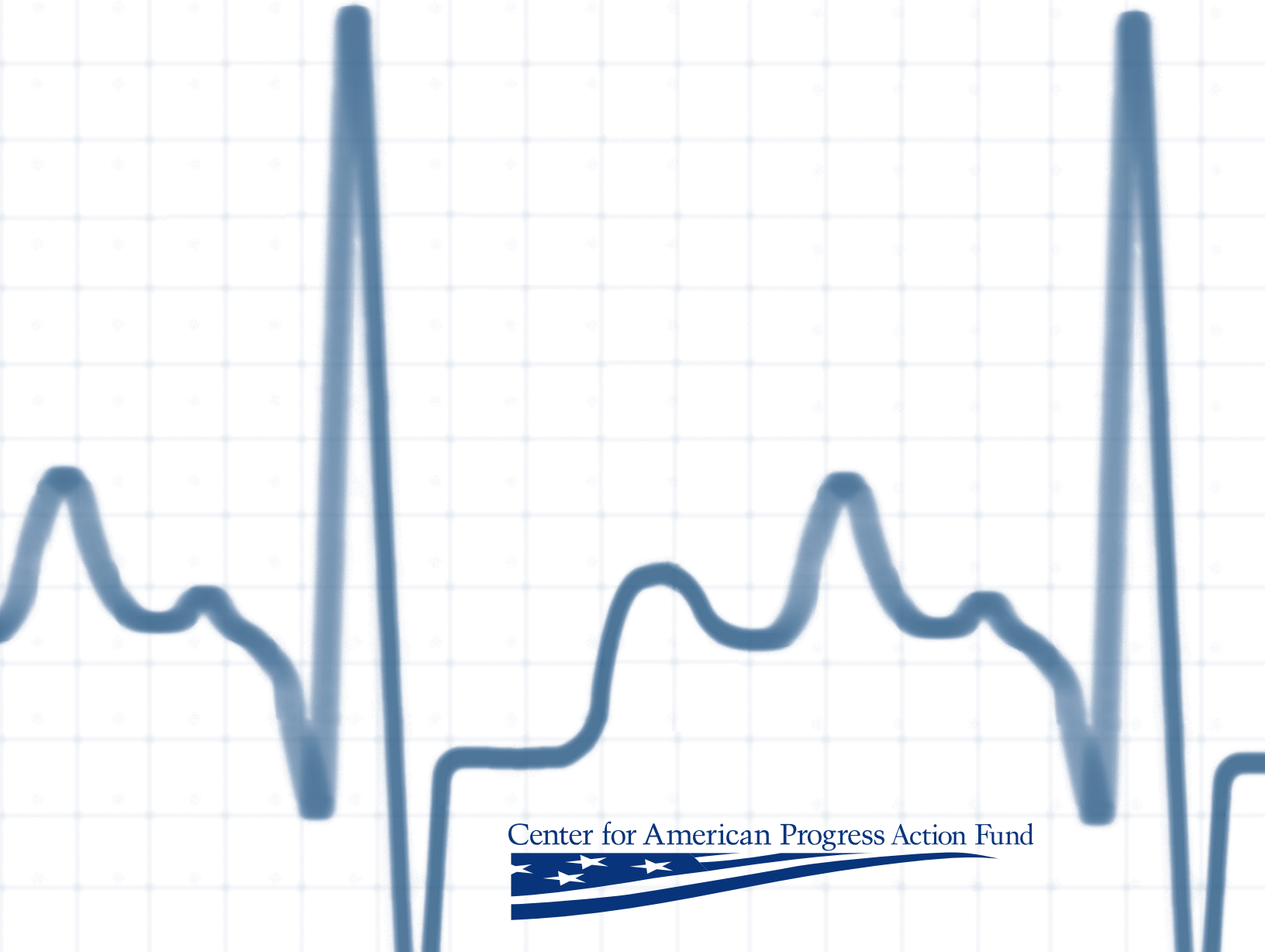
NEW LEADERSHIP ON HEALTH CARE
A PRESIDENTIAL FORUM

Candidate Briefing Book

March 24, 2007

Las Vegas, Nevada



Center for American Progress Action Fund

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THE UNINSURED

Overview

Nearly 47 million Americans—9 million of whom are children—are uninsured. Individuals who lack health care coverage are more likely to postpone medical care, go without needed medical care, or go without prescription medicines. Individuals without health coverage are also more likely to use emergency rooms as their regular source of care.

Who Are the Uninsured?

Work Status

Although most Americans obtain coverage through their employer, employer-sponsored health insurance is voluntary. In 2005, more than 80 percent of individuals without health coverage lived in working families. Nearly 70 percent of individuals without health coverage came from families with one or more full-time workers, and 11 percent came from families with part-time workers. Coverage varies by industry, firm size, locale, and other factors. [The Uninsured: Kaiser Family Foundation]

Income

Individual and family income is a key determinant of insurance status. Nearly 36 percent of the non-elderly poor—families of four with an income of $20,000 or less—lack health insurance. This is twice as high as the national average of 18 percent. The near-poor also face the threat of being without health insurance—26 percent of the uninsured live in families with earnings between $25,000 and $49,999. Low-income workers are less likely to be offered health coverage by their employers, and are more likely to decline coverage when offered if they have to pay a share of the premium. Single adults and childless couples are also usually ineligible for public health insurance programs, no matter how low their incomes may be. [The Uninsured: Urban Institute and Kaiser Family Foundation]

Age

Since most older Americans have health coverage through the Medicare program, nearly all individuals without health insurance are children and working-age adults: eighty percent are adults under the age of 65. The rate of uninsured children increased for the first time in eight years in 2005 to more than 11 percent. Children are more likely than adults to have health insurance, in large part because of their broader eligibility for public coverage. Most uninsured children qualify for Medicaid or the State Children's Health Insurance Program, but there are more than 6 million eligible children who are not enrolled. Nine percent of the near-elderly—individuals between 55 and 64 years of age—who typically face higher-than-average health care costs are also uninsured. And young adults—19- to 29-year-olds—account for 30 percent of the uninsured population, representing the fastest-growing segment of the U.S. population without health insurance. [Young Adults: Commonwealth Fund, The Uninsured: Kaiser Family Foundation]

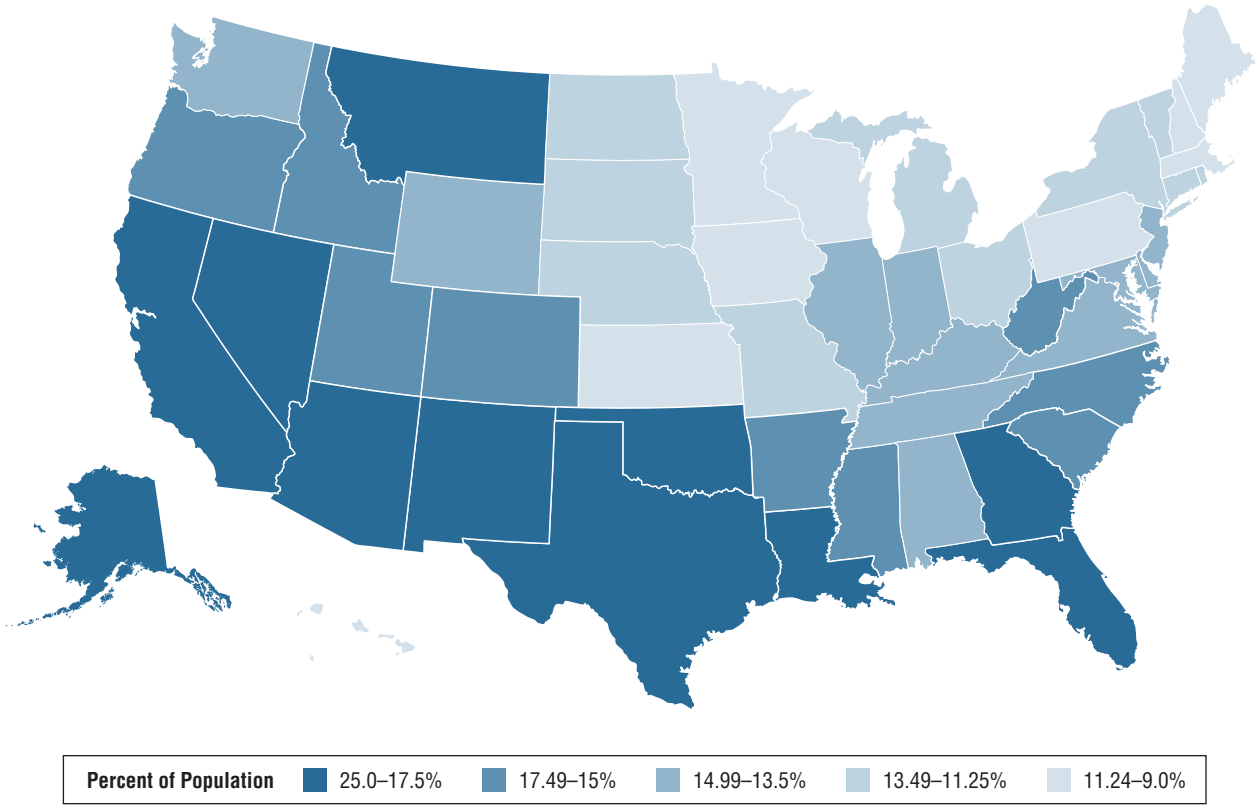
Race and Ethnicity

Racial and ethnic minorities are more likely to be uninsured than white Americans. Nearly one in three Hispanics and American Indians are uninsured and one in five African Americans and Asian Americans are uninsured, compared with just over one in ten white Americans. The percent of minority workers without health coverage is also staggering: nearly 40 percent of Hispanic workers and roughly 23 percent of African American workers are without health coverage. Research shows that health insurance is the largest access barrier to health care for people of color. [Race: Kaiser Family Foundation, Racial Health Disparities: *Health Affairs*]

Residence

Sixteen percent of the national population lacks health insurance. However, uninsured rates vary across the country. For example, 25 percent of Texans lack health coverage, while only 10 percent of Hawaiians, Iowans, and Minnesotans are without health insurance. Nevada, with more than 18 percent of its residents lacking health insurance, has a higher-than-average rate. And states in the Southwest—Arizona, New Mexico, Oklahoma, and Texas—represent the regional high end with an average uninsured rate of 21 percent, while states in the Northeast—Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont—have the lowest average uninsured rate of 11 percent. [State Health Facts: Kaiser Family Foundation]

Uninsured Rate by State, 2005
(National Average = 16%)



Source: Kaiser Family Foundation.

Consequences of Being Without Health Coverage

- **Regardless of health condition, uninsured individuals are three times more likely than insured individuals to report problems obtaining needed medical care.** Over 40 percent of uninsured individuals postpone or forgo needed medical care, largely due to not having a regular source of care. Twenty percent of the uninsured—compared to three percent of those with coverage—report that their usual source of medical care is an emergency room. Adolescents who are uninsured are four times more likely to report unmet health needs than those who are insured. [The Uninsured: Kaiser Family Foundation]

- **Cost of care makes it difficult for individuals without health coverage to follow recommended treatment.** More than one in three uninsured adults report going without recommended medical tests, treatment, or prescribed medications due to cost. Nearly half of uninsured young adults go without needed medical care and two-thirds report being unable to pay a medical bill or being contacted by a collection agency. [The Uninsured: Urban Institute and Kaiser Family Foundation]

- **Individuals without health coverage are unlikely to receive timely preventive care.** Forty percent of uninsured adults under 30 years of age reported not receiving preventive care services in the past year. In New York, the expansion of public programs for children contributed to a rise in the immunization rate among children ages 1 to 5 from 83 percent to 88 percent. People with insurance are much more likely to have had recent mammograms and colon and cervical cancer screenings. For this reason, uninsured cancer patients are more likely to be diagnosed in later stages of the disease and die earlier than those with insurance. [Young Adults: Commonwealth Fund, The Uninsured: Kaiser Family Foundation]

- **The mortality rates of individuals without health insurance could be reduced by 10 percent to 15 percent with the provision of health coverage.** Estimates show that the number of excess deaths among uninsured adults between 25 and 64 years of age is in the range of 18,000 a year. [Institute of Medicine]

- **Government programs and individuals with insurance pay for much of the health care cost for uninsured individuals.** Individuals without health insurance currently pay approximately 35 percent of the cost of needed health care out-of-pocket. Of the remaining 65 percent, one-third of the cost is paid for by government programs and the remaining two-thirds is paid through higher insurance premiums incurred by those with insurance. Guaranteeing all Americans affordable health care would eliminate the cost-shifting related to uncompensated care.

- **Effect on Individuals:** Nearly 40 percent of the cost of health care services uninsured individuals receive is shifted to individuals with health insurance. In 2005, family health insurance premiums were $922 higher and individual health insurance premiums were $341 higher due to the cost of health care for those without health insurance. [Families USA]

- **Effect on Society:** Individuals without health insurance do not have a regular doctor, so high-cost emergency rooms serve as the usual source of medical care for nearly 50 percent of the uninsured. This overcrowding makes emergency rooms unable to treat patients with real health emergencies. Additionally, the Institute of Medicine estimated that the economic benefit of insuring all people would range from $65 billion to $130 billion per year largely from better health and longer lives of individuals with coverage, decreases in Medicare and disability support payments, lower demands on the public health infrastructure, and increased local health service capacity. [Health Care Costs: Commonwealth Fund, Health Care Costs: *Health Affairs*]

- **More than half of all individuals who file for bankruptcy do so because of medical debt.** The uninsured are more than twice as likely as those who have coverage to have had problems paying medical bills in the past year. Nearly one in five individuals without health insurance reported that they had to significantly change their way of life in order to pay medical bills. Twenty-five percent of the uninsured also reported spending less on other basic needs such as food and heat in order to pay medical bills. [The Uninsured: Kaiser Family Foundation]

Issues for Policymakers

- Given a goal of guaranteeing health coverage to all Americans, what is the best way to achieve this?

- How can national goals like covering all Americans be balanced with existing differences across the states?

- What is the right balance between public and private coverage?

- Past efforts to reform the nation's health care system have raised fears for individuals with insurance coverage that they may have to give up the coverage they have to achieve this goal. Yet the entire nation is affected by having 47 million Americans without health coverage. Can policymakers balance these conflicting needs?

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HEALTH CARE COSTS AND HEALTH CARE SPENDING

Overview

Health coverage affordability is a pressing issue for all stakeholders involved in the health care system. Since 2000, health insurance premiums have increased four times faster than wages, and health care costs have grown to comprise 16 percent of the U.S. gross domestic product. As financial constraints continue to increase, discussion of how to curtail health care costs will become a key part of the national health care reform debate.

Sources of Health Care Spending

Hospital Care

Hospital care makes up the largest portion of and is the greatest contributor to rising health care spending. National health expenditures devoted to hospital care were 30.4 percent in 2004, and comprised more than 25 percent of the increase in total health spending between 1994 and 2004. Increased consolidation and mergers of hospitals over the past decade have culminated in more negotiating clout, allowing hospitals to charge higher prices for the services rendered. Additionally, administrative costs such as paper billing and paper health records increase overall hospital costs. [Trend Data: Kaiser Family Foundation]

Physician Services

Payments to physicians represented 20 percent of total health care spending in 2004, and comprised nearly 21 percent of the total growth in national health expenditures between 1994 and 2004. Physician payments are closely related to the amount of services and intensity of services that doctors provide—their fee-for-service reimbursement provides an incentive for them to see more patients and do more procedures. Like hospitals, 20 percent to 30 percent of physicians' costs result from administration, largely due to the complex nature of the health insurance system. While some policymakers argue that reforming the medical malpractice system could reduce health care spending, it is unlikely to solve the cost problem. A recent study found that when all of the United States' malpractice costs are tabulated, including awards, legal costs, and underwriting costs, they account for only 0.46 percent of total health spending. [Trend Data: Kaiser Family Foundation, McKinsey & Company, Physician Costs: Commonwealth Fund, Global Comparisons: *Health Affairs*]

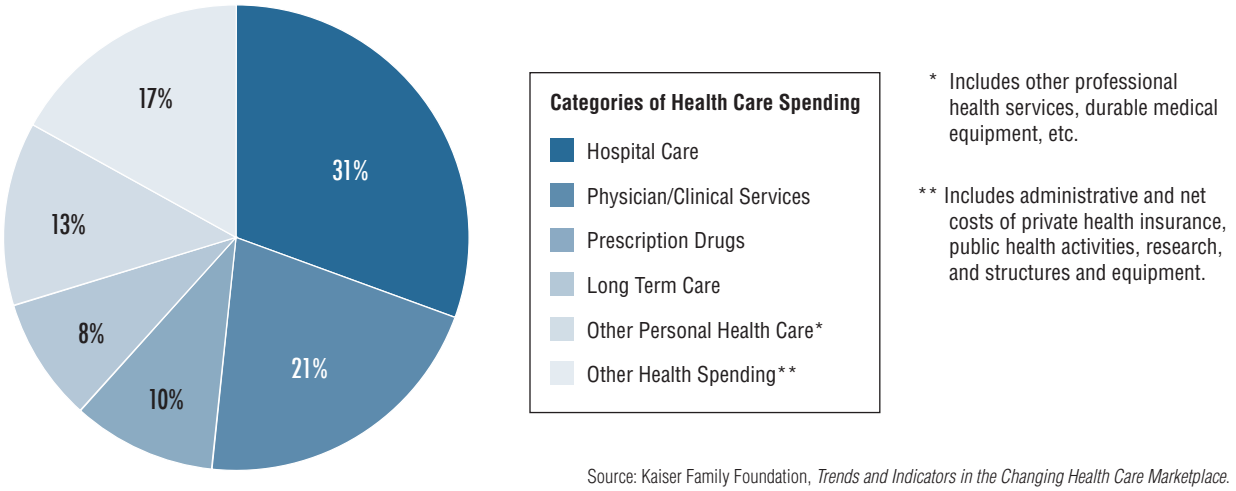
Prescription Drugs

The cost of prescription drugs is the third-largest contributor to increased health care spending. In 2004, prescription drugs made up 10 percent of national health expenditures, but contributed to nearly 15 percent of the increase in total health care spending between 1994 and 2004. Direct-to-consumer advertising is responsible for more than 12 percent of this increase. Additionally, although more than half of all prescriptions are filled with generic medicines, they only account for 12 percent of total pharmaceutical cost. [Trend Data: Kaiser Family Foundation, Direct-to-Consumer Advertising: Kaiser Family Foundation]

Long-Term Care

Long-term care spending totaled almost $207 billion in 2005—more than 10 percent of national health expenditures. Nursing home care represented 60 percent of this spending, and home-based care constituted the remaining 40 percent. This spending does not include the uncounted and unpaid help of family and friends, which most people with long-term care needs rely on. Medicaid covers nearly half of these costs—$101 billion—while Medicare picks up $42 billion, and patients and families pay more than $37 billion out-of-pocket. Long-term care needs are often a consequence of aging, with nearly half of the population over age 85 needing some kind of long-term care help; as the population ages, long-term care spending is expected to grow as a share of our nation's health expenditures. [Georgetown University; National Health Expenditure data; Kaiser Family Foundation]

Health Expenditures, 2004
(Total = $1.9 Trillion)



Source: Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace.*

Technology

Health services research suggests that technological improvements account for at least 50 percent of the growth in medical service costs. Many of these technological advances result in treatment changes that lead to improved quality of life or length of life, and these improved outcomes represent enhanced value. Other technological advances may be less cost-effective—raising costs but not improving value. [Technology: *Health Affairs*]

Misplaced Priorities

More than 70 percent of deaths and health costs are attributable to chronic diseases, many of which are preventable. Yet, a recent study found that only half of recommended clinical preventive services are provided to adults. For example, only 48 percent of U.S. adults received advice from their doctors on weight, nutrition, or exercise in the last year. Ignoring prevention also has economic consequences. Preventive health care services could reduce government spending on health care. If all elderly Americans received a flu vaccine, health care costs

could be reduced by nearly $1 billion per year. If we were able to reduce obesity to 1980s levels, Medicare would save $1 trillion. [Centers for Disease Control and Prevention, Preventive Services: Commonwealth Fund]

Consequences of Increasing Health Care Spending and Costs

- **Affordable health care is out of reach for many Americans.** Since 2000, health care premiums have increased over four times faster than wages and inflation. The average health care premium for a family of four is $11,480, which exceeds a minimum wage worker's annual earnings of $10,712 ($5.15/hr, no deductions). [Center for American Progress]

- **Individuals with and without health insurance are often forced into bankruptcy and medical debt due to rising health care costs.** The uninsured are more than twice as likely to have had problems paying medical bills in the past year as those who have coverage. Nearly one in five individuals without health insurance reported that they had to significantly change their way of life in order to pay medical bills. Additionally, 25 percent of the uninsured reported spending less on other basic needs such as food and heat in order to pay medical bills. Health care costs can also severely affect families with health insurance; nearly 75 percent of individuals who file for bankruptcy due to health care costs had insurance coverage at the onset of their illness. [Bankruptcy: *Health Affairs*]

- **Health care costs have taken their toll on American businesses.** Nearly half of all small businesses no longer offer health coverage to their employees, creating a "race to the bottom" for workers' benefits. Estimates suggest that the cost of health care benefits will exceed profits in Fortune 500 companies by 2008. Businesses must make trade-offs between providing health care to their employees and other business investments. [Kaiser/HRET Employers Benefit Survey, *McKinsey Quarterly*]

- **American businesses are losing their competitive edge due to rising health care costs.** Health care costs are a major component of American business costs. General Motors, for example, spends more on health care than on steel, and Starbucks pays more for health care than for coffee beans. Neither corporation bears similar costs on behalf of their employees who work in countries that provide health coverage to their entire citizenry. Rising health costs diminish innovation and competitiveness by forcing American businesses to choose between investing in technology and paying for health care benefits. [CNNMoney.com, *Forbes*]

- **Rising health care costs are pressuring our public health insurance programs.** While Medicare spending will increase with the aging of the baby-boom generation and related growth in Medicare enrollment, rising health care costs will place additional strains on program spending. Medicaid and SCHIP, the country's public insurance programs for low-income adults and children, serve as safety nets during economic downturns. Enrollment in these programs grew by 2.1 percentage points from 2000 to 2003, for example. However, rising health care costs may force state officials to cut covered benefits or covered families for both programs. [Center on Budget and Policy Priorities]

Issues for Policymakers

- Can we effectively control health care costs without universal health coverage?
- What are appropriate public investments in the health care system that could yield long-term savings? Would policymakers be willing to make these investments even though the savings would accrue outside of standard budget estimating timeframes?
- What policy changes short of systemic reform would help control health care cost increases?

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PUBLIC HEALTH INSURANCE PROGRAMS

MEDICARE, MEDICAID, AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Overview

Both federal and federal-state run public health programs have effectively insured the country's most vulnerable populations: the elderly, indigent children and parents, pregnant women, and disabled individuals. More than 80 million Americans have health coverage through Medicare, Medicaid, the State Children's Health Insurance Program, and other public health programs.

Medicare

Medicare, the federal health insurance program for Americans over age 65 and people with disabilities, provides health insurance to roughly 43 million Americans, who are eligible for coverage by virtue of age, disability, and work history. Approximately 2 million Medicare beneficiaries live in nursing homes, and those who live in the community have a median income of $20,000. Medicare pays for hospital care, physician services and other outpatient care, limited post-acute care in skilled nursing facilities, and hospice care. People with Medicare coverage also pay for significant health care services out-of-pocket—in 2002, non-institutionalized Medicare beneficiaries paid an average of $1,500 for health care services, while people in poor health spent on average $2,700. Medicare does not cover long-term care needs, and does not have a catastrophic limit on beneficiary cost-sharing.

Medicare is financed through a combination of dedicated revenues, general revenues, and enrollee premium contributions. Medicare Part A—inpatient hospital services—is paid for through the Hospital Insurance Trust Fund, which is financed by federal payroll taxes. While the Trust Fund currently collects more in payroll taxes than it pays in benefits, it is expected to exhaust its resources by 2018 as spending grows faster than payroll tax income. Medicare Part B—physician and other outpatient services—is paid for through general federal revenues plus enrollee premiums that cover 25 percent of the cost of Part B benefits. The Part B premium in 2007 is $93.50 per month, although Medicare enrollees with higher incomes—more than $80,000 for individuals and $160,000 for couples—pay a higher premium.

In 2006, Medicare launched the Medicare Part D outpatient prescription drug benefit—the largest expansion since the program's inception. As of January, almost 24 million people with Medicare hold drug coverage through Medicare Part D, while another 15 million individuals have drug coverage through other sources, such as employer-sponsored retiree coverage. [Kaiser Family Foundation Medicare Chart Book, Medicare Trustees Report, HHS, CMS]

Medicaid

Medicaid is the country's main public health insurance program for low-income Americans, including pregnant women, children, and individuals with long-term care needs. From 2004 to 2005, 13 percent of the population—more than 38 million people—were covered by Medicaid. Eighty-one percent of the non-elderly individuals enrolled in Medicaid have incomes below 200 percent of the poverty level. Roughly half of Medicaid enrollees are racial and ethnic minorities; one in five non-elderly African Americans, Latinos, and American Indian/Alaskan Natives are covered by Medicaid. Medicaid covers about 41 percent of all births in the United States, and finances 49 percent of all long-term care services.

The federal and state governments jointly finance Medicaid. The federal contribution covers 57 percent of Medicaid spending, although matching rates vary from state to state. Most Medicaid enrollees are members of low-income families, but roughly 70 percent of program spending is dedicated to the elderly and people with disabilities. In general, Medicaid covers the poorest, sickest, and neediest Americans—in 2003, Medicaid spent $11,659 per disabled enrollee and $10,417 per elderly enrollee in comparison to average per capita health expenditures of $5,879.

Medicaid provides a health coverage safety-net during economic downturns. As expected, Medicaid enrollment and spending growth increased during the recession in the early years of this decade. As the economy recovers, Medicaid enrollment and spending growth has slowed, but there remains pressure to increase the predictability of Medicaid spending. The Deficit Reduction Act of 2005 gave states new flexibility to limit benefits, impose premiums, and increase cost-sharing for people with Medicaid coverage, and required states to obtain proof of citizenship for all Medicaid enrollees and applicants. The full impact of these changes has not yet been seen, but advocates expect that the availability and affordability of coverage for Medicaid-eligible individuals will be diminished. [Current Population Survey Data, 2006, Center on Budget and Policy Priorities, Medicaid: Kaiser Family Foundation, DRA: Kaiser Family Foundation]

State Children's Health Insurance Program

Along with Medicaid, the State Children's Health Insurance Program provides a safety-net for health insurance for low-income children. SCHIP typically covers children whose families have incomes too high to qualify for Medicaid, but below 200 percent of poverty. In 2005, SCHIP covered 4 million low-income children. The SCHIP benefit package is similar to private insurance.

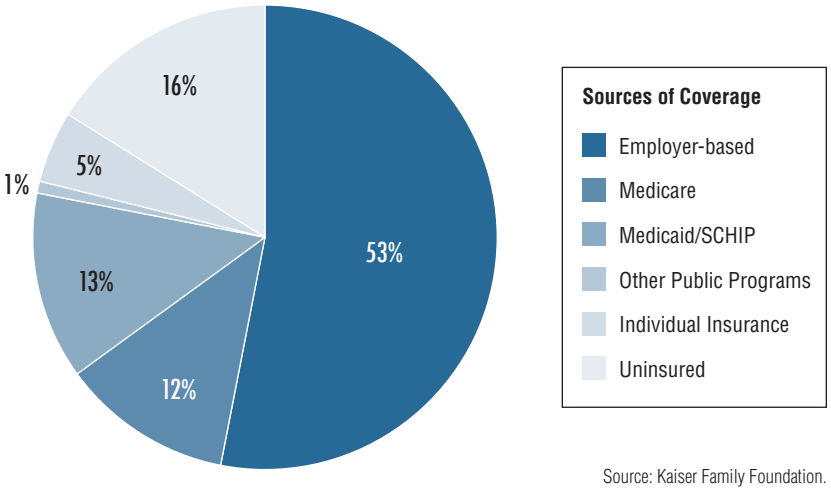
Like Medicaid, the federal and state governments jointly finance SCHIP. Unlike Medicaid, federal SCHIP funds are capped nationwide and by state. The federal government matches state spending on eligible program beneficiaries up to a state-specific limit. If states are unable to spend their federal allotment within three years, funds may be redistributed to states that exceeded their funding allotments.

The SCHIP statute expires in September, 2007. Estimates suggest that additional funds—$15 billion over the current budget baseline—will be needed to maintain current SCHIP enrollment for the next five years. These estimates do not include costs related to the 6 million children who are eligible for Medicaid and SCHIP but remain uninsured. The level of funding and the distribution of funds to states will be key issues in the SCHIP reauthorization debate. [Current Population Survey Data, 2006, SCHIP–Center on Budget and Policy Priorities, SCHIP–Kaiser Family Foundation]

Other Public Health Programs

The federal government also finances health coverage for active military personnel, retirees, and dependents through TRICARE, and provides medical benefits to enrolled veterans through the Veterans Administration. In addition, the Indian Health Service provides health services to American Indians and Alaska Natives who belong to federally-recognized tribes.

Sources of Health Insurance Coverage, 2005
(Percent of Population)



Source: Kaiser Family Foundation.

Issues for Policymakers

- As we consider how to provide affordable coverage for all Americans, what is the right balance between public coverage and private coverage?
- What role does SCHIP reauthorization play in larger efforts to establish universal coverage?
- How should public health insurance programs be reconfigured as we reform the health care system to provide affordable coverage for all?

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EMPLOYER-BASED HEALTH COVERAGE

Overview

The employer-sponsored health insurance system is voluntary, where employers are not required to offer health coverage to their employees. Employers first began to offer health insurance in large numbers during the 1940s, and employer-sponsored health care grew rapidly after World War II, peaking in the 1980s. Today, 156 million people—roughly 61 percent of non-elderly Americans—receive health insurance through employers. As health care costs have escalated, employer-sponsored insurance has declined, the American economy has evolved away from a manufacturing base, and workers have begun to change jobs more frequently, some stakeholders have expressed interest in severing the tie between employment and health insurance. But employer-based coverage for now remains the backbone of the country's health coverage system.

Characteristics of Employers Who Offer Health Coverage

Sixty-one percent of firms offer health benefits to at least some of their employees—a number that has fallen from 69 percent in 2000. Multiple factors determine the likelihood that a firm offers health benefits to its workers; key determinants include firm size, industry, wage characteristics, proportion of part-time workers, whether workers are unionized, and region. [The Urban Institute, Employer Health Benefits: HRET/KFF, State Health Facts: Kaiser Family Foundation]

Firm Size: Nearly all firms with 200 or more workers offer health benefits to employees and their dependents, but firms with 199 or fewer workers are significantly less likely to do so. In 2006, 98 percent of large firms and 60 percent of small firms offered health benefits. The smallest firms are the least likely to offer health insurance. Only 48 percent of firms with three to nine workers offer coverage, compared to 73 percent of firms with 10 to 24 workers and 87 percent of firms with 25 to 49 workers. Ninety percent of firms with 50 or more workers offered health coverage in 2006.

Industry: Employers in service, retail, construction, agriculture, and forestry industries are less likely to offer health insurance to their employees than government and other private sector employers. In fact, 56 percent of workers in agriculture, 54 percent of workers in construction, and 39 percent of workers in retail industries are uninsured.

Higher v. Lower Wage Firms: Higher wage firms—where less than 35 percent of workers earn $20,000 or less annually—are more likely to offer health insurance than lower wage firms—where 35 percent or more of workers earn $20,000 or less annually. Sixty-five percent of higher wage firms offer health benefits, compared to 42 percent of lower wage firms.

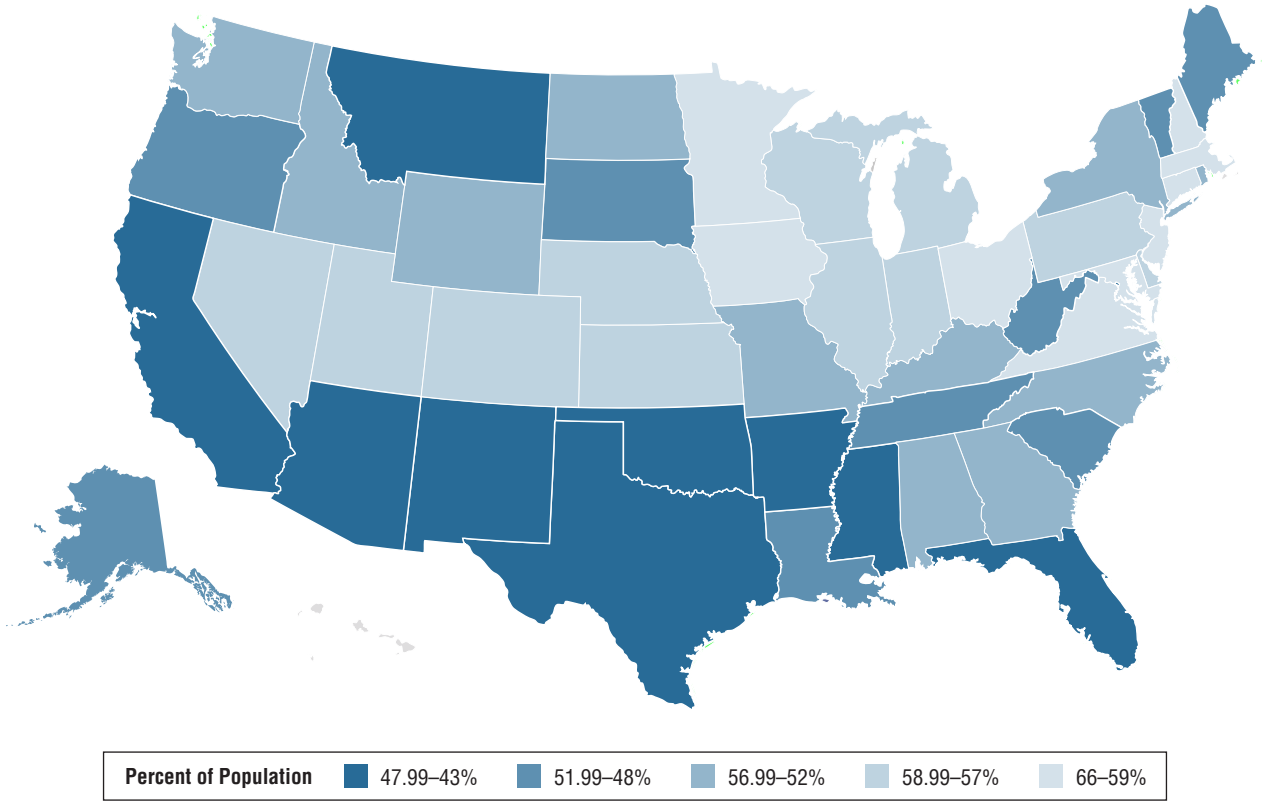
Part-time Workers: Firms where fewer than 35 percent of employees work part-time are more likely to offer coverage to their workers than firms with many part-time workers. Sixty-

seven percent of firms with fewer part-time workers offer health insurance, compared to only 44 percent of firms with a higher percentage of part-time workers. In 2006, 31 percent of all firms that offered health benefits offered them to part-time workers. Firms with 200 or more workers are also more likely to offer health benefits to part-time employees than small firms.

Unionized Workers: Employers with at least some union workers are much more likely than firms without union workers to offer health benefits to their employees. Eighty-seven percent of firms with union workers offer health benefits, whereas 60 percent of firms that do not have union employees offer health coverage.

Region: Fifty-three percent of the national population has employer-based health insurance, but coverage rates vary across the country. For example, only 43 percent of the residents of New Mexico have health coverage through an employer, while 66 percent of the residents of New Hampshire have employer-based health insurance. Nevada, with more than 57 percent of its residents having employer-based health insurance, has a higher-than-average rate. And residents of the Southwest—New Mexico, Arizona, Oklahoma, and Texas—where employers cover an average of 49 percent of the population, are the least likely to have employer-sponsored coverage. In contrast, residents of eastern states such as New Jersey, Connecticut, Maryland, and Virginia have the highest average rate of employer-based health coverage—61 percent.

Employer-Based Insurance Rates by State, 2005
(National Average = 53%)



If Offered, Do Employees Enroll in Employer-Based Coverage?

Employees who are offered coverage through their employer generally elect to enroll in health insurance. Regardless if the employee works in a large or small firm, more than 80 percent of eligible workers elect to take up coverage when it is offered. The likelihood of a worker enrolling in company-sponsored coverage does, however, vary by wage level. For example, 83 percent of eligible employees in higher-wage firms choose to participate in coverage compared to only 71 percent of eligible employees in firms where 35 percent or more of workers earn $20,000 or less per year.

In part, employees choose not to enroll in employer-based coverage when faced with high premium responsibilities and cost-sharing. Since 2000, average workers' contributions for family coverage have grown from $135 per month to $248 per month. Employees also face increased out-of-pocket costs. More than a quarter of enrollees in preferred-provider organization (PPO) plans—the most popular plan arrangement in 2006—paid a single deductible of more than $500 for in-network services. [Employer Health Benefits: HRET/KFF]

Consequences of an Unraveling Employer-Based Insurance System

- **Workers from low-income families are less likely to have job-based insurance.** In 2005, 55 percent of employees from poor families did not have access to employer-based insurance through either their own job or a family member's job, while only four percent of employees from higher income families did not have access. Similarly, in 2004 almost 89 percent of working families with incomes above 400 percent of poverty held employment-based coverage, while only 39 percent of working families with incomes below 200 percent of poverty had coverage through an employer. [Employer-Sponsored Health Insurance: Kaiser Family Foundation, *Health Affairs*]

- **African American and Hispanic workers fared worse with the decline in employer-based insurance from 2001 to 2005.** The share of black employees who had employer-based health insurance dropped from 79 percent in 2001 to 73 percent in 2005, and the share of Hispanic employees dropped from 60 percent to 54 percent, while white employer-based insurance rates stayed at over 82 percent. [Employer-Sponsored Health Insurance: Kaiser Family Foundation]

- **Medicaid and the State Children's Health Insurance Program have picked up the slack from declining employer-based coverage.** Between 2005 and the first six months of 2006, the percentage of children with private coverage decreased significantly from 62.4 percent to 60 percent, and the proportion of children with public health insurance coverage grew from 29.9 percent to 32.2 percent. In recent years, Medicaid and SCHIP have provided a counter-cyclical support to the health insurance system as employer coverage has declined. [2006 National Health Interview Survey, Center on Budget and Policy Priorities]

- **Since 2000, the number of uninsured Americans has increased in part because employer-based insurance has declined.** The number of Americans with employer-sponsored coverage fell by 3 million between 2000 and 2005, while the number of uninsured Americans grew by 6.7 million over the same period. [U.S. Census Bureau]

Issues for Policymakers

- Today, employer-provided insurance is the backbone of our health coverage system. Should policymakers build upon this platform, or go in another direction, as they seek to provide affordable coverage to all Americans?

- As employers shift a larger proportion of overall health care costs to employees, what role can the federal government play to ensure that employer-sponsored health coverage is affordable for workers?

- Are there policy changes that could stem the decline in employer-sponsored health coverage or help employers continue to offer health insurance coverage?

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IMPROVING VALUE IN HEALTH CARE

Overview

Our current healthcare system provides valuable services to millions of Americans—lifesaving, high-tech interventions, ongoing care for chronic diseases, and important preventive care such as childhood immunizations. But there is much room for improvement. Fewer than 50 percent of patients receive care that comports with accepted guidelines, and adults receive less than half of recommended clinical preventive services. Health care providers continue to use paper-based systems to share patient information and coordinate care, and our information base on the comparative effectiveness of various treatments is in its infancy. By improving health care quality, outcomes, and efficiency, we can secure better value for our health care dollars.

The Status Quo

Prevention

The United States spends more on health care than any other nation. Yet we are far from the healthiest people in the world. For example, in 2002, 65 percent of adults were considered obese or overweight. This is a 50 percent increase since 1980. Many Americans are plagued with preventable diseases that have a devastating impact on their health and quality of life. Yet proven preventive services remain largely unused, and healthy communities and lifestyles are undervalued.

Our lack of health also contributes to the nation's soaring health care costs. In 2005, the U.S. spent $2 trillion on health care—$6,697 per person. Yet only an estimated one to three percent of national health expenditures were spent on preventive health care services and health promotion. Despite the development of advanced screenings and early interventions, and the increase in preventable diseases, the percentage of national health expenditures dedicated to prevention has only increased 1.4 percent since 1929. [Centers for Disease Control and Prevention]

Quality and Outcomes

Over the last two decades, health care stakeholders have worked together to improve quality and outcomes. Early efforts to measure and report quality of care resulted in health plan "report cards," which examine the use of widely-accepted preventive care and chronic disease management measures such as screening mammography and cholesterol control among target populations. Further initiatives have developed with the evolution of quality measurement and reporting, including pay-for-performance approaches that reward practitioners and institutions who deliver high-quality, appropriate care. Other initiatives include the development and implementation of treatment guidelines and process improvement efforts designed to improve patient safety and reduce medical errors.

In spite of these advances, we have little information on what constitutes high-quality, high-value care. We learn whether a particular medication or treatment is safe and effective through medical research, but we have little information that helps us understand the comparative effectiveness of various treatment options. This type of information, which would evaluate the relative merits of different drugs, surgical interventions, or treatment strategies for defined conditions would help patients, providers, and payers make sensible health care choices. [AcademyHealth]

Efficiency

There has been a recent explosion of interest in health information technology, yet our health system still languishes in the information dark ages. Many providers use electronic billing systems, but other critical medical information transactions are stuck in a paper-based system that is prone to error. Health IT systems can reduce administrative and clinical inefficiency and facilitate improved quality of care through reduced prescribing errors and other improvements. But only 24 percent of physicians currently use electronic health records, and only five percent of hospitals use health IT systems that include computerized physician order entry. Barriers to greater diffusion of health IT include acquisition cost, privacy issues, and limited interoperability between systems. [*Health Affairs*]

Consequences

Prevention

- **A gap exists between knowledge and implementation of disease prevention activities in the U.S.** A recent study found that only half of recommended clinical preventive services are provided to adults. For example, only 48 percent of U.S. adults received advice from their doctors on weight, nutrition, or exercise in the last year. Another study found that only about 38 percent of participants had received colorectal cancer screening. The statistics are similarly grim for most recommended services. [Preventive Services: Commonwealth Fund, *New England Journal of Medicine*]

- **Preventive health care services could reduce government health care spending.** Short-term solutions like providing flu vaccines to all elderly Americans could reduce health costs by nearly $1 billion per year. Long-term solutions like investing in reducing obesity to 1980s levels would save $1 trillion in Medicare spending. [Centers for Disease Control and Prevention, Preventive Services: Commonwealth Fund]

Quality and Outcomes

- **Medical errors are one of the leading causes of death in our health care system.** Approximately 98,000 people die in a given year as a result of medical errors—more than the number of people who die from diabetes (72,815), motor vehicle accidents (43,947), breast cancer (40,880), or HIV (12,995). [Institute of Medicine, CDC National Vital Statistics Reports]

- **The United States spends more per capita on health care than any other developed country, but does not experience better results.** In 2004, the U.S. spent more than twice as much per capita on health care than the average per capita health spending of Organization for Economic Co-operation and Development countries, even though our life expectancy falls below the OECD average, our infant mortality exceeds the OECD average, and our obesity rate is the highest of any OECD country. [OECD Health Data 2006]

Efficiency

- **Almost 25 percent of health spending in the United States is unrelated to clinical care.** Some of these administrative costs are necessary to coordinate care and measure outcomes, but 20 percent to 22 percent goes to billing and insurance-related activities. These functions can be enabled and streamlined with technology, which will allow a greater proportion of health care dollars to be devoted to patient care. [Efficiency: *Health Affairs*]

- **We lack widespread implementation of technology tools that can reduce errors, improve quality of care, and reduce health spending.** Computerized order entry systems can help avoid 522,000 serious medication errors per year and reduce intensive care costs by 25 percent. [Commonwealth Fund, 2004]

Issues for Policymakers

- Research shows that health promotion and disease prevention increases an individual's quality of life and saves the private sector and public health programs money. What role should the federal government play in making preventive health care a priority?

- What role should the federal government play in spurring widespread, rapid adoption of health IT? How important is this to overall health system reform?

- Can we turn to clinical effectiveness research and other analysis to help us improve outcomes and control health care spending? Is information alone sufficient to prompt better treatment decisions, or do we need to change public program rules and payment incentives as well?

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