NEWS RELEASE

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First State Health System Scorecard Finds Wide Differences in Quality, Access, Avoidable Hospitalization and Costs

Report Finds Insurance Coverage Closely Linked to Quality of Care; Thousands of Lives and Billions of Dollars Could be Saved if All States Performed as Well as the Top States

Hawaii, Iowa, New Hampshire, Vermont and Maine Lead in State Rankings

New York, NY, June 13, 2007— There are large gaps in quality of care, access to care, avoidable hospitalizations and costs, equity and healthy lives among states, according to a new state scorecard. Issued by The Commonwealth Fund Commission on a High Performance Health System, the scorecard is the first report to assess how the health system is performing across these five dimensions on a state-by-state basis.

The striking variability across states adds up to substantial human and economic costs for the nation. The report estimates that if all states could do as well as the top states, 90,000 lives could be saved annually, 22 million additional adults and children would have health insurance and millions of older adults, diabetics and young children would receive essential preventive care. In addition, Medicare could save $22 billion a year if high cost states moved down to spending levels of the average states.

The report ranks states on 32 indicators grouped in categories that include access, quality, avoidable hospital use and costs, equity and healthy lives. While no single state performed at the top across all categories, some states far surpassed others. States in the Northeast and Upper Midwest often rank high in multiple areas. In contrast, states with the lowest rankings tend to be concentrated in the South.

“The differences we found between the top and bottom states were shocking, often a two- to three-fold variation or greater,” said co-author and Commonwealth Fund Senior Vice President Cathy Schoen. “Where you live clearly matters: for access to care when you need it, the quality of care you receive, and opportunities to live healthier lives.”

The report, *Aiming Higher: Results from a State Scorecard on Health System Performance,* compares each state to benchmarks that have already been achieved in states across the country. Although some states ranked highly on multiple indictors, the report finds that that no one or group of states scored top marks in every area.

"As policy-makers and private sector leaders look at how their states did on this scorecard, it should be clear that there is room for improvement in all states," said lead author and Director of the Center for State Health Policy at Rutgers University Joel Cantor. "In key areas, even the top states aren't doing as well as they could be."

Access to Health Care and Quality Are Closely Linked

Across the country, the scorecard found that states that do well on access to care—particularly health insurance coverage—were also more likely to do better on quality of care. Four of the five states with the best access to care rankings (Massachusetts, Iowa, Rhode Island, and Maine) are also among the highest on quality of care. States with low quality rankings tend to have high rates of uninsured residents.

Notably, the five top ranked states overall (Hawaii, Iowa, New Hampshire, Vermont and Maine) all have high rates of insurance coverage, with nearly 90 percent of working-age adults insured. In contrast, in the five lowest ranked states (Nevada, Arkansas, Texas, Mississippi and Oklahoma) the share of adults insured ranges between 70 and 78 percent.

These findings point to improving access to care and health insurance coverage as important first steps toward ensuring that all patients get recommended care that is patient-centered, well-coordinated and efficient. In states with low rates of uninsured, adults and children are more likely to receive essential preventive and chronic care and to have an ongoing connection to care.

High Cost Doesn't Equal High Quality Care

Researchers found no systematic connection between high spending and high quality health care. Some states achieve high quality at relatively low costs. The states with the highest levels of spending tended to have higher rates of preventable hospital use including readmissions and admissions for diabetes, asthma, and other chronic illnesses that should be effectively treated outside the hospital. The scorecard documents stark variability across states in potentially preventable use of hospitals. For example, the rate of children admitted to the hospital for asthma ranges from 55 per 100,000 in Vermont to 300 per 100,000 in South Carolina.

Opportunities to Improve

The scorecard points to the substantial gains for the nation if all states could reach levels achieved by the top performing states on key indicators.

* Nearly 90,000 fewer deaths before the age of 75 would occur annually from conditions amenable to health care if all states achieved the level of the lowest rate state.

* The uninsured population would be cut in half if insurance rates nationwide reached insurance rates in the top states.

* Nearly 4 million more diabetics across the nation would receive basic recommended care, helping to avoid renal failure and lost limbs, and 9 million adults age 50 or older would receive essential preventive care.

* If all states reached the lowest levels of potentially preventable admissions and readmissions, these hospitalizations could be reduced by 30 percent to 47 percent and save Medicare $2 billion to $5 billion each year.

Wide Variations -- Additional Report Findings:

Access

- The percent of adults under age 65 who were uninsured in 2004–2005 ranges from a low of 11 percent in Minnesota to a high of 30 percent in Texas. The percent of uninsured children varies from 5 percent in Vermont to 20 percent in Texas.

Quality

- Even in the best states, performance falls far short of optimal standards. The percent of adults age 50 or older receiving all recommended preventive care ranges from a high of 50 percent in Minnesota to 33 percent in Idaho. The percent of diabetics receiving basic preventive care services varies from 65 percent in Hawaii to 29 percent in Mississippi. Childhood immunization rates range from 94 percent in Massachusetts to less than 75 percent in the bottom five states.

Potentially Avoidable Use of Hospitals and Costs of Care

- Rates of potentially preventable hospital admissions among Medicare beneficiaries range from more than 10,000 per 100,000 beneficiaries in the five states with the highest rates to less than 5,000 per 100,000 in the five with the lowest rates (Hawaii, Utah, Washington, Alaska and Oregon).

Equity

- On average, 78 percent of uninsured and 71 percent of low-income adults age 50 and older did *not* receive recommended preventive services.

Healthy Lives

- Death rates before age 75 from conditions that might have been prevented with timely and appropriate health care are 50 percent lower in the lowest-rate states (Minnesota, Utah, Vermont, Wyoming and Alaska) than the District of Columbia and states with the highest rates (Tennessee, Arkansas, Louisiana and Mississippi). Average death rates were 74.1 per 100,000 persons in the top five states compared with 141.7 per 100,000 persons in the bottom five states.

Moving Forward

The report points to the need for action in four key areas: expanding health insurance to all; having better information to assess performance to guide and drive change; analyses to determine the key factors that contribute to state variations; and national leadership and collaboration across public and private sectors.

In addition, the report underscores opportunities for states to look to each other as well as models of excellence within their own borders to inform efforts to improve. For example, in 1974, Hawaii became the first state to enact legislation requiring employers to provide health insurance to full-time workers; it now ranks first in terms of access to care. For the past decade, Rhode Island has provided incentive payments to Medicaid managed care plans that reach quality targets; it now ranks first on measures of the quality of care.

"The scorecard tells us where we are. Now we need to decide where we're going," said Commonwealth Fund President Karen Davis. "States need healthy and productive citizens. Doing better is possible but it will take commitment and action on all levels to achieve real change. The state scorecard documents that we have much to gain as a nation with coherent national and state policies that respond to the urgent need for action."

Methodology:

The state scorecard includes 32 indicators grouped into five dimensions of performance—access, quality, avoidable hospital use and costs, equity and healthy lives. The analysis ranks states on each indicator and then averages the indicator ranks to determine the dimension rank. Dimension scores determine the overall rank.

The Commonwealth Fund Commission on a High Performance Health System, formed in April 2005, seeks opportunities to change the delivery and financing of health care to improve system performance, and will identify public and private policies and practices that would lead to those improvements.

The Commission members are: **James J. Mongan, M.D.** (Chair), Partners HealthCare System, Inc.; **Maureen Bisognano**, Institute for Healthcare Improvement; **Christine K. Cassel, M.D.**, American Board of Internal Medicine and ABIM Foundation; **Michael Chernew,** Ph.D., Department of Health Care Policy, Harvard Medical School; **Patricia Gabow, M.D.**, Denver Health; **Robert Galvin, M.D.,** General Electric Company; **Fernando A. Guerra, M.D., M.P.H**., San Antonio Metropolitan Health District; **George C. Halvorson**, Kaiser Foundation Health Plan Inc.; **Robert M. Hayes, J.D.**, Medicare Rights Center; **Glenn M. Hackbarth, J.D.,** Consultant; **Cleve L. Killingsworth**, Blue Cross Blue Shield of Massachusetts; **Sheila T. Leatherman**, School of Public Health, University of North Carolina; **Gregory P. Poulsen, M.B.A**., Intermountain Health Care; **Dallas L. Salisbury**, Employee Benefit Research Institute; **Sandra Shewry**, State of California Department of Health Services; **Glenn D. Steele, Jr., M.D., Ph.D**., Geisinger Health System; **Mary K. Wakefield, Ph.D., R.N.,** Center for Rural Health, University of North Dakota; **Alan R. Weil, J.D., M.P.P**., National Academy for State Health Policy; and **Steve Wetzell**, HR Policy Association.

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