USING WHAT WORKS: MEDICARE, MEDICAID, AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM AS A BASE FOR HEALTH CARE REFORM

Karen Davis and Cathy Schoen
President and Senior Vice President for Research and Evaluation
The Commonwealth Fund
One East 75th Street
New York, NY 10021
kd@cmwf.org

Invited Testimony
House Committee on Energy and Commerce, Subcommittee on Health
Hearing on
"America's Need for Health Reform"

September 18, 2008

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Executive Summary

As the nation begins serious consideration of health reform, it is instructive to review the contributions of Medicare and Medicaid over their 40-year history of covering the sickest and poorest Americans—those who typically do not fare well in private insurance markets. These two programs, together with the more recently enacted State Children's Health Insurance Program (SCHIP), have provided many of our most vulnerable citizens with improved access to health care and greater financial protection. Because of their success, they warrant serious consideration as building blocks for a new system of seamless coverage for America's 46 million uninsured people.

Currently, more than one of four Americans, or some 83 million people, are covered by Medicare, Medicaid, SCHIP, or other public programs. About three of five Americans are insured by private insurance—mostly employer coverage—while 15 percent are uninsured. As the nation moves to cover the uninsured, preserving a mixed private–public system of coverage has many advantages: 1) it minimizes disruptions in current coverage; 2) it can build on the strengths of public programs and private coverage; and 3) it requires only minimal new administrative structures.

Public programs can be especially valuable components to health reform. For one, they have low administrative costs and a track record of providing access to needed health care for those who are the most difficult to serve. Medicare, in particular, is an ideal coverage source for older and disabled adults without employer insurance who will transition to Medicare coverage once they turn 65 or are disabled for two years. Such individuals are rarely able to obtain affordable private coverage, since insurers in the individual market have a strong financial incentive to restrict enrollment or limit the benefits of people with serious health problems. Opening up Medicare to these at-risk adults could help prevent serious health conditions from deteriorating and resulting in

higher costs to Medicare once they become eligible. Medicare beneficiaries report high satisfaction with their coverage and their ability to access health care services.

Medicaid and SCHIP are also ideal coverage sources for low-income adults and children. These programs often serve as the source of coverage for those with the most serious health problems—children with developmental disabilities, adults with HIV/AIDS, frail elders, and others with serious physical and mental disabilities. SCHIP has been highly successful in reducing the rate of uninsured children; most states have responded to the offer of favorable federal matching by expanding their coverage of low-income children. States' ability to do this, however, depends on how the economy is doing, and may be subject to retrenchment in economic downturns.

Private employer insurance now covers 160 million working Americans and their families. For the most part, employer coverage works well for those Americans whose employers contribute an average of 75 to 80 percent of the plan premium. However, coverage has become increasingly unaffordable for small firms, which are unable to obtain the same benefits at the premium rates paid by larger firms.

For those individuals whose only recourse is the individual insurance market, the availability and affordability of coverage depend heavily on state regulation. Of those who seek coverage in the individual market, about nine of 10 do not buy a plan—because it is difficult or impossible to find a plan that is affordable, because they are turned down, or because they cannot find a plan that meets their needs.

Congress can take steps now to lay the foundation for broader health reform that ensures affordable coverage for all Americans. These include: 1) leveraging Medicare's position as the largest payer for health care to improve health care quality and slow the growth in health care costs; 2) strengthening Medicaid and SCHIP to serve as a base of coverage for all low-income children and adults; 3) reforming individual insurance markets; and 4) making affordable insurance options, including a public insurance option, available to small businesses and individuals through an insurance connector.

Medicare can be a leading force for change in the health care system. It can serve as a model for private insurers in public reporting, rewarding quality, requiring evidence-based care, and encouraging the use of modern information technology. Reforms to Medicare's payment system could improve the accessibility and coordination of care through patient-centered medical homes; help shape a more organized, higher-performing

health system; and create incentives for delivering care more efficiently, for example, by preventing avoidable hospitalizations. If initiated early, such reforms could slow the growth in health care costs and "bend the curve" in national health expenditure trends.

Reauthorization and adequate funding of SCHIP are essential steps to covering many of the nation's 8 million uninsured children. Medicaid programs could be strengthened by providing a counter-cyclical federal matching rate that adjusts automatically in times high unemployment, when states undergo serious financial strains. States should also have an incentive to learn from each other—to spread the latest innovations and best practices in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

Finally, insurance market reforms—including minimum requirements on insurers to cover both the sick and the healthy at the same premium—could ensure the availability of coverage in all states. By organizing a national insurance connector that draws from the experience of Massachusetts, we could expand insurance choices to small businesses and individuals. With more integrated benefits and innovative payment policies, a Medicare-sponsored public plan could also be offered as an option to small businesses and individuals.

A mixed private–public system of universal coverage featuring seamless coordination across sources of coverage could transform both the financing and delivery of health care services. Such a system would build on the best that both private insurance and public programs have to offer while achieving needed savings and ensuring access to care for all.

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The Commonwealth Fund

Thank you, Mr. Chairman, for this invitation to testify regarding the role of public programs in health reform. As this Committee knows well, public programs today cover more than one of four Americans—83 million people—including elderly and disabled adults under Medicare; low-income families, the elderly, and the disabled under Medicaid; and low-income children under the State Children's Health Insurance Program (SCHIP). Covering many of the sickest and poorest Americans, these programs have improved access to health care for those who typically do not fare well in a private insurance market. They warrant serious consideration as building blocks in a system of seamless coverage for America's 46 million uninsured people.

Congress can take steps now to lay the foundation for broader health reform that ensures affordable coverage for all Americans. These include: 1) leveraging Medicare's position as the largest payer for health care to improve the quality of care and slow the growth in health care costs; 2) strengthening Medicaid and SCHIP to serve as a base of coverage for all low-income children and adults; 3) reforming individual insurance markets; and 4) making affordable insurance options, including a public insurance option, available to small businesses and individuals through an insurance connector.

If initiated early and combined with strategic policies aimed at quality and efficiency, these reforms could slow the growth in health care costs and "bend the curve" in national health expenditure trends.[1] In doing so, a mixed private–public system of universal coverage that features seamless coordination across sources of coverage could transform both the financing and delivery of health care services. Such a system would

[1] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: The Commonwealth Fund, Dec. 2007).

build on the best that private insurance and public programs have to offer while achieving needed savings and ensuring access to essential care for all.[2]

The Uninsured

Last month, the U.S. Census Bureau released the latest data on the number of Americans without health insurance. The number of uninsured individuals fell to 45.7 million in 2007, from 47.0 million in 2006.[3] While the new figure represents the first decline since 1999, there are still 7 million more uninsured people now than at the beginning of the decade. And these statistics fail to count the millions more who experience lapses in their coverage during the year, or the millions of "underinsured" people whose inadequate coverage ensures neither access nor financial protection.[4]

The new census data show the importance of the nation's safety-net insurance system—Medicaid and SCHIP. The decline of 1.3 million uninsured people between 2006 and 2007 was entirely attributable to an equal growth in coverage under Medicaid. In contrast, employment-based coverage declined slightly, from 59.7 percent of the population to 59.3 percent.

The major bright spot in the last eight years has been the improved rate of coverage for children, with the proportion of uninsured children declining from 12.5 percent in 1999 to 11.0 percent in 2007. This improvement was a reflection of increased coverage for children under SCHIP. However, more than 8 million children remain uninsured, which highlights the importance of permanent reauthorization of the SCHIP program and adequate funding to cover all low-income children.

By contrast, the proportion of uninsured adults ages 18 to 64 has increased markedly since 1999, from 17.2 percent to 19.6 percent. The gap between coverage rates for working-age adults and children has widened in the last eight years—in contrast with the 1990s, when rates for both rose in concert. The differential experience for adults, who were not covered by SCHIP, attests to the success of offering states fiscal incentives to

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[2] C. Schoen, K. Davis, and S. R. Collins, "Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance," *Health Affairs*, May/June 2008 27(3):646–57; K. Davis, C. Schoen, and S. R. Collins, *The Building Blocks of Health Reform: Achieving Universal Coverage and Health System Savings* (New York: The Commonwealth Fund, May 2008).

[3] C. DeNavas-Walt, B. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (U.S. Census Bureau, Aug. 2008).

[4] C. Schoen, S. Collins, J. Kriss and M. M. Doty, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007," *Health Affairs* Web Exclusive, June 10, 2008, 27(4).

cover low-income children. Extending federal financial assistance to states to cover low-income adults could have a similar impact in alleviating some of the most serious health care access problems created by gaps in coverage.

Some states have stepped up to the plate to find ways to cover both children and adults who are uninsured. Massachusetts, which enacted health reform in April 2006 with the help of a Medicaid waiver, has moved into first place, with the lowest uninsured rate in the nation in 2007. In that state, 7.9 percent of the population was uninsured in 2006–2007, compared with 24.8 percent in Texas, the state with the highest uninsured rate. A recent report from the Massachusetts Commonwealth Connector indicates that 439,000 residents have obtained coverage under the Massachusetts health insurance reforms.[5]

Despite success stories such as the one in Massachusetts, most states have not been able to move forward without federal financial assistance, even when governors have proposed ambitious health reform plans. Most of the uninsured have low incomes and cannot contribute in a significant way to today's health insurance premiums that, even under employer-based plans, run over $12,000 for a family.[6] Sixty-two percent of the uninsured have incomes below $50,000, and 80 percent have incomes below $75,000.[7] Without employers or government paying a substantial part of premiums, few uninsured families could afford to pay a $12,000 premium on their own. Even at an income of $75,000, typical group-rate health insurance premiums would consume 16 percent of income.

Any American could be at risk of losing health insurance coverage—when they lose a job, when they develop a serious health problem that leaves them unable to work, when they become widowed or divorced, when they reach their 19th birthday and lose eligibility under a parent's policy or Medicaid, or when they or their employer can no longer afford to pay their share of the health insurance premium. But certain groups have typically been most at risk: low- and middle-wage workers, who represent the bottom 60 percent of all wage earners. Over the last decade, the loss of employer-provided health

[5] J. M. Kingsdale, *Executive Director's Monthly Message*, The Massachusetts Commonwealth Connector, Aug. 25, 2008.

[6] The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2007 Annual Survey.

[7] C. DeNavas-Walt, B. Proctor, and J. Smith, *Income, Poverty, and Health Insurance Coverage in the United States: 2007* (US Census Bureau, Aug. 2008).

insurance coverage among these workers has been most marked.[8] Also at high risk are employees of small businesses. While 99 percent of firms with 200 or more employees continue to offer health insurance coverage, the corresponding rate for the smallest firms—those with fewer than 10 employees—is far lower at 45 percent.[9] Employees of small businesses, moreover, often face higher premiums and receive fewer benefits.[10]

Only about two of five children and adults in families with incomes placing them below 200 percent of the federal poverty level have employer-sponsored coverage. Not surprisingly, low-income families are more vulnerable than higher-income families to being without health insurance at some point during the year. They also are more likely to have inadequate insurance, when they have it at all. In fact, 72 percent of working-age adults with incomes of less than twice the federal poverty level are either uninsured at some point during the year or are underinsured.[11] Simply put, private markets are not working for low-income adults.

The economic consequences of being uninsured or underinsured are now well documented. A recent study by The Commonwealth Fund found that 79 million Americans have problems paying medical bills or are paying off accumulated medical debt.[12] Adults who experienced medical bill problems face dire financial problems: 29 percent are unable to pay for basic necessities like food, heat, or rent because of their bills; 39 percent use their savings to pay bills; and 30 percent take on credit card debt. Nobody should face bankruptcy or the loss of their home because of a serious illness.

The health consequences are also stark. The uninsured are less likely than the insured to receive preventive care such as immunizations, Pap tests, mammograms, and colon cancer screening.[13] Uninsured and underinsured adults with chronic conditions are

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[8] E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

[9] S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007).

[10] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs*, May/June 2006 25(3):832–43.

[11] 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, T*he Commonwealth Fund, July 2008.

[12] 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).

[13] 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).

more likely to forgo filling their medications or to skip doses because of costs. As a consequence, they are much more likely to visit an emergency room or be hospitalized for their chronic condition. People without insurance who have life-threatening conditions such as cancer are at very high risk for preventable deaths due to delays in detection plus lack of adequate treatment.[14]

We can no longer afford to ignore the fact that the U.S. is the only industrialized nation that fails to ensure access to essential health care for all its population. In 2007, a staggering two-thirds of all working-age adults—116 million people—were uninsured at some time during the year; underinsured; had a medical bill problem; and/or did not obtain needed health care because of the cost.[15]

Medicare

Medicare was created in 1965 because elderly Americans lost their private insurance when they retired. Private insurers were unwilling to take the financial risk of covering a population at risk for significant health problems and substantial health care outlays. With Medicare's broad risk-pooling, the sick are automatically cross-subsidized by the healthy. Administrative costs in Medicare, as well as in the Medicaid program, average less than 2 percent of premiums; large employer plans, meanwhile, expend 5 to 15 percent of premiums, and nongroup plans spend 25 to 40 percent or more on administrative overhead.[16]

Costs in Medicare are also lower than those in private coverage because the Medicare program pays prices for hospitals, physicians, and other health care providers that are lower than prices paid by private insurance. Even so, Medicare continues to experience high provider participation rates. Surveys show that Medicare beneficiaries are more likely than people who are privately insured to report that they have never encountered a delay in getting a physician appointment for routine care of an illness or

[14] C. J. Bradley, D. Neumark, L. M. Shickle, and N. Farrell, *Differences in Breast Cancer Diagnosis and Treatment: Experiences of Insured and Uninsured Patients in a Safety Net Setting,* NBER Working Paper No. 13875, March 2008.

[15] S. R. Collins et al., *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families.*

[16] K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M. A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs*, March/April 2000 19(2):173–84.

injury.[17] Three-fourths of those covered by Medicare and by private insurance report no difficulties in finding a primary care physician, and Medicare beneficiaries are somewhat more likely than those covered by private insurance to report that they did not encounter problems finding a specialist physician.

Compared with health insurance coverage for those under age 65, Medicare beneficiaries report better access to health care services and financial protection from burdensome medical bills. Medicare beneficiaries age 65 and over are less likely to report going without needed care in the past year due to costs.[18] In particular, Medicare beneficiaries are less likely than nonelderly adults covered by employer plans or individual coverage to report access problems related to cost—such as not going to a doctor when needing medical attention; not filling a prescription; skipping a medical test, treatment, or follow-up visit recommended by a doctor; or not seeing a specialist when a doctor thought it was needed. Medicare's cost-sharing, however, can be a deterrent to care for lower-income beneficiaries or those without supplemental coverage.[19]

Originally, Medicare did not cover preventive services. Beginning in the 1990s, however, preventive care was gradually added, and Medicare now covers women's preventive services, pneumococcal pneumonia, and influenza vaccine, among other services. Gaining Medicare coverage greatly improves access to preventive services for those who were uninsured prior to becoming eligible for the program.[20]

In addition to ensuring access to needed care, Medicare's other major goal is to provide financial protection to beneficiaries. Studies have documented that Medicare beneficiaries are less likely than adults under age 65 to report problems paying medical bills.[21] Medicare beneficiaries are also less likely than those under 65 to report times when they had difficulty paying or were unable to pay their bills, were contacted by a

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[17] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, March 2006, p.85.

[18] K. Davis and S. R. Collins, "Medicare at Forty," *Health Care Financing Review*, Winter 2005–2006:53–62; K. Davis, C. Schoen, M. M. Doty et al., "Medicare vs. Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive, Oct. 9, 2002: W311–324.

[19] T. Rice and K. Y. Matsuoka, "The Impact of Cost-Sharing on Appropriate Utilization and Health Status: A Review of the Literature on Seniors," *Medical Care Research and Review*, Dec. 2004 61(4):415–52.

[20] J. M. McWilliams, A. M. Zaslavsky, E. Meara, and J. Z. Ayanian, "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *Journal of the American Medical Association*, Aug. 13, 2003 290(6):757–64.

[21] S. R. Collins, K. Davis, C. Schoen, M. M. Doty, S. K. H. How, A. L. Holmgren, *Will You Still Need Me? The Health and Financial Security of Older Americans* (New York: Commonwealth Fund, June 2005).

collection agency concerning outstanding medical bills, or had to change their way of life significantly in order to pay their bills.

Nevertheless, elderly beneficiaries still spend an average of 22 percent of their income on premiums and out-of-pocket health care costs.[22] This is projected to grow to 30 percent by 2025. Few older adults entering retirement have substantial savings from which to draw to meet these expenses.[23]

Medicare beneficiaries are much more likely to rate their insurance as excellent or very good than are those covered by employer plans or individual coverage.[24] Two-thirds (68%) of elderly Medicare beneficiaries rate their insurance as excellent or very good, compared with 44 percent of those with employer coverage, 41 percent of those with individual coverage, and 54 percent of those with Medicaid coverage.

Medicare beneficiaries are also more likely than those under age 65 and covered by private insurance to report being very or somewhat confident that they will get the best medical care available when they need it. Aged Medicare beneficiaries report more choice in where to go for medical care, compared with nonelderly adults.[25]

Beneficiaries' high level of satisfaction with their coverage is also reflected in the interest older Americans attach to qualifying for Medicare coverage. The Commonwealth Fund Survey of Older Adults found that nearly three-fourths of respondents ages 50 to 64 were interested in becoming eligible for Medicare.[26] This was particularly true of older adults with individual coverage and those who were uninsured, with 84 and 94 percent, respectively, indicating interest in becoming eligible. Meanwhile, older adults in lower income groups also reported interest at high rates.

Medicare has often been an innovative leader in provider payment reform. Its DRG (diagnosis-related group) method of hospital payment, introduced in 1983, shortened hospital lengths of stay by 10 percent. Its RBRVS (resource-based relative value schedule) method of physician payment, introduced in 1992, has been widely used

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[22] S. Maxwell, M. Storeygard, and M. Moon, *Modernizing Medicare Cost-Sharing: Policy Options and Impacts on Beneficiary and Program Expenditures* (New York: The Commonwealth Fund, Nov. 2002).

[23] S. R. Collins, M. M. Doty, K. Davis, C. Schoen, A. L. Holmgren, and A. Ho, *The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey* (New York: The Commonwealth Fund, March 2004).

[24] K. Davis and S. R. Collins, "Medicare at Forty," *Health Care Financing Review*, Winter 2005–2006 27(2):53–62; K. Davis, C. Schoen, M. M. Doty et al., "Medicare vs. Private Insurance: Rhetoric and Reality," *Health Affairs* Web Exclusive, October 9, 2002: W311–324.

[25] K. Davis and S. R. Collins, "Medicare at Forty."

[26] S. R. Collins et al., *Will You Still Need Me? The Health and Financial Security of Older Americans*.

by private insurers and during the mid-1990s facilitated the growth of managed care discounted networks. Medicare has had some success with demonstrations of new payment methods, and is launching others (e.g., a newly announced bundled-payment method for acute episodes of care provided by hospitals and physicians).[27]

Both Medicare and private insurers could move much more quickly to offer new methods of payment for patient-centered medical homes, physician group practices, hospital systems that have the capacity to provide transitional care, and integrated delivery systems that are willing to be accountable for the total care of patients and willing and able to assume financial risk for a longer continuum of care.[28]

Medicare, as the largest single payer for health care, could also use its purchasing leverage to require that providers adopt electronic information technology and evidence-based medicine. It has begun a major effort to report publicly quality-of-care information at the provider level, but such initiatives could be accelerated. Medicare could also be granted greater flexibility to translate into payment policy more rapidly the lessons learned from its demonstrations on rewarding providers for excellence.

If initiated early, such reforms could slow the growth in health care costs. A recent report prepared for The Commonwealth Fund Commission on a High Performance Health System analyzed the impact on national health expenditures of various reform options, including those designed to: ensure that the best-possible information is used for health care decision-making; promote health and enhance disease prevention efforts; align financial incentives with health quality and efficiency; and correct price signals in health care markets.[29] Based on analysis provided by the Lewin Group, the report estimated that over a 10-year period, multiple years of savings add up to a $1.6 trillion cumulative difference in expenditures below projected trends. A combination of actions,

[27] S. Guterman and M. P. Serber, *Enhancing Value in Medicare: Demonstrations and Other Initiatives to Improve the Program* (New York: The Commonwealth Fund, Jan. 2007); J. Reichard, "Medicare Hopes to Bundle Way to Better Hospital Care," *CQ HealthBeat*, May 16, 2008.

[28] K. Davis and S. Guterman, "Rewarding Excellence and Efficiency in Medicare Payments." *Milbank Quarterly*, Sept. 2007 85(3):449–68; K. Davis, "Paying for Episodes of Care and Care Coordination," *New England Journal of Medicine*, March 15, 2007 356(11):1166–68; A. Mutti and C. Lisk, "Moving Toward Bundled Payments Around Hospitalizations," presentation to Medicare Payment Advisory Commission, Washington, D.C., April 9, 2008.

[29] C. Schoen, S. Guterman, A. Shih, J. Lau, S. Kasimow, A. Gauthier, and K. Davis, *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending* (New York: Commonwealth Fund, Dec. 2007).

each contributing small percentage changes each year, can add up to substantial cumulative effects over time.

Medicaid and SCHIP

Medicaid, the nation's safety-net health insurance program, covers more than 50 million people, including 41 percent of all births, nearly two-thirds of nursing home residents, 44 percent of persons with HIV/AIDS, and one of five people with severe disabilities.[30] Without Medicaid, we would have far more than 46 million uninsured.[31] In particular, state expansions of Medicaid and SCHIP eligibility over the last decade have helped offset the declines in private health insurance for children.[32] Reauthorization and adequate funding of SCHIP are essential to covering more of the nation's 8 million uninsured children.

Medicaid eligibility for parents and adults without children, however, varies greatly across states: 14 states cover parents only if their incomes are below 50 percent of poverty, which is approximately equivalent to an annual income of just over $10,000 for a family of four.[33] Thirty-five states set thresholds for parents below the poverty level, while 34 states provide no Medicaid coverage at all for non-disabled adults who do not have children. As a result, in the vast majority of states, an adult working full-time, year-long at minimum wage is ineligible for premium assistance.

Elderly and disabled Medicaid beneficiaries account for one-fourth of Medicaid enrollees but 70 percent of Medicaid medical care outlays. Medicaid provides many needed services for patients with complex medical problems—services that are not typically covered by private plans. For example, 35 percent of Medicaid spending goes for long-term care. Medicaid is also a major source of support for safety-net providers,

[30] Kaiser Commission on Medicaid and the Uninsured.

[31] D. Rowland, "Medicaid—Implications for the Health Safety Net," *New England Journal of Medicine*, Oct. 6, 2005, 353(14):1439–41.

[32] J. C. Cantor, C. Schoen, D. Belloff, S. K. H. How, and D. McCarthy, *Aiming Higher: Results from a State Scorecard on Health System Performance* (New York: The Commonwealth Fund, June 2007).

[33] Kaiser Family Foundation, "Income Eligibility Levels for Children's Separate SCHIP Programs, 2006" and "Income Eligibility for Parents applying for Medicaid, 2006," available online at http://www.statehealthfactsonline.org.

accounting for 39 percent of the revenues of public hospitals and 37 percent of the revenues of safety-net clinics.[34]

Medicaid has been successful in improving access to care for both low-income adults and children.[35] Compared with uninsured adults, adults covered by Medicaid are much more likely to have a regular source of care, less likely to have postponed seeking care because of the cost, and less likely to report that there was a time when they failed to receive needed care or were unable to afford a prescription drug.[36] Similarly, children covered by Medicaid are more likely to have a usual source of care than uninsured children, more likely to have seen a physician in the last two years, and more likely to have had a dental visit in the last two years.[37]

Medicaid and SCHIP are ideal coverage sources for low-income adults and children, and they have a long history of serving low-income children and adults and people with the most serious health problems. In addition, Medicaid's cost per person covered is lower than per-person costs under private coverage.[38]

SCHIP has been highly successful in reducing the rate of uninsured children and improving care for children, with most states accepting the offer of favorable federal matching to expand coverage for low-income children. States' ability to do so, however, depends on economic conditions and may be subject to retrenchment during downturns. Medicaid programs could be strengthened by adjusting the federal matching rate upward in times of high unemployment, when states undergo serious financial strains.

States have also led in test-driving promising approaches for meeting the particular needs of their populations. Iowa, for example, has reduced the growth in its Medicaid outlays by 3.8 percent over eight years through primary care case management, which is similar to the patient-centered medical home model.[39] North Carolina has

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[34] Kaiser Commission on Medicaid and the Uninsured, based on *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, Oct. 2006. KCMU Analysis of 2006 UDS Data from HRSA.

[35] D. Rowland and J. R. Tallon, Jr.,"Medicaid: Lessons Drawn from a Decade," *Health Affairs*, Jan./Feb. 2003 22(1):138–144.

[36] Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data.

[37] Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC, 2007, and Summary of Health Statistics for U.S. Children: NHIS, 2006.

[38] J. Hadley and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?" *Inquiry*, Winter 2003 40(4):323–42.

[39] E. T. Momany, S. D. Flach, F. D. Nelson, and P. C. Damiano, "A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program," *Health Research and Educational Trust*, Dec. 2006 41(4 Pt. 1):1357–71.

improved care, reduced pediatric hospitalization rates, and saved money in its Medicaid program through Community Care of North Carolina, an enhanced primary care case management system and patient-centered medical home model of care.[40] Vermont is using state-employed nurses to assist physician practices with chronic care management.

States are also investing in electronic medical information capacity to ensure that information travels with patients, provide physicians with decision support to enhance patient outcomes, and reduce the risk of errors and duplication of effort. State governments in Massachusetts, Minnesota, Washington, and Wisconsin are employing value-based purchasing in their state public employee or Medicaid programs and joining with other payers to improve quality, reduce administrative cost, provide financial incentives, and leverage health system change.[41]

Yet, more could be done to share best practices and accelerate the dissemination of these innovative models to other states. States should also have an incentive to learn from each other—to spread innovations in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

Public Programs and Private Insurers

It is important to note that public insurance programs work hand-in-hand with—not to the exclusion of—the private market. While funded by the government, Medicare and Medicaid use private insurers when it is efficient to do so. Both programs purchase services from private managed care plans and make extensive use of private insurers as administrative claims payment agents. By utilizing the private market as appropriate, public programs are able to offer beneficiaries a wide array of options.

Public programs lower the cost of private coverage because they enroll everyone who meets statutory age or income criteria, regardless of health status. A study for The Commonwealth Fund found that if the sickest 2 percent were excluded from the nongroup private insurance market, the average cost of coverage would drop by more than 20 percent.[42] Clearly, Medicare and Medicaid help private markets work by covering the elderly, the disabled, special-needs children, people with HIV/AIDS, and

[40] L. Allen Dobson, presentation to ERISA Industry Committee, Washington, D.C., March 12, 2007.

[41] S. Silow-Carroll and T. Alteras, *Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve* (New York: The Commonwealth Fund, Aug. 2007).

[42] S. A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance* (New York: The Commonwealth Fund, Jan. 2001).

those with serious mental illnesses. Expanding public programs to cover the sickest and poorest of the uninsured would help ensure affordable private insurance premiums for many of the remaining uninsured. By reducing bad debt and the burden of charity care, expanding public programs would also enhance the financial stability of rural and inner-city hospitals, academic health centers, community health centers, and other safety-net providers—many of which have experienced an increased uninsured patient load in recent years.

Private employer insurance now covers 160 million working Americans and their families. For the most part, employer coverage works well for healthy working families, whose employers contribute, on average, 75 to 80 percent of the premium. However, coverage has become increasingly unaffordable for small firms that are unable to obtain the same benefits and premiums of larger firms.[43]

For those Americans whose only recourse is the individual insurance market, the availability and affordability of coverage depend heavily on state regulation. Of those seeking coverage in the individual market, about nine of 10 do not buy a plan, because it is difficult or impossible to find a plan that is affordable, because they are turned down, or because they cannot find a plan that meets their needs.[44]

Insurance market reforms—including minimum requirements on insurers to cover everyone, the sick and healthy alike, at the same premium—could ensure the availability of coverage in all states. Without such requirements, insurers have a strong incentive to enroll the healthiest people, given the strong skewing in the distribution of health expenditures, with 10 percent of people accounting for 64 percent of outlays.[45]

By organizing a national insurance connector that builds on the experience of Massachusetts, we could expand insurance choices to small businesses and individuals. With more integrated benefits and innovative payment policies, a Medicare-sponsored public plan could also be offered as an option to small businesses and individuals.

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[43] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[44] 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 Well-being of American Families* (New York: The Commonwealth Fund, Sept. 2006).

[45] S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan./Feb. 2007 26(1): 249–57.

The Road Ahead: Using What Works

The American health care system falls far short of what is achievable. We spend twice as much per person as any other country, yet the U.S. is the only nation that fails to ensure universal financial access to health care. We are slipping further behind what other countries achieve with their more modest investment in health care. Yet, we have at our disposal solid starting points for health care reform, established bases on which to model the system we seek: Medicare, Medicaid, and SCHIP.

Congress can take steps now to lay the foundation for broader health reform that ensures affordable coverage for all Americans. These include: 1) leveraging Medicare's position as the largest payer for health care to improve health care quality and slow the growth in health care costs; 2) strengthening Medicaid and SCHIP to serve as a base of coverage for all low-income children and adults; 3) reforming individual insurance markets; and 4) making affordable insurance options, including a public insurance option, available to small businesses and individuals through an insurance connector.

Medicare can be a leading force for change in the health care system. Its beneficiaries are highly satisfied with their coverage. It offers a wide choice of providers. It has low administrative costs and, as a major purchaser, has lower provider payment rates than private insurance—making it less expensive than premiums available to small businesses. It can serve as a model for private insurers in public reporting, rewarding quality, requiring evidence-based care, and encouraging use of modern information technology. Reforms to Medicare's payment system can improve the accessibility and coordination of care through patient-centered medical homes, help shape a more organized, high performance health system, and create incentives to prevent avoidable hospitalization. These reforms could slow the growth in health care costs and "bend the curve" in national health expenditure trends.

Medicaid and SCHIP have been successful in improving access to care for both low-income adults and children. Compared with uninsured adults, adults and children covered by Medicaid and SCHIP are more likely to get needed care, including preventive care. Many states have shown that they will act to insure low-income individuals if the federal government provides matching financial assistance. Reauthorization and adequate funding of SCHIP are essential steps to covering many of the nation's 8 million uninsured children.

Making federal matching funds available for coverage of low-income adults could also help reverse the trend toward greater gaps in coverage for working-age adults. Expansions to low-wage working adults could also enhance continuity as workers move across multiple jobs and employers. The federal government could further help states maintain and expand coverage in economic downturns by automatically raising the matching rate in times of high unemployment. States should also have an incentive to learn from each other about innovations and best practices in information technology, pay-for-performance, patient-centered medical homes, and chronic care management.

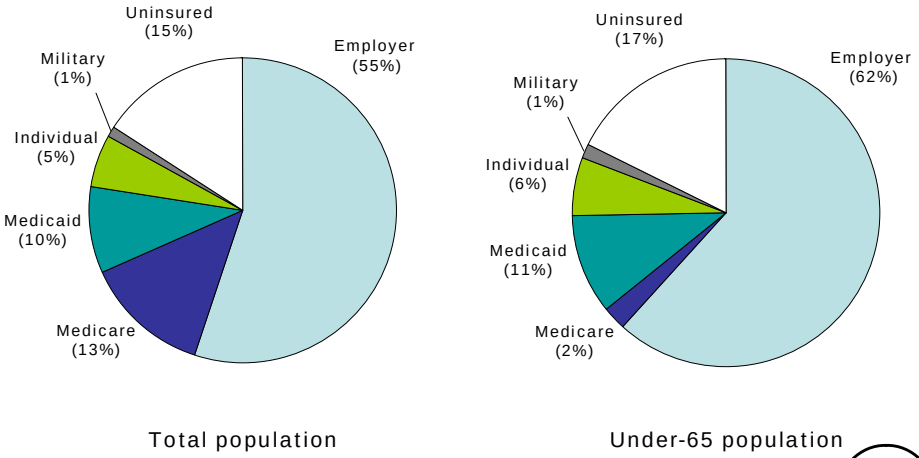
Insurance market reforms—such as requiring insurers to cover everyone, regardless of health status, at the same premium—could ensure the availability of coverage in all states. A new national insurance connector, building on the experience of Massachusetts, could expand insurance choices to small businesses and individuals. With more integrated benefits and innovative payment policies, a Medicare-sponsored public plan could also be offered as an option to small businesses and individuals.

These are steps that build on what already works. As the nation begins serious consideration of health reform, Medicare, Medicaid, and SCHIP must be seen as building blocks in a system of seamless coverage for America's 46 million uninsured people. A mixed private–public system of universal coverage, with coordination across sources of coverage, could transform both the financing and delivery of health care services. Such a system would build on the best that both private insurance and public programs have to offer and also achieve needed savings and ensure access to essential care for all.

Thank you for this opportunity to participate in today's hearing on health care reform and to address questions of the Committee.

Health Insurance Coverage

45.7 Million Uninsured, 2007



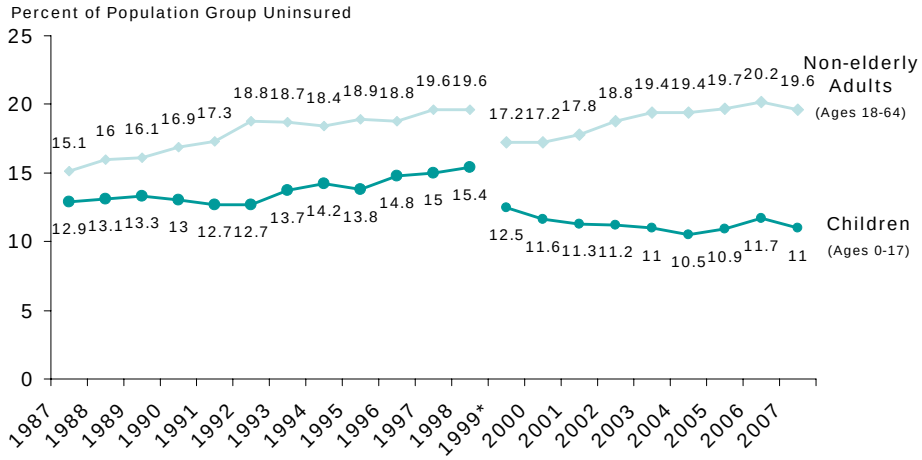
Total population

Under-65 population

Source: Authors' estimates based on S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007) and analysis of the Current Population Survey, March 2008, by Bisundev Mahato of Columbia University.

THE COMMONWEALTH FUND

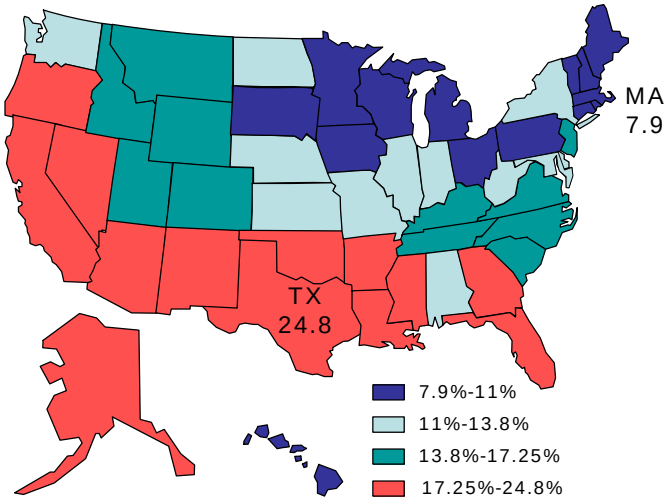
Percentage of Uninsured Children Has Declined Since Implementation of SCHIP While Uninsured Working-Age Adults Have Increased, 1987–2007



Note: Census methodology changed with the 2000 ASEC, which collected data for 1999. Population controls and implementation of the verification question led to lower estimates of the uninsured.
Source: Calculated from DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

THE COMMONWEALTH FUND

Uninsured Rates, By State, Two-year Average, 2006–07



Source: DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

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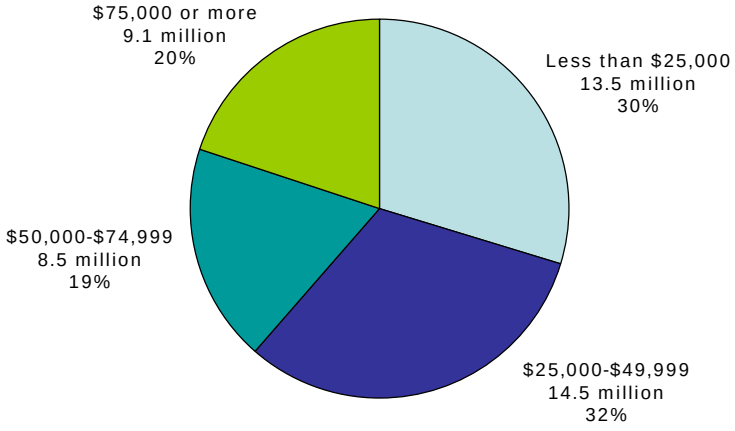
Uninsured by Household Income, 2007

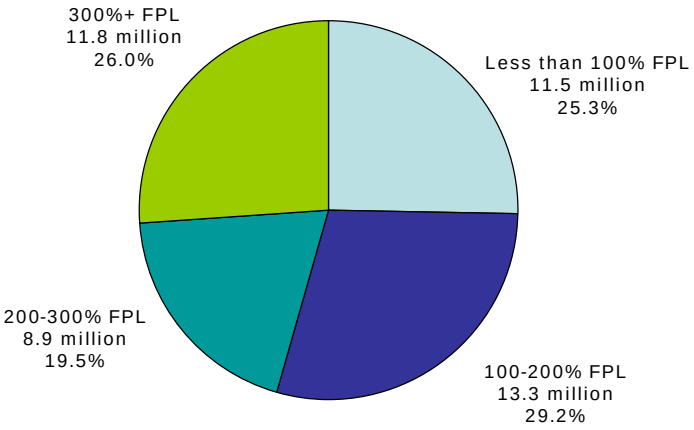


Total Uninsured Population = 45.7 Million

Source: DeNavas-Walt C, Proctor B, and Smith J. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Washington: Census Bureau, 2008.

THE COMMONWEALTH FUND

Uninsured by Federal Poverty Level, 2007



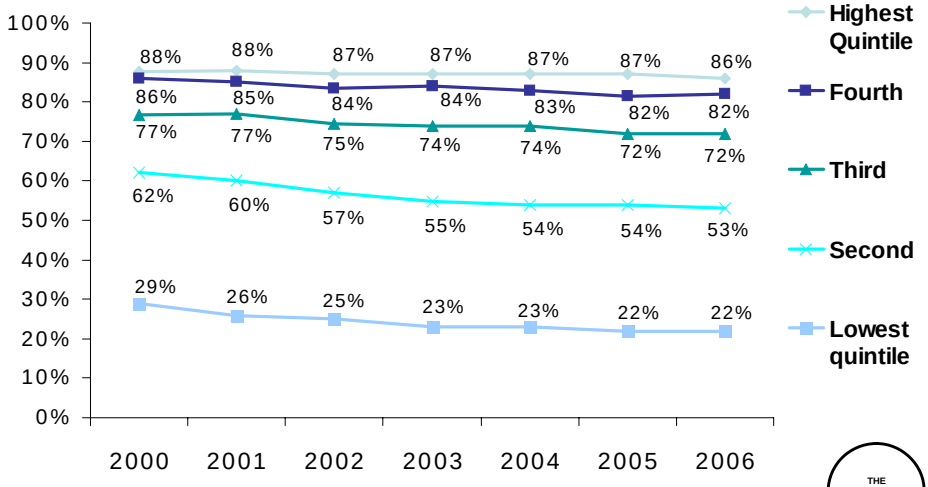
Total Uninsured Population
(Persons in Poverty Universe) =
45.6 Million

Source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

THE COMMONWEALTH FUND

Employer-Provided Health Insurance, by Income Quintile, 2000–2006

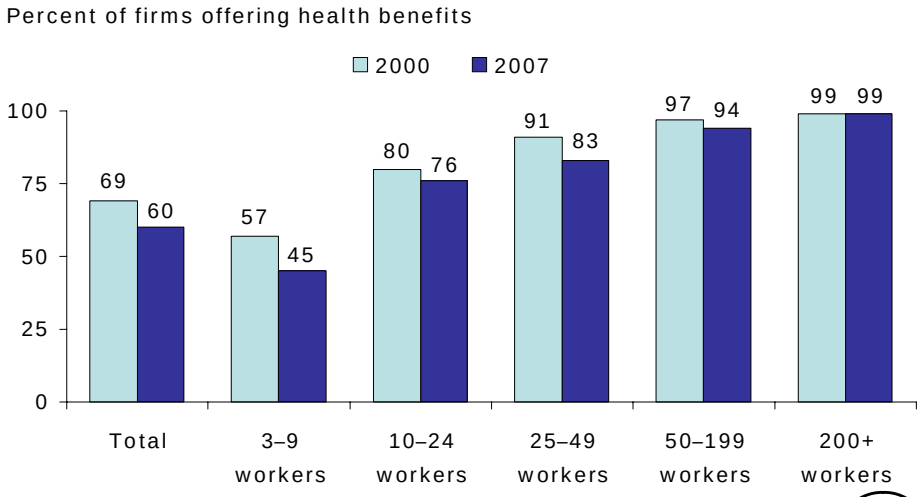
Percent of population under age 65 with health benefits from employer



Source: E. Gould, *The Erosion of Employment-Based Insurance: More Working Families Left Uninsured,* EPI Briefing Paper No. 203 (Washington, D.C.: Economic Policy Institute, Nov. 2007).

THE COMMONWEALTH FUND

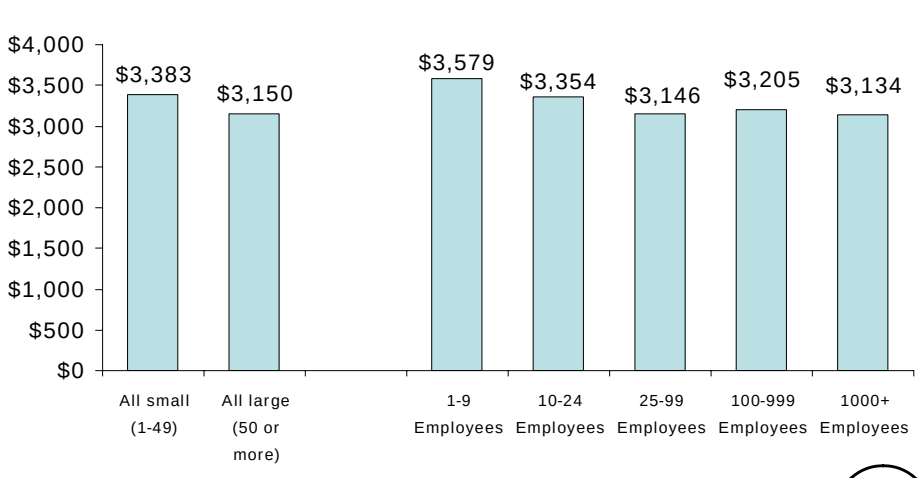
Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms



Source: S. R. Collins, C. White, and J. L. Kriss, *Whither Employer-Based Health Insurance? The Current and Future Role of U.S. Companies in the Provision and Financing of Health Insurance* (New York: The Commonwealth Fund, Sept. 2007). Data: The Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits*, 2000 and 2007 Annual Surveys.

THE COMMONWEALTH FUND

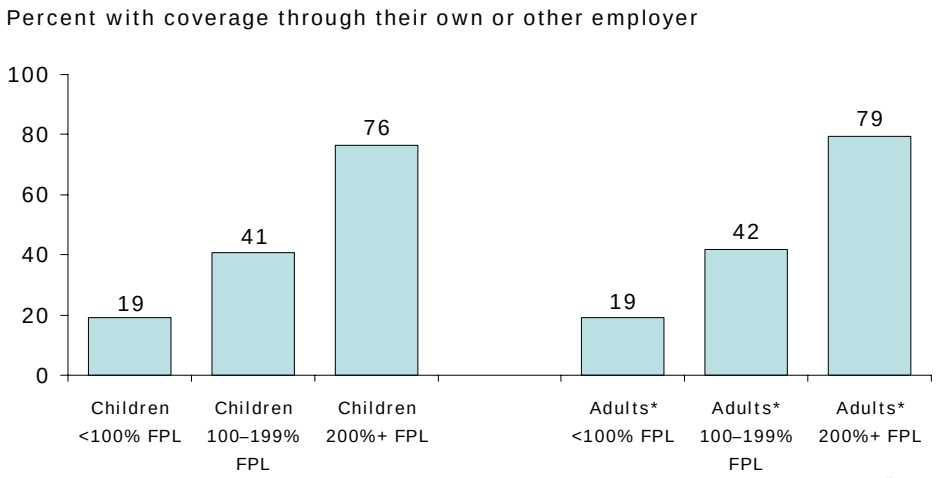
Single Premium by Size of Firm, Adjusted for Actuarial Value



Source: J. Gabel, R. McDevitt, L. Gandolfo et al., Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down, Health Affairs, May/June 2006 25(3):832–43.

THE COMMONWEALTH FUND

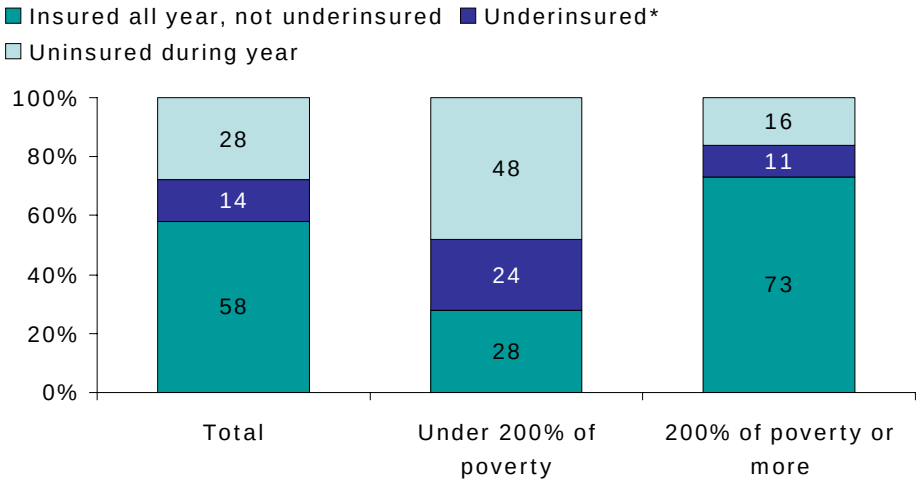
Percent of Children and Adults with Employer-Sponsored Coverage, by Poverty



FPL = federal poverty level.
*Adults age 19 and over; children are age 18 and under.
Source: Analysis by S. Glied and B. Mahato of Columbia University of the 2006 Current Population Survey.

THE COMMONWEALTH FUND

Adults Ages 19–64 Who Are Uninsured and Underinsured, By Poverty Status, 2007

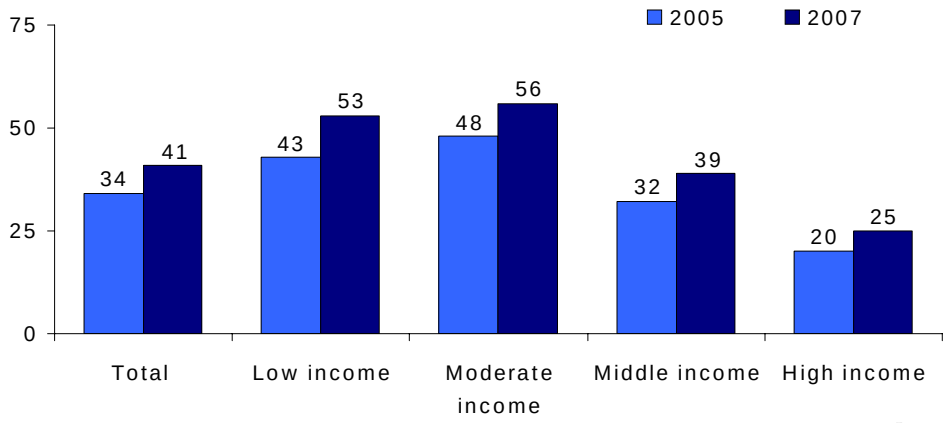


*Underinsured defined as insured all year but experienced one of the following: medical expenses equaled 10% or more of income; medical expenses equaled 5% or more of incomes if low-income (<200% of poverty); or deductibles equaled 5% or more of income.
Data: 2007 Commonwealth Fund Biennial Health Insurance Survey
Source: Schoen C, Collins SR, Kriss JL, Doty MM. How many are underinsured? Trends among U.S. adults, 2003 and 2007. Health Aff (Millwood). 2008 Jul-Aug;27(4):w298-309. Epub 2008 Jun 10.

THE COMMONWEALTH FUND

Problems with Medical Bills or Accrued Medical Debt Increased, 2005–2007

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

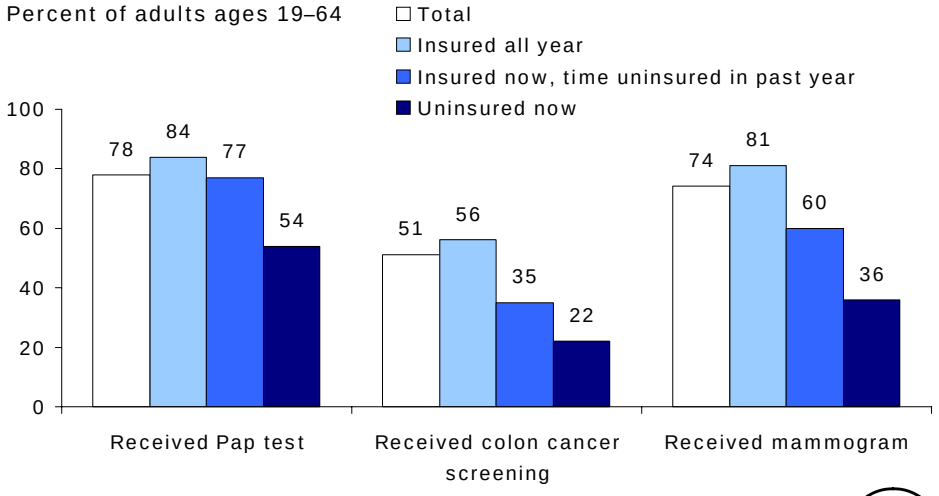


Note: Income refers to annual income. In 2005 and 2007, low income is <$20,000, moderate income is $20,000–$39,999, middle income is $40,000–$59,999, and high income is $60,000 or more.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2007).

THE COMMONWEALTH FUND

Uninsured Adults and Adults with Gaps in Coverage Have Lower Rates of Cancer Screening Tests, 2007

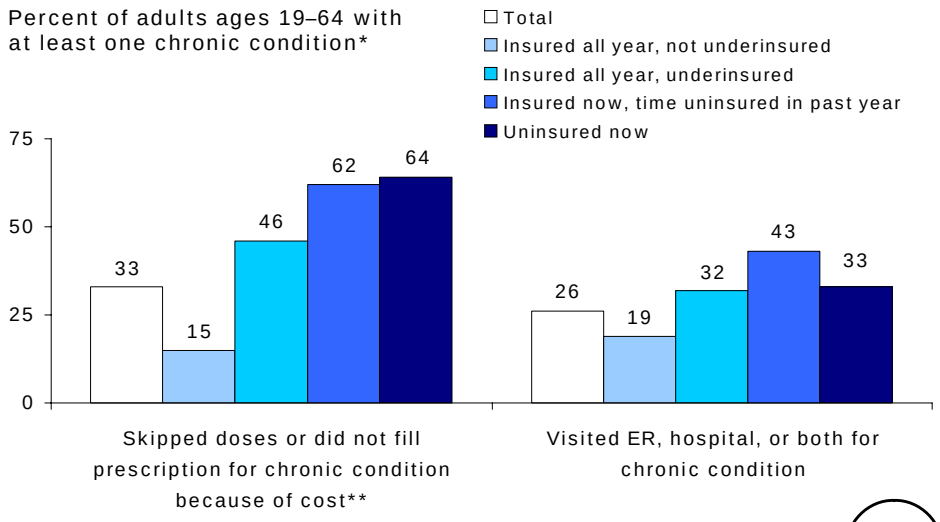
Percent of adults ages 19–64



Note: Pap test in past year for females ages 19–29, past three years age 30+; colon cancer screening in past five years for adults ages 50–64; and mammogram in past two years for females ages 50–64.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

THE COMMONWEALTH FUND

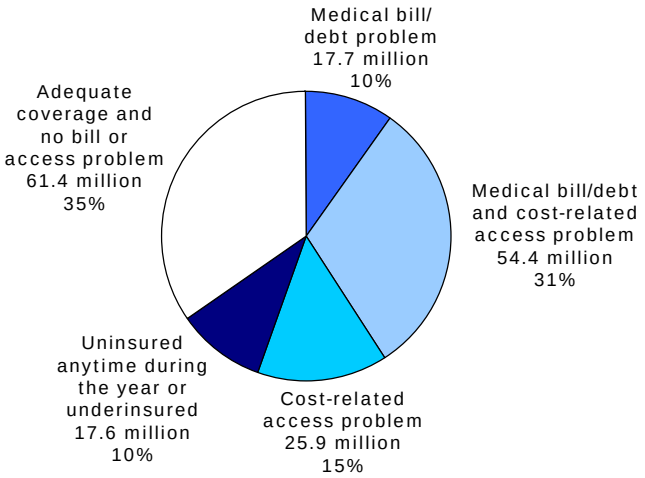
Uninsured and Underinsured Adults with Chronic Conditions Are More Likely to Visit the ER for Their Conditions



*Hypertension, high blood pressure; heart disease; diabetes; asthma, emphysema, or lung disease.
**Adults with at least one chronic condition who take prescription medications on a regular basis.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

THE COMMONWEALTH FUND

An Estimated 116 Million Adults Were Uninsured, Underinsured, Reported a Medical Bill Problem, and/or Did Not Access Needed Health Care Because of Cost, 2007

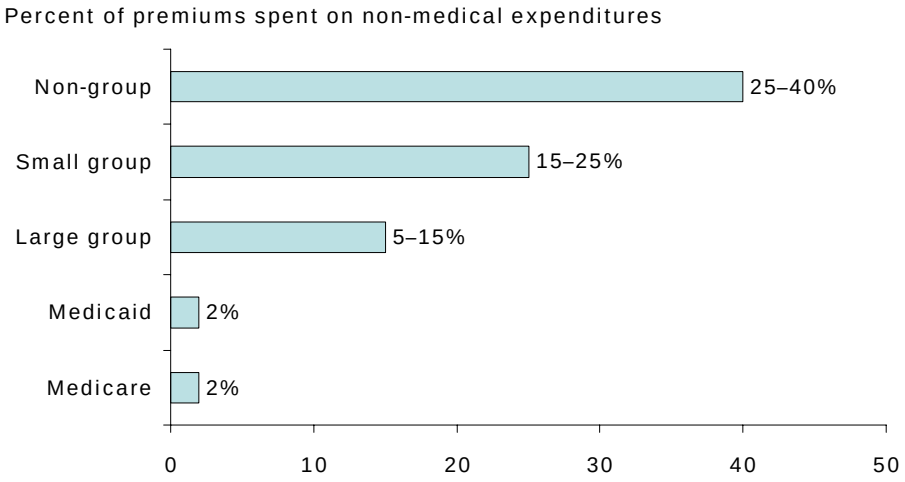


177 million adults, ages 19–64

Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

THE COMMONWEALTH FUND

Only Two Percent of Premiums in Medicare and Medicaid Are Spent on Non-Medical Expenditures



Source: K. Davis, B. S. Cooper, and R. Capasso, *The Federal Employees Health Benefit Program: A Model for Workers, Not Medicare* (New York: The Commonwealth Fund, Nov. 2003); M. A. Hall, The geography of health insurance regulation, *Health Affairs*, March/April 2000; 19(2): 173–184;

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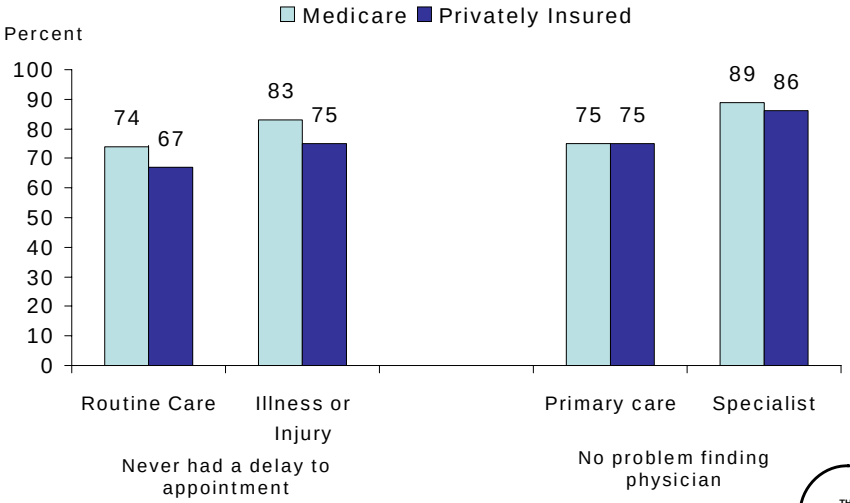
Access to Physicians for Medicare Beneficiaries and Privately Insured People, 2005



Source: MedPAC Report to the Congress: Medicare Payment Policy, March 2006, p. 85.

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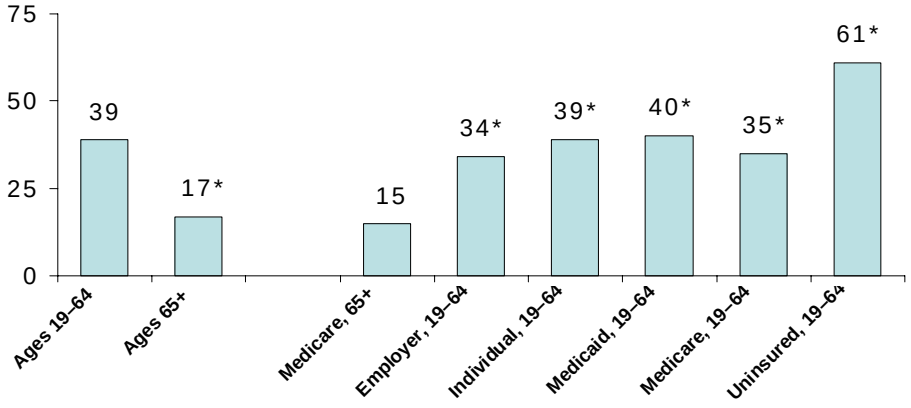
Access Problems Because of Cost

Percent of adults who had any of four access problems[1] in past year due to cost



Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.

[1]Did not fill a prescription; did not see a specialist when needed; skipped medical test, treatment, or follow-up; did not see doctor when sick.

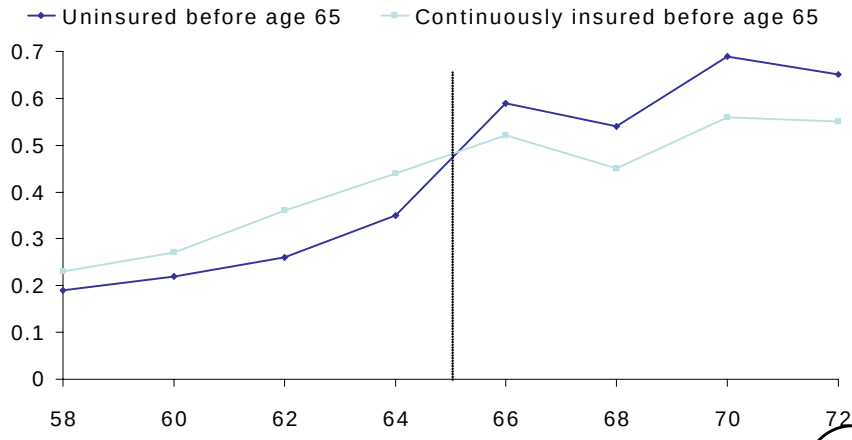
* Significant difference at $p \leq .01$ or better; referent categories are "ages 19–64" and "Medicare 65+".

Source: K. Davis and S.R. Collins, "Medicare at Forty," *Health Care Financing Review,* Winter 2005–2006 27(2):53–62.

THE COMMONWEALTH FUND

Previously Uninsured Medicare Beneficiaries with History of Cardiovascular Disease or Diabetes Have Much Higher Self-Reported Hospital Admissions After Entering Medicare Than Previously Insured

Number of hospital admissions per 2-year period



Source: J. M. McWilliams et al., "Use of Health Services by Previously Uninsured Medicare Beneficiaries," *New England Journal of Medicine* 357;2, Jul 12 2007.

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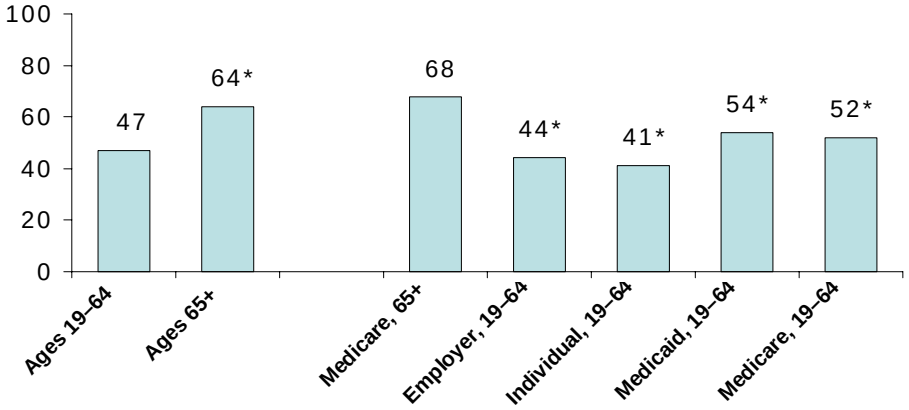
Rating of Current Insurance

Percent of adults who rated their current insurance as "excellent" or "very good"

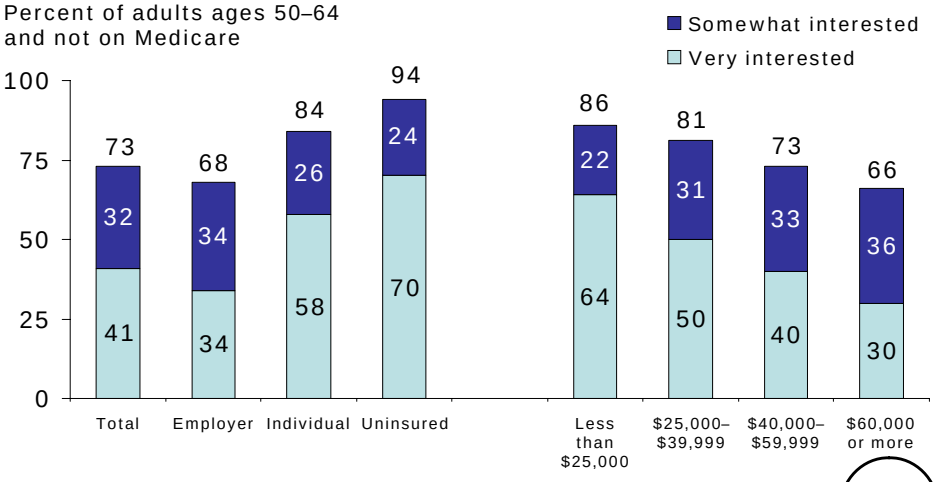


Note: Adjusted percentages based on logistic regression models; age groups controlled for health status and income; insurance status controlled for health status, income, and prescription coverage.
* Significant difference at p≤.01 or better; referent categories are "ages 19–64" and "Medicare 65+".
Source: K. Davis and S.R. Collins, "Medicare at Forty," *Health Care Financing Review,* Winter 2005-2006 27(2):53-62.

THE COMMONWEALTH FUND

Percent of Adults Ages 50–64 Who Are Very/Somewhat Interested in Receiving Medicare Before Age 65, by Insurance Status and Income

Percent of adults ages 50–64 and not on Medicare



Source: S. R. Collins, et al., *Will You Still Need Me? The Health and Financial Security of Older Americans: Findings from The Commonwealth Fund Survey of Older Adults*, Commonwealth Fund, June 2005.

THE COMMONWEALTH FUND

Bending the Curve:
Fifteen Options that Achieve Savings
Cumulative 10-Year Savings

Producing and Using Better Information	
• **Promoting Health Information Technology**	**-$88 billion**
• **Center for Medical Effectiveness and Health Care Decision-Making**	**-$368 billion**
• **Patient Shared Decision-Making**	**-$9 billion**
Promoting Health and Disease Prevention	
• **Public Health: Reducing Tobacco Use**	**-$191 billion**
• **Public Health: Reducing Obesity**	**-$283 billion**
• **Positive Incentives for Health**	**-$19 billion**
Aligning Incentives with Quality and Efficiency	
• **Hospital Pay-for-Performance**	**-$34 billion**
• **Episode-of-Care Payment**	**-$229 billion**
• **Strengthening Primary Care and Care Coordination**	**-$194 billion**
• **Limit Federal Tax Exemptions for Premium Contributions**	**-$131 billion**
Correcting Price Signals in the Health Care Market	
• **Reset Benchmark Rates for Medicare Advantage Plans**	**-$50 billion**
• **Competitive Bidding**	**-$104 billion**
• **Negotiated Prescription Drug Prices**	**-$43 billion**
• **All-Payer Provider Payment Methods and Rates**	**-$122 billion**
• **Limit Payment Updates in High-Cost Areas**	**-$158 billion**

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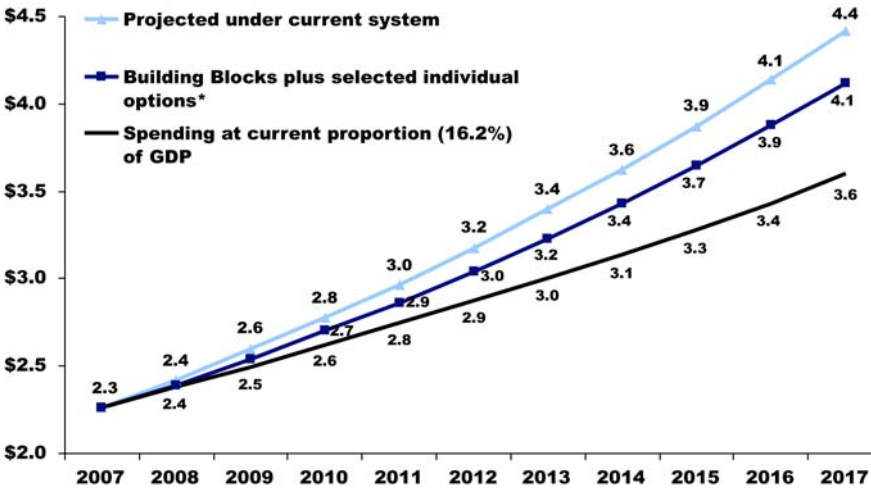
Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending*, Commonwealth Fund, December 2007.

Total National Health Expenditures, 2008–2017
Projected and Various Scenarios

Dollars in trillions



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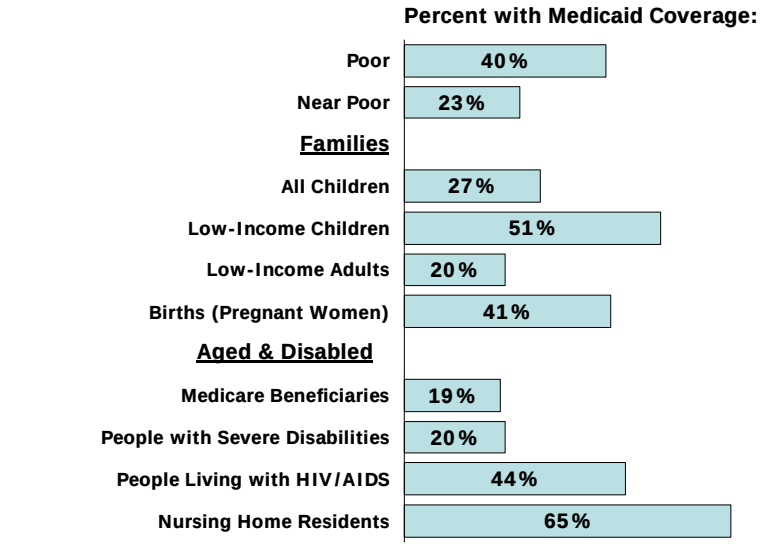
* Selected individual options include improved information, payment reform, and public health.
Source: C. Schoen et al., *Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending,* The Commonwealth Fund, December 2007. Data: Lewin Group estimates.

Medicaid's Role for Selected Populations



Note: "Poor" is defined as living below the federal poverty level, which was $17,600 for a family of 3 in 2008.
SOURCE: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, and Urban Institute estimates; Birth data: NGA, MCH Update.

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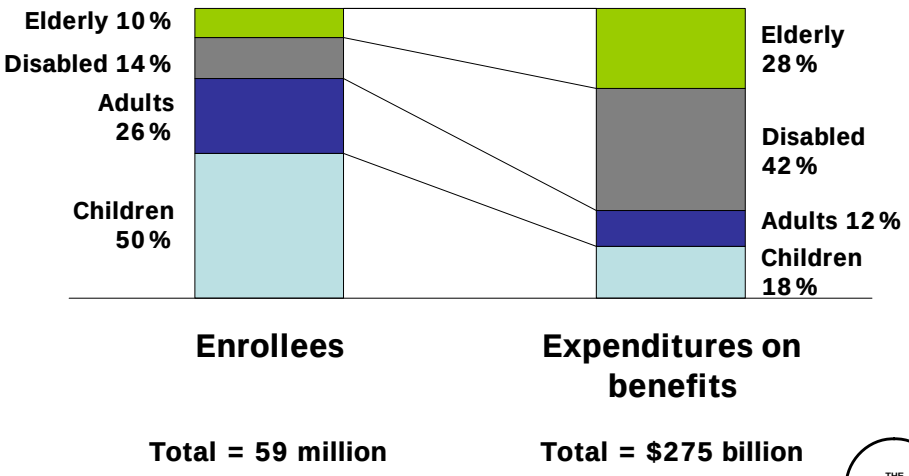
Medicaid Enrollees and Expenditures by Enrollment Group, 2005



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data.

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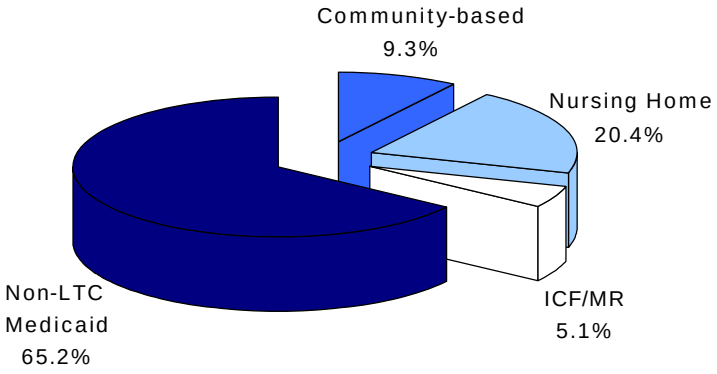
Thirty-five Percent of Medicaid Spending Goes to Long-Term Care



Note: ICF/MR = intermediate care facilities for the mentally retarded
Source: MEDSTAT HCBS

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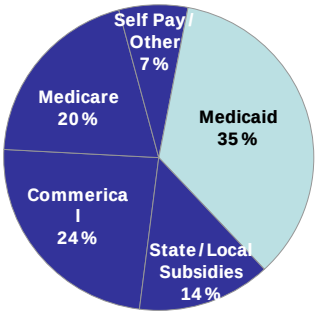
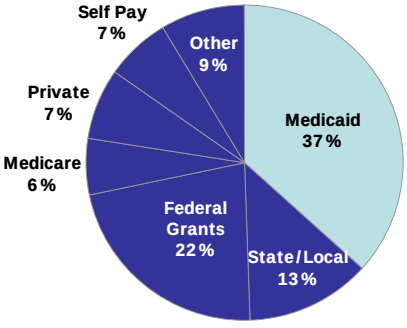
Medicaid Financing of Safety-Net Providers

Public Hospital Net Revenues by Payer, 2004



Total = $29 billion

Health Center Revenues by Payer, 2006



Total = $8.1 billion

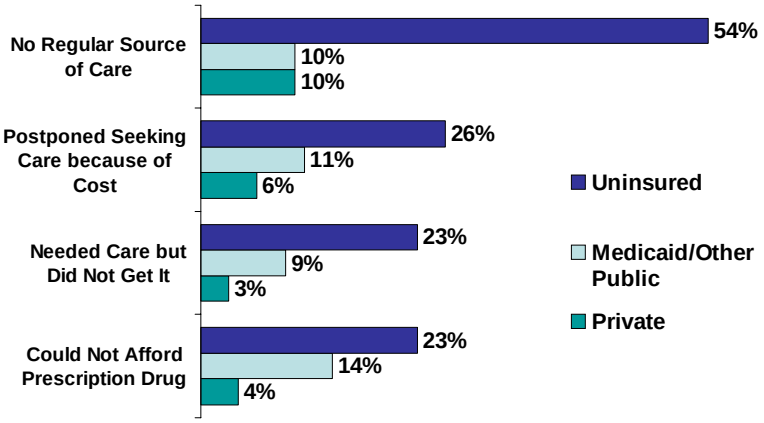
SOURCE: Kaiser Commission on Medicaid and the Uninsured, based on *America's Public Hospitals and Health Systems, 2004*, National Association of Public Hospitals and Health Systems, October 2006. KCMU Analysis of 2006 UDS Data from HRSA.

THE KAISER FAMILY FOUNDATION

THE COMMONWEALTH FUND

Barriers to Health Care Among Nonelderly Adults, by Insurance Status, 2006

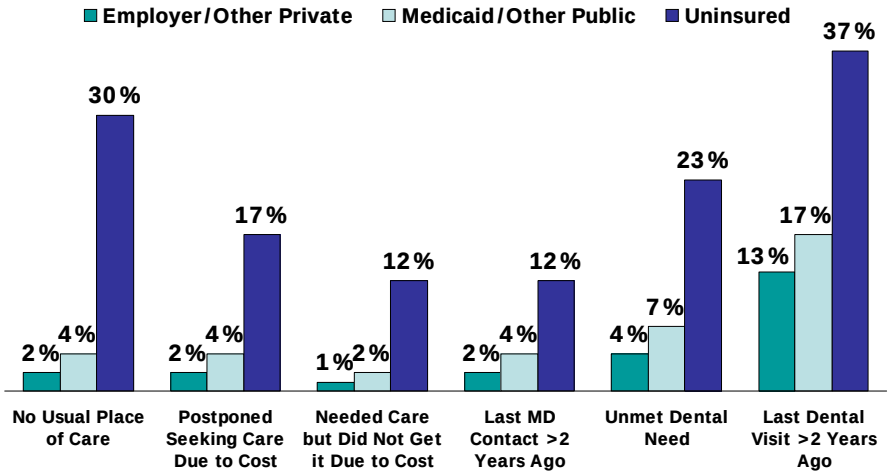
Percent of adults (age 19 – 64) reporting in past 12 months:



NOTE: Respondents who said usual source of care was the emergency room were included among those not having a usual source of care.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data.

THE COMMONWEALTH FUND

Children's Access to Care, by Health Insurance Status, 2006

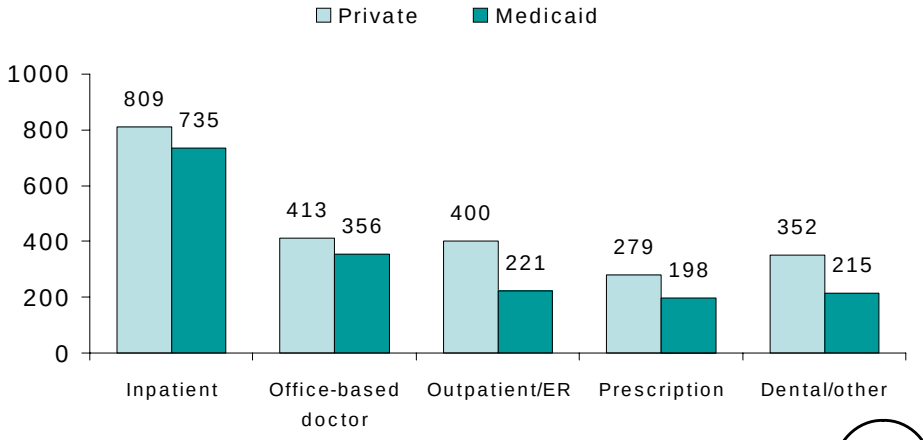


NOTE: MD contact includes MD or any health care professional, including time spent in a hospital. Data is for all children under age 18, except for dental visit and unmet dental need, which are for children age 2-17. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All estimates are age-adjusted.
SOURCE: Kaiser Commission on Medicaid and the Uninsured analysis of National Center for Health Statistics, CDC. 2007. Summary of Health Statistics for U.S. Children: NHIS, 2006.

THE COMMONWEALTH FUND

Medicaid's Spending on Health Services Is Lower Than That of Private Coverage

Expenditures ($) on health services for people without health limitations in private coverage and Medicaid



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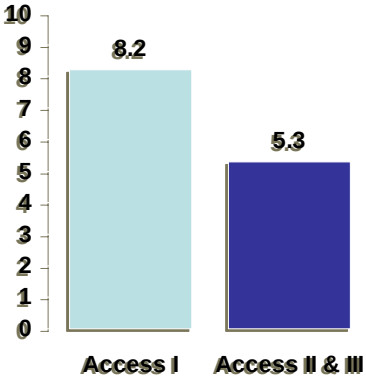
Source: Hadley J., Holahan J., Is health care spending higher under Medicaid or private insurance? *Inquiry*. 2003 Winter;40(4):323-42.

Community Care of North Carolina: Medical Homes Can Save Health Care Costs

Asthma Initiative: Pediatric Asthma Hospitalization Rates

(April 2000–December 2002)

Inpatient admission rate per 1000 member months



- **14 networks, > 3,200 MDs, >800,000 patients**
- **$3 PMPM to each network**
- **Hire case managers/medical management staff**
- **$2.50 PMPM to each PCP to serve as medical home and participate in disease management**
- **Care improvement: asthma, diabetes, screening/referral of young children for developmental problems, and more!**
- **Case management: identify and facilitate management of costly patients**
- **From July 1, 2003 through June 30, 2006, actuarial studies conducted by Mercer documented that CCNC saved the state over $473 million dollars [September 2007].**

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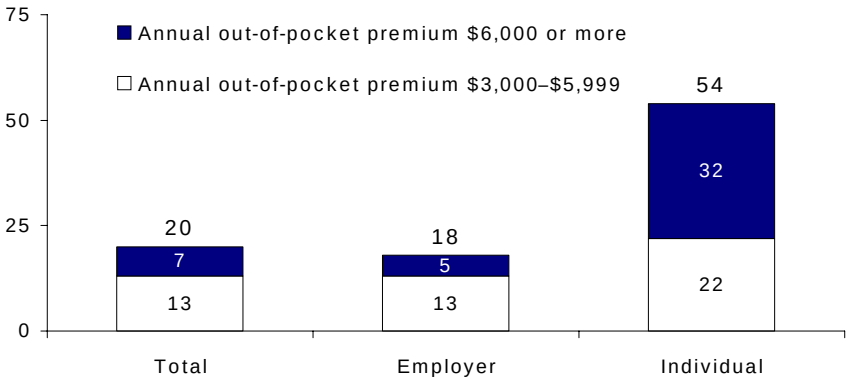
Source: L. A. Dobson, Presentation to ERISA Industry Committee, Washington, DC, Mar. 12, 2007 (Updated 6/13/08)

Risk Pooling and Employer Premium Contributions Lower the Cost of Health Benefits for Adults with Employer Coverage Relative to Those with Individual Market Coverage

Percent of adults ages 19–64 insured all year with private insurance



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, The Commonwealth Fund, September 2006.

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Individual Market Is Not an Affordable Option for Many People

Adults ages 19–64 with individual coverage or who thought about or tried to buy it in past 3 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 pre-existing 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 Well-being of American Families, The Commonwealth Fund, Sept 2006.

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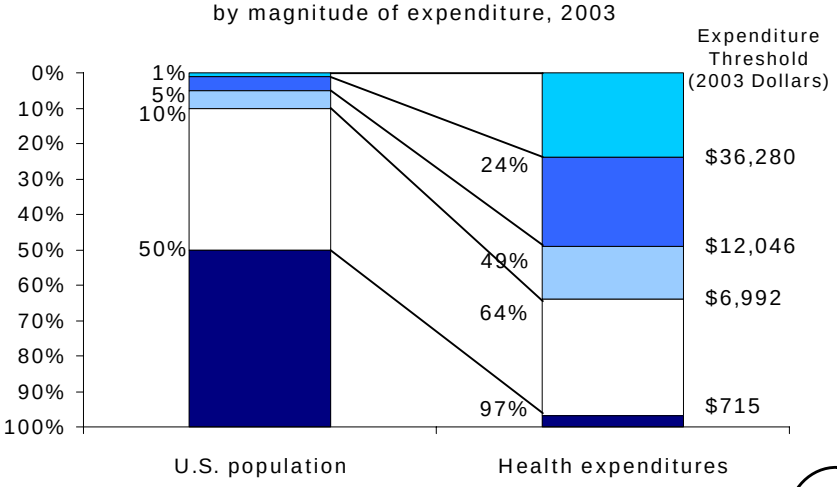
Health Care Costs Concentrated in Sick Few
Sickest 10% Account for 64% of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2003



Source: S. H. Zuvekas and J. W. Cohen, "Prescription Drugs and the Changing Concentration of Health Care Expenditures," *Health Affairs*, Jan/Feb 2007 26(1): 249–257.

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