¹ Yet only two-thirds of American adults under age 65 report having an accessible primary care provider (Exhibit 7).²² In addition, nearly three-quarters of all adults were not able to see their doctor quickly when sick, found it difficult to get

Exhibit 7. Only 65 Percent of Adults Report Having an Accessible Personal Clinician

Percent of adults ages 19–64 with an accessible primary care provider*



* An accessible primary care provider is defined as a usual source of care who provides preventive care, care for new and ongoing health problems, referrals, and who is easy to get to.
 Data: B. Mahato, Columbia University analysis of Medical Expenditure Panel Survey.
 Source: The 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).

through to their doctors by phone, or said it was difficult to get care after regular work hours without going to the emergency room (Exhibit 8).²³

Health reform will test a new model of care that changes the way health care is organized. Patients can enroll in a patient-centered medical home, which is accountable for ensuring that patients get all recommended care. By offering care on nights and weekends, by using information technology and office systems to remind patients about preventive care, and by assisting them with obtaining needed specialty care, medical homes provide high-quality, coordinated care.

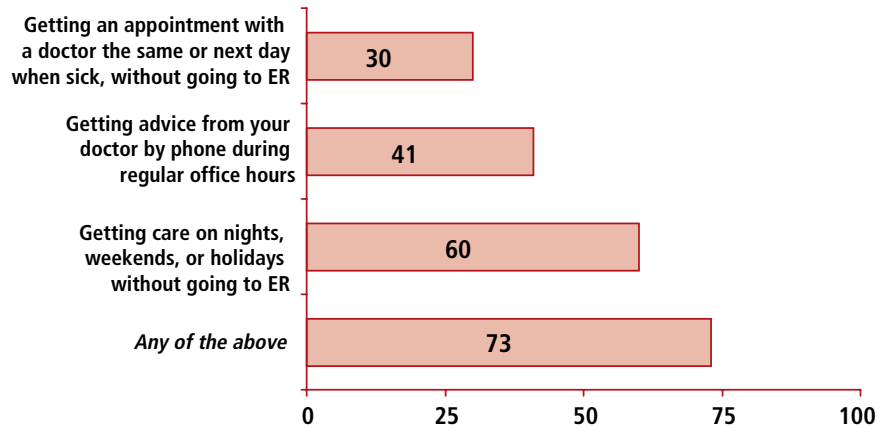
Financial incentives will help these practices succeed. New pilot programs will support and reward practices with an extra “medical home fee” paid by insurers and public programs. Moreover, they can earn bonuses for ensuring that their patients receive preventive care and help with managing a chronic illness. Care teams, including physicians, nurses, pharmacists, and other health professionals, will

ensure coordination of care and shared accountability for health outcomes. This major change from solo or small group practices will require not just funding but technical assistance and infrastructure support. To support provider groups as they reorganize—a challenging task even for large providers—the government will begin to fund regional or state health information exchange networks, and test strategies for ensuring access to after-hours care, case management help, and more.

The new law will also establish a Center for Medicare and Medicaid Innovation, effective January 2011, to oversee and test these and other innovative payment methods. Priority will be given to models that both improve quality and reduce costs such as medical homes, accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, funding for care coordination, and bundled payment for hospital acute and post-acute care.

Exhibit 8. Three of Four Adults Have Difficulty Getting Timely Access to Their Doctor

Percent reporting that it is very difficult/difficult:



Source: S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund, Aug. 2008).

By increasing primary care payment rates, and making low-interest student loans more available, the Affordable Care Act also aims to increase the supply of primary care physicians and advanced practice nurses, making it easier for patients to find a primary care provider.

- **Better access to community health centers able to serve more patients.**

Federally qualified health centers provide comprehensive primary care and mental health services to some of our nation's most vulnerable individuals and families. Recent Commonwealth Fund analysis shows that of the 16 million patients who received care from health centers in 2007, 90 percent were at or below 200 percent of the federal poverty level, 45 percent had public insurance, and 40 percent had no insurance at all.²⁴ These centers are truly the cornerstone of our nation's health care safety net, providing care to everyone regardless of their insurance status or ability to pay.

The Affordable Care Act expands funding to community health centers by \$11 billion over five

years beginning in 2010; provides state grants for health care providers that serve a large percentage of medically underserved populations; and provides for a Medicaid global payment system demonstration project that allows up to five states to make global capitation payments—covering all services provided to a patient during an episode of care—to safety-net hospitals from 2010 to 2012. It also provides grants to assist in development of community-based collaborative care networks, or integrated health care delivery systems, to serve low-income or medically underserved communities from 2011 to 2015.

- **Electronic medical records which ensure, with the patient's authorization, complete medical records are accessible when needed.**

U.S. health providers have been slow to adopt electronic health information systems, in part because of concerns about the value and the costs of implementation.²⁵ A 2009 Commonwealth Fund survey of primary care physicians shows that the U.S. is far behind most of its industrialized peers in the use of health information technology (IT) (Exhibit 9).²⁶

Without an information system that ensures the right information is available at the right time, tests are repeated, appointments with specialists have to be rescheduled, and patients are not informed about abnormal lab tests in a timely manner (Exhibit 10).

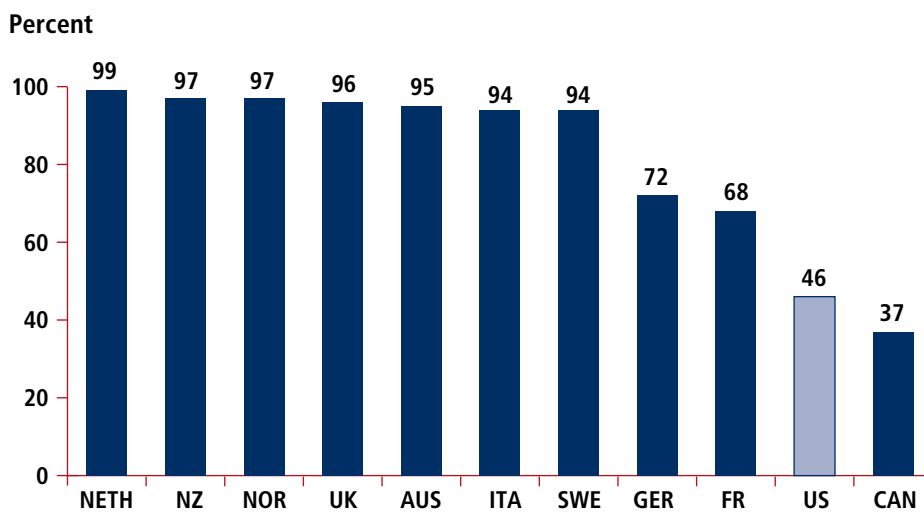
The American Recovery and Reinvestment Act of 2009 provides financial assistance for physicians and hospitals to adopt health information systems to report quality information, deploy decision support to help providers provide the best care, and improve the quality of care. It funds regional extension centers that link information systems across providers, so that with the patient’s permission all of a patient’s pertinent medical information is accessible to primary care physicians, emergency room physicians, specialists, hospitals, nursing homes, and home health nurses. The Affordable Care Act provides further incentives to establish such information systems: it rewards high-quality care and enables health care organizations that assume responsibility for total patient care to share in the savings.

- **Doctors and hospitals that are rewarded for higher quality and better patient outcomes.**

The prevailing fee-for-service payment system rewards physicians for the volume of care they provide, rather than the value of that care. The U.S. lags behind its counterparts in this regard (Exhibit 11).²⁷

The new reform law will reward hospitals for achieving benchmark levels of performance in heart attack, heart failure, and pneumonia care, and for preventing surgical infections. Starting in October 2012, hospitals that meet or exceed the designated performance standards will receive enhanced Medicare payments, taken from a pool of money collected from all hospitals. These process-of-care measures were designed to be achievable—the ultimate goal for all hospitals should be 100 percent performance. By 2012, the Secretary of Health and Human Services (HHS) is required to submit a plan to Congress on how to move home health and nursing home providers into a value-based purchasing payment system.

Exhibit 9. Doctors Use of Electronic Patient Medical Records



Note: Not including billing systems.
 Source: C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs* Web Exclusive, Nov. 5, 2009, w1171-w1183.

The legislation also includes physician payment reforms that encourage physicians, hospitals, and other providers to join together to form accountable care organizations to gain efficiencies and improve quality of care. Those that meet quality-of-care targets and reduce costs relative to a spending benchmark can share in the savings they generate for Medicare. Furthermore, all physicians and hospitals meeting benchmarks for high-quality care will be eligible for bonuses under new value-based purchasing provisions.

- **Better information and support when discharged from the hospital.**

U.S. hospital readmission rates for Medicare patients within the first 30 days following discharge range from 14 percent to 21 percent.²⁸ Inadequate communication during care transitions—when patients are discharged from the hospital to home or to a nursing facility, for example—often contributes to readmissions or avoidable complications. The Commonwealth Fund is working with Massachusetts, Michigan, and Washington State on the State Action on Avoidable Rehospitalizations (STAAR) initiative to test interventions that reduce readmissions, such as making sure patients have the information they need for self-care and have scheduled a follow-up appointment with their physician.

Medicare payments will be reduced for hospitals with high rates of potentially preventable readmissions for certain eligible conditions or procedures, as determined by the HHS secretary. In addition, by 2013, HHS will develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to test “bundled” Medicare payment models spanning three days before and 30 days after a hospitalization. If the pilot programs

improve care and reduce spending, HHS is required by 2016 to submit a plan for expansion.

- **Hospitals with an incentive to reduce hospital-acquired infections**

The new legislation demands greater transparency and public reporting on hospitals’ performance at preventing infection. Later this year, the Centers for Medicare and Medicaid Services (CMS) will begin reporting rates of medical errors and selected hospital-acquired conditions on its Hospital Compare Web site. Starting in 2011, federal payments for Medicaid services related to hospital-acquired conditions will be prohibited. Beginning in 2015, hospitals that have among the highest rates of these hospital-acquired conditions will have their Medicare payments reduced by 1 percent.

- **More patient information on quality of physicians, hospitals, and health plans.**

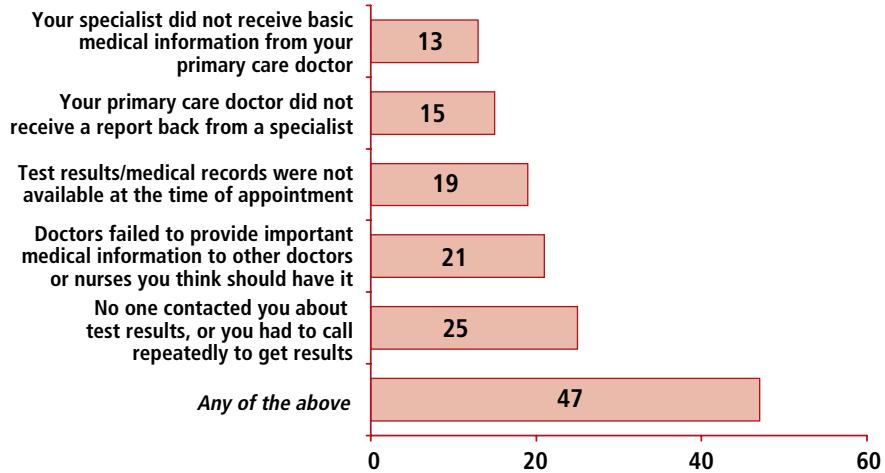
Physicians who report data on the quality of their care through a qualified program will be eligible for one-half-percent Medicare bonus payments. In addition, HHS will develop a Physician Compare Web site by January 2011. Combining Medicare data on quality with that of private insurers should improve the scope and reliability of information on performance. To further this aim, the legislation also authorizes, effective January 2012, the release of Medicare claims data to measure the performance of providers and suppliers in a way that protects patient privacy.

- **More choice of health insurance plans, including nonprofit plans.**

A 2007 Commonwealth Fund survey showed that 42 percent of workers with employer-based coverage had only one choice of health plan. Even when

Exhibit 10. Nearly Half of U.S. Adults Report Failures to Coordinate Care

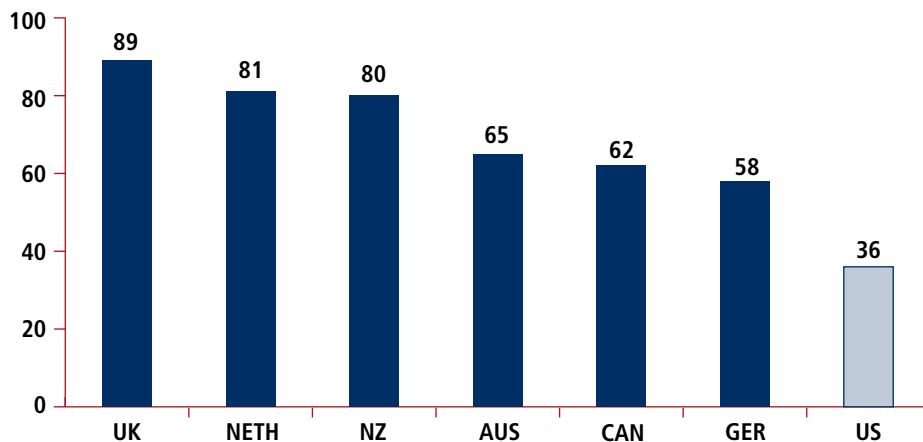
Percent U.S. adults reported in past two years:



Source: S. K. H. How, A. Shih, J. Lau, and C. Schoen, *Public Views on U.S. Health System Organization: A Call for New Directions* (New York: The Commonwealth Fund, Aug. 2008).

Exhibit 11. Physicians in U.S. Less Likely to Receive Incentives for Quality or Meeting Goals

Percent of physicians reporting any financial incentive for targeted care or meeting goals*



* Can receive financial incentives for any of six: high patient satisfaction ratings, achieve clinical care targets, managing patients with chronic disease/complex needs, enhanced preventive care (includes counseling or group visits), adding non-physician clinicians to practice, and non-face-to-face interactions with patients.
Source: C. Schoen, R. Osborn, M. M. Doty, D. Squires, J. Peugh, and S. Applebaum, "A Survey of Primary Care Physicians in 11 Countries, 2009: Perspectives on Care, Costs, and Experiences," *Health Affairs Web Exclusive*, Nov. 5, 2009, w1171-w1183.

workers have a choice of plans, the plans are often different products offered by the same insurer. Nor do all plans provide adequate benefits or ensure adequate participation of physicians in essential specialties.

Health insurance exchanges will increase the choice of high-quality private plans and health care cooperative plans, and will make it easy to compare these choices. In addition, the federal government will contract with private insurance carriers to offer multistate plans through each exchange. At least one of the new multistate plans must be nonprofit. The government will negotiate contracts, much as it does for the Federal Employees Health Benefits Program.

The new Consumer Operated and Oriented Plan (CO-OP) program, meanwhile, will foster the creation of nonprofit, member-run health insurance companies, or cooperatives, that will provide coverage and deliver health services. In making grants, priority will be given to cooperatives that operate on a statewide basis, are organized as integrated care systems, and have significant private support.

The insurance exchanges provide an important avenue for setting quality standards on insurance and care. In overseeing the exchanges, the HHS secretary is charged not only with ensuring a sufficient choice of qualified plans and providers but also with establishing certification criteria for qualified plans, requiring plans to provide the essential benefits package and meet marketing requirements, and ensuring that essential community providers are included in networks and accredited on quality.

- **Private plans that are rewarded for better care.**

Currently, employers and Medicare beneficiaries tend to make choices based largely on premiums, without information showing whether plans are

actively trying to ensure high quality care—either through the way they select participating physicians and hospitals, or through the information and support they offer to providers regarding benchmark quality care.

Under health reform, Medicare private managed care plans that receive a four- or five-star quality designation will receive bonuses. Health plans that operate through the new health insurance exchanges will report on their quality improvement activities, including their efforts to prevent hospital readmissions. By 2015, health plans operating in the exchanges will be allowed to enter into contracts with hospitals with fewer than 50 beds only if the hospitals use a patient safety evaluation system and have implemented a comprehensive program for patient discharge.

- **Reduced health insurance premiums and health spending.**

Between 2000 and 2009, health insurance premiums rose by 108 percent, while workers' earnings rose by just 32 percent. As a result, average family premiums for group policies have risen from 11 percent to 18 percent of median family income.²⁹ In the absence of reform, premiums were projected to rise to 24 percent of a family's income by 2020. Under the new reform law, the average family stands to save nearly \$2,000 or more in 2019.³⁰

Premiums will be held down by requirements that limit the percentage of premium revenue going to administrative costs, and that require carriers seeking certification as qualified health plans to submit a justification in advance for any premium increase. Premium growth will be monitored and used as a criterion for allowing plans into the exchanges.

The establishment of health insurance exchanges in 2014 will further lower administrative costs and

premiums in the individual and small-business markets as transparency, choice among plans with comparable actuarial value, and new nonprofit plans enhance competition, and the requirement for people to obtain coverage broadens the risk pool.

The upward spiral of health care costs will also slow as those that pay for health care begin to adopt innovative payment methods that reward quality and value, rather than volume. For example, the new Independent Payment Advisory Board within the executive branch will have significant authority to identify areas of waste and additional federal budget savings. This 15-member board will present Congress with comprehensive proposals to reduce “excess cost growth” and improve quality of care for Medicare beneficiaries. In years when Medicare costs are projected to be unsustainable, the board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The board will be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. Beginning in 2014, it will issue an annual public report that provides information on health system costs, utilization, access and quality of care, and will issue nonbinding recommendations to control medical costs throughout the health system.

A Commonwealth Fund report found that the impact of health reform on health insurance premiums and health spending will be significant. It estimates that, on net, the combination of provisions in the new law will reduce health care spending by \$590 billion over 2010–2019. The annual growth rate in national health expenditures would be slowed from 6.3 percent to 5.7 percent.³¹

CHALLENGES IN IMPLEMENTATION AND LONG-TERM CONCERNS

For the Affordable Care Act to achieve its goals, all stakeholders must work together to realize its potential. Employers play a particularly pivotal role. Our current system of private employer-based coverage is preserved under health reform. But employers must maintain and expand their commitment to financing coverage for employees, or the cost to the federal government will grow significantly.

The insurance exchanges will be open to all individuals and small businesses and ultimately may be open to firms of all sizes. Risk adjustment and reinsurance will protect against adverse selection. Insurers are required to meet the same conditions inside and outside exchanges. But the potential to selectively move higher-risk individuals or small groups to coverage through the exchange while covering healthier individuals directly is worrisome and will need to be closely monitored.

The new innovation center is charged with rapidly testing innovative methods of payment that will move away from fee-for-service to a system that rewards results. It will be successful, however, only if providers participate and work to develop and execute the most promising payment and delivery system models and implement “best practices” that offer better care to patients, lower costs to payers, and stable financing for providers. Innovations in Medicare’s method of paying providers should be leveraged by similar changes in private insurance plans. Qualified health plans participating in health exchanges will need to adopt cutting-edge methods of payment and ensure adequate networks of participating providers.

Any attempt to game the system by increasing premiums or prices in advance of implementation will increase cost and undermine the success of

health reform. Particular attention will need to be paid to reviewing premium and health care prices in the transition to coverage implementation.

States and the federal government share in implementation responsibilities. Adequate resources will be required to ensure effective implementation. Economic stresses on states from the economic contraction will need to be alleviated to ensure that Medicaid remains a quality program ready to absorb a large number of newly eligible poor and near-poor individuals.

A special focus on our nation's fragile safety net of hospitals and clinics serving the poor and uninsured will also be necessary in the transition to coverage. Community-oriented health systems must be developed to be accountable for meeting the needs of the vulnerable population they serve. Over the longer term, stakeholders must ensure that affordability provisions for low- and moderate-income families remain adequate, and prevention, control of chronic disease, and promotion of good health are a national priority.

While all stakeholders understand that we can no longer conduct business as usual, meaningful health reform will require an ongoing commitment to innovation and improvement. Learning quickly as

experience is gained from payment and system reforms will be essential—as will flexibility, cooperation, and coordination among public and private payers, providers, and patients. Moving toward a high-performance health system requires vigilance and participation from a diverse set of stakeholders. This may prove difficult. Uniting these interests, however, would help bring us closer to a health system in which everyone gets the care they need, and everyone has the opportunity to live a long, healthy, and productive life.

CONCLUSION

The Affordable Care Act will usher in a new era in American health care—one in which every American has access to affordable health insurance coverage and no one is turned away simply because they have a preexisting condition. The new insurance market protections set to take effect in this and subsequent years are designed to work in concert with important payment and system reforms that will improve access and quality and reduce cost growth for everyone. Reform is a historic victory for all Americans. But it will require the efforts of all stakeholders to make the promise a reality.

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ABOUT THE AUTHOR

Karen Davis, Ph.D., is president of The Commonwealth Fund. She is a nationally recognized economist with a distinguished career in public policy and research. In recognition of her work, Ms. Davis received the 2006 AcademyHealth Distinguished Investigator Award. Before joining the Fund, she served as chairman of the Department of Health Policy and Management at The Johns Hopkins Bloomberg School of Public Health, where she also held an appointment as professor of economics. She served as deputy assistant secretary for health policy in the Department of Health and Human Services from 1977 to 1980, and was the first woman to head a U.S. Public Health Service agency. A native of Oklahoma, she received her doctoral degree in economics from Rice University, which recognized her achievements with a Distinguished Alumna Award in 1991. Ms. Davis has published a number of significant books, monographs, and articles on health and social policy issues, including the landmark books *Health Care Cost Containment; Medicare Policy; National Health Insurance: Benefits, Costs, and Consequences*; and *Health and the War on Poverty*. She can be e-mailed at kd@cmwf.org.

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1 East 75th Street • New York, NY 10021

Tel: 212.606.3800

1150 17th Street NW • Suite 600 • Washington, DC 20036

Tel: 202.292.6700

