

**A Blueprint for Health Care Reform in West Virginia:  
A Shared Responsibility**

**West Virginians for Affordable Health Care**

NOTE: WVAHC developed A Blueprint for Health Care Reform through a grant from the Claude Worthington Benedum Foundation. The West Virginia Council of Churches is the fiscal agent for this Benedum grant.

***Serious problems call for serious solutions.***

During the past century, we've built powerful networks that propel our economy and quality of life – expansive power grids, sophisticated phone systems, effective water systems, and far-reaching interstate highways. We've experienced immense progress, overcoming challenges that once seemed insurmountable.

But we have never built a modern infrastructure for health care. Our health care “system” is more like having a different phone system in every city, scattered wells, individual generators, and nothing but two-lane county roads. If we apply the same ingenuity to health care that we have to highways, we can provide quality and affordable health care to all West Virginians.

Solutions are within our reach. While some of these may be found in federal programs like Medicare, many others can be pursued within West Virginia *right now*. And everyone has a role to play – individuals, health care providers, insurance companies, government agencies, and faith and community-based organizations.

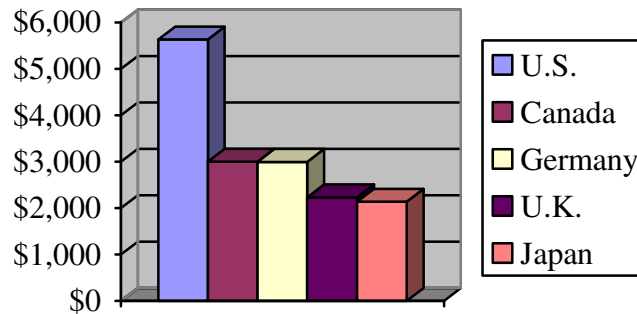
West Virginians for Affordable Health Care proposes a two-pronged approach: (1) control health care costs, and (2) provide health coverage to everyone. This paper outlines specific, doable actions that would go a long way toward building a 21<sup>st</sup> century infrastructure for health care in our state.

***Cost and quality are the crux of the problem.***

We are already spending enough money on health care in the United States to provide care for everyone. The problem is that we're not spending our money wisely or getting the outcomes we should expect.

The U.S. spends *double* the average of what other industrialized countries spend. The average cost per person in the U.S. is \$5,635, almost a quarter of what the average American earns each year before taxes.<sup>1</sup>

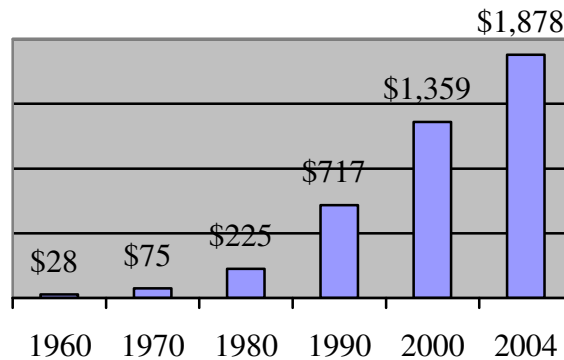
### Health Expenditures Per Capita (2003)



Our return on investment in health care is dismal on several key measures. The World Health Organization ranked our health outcomes lower than 36 other countries.<sup>2</sup> More newborns die in the U.S. than in any other industrialized nation. We fare equally poorly at the other end of life, tying for last among industrialized countries on life expectancy at age sixty.<sup>3</sup>

And the problem is getting worse, with health care spending growing at an unsustainable rate. The amount of money spent on health care for the entire year of 1960 would buy only five days of coverage in 2004. Health care spending was about 5% of our Gross Domestic Product (GDP) in 1960. By 2004, health care's portion of the GDP had more than tripled to 16%.<sup>4</sup>

### U.S. Health Care Costs 1960-2004 (in billions)



***Everyone suffers from the problem.***

Those who suffer most directly, of course, are the uninsured. One in every six West Virginians has no health insurance whatsoever. Much progress has been made in expanding coverage for children and for adults who are elderly or disabled. But there are few alternatives for working-age adults who can't get affordable insurance through their employers. The fastest growing segments of the uninsured population are low- and middle-income workers.<sup>5</sup>

People without insurance put off getting primary care. When they do seek treatment, their illnesses are at a more advanced stage and more expensive to treat. They are frequently treated in the most expensive settings: emergency rooms and hospitals. The uninsured use emergency rooms for conditions that could have been treated by a regular doctor at a rate 64 percent higher than people who insured.<sup>6</sup>

An estimated 18,000 Americans die each year as a consequence of not having health insurance.<sup>7</sup> That translates into about 124 deaths in West Virginia, or one death every three days, because people don't have access to timely and appropriate care.

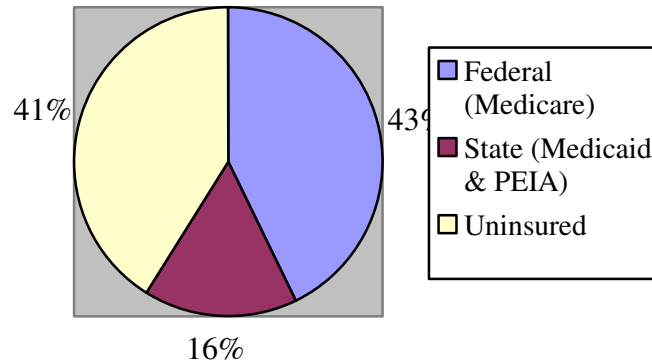
While the uninsured suffer the most direct and serious harm, all of us are affected by the problem. The cost of caring for those without insurance is passed on to businesses and individuals who do have health insurance. Family health plans in West Virginia cost almost \$1,800 more a year due to the health care costs of the uninsured. Our "cost shift" is the second highest in the country, following New Mexico.<sup>8</sup>

***In West Virginia...***

- One in every six people is uninsured.
- One person dies every three days as a consequence of being uninsured.
- The average family health plan costs \$1,800 more per year due to the costs of the uninsured.

Another source of cost shifting is government health plans, including Medicare and Medicaid, which pay less than the actual cost of care. The total shortfall in payments to West Virginia hospitals in FY 2004 was more than a half billion dollars.

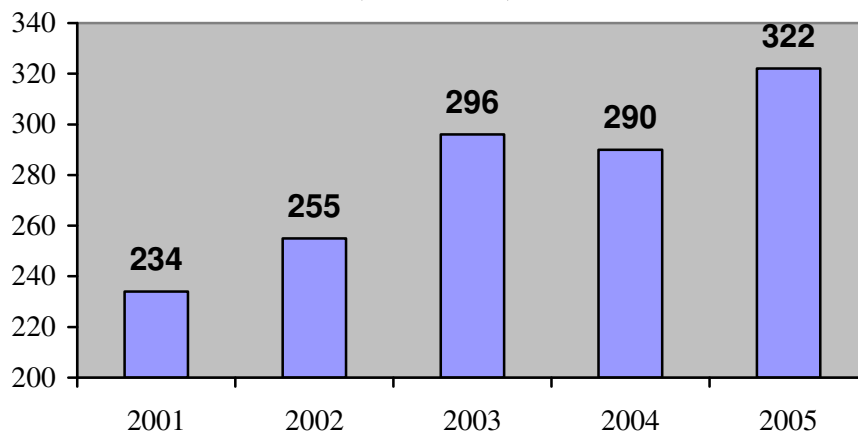
**Sources of Payment Shortfalls to Hospitals**  
**Total \$551 million in FY 2004**



***Doing nothing is no longer an option.***

More than 46 million Americans, including 322,000 West Virginians, are uninsured. The number of people in our state who have health coverage plummeted 22,000 per year, on average, between 2001 and 2005.<sup>9</sup> That's a total of 88,000 people, the size of the combined populations of Beckley, Bluefield, Clarksburg, Elkins, Martinsburg and Weirton. If current trends continue, and we do nothing to change their course, one in four West Virginians will be uninsured by 2011.

**Uninsured West Virginians**  
(in thousands)



The rising numbers of uninsured, coupled with high health care inflation rates, have a snowball effect. The annual cost shift of \$1,800 per family health plan is predicted to reach almost \$3,000 by 2010.<sup>10</sup> This, in turn, will put the price of health insurance beyond the reach of increasing numbers of employers and employees.

“Doing nothing and maintaining the status quo with over 43 million uninsured Americans is expensive,” says the Institute of Medicine. “The nation suffers losses due to ill health, impaired development, early deaths, and lost productivity. The lack of health insurance is a destabilizing factor in families and for health care institutions that serve uninsured patients. In fact, the presence of the uninsured creates insecurity for everyone, even those with health insurance today, because losing that coverage tomorrow is so easy.”<sup>11</sup>

We have an economic and moral crisis on our hands. While we may not have all the answers or agree on all the particulars, it is no longer an option to wait for someone else will solve the problem. We are, in fact, the people we’ve been waiting for. We each have something of value to offer in resolving the problem.

## **A Blueprint for Health Care Reform in West Virginia An Overview**

This “blueprint” was developed by the board and staff of West Virginians for Affordable Health Care, with extensive input from experts and stakeholders in health care. This report summarizes the recommendations, which are organized around a two-pronged approach: (1) control health care costs, and (2) provide health coverage to everyone.

The two parts are interrelated, and each is necessary. Without controlling costs, we won’t be able to sustain health care for the people who already have insurance, let alone add people who are now uninsured.

### **1. Control health care costs.**

There are trade-offs we have to make if we’re serious about improving health care and coverage. As a state and nation, we have to grapple with these questions: In a world of finite resources, what health care is essential and what is not? How can we provide *quality* care without providing *excessive* care? What are we willing to do personally to help control costs so that we have a sustainable health care system we all can count on? The following recommendations address these issues.

#### **A. Prevent illness and injury.**

The first step in controlling health care costs is preventing illness and injury whenever possible. A prime example is tobacco-related illnesses. At least 8.6 million persons in the United States are living with one or more serious illnesses that are due to smoking. For every one person who dies from a smoking-related disease, 20 more people have a serious illness caused by smoking. The direct medical costs from smoking are \$75 billion per year in the U.S.<sup>12</sup>

Prevention begins with all of us taking *personal responsibility* for preserving our health. This includes diet, exercise, seat belt use and other healthy behaviors. Tobacco is a powerful addiction, and we need to provide professional assistance to tobacco users who would like to quit. With a combination of personal responsibility and community support, West Virginia should set as a goal to substantially reduce our rates of obesity and tobacco use by 2015.

In addition, we need *a health care system that is oriented toward prevention*. The U.S. spends only 3 percent of its health care budget on prevention. The national Partnership for Prevention<sup>13</sup> has rated 25 preventive services for both cost-effectiveness and their ability to add years to a patient's life. West Virginia should use this research to require all insurance plans to provide appropriate preventive services, including childhood immunizations, tobacco cessation, age appropriate colorectal screens, pap smears, mammography, and Chlamydia screens.

## **B. Manage long-term conditions effectively.**

We spend 70 to 80 percent of all health care dollars for the treatment of chronic diseases, such as diabetes, asthma, and heart disease. West Virginia has an older and sicker population than most of the nation. Doing a better job of helping people manage chronic disease would save considerable amounts of money, as well as improve people's quality of life.

Our medical care and payment policies have their basis in the first half of the 20<sup>th</sup> century when most health problems were the result of infectious disease and acute conditions. We now have different problems and need a different response. Health care providers must be rewarded for spending more time counseling their patients on healthy behaviors. Individuals must be supported in *making healthy lifestyle changes* through programs that help them lose weight or quit smoking, for example.

WVAHC proposes that a Public/Private Partnership be formed to help fund disease management. The Partnership would be composed of the various private and governmental payers of health care. Each payer would pay physician offices and community health centers a monthly fee for those patients receiving *patient education*. In exchange for higher reimbursement, the payers should expect improvements in the health status of the people they insure: fewer obese persons, lower LDL levels (bad cholesterol), lower A1c levels (a blood test given to diabetics), etc.

We also need to support people in making informed decisions about end-of-life care through *advance directives*. Living wills enable people to express the kinds of treatment they want and don't want if they are terminally ill and become unable to make their wishes known. Medical power of attorney allows people to designate someone to make medical decisions on their behalf should they become unable to do so. Both living will and medical power of attorney forms can be downloaded from our web site at: [www.wvahc.org](http://www.wvahc.org).

It is important that we all have conversations with our family members and physicians about end of life issues. Some may wish to continue aggressive treatment of terminal illnesses, while others may prefer only palliative care. What is most important is that people actively consider their options and make their wishes known.

### **C. Use technology wisely.**

The use of medical technology has many positive impacts on the health care we receive. However, some experts believe that without controlling technology, we will be unable to bring the medical rate of inflation in line with the overall rate of inflation.<sup>14</sup> And, as a consequence, more and more of our gross domestic product will be consumed by health care.

Oregon, which spearheaded the efforts to identify which drugs were the most cost-effective, has begun a similar effort with technology. The Medical Technology Assessment Program (MedTAP) is reviewing equipment and devices, as well as medical and surgical procedures. Their goal is to answer these critical questions: Does new technology offer clinical advantages over the alternatives? What is the balance of benefit and risk? Is it cost-effective? Which conditions or patients would benefit from its use, and which should be excluded?

West Virginia should join with Oregon and other states to *independently review new technologies* to determine their effectiveness and their impact on cost. The results of these reviews should be adopted and used by the state Health Care Authority when they approve or disapprove major capitol improvements by the state's hospitals and other facilities.

In addition to better care, today's electronic technology offers at least two important opportunities to reduce costly paperwork and improve patient care. The first is *electronic prescribing*, whereby a physician can transmit prescriptions by e-mail, as well as check on possible interactions with other drugs and whether or not the drug is covered under the patient's health plan. E-prescribing improves patient safety and saves time for physicians and pharmacists.

WVAHC recommends that a public/private partnership fund a pilot project of up to 500 physicians throughout the state and pay a portion of the cost to install e-prescribing hardware and software. The technology for e-prescribing has already been developed. All that is needed to implement this technology is leadership.

*Electronic medical records* (EMRs) also hold enormous potential to improve patient safety and lower costs. Most doctors in England, the Netherlands, Australia, and New Zealand routinely use EMRs in their practices, while slightly more than one in four U.S. physicians have adopted this technology.<sup>15</sup> EMRs help physicians keep thorough and legible records, track treatment of chronic conditions, and provide automatic prompts when routine preventive procedures (pap smears, for example) are due.

#### **D. Establish a Comprehensive Budget for Health Care**

The United States is one of the few industrialized countries that do not establish a comprehensive budget for health care. West Virginia should establish a budget review process that establishes a benchmark for total health care expenditures and projected expenditures for each sector of the health care system (e.g., pharmaceuticals, inpatient, outpatient, professional services).

Annually, the Health Care Authority would compare the actual expenditures of each sector with the projected expenditures. If the actual expenditures exceed the projected expenditures, the Health Care Authority would make recommendations to the Governor and Legislature on means of reducing costs for that sector.

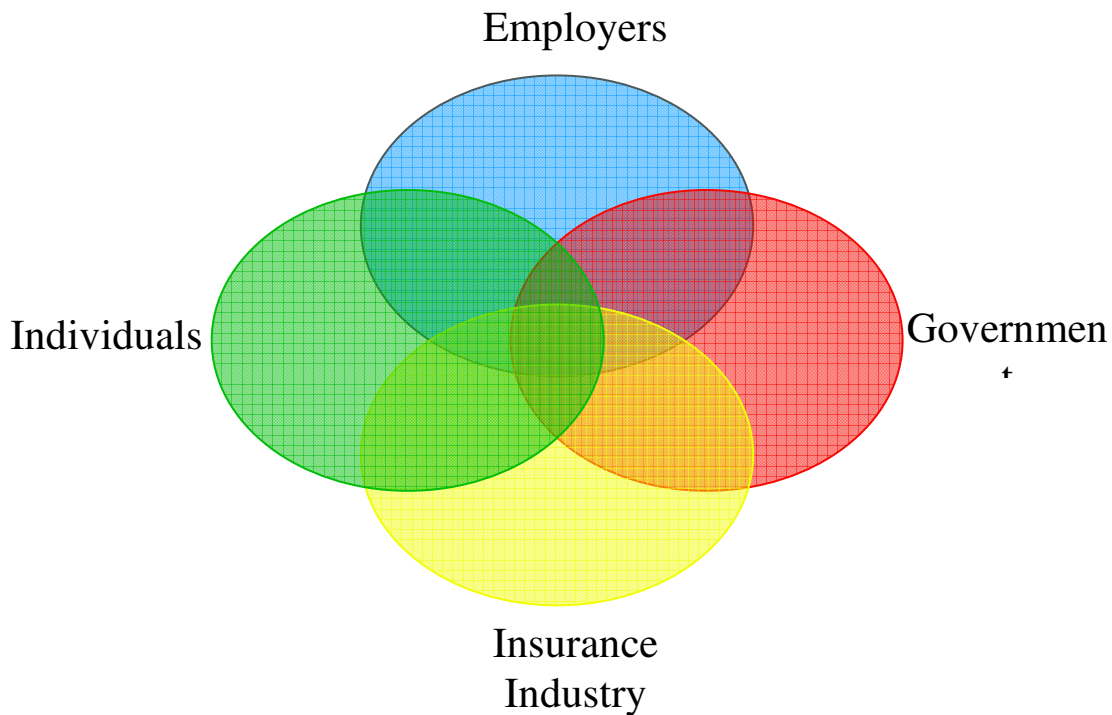
#### **II. Provide health coverage to all West Virginians.**

In the absence of a national solution to the health insurance crisis, it is up to the states to be the incubators of reform. In fact, some strategies may be best initiated and implemented at the state level. WVAHC is recommending a set of actions that would create a seamless system of health coverage, building on our traditional shared responsibilities that include:

- (a) *employer responsibility* to provide health plans to employees
- (b) *individual responsibility* to purchase health plan if not provided by employer
- (c) *insurance industry responsibility* to make quality, affordable health plans available to employers and individuals
- (d) *government responsibility* to provide health coverage for public employees and people who are low-income, elderly or disabled

Our proposed plan would enable West Virginia to provide universal coverage, lower premium costs for employers, and make affordable plans available to individuals.

## Health Coverage: A Shared Responsibility



### A. Employer Responsibility

Our system of health care is based largely on employer-sponsored health insurance. WVAHC recommends that employers with more than 10 employees be required to either provide their employees with health insurance or pay a fee into a fund to help insure the uninsured. The fee for not providing insurance would be \$500 per full-time equivalent employee per year.

Most employers favor this approach. According to a recent national survey of 2,000 employers, two-thirds either somewhat agreed or strongly agreed with the statement that “all employers should share in the cost of health insurance for employees, either by covering their own workers or by contributing to a fund to cover the uninsured.”<sup>16</sup> Even a majority of firms that did not provide health insurance benefits agreed with this statement.

About three-quarters of West Virginia’s 550,000 private sector workers have health insurance through their employers. This proposal would extend health coverage to

almost 77,000 currently uninsured workers in businesses employing more than 10 people.<sup>17</sup>

**Impact of Proposed Employer Requirement  
To Provide Health Insurance**

<b>Employer Size</b>	<b>Total Employees</b>	<b># Currently Uninsured*</b>
10 or fewer (exempt from requirement)	78,758	46,152
11 or more (subject to requirement)	467,604	76,911

\*These numbers assume that there is a 100% take-up rate by employees who are offered insurance. These numbers also assume that all employees who are not offered insurance are uninsured. Some employees would have coverage their spouse or may have purchased an individual policy.

**B. Individual Responsibility**

Individuals who do not qualify for Medicaid, who have been uninsured for 12 months, and who do not receive insurance through their employer would be required to purchase a basic, affordable insurance policy. People who earn between 100 and 300 percent of the federal poverty level (about \$20,500 to \$62,000 annually for a family of four) would have their premiums subsidized on a sliding scale.

Individuals who do not purchase a health insurance policy and remain uninsured would be charged a 10% surcharge on their state income taxes. This fee would amount to \$150-200 per year for low-income workers and \$1,000 or more for higher income workers. The fees would be paid to the Health Care Trust Fund, described below. Prior to implementation of this requirement, state government would have to certify that a basic health insurance plan is available throughout the state at an affordable rate.

**C. Insurance Industry Responsibility**

Our plan calls for insurance reforms that would reduce premiums for people who are purchasing an individual policy and for businesses that provide health insurance to their employees. When health insurance began in the 1940s, a few plans spread the risk among large numbers of insured people. They tended to take all applicants and charge the same premium regardless of health status.

The system worked well until the 1980s when more plans came into the market. Instead of spreading the risk of illness across a large population, insurers fragmented the market by competing for healthy people and excluding potentially high-cost enrollees through medical underwriting. Insurance reforms in the 1990s have tried to correct some

of the worst abuses of this system. Despite these reforms, however, the market system continues to fail Americans who are older, poorer and sicker.

If we want the private insurance system to work, we must go back to the earlier principles. WVAHC therefore proposes the following interrelated insurance reforms:

***Universal acceptance.*** Insurance plans should be required to enroll all eligible applicants, regardless of medical or family history. Without this requirement, potentially risk-cost individuals will continue to be excluded from the private market, run the risk of personal bankruptcy, and place the financial burden of their care on public sector health plans, like Medicaid.

***No medical underwriting.*** The practice of computing people's premium costs based on their past, current or potential future medical conditions should be eliminated. This would restore the insurance industry's original practice of sharing risk and cost across large populations.

***Reasonable premium levels.*** Insurance plans should be required to charge premiums within a reasonable, narrow range, with differentials allowed only for age and gender. We recognize that healthy young people are reluctant to buy into an expensive system that brings them few benefits. WVAHC successfully supported legislation in 2007 allowing young adults who are dependents to remain on their parents health insurance policy until they reach the age of 25 regardless of whether they are a full-time student.

In order for private health plans to offer reasonable premiums, public sector plans, such as Medicare and Medicaid, must carry their own weight. Providing a health insurance plan for the uninsured, coupled with requiring Medicare, Medicaid and PEIA to pay the actual cost of hospital services, will significantly reduce the "cost shift" to private insurance plans.

#### **D. Government Responsibility**

Government has an important, historic role in providing health coverage for our most vulnerable citizens – children, the elderly, people with disabilities and the poor. The federal government administers Medicare, the health insurance program for the elderly, and we will continue to expect their participation in health care reforms. Our plan also calls upon state government to continue and expand its role to assure health coverage for all West Virginians.

WVAHC recommends that the state expand the Medicaid program to cover all adults who have incomes below 100% of the federal poverty level. The program currently provides coverage primarily for children and for adults who are elderly or disabled. Parents of children who receive Medicaid qualify for coverage only if their incomes are below 29% of the federal poverty level.

We make this recommendation for three reasons. First, for every dollar West Virginia puts into Medicaid, the federal government puts in almost \$3. Second, the administrative costs for Medicaid are far less than private insurance companies, so more money goes to providing health care. Third, West Virginia can provide a quality insurance program for a very reasonable price, less than \$1,000 a year in state money.

West Virginia could cut the number of uninsured by one-fourth by expanding Medicaid to cover adults to 100 percent of the federal poverty level. We could provide 94,400 low income adults with a comprehensive health insurance plan at a cost of just over \$50 million to the state.<sup>18</sup>

### **Impact of Proposed Medicaid Expansion**

	<b># Eligible Adults</b>	<b>Cost to State</b>
Parents of children on Medicaid (29-100% federal poverty level)	18,400	\$9.4 million
Other adults, ages 18-64 (0-100% federal poverty level)	76,000	\$40.8 million
<b>Total</b>	<b>94,400</b>	<b>\$50.2 million</b>

We also recommend that state government assure that a quality, affordable health plan is *available* to every West Virginian, and to be the insurer of last resort for individuals if such plans are not provided by the private market. A state entity should be created or designated to coordinate health care policy, with the following duties:

- Certify whether quality, affordable insurance is available throughout the state for businesses and individuals to purchase.
- Operate a high quality insurance plan for businesses and individuals, if there are inadequate numbers of such plans available from the private market.
- Operate the Health Care Trust Fund, which provides health plan subsidies for low and moderate income individuals and families.
- Serve as a resource for businesses and individuals who want to purchase health insurance by matching them with affordable health insurance plans.
- Oversee the development of cost containment strategies.

In order to be considered “quality, affordable health insurance,” plans must offer, at a minimum, the following:

- Physician office visits.
- Preventive services (childhood immunizations, access to a smoking cessation program, age appropriate colorectal screens, pap smears, mammography, and Chlamydia screens.)
- Mental health services.

- Inpatient and outpatient hospitalization.
- Durable medical equipment.
- Prescription drug benefits.
- Basic dental care.

The Health Care Trust Fund would fund the Medicaid expansion and subsidize the premiums for low and middle income individuals and families. Sources of funding would include increased taxes on tobacco, soda and alcohol products; fees from businesses not offering health plans to their employees; and fees from individuals who do not purchase health insurance. West Virginia should also explore the possibility of using Medicaid disproportionate-share hospital (DSH) payments to help fund the Health Care Trust Fund. These are payments by Medicaid to hospitals that disproportionately serve Medicaid patients. With a requirement that Medicaid pay hospitals actual cost, the DSH payments may become an additional source of funds to expand health insurance to the uninsured.

The Health Care Authority is in the process of determining what level PEIA and Medicaid (frequently referred to as the state payers) pay hospitals for services. Both PEIA and Medicaid should pay a reasonable cost of delivering services to their enrollees. Additionally, the state should seek a Medicare (a federal payer) demonstration project that would have Medicare also pay reasonable cost.

The United States is one of the few industrialized countries that do not establish a comprehensive budget for health care. West Virginia should establish a budget review process that establishes a benchmark for total health care expenditures and projected expenditures for each sector of the health care system (e.g., pharmaceuticals, inpatient, outpatient, professional services).

Annually, the Health Care Authority would compare the actual expenditures of each sector with the projected expenditures. If the actual expenditures exceed the projected expenditures, the Health Care Authority would make recommendations to the Governor and Legislature on means of reducing costs for that sector.

***Conclusion: The time to act is now, and we are the actors.***

It would be easy, at least for those of us who are still insured, to throw up our hands and say that the problems in health care are simply beyond our control. But this would not be true. We've looked at the research, consulted experts, and talked with our fellow West Virginians, and ***we see solutions***. They involve straightforward, doable actions to control health care costs, provide health coverage to everyone, and reform insurance. While we will continue to call for the federal government to participate in the solution, particularly as the sponsor of Medicare, we can and should pursue the many improvements and reforms that are entirely possible ***within our state, right now***.

What this requires of us is a commitment to the public good, realizing that our own health security hinges on a sound health care system. Each of us needs to do our part – as individuals, health care providers, insurance companies, government agencies, and faith and community-based organizations. We invite you to consider the following:

***Personal responsibility for individual health***

- Take action to improve and maintain your own health through diet, exercise and healthy behaviors. There are dozens of good Web sites with helpful information about personal health. A good place to start is with Healthy People 2010, a national initiative to promote better health, at [www.healthypeople.gov/BeHealthy](http://www.healthypeople.gov/BeHealthy).
- Be informed consumers of health care. Examine your health care options and choose care that you feel will provide the best service at the lowest price. Ask in advance what the service will cost, even if you have insurance that will pay for it. The West Virginia Health Care Authority has established a web site that provides information of the cost of some hospital cost so you can compare hospital cost. You can visit their web site at: <http://www.comparecarewv.gov/notyetlivev2007/>.

***Collective action for quality health care for everyone***

- Join West Virginians for Affordable Health Care. You can do so online at [www.wvahc.org](http://www.wvahc.org). You can also register for free e-Updates, which we send weekly during the legislative session and periodically during other times of the year.
- Talk and write letters to your state Senators and House of Delegates members. Urge them to take action to reform our health care system.
- Send a letter to the editor of your local newspaper outlining some of the problems with health care and some of WVAHC's reform proposals.
- Share this guide and talk about it with people where you work, in your community and at your place of worship. Contact us at (304) 344-1673 if you'd like more copies.

**Acknowledgement**

West Virginians for Affordable Health Care has developed this proposal through a grant from the Claude Worthington Benedum Foundation. The West Virginia Council of Churches is the fiscal agent for this grant.

**About West Virginians for Affordable Health Care**

West Virginians for Affordable Health Care is a tax-exempt, nonprofit organization under IRC 501(c)(4) organized in November, 2005 by a diverse group of individuals concerned about the rising cost of health care and health care insurance

coverage. We are funded by membership dues, public donations, and grants. No member is paid for serving on our Board of Directors.

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<sup>1</sup> G.F. Anderson et al., “Health Care Spending and Use of Information Technology in OECD Countries,” *Health Affairs* 25, no. 3 (2006): 819-831.

<sup>2</sup> World Health Organization, *The World Health Report 2000- Health Systems: Improving Performance*. The table ranking countries by overall performance can be found at: [http://www.who.int/whr/2000/en/annex10\\_en.pdf](http://www.who.int/whr/2000/en/annex10_en.pdf) (accessed March 2007).

<sup>3</sup> C. Schoen et al., “U.S. Health System Performance: A National Scorecard,” *Health Affairs* 25 (2006): w457-w475 (published on line 20 September 2006; 10.1377/hlthaff.25.w457).

<sup>4</sup> Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace*, Exhibit 1.1. This chart can be found at: <http://www.kff.org/insurance/7031/ti2004-1-1.cfm> (accessed December 2006).

<sup>5</sup> Ferry, Danielle. “Analysis of the March 1988-2004 Current Population Surveys,” Columbia University, for the Commonwealth Fund.”

<sup>6</sup> Schoen et al., “U.S. Health System Performance: A National Scorecard,” *Health Affairs*, (2006) 25: (published online 20 September 2006; DOI 10.1377/hlthaff.25.w457).

<sup>7</sup> Institute of Medicine, “Care Without Coverage: Too Little, Too Late,” May 2002. The Executive Summary may be found at: [http://www.kaisernetwork.org/health\\_cast/upload\\_files/Uninsured2FINAL.pdf](http://www.kaisernetwork.org/health_cast/upload_files/Uninsured2FINAL.pdf) (accessed March 2007).

<sup>8</sup> Families USA, *Paying a Premium: The Added Cost of Care for the Uninsured*, June 8, 2005. This report can be found at: <http://www.familiesusa.org/resources/publications/reports/paying-a-premium.html> (accessed March 2007).

<sup>9</sup> United States Census Bureau at: <http://www.census.gov/hhes/www/hlthins/historic/hihist4.html> (accessed March 2007).

<sup>10</sup> Families USA, 2005, op. cit.

<sup>11</sup> Institute of Medicine (IOM). (2004). *Insuring America’s Health: Principles and Recommendations*. Washington D.C.: National Academy Press p. 14.

<sup>12</sup> Hyland A, Vena C, Bauer J, Li Q, Giovino GA, Yang J, Cummings KM, Mowery P, Fellows J, Pechacek, Pederson L. “Cigarette smoking-attributable morbidity: United States, 2000.” *MMWR* 2003;52(35):842-4.

<sup>13</sup> “Priorities for America’s Health: Capitalizing on Life-Saving, Cost-Effective Preventive Services,” Partnership for Prevention (2006) at <http://www.prevent.org/content/view/46/96/> (accessed December 2006); and “Guide to Clinical Preventive Services, 3<sup>rd</sup> Edition: Recommendations and Systematic Evidence Reviews, Guide to Community Preventive Services,” Health Services/Technology Assessment Text, National Library of Medicine, at <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat3.part.1> (accessed December 2006).

<sup>14</sup> Kaiser Family Foundation, “Comparing Projected Growth in Health Care Expenditures and the Economy,” (May 2006); published online at <http://www.kff.org/insurance/snapshot/chcm050206oth2.cfm> (accessed December 2006).

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