Achieving Affordable Health Insurance Coverage for All within Seven Years:

A Proposal from America's Internists

American College of Physicians-American Society of Internal Medicine

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Executive Summary

The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) has a long-standing commitment to making affordable health insurance coverage available to all Americans. In previous papers, the College has documented the impact of lack of health insurance coverage on health outcomes; proposed core principles for evaluating proposals to expand coverage; and assessed various options for expanding coverage against the core principles.

The paper offers a framework for policies that would enable all Americans to have access to affordable health insurance coverage within the next seven years. The dates suggested in the paper represent a logical and sequential series of steps to achieve universal coverage; however, actual dates of implementation and the sequence of steps required may be modified based on further discussion and the response of Congress to the recommendations.

The recommended steps and timetable are as follows:

ACP-ASIM believes that Congress should enact legislation to establish a framework of a step-by-step plan to make affordable coverage available to all Americans within seven years:

STEP ONE: Congress adopts a resolution establishing the goal of making health insurance coverage available to all within seven years. ***Resolution to be enacted by December 31, 2002.***

STEP TWO: Congress creates an advisory commission to report annually on the effectiveness of measures to expand coverage and how successful they are in making progress on the goal of achieving affordable coverage for all within seven years. The Commission is also charged with developing a basic benefits package that will be required of qualified health plans under the subsequent steps. ***Legislation to be enacted by December 31, 2002. Commission to be appointed by July 1, 2003. First report to Congress: September 30, 2003. Recommendations on benefits package to be submitted by September 30, 2004.***

STEP THREE: Congress enacts legislation to make affordable coverage available to all people with incomes up to 200% of the Federal poverty level. Reforms will include: uniform national income eligibility for Medicaid (up to 100% of the federal poverty level); converting S-CHIP to a federal-state entitlement program; federal contribution to Medicaid increased to fully cover the costs of the expanded enrollment; premium subsidy program for individuals with incomes from 100-200% of the federal poverty level, to be applied to Medicaid or S-CHIP "buy in" or toward purchase of individual or employer coverage. ***Legislation to be enacted by December 31, 2003; expanded Medicaid enrollment, premium subsidies, and buy-in programs to be implemented as of January 1, 2005.***

STEP FOUR: Congress expands the income-related premium subsidy program to all uninsured individuals with incomes above 200% of the federal poverty level. Legislation also authorizes the creation of purchasing groups to facilitate the purchase of qualified health plans; and establishes conditions of participation for qualified health plans, to include basic benefits requirements and market reforms, modeled after the Federal Employees Health Benefits program. ***Legislation to be enacted by December 31, 2004; new coverage options and requirements to go into effect on January 1, 2007.***

STEP FIVE: Congress enacts legislation to authorize states to request a waiver to opt-out of the national framework for coverage, so that they have the option of establishing their own programs for universal coverage, subject to federal guidelines. States that meet the federal guidelines would be able to have federal funding for existing programs re-directed to support the state program. ***Legislation to be enacted by December 31, 2005; state can begin requesting waivers as of January 1, 2007.***

STEP SIX: National Commission on Expanded Access submits a recommendation to Congress on mechanisms to discourage individuals from voluntarily opting out of insurance coverage. Options that would be considered would include: automatic enrollment in Medicaid, S-CHIP, or Medicare, with a tax surcharge imposed on the individual to cover a portion of the costs of enrollment. ***Commission reports its recommendations by September 30, 2006; Congress enacts legislation to provide coverage for individuals who otherwise would opt-out by December 31, 2007; implementation of programs to provide coverage to such individuals and financial incentives to obtain coverage to be effective January 1, 2009.***

Through these steps, ACP-ASIM believes all Americans would have access to affordable coverage: from Medicaid or S-CHIP if they are within the qualifying income levels, or from health plans that meet the qualifications of the purchasing groups that would be

established under our proposal, or from a waived state health coverage plan. The legislation to discourage opt-outs would bring almost all Americans into the insurance pool, by making it more expensive for them if they chose not to obtain coverage.

The paper is intended to be a conceptual and analytical framework that would serve as the basis for further analysis, debate, and action. The paper acknowledges that more work needs to be done in several key areas, including determination of a basic benefits package; the respective roles of federal and state authorities; costs of implementing the program; measures to control costs and assure quality; "modeling" on the interaction of the various reforms (i.e. a technical analysis of how the changes proposed in one step may affect other proposed steps); administrative roles of the federal and state governments; and the changes that would need to be made by various stakeholders. **ACP-ASIM encourages further analysis of the framework proposed in this paper, including discussion and modeling of the interaction of the various elements, the role of state and federal governments in administering the program, how individuals will respond to the proposed programs, methods of controlling costs, and methods to assure adequate reimbursement for covered services. The College also encourages discussion of methods of financing coverage. Such methods should be progressive and result in predictable and sustainable financing.**

The paper acknowledges that expanding health insurance coverage will not, by itself, assure that individuals have access to high quality medical care. Other reforms to break down barriers to high quality medical care will be required. The focus of this paper, however, is on expanding health insurance to those who now lack access to affordable coverage. *Health insurance coverage will not remove all of the barriers, but it is a pre-requisite for individuals to be able to have access to quality medical care.* **ACP-ASIM encourages discussion of further reforms that will be required to make affordable health care available to all, including: establishing better systems of accountability for quality and cost; reducing administrative barriers; and reducing disparities in treatment based on race, ethnicity or gender.**

Finally, the paper responds to those who argue that building upon the existing pluralistic system of public and private health insurance coverage is the wrong way to reform the health care system. It makes the case that step-by-step reform, which builds upon existing sources of coverage, is the most viable way to achieve affordable coverage for all. Rather than being half-measures, as some have suggested, the step-by-step reforms recommended in the paper would represent a dramatic change in the way that individuals obtain coverage. For the first time, *everyone* would have access to a subsidized health insurance program; *every* health plan would be required to offer a basic standard package of benefits including preventive services; *every* health plan would be required to agree to uniform new federal rules on risk rating and renewability as a condition of participating in the program; purchasing groups would give individuals the collective buying power that is now available only to large groups; and people would have a much greater choice of health plans and more continuity of care than is typically the case in today's fragmented health care system.

I. INTRODUCTION

The American College of Physicians-American Society of Internal Medicine is the largest medical specialty society in the United States, with over 115,000 physician and medical student members. The College has been a long-standing advocate for national and state policies to expand health insurance coverage to the uninsured, with the goal of providing affordable health care coverage to all Americans.

Over the past two years, the College has spent approximately $1,000,000 to educate health policy-makers on the health consequences of being uninsured. Our campaign, called the Hidden Epidemic Campaign, produced studies that documented that uninsured Americans are less likely to have access to a regular source of care, less likely to receive important preventive and screening procedures, more likely to receive care at an advanced stage of illness, and may experience poorer outcomes—including more suffering and premature death—as a result.[1] Through news media coverage of the College's studies and related activities, and paid educational messages on cable television, the message on the health consequences of being uninsured reached an estimated 70 million Americans.[2]

Despite the efforts of ACP-ASIM and others to educate policy-makers about the health consequences of being uninsured, the problem persists. Although there has been modest reduction in the numbers of uninsured over the past two calendar years, according to the Census Bureau, the recent downturn in the economy, coupled with rising health insurance premiums, is likely to lead to substantial increase in the ranks of the uninsured. The November 2001 unemployment rate reached 5.7 percent, the highest in six years, and the total monthly premium for an employer-sponsored health insurance plan increased by 11 percent from 2000 to 2001.[3] The economic and social consequences of the terrorist attacks on this country that occurred on September 11, 2001 have led to a further increase in the number of uninsured, particularly for individuals that lost health insurance benefits because of job losses in industries that were disproportionately affected by the attacks. Although the College recognizes that the necessity of countering terrorism will appropriately alter federal budgetary priorities towards measures to prevent further attacks, the College also believes that Congress should not neglect the continued urgency of making resources available to expand coverage to the uninsured.

II. EXISTING COLLEGE PRINCIPLES AND POLICIES ON ACCESS

The steps proposed in this paper are based on the College's CORE PRINCIPLES ON ACCESS, approved by the Board of Regents in October, 2000, and by existing College position papers and policy monographs approved over the past two years. The core principles called for development of step-by-step reforms that would provide coverage for all Americans by a defined date and presented certain criteria for evaluating the effectiveness of such reforms:

1. Proposals to expand access to health insurance coverage should have an explicit goal of resulting in all Americans being covered by an adequate health insurance plan by a specified date.

    A. There should be a mechanism for determining scope of benefits, recognizing the inherent difficulties involved in developing a consensus on scope of benefits, particularly for population groups with different demographic characteristics. There should be a uniform minimum package of benefits for all.
    B. Coverage and benefits should be continuous and independent of place or residence or employment status.

2. Sequential reforms that expand coverage to targeted groups should be considered, but such proposals should:

    A. identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage
    B. include a defined target date for achieving affordable coverage of all Americans.
    C. include an ongoing plan of evaluation. The evaluation plan should provide for an ongoing assessment by health policy experts, physicians, patients, and others of the effectiveness of the sequential reforms in expanding coverage to the targeted groups and in achieving the goal of making affordable coverage available to all Americans by the defined target date. The evaluation plan should include a process for proposing to Congress and the President further recommendations for reforms to achieve the goal of making coverage available to all Americans. [4]

In developing the following discussion paper, the College selected approaches that offer the greatest potential for meeting the core principles approved by our Board of Regents. We were particularly interested in approaches that would improve continuity of care, increase administrative efficiency, provide for portability of coverage, and allow for greater choice of physicians and health plans. A comparison of the steps proposed in this discussion paper with the core principles is appended to this report. The College also developed the recommended steps in this paper based upon more detailed monographs on the effectiveness of various options for expanding coverage from our Health and Public Policy Committee, as approved by our Board of Regents. The monographs address the viability of expanding coverage through the Medicaid and S-CHIP programs; tax credits for the uninsured; individually-owned insurance and defined contributions; and the Federal Employees Health Benefit program. Specific references to those monographs appear throughout this paper.

This discussion paper goes beyond the proposals that the College has supported to date, however, by providing a step-by-step plan to make coverage available to everyone within the next seven years. The paper builds upon approaches, such as tax credits and Medicaid and S-CHIP expansion, that are already under discussion and that have considerable public support. It proposes a way to combine such programs and

sequentially expand them to larger populations of uninsured Americans so that affordable coverage is made available to everyone.

This paper was reviewed in draft form by the College's Board of Governors, which is an advisory group to the Board of Regents of elected leaders from the College's chapters in the United States and central and North America. The College also solicited comments from individual internist-members through a posting on the home page of ACP-ASIM online (www.acponline.org), from state and national leaders of ACP-ASIM, from other medical and health-related organizations, consumer groups, and other interested parties on the earlier draft of this paper. Each comment was evaluated by the ACP-ASIM's Health and Public Policy Committee, and in many cases, changes were made in the paper in response to the suggestions for improvement. The final paper was approved by the Board of Regents in April, 2002.

III. THE CASE FOR A STEP-BY-STEP FRAMEWORK

As noted above, ACP-ASIM's proposal builds on the existing mixed pluralistic system of coverage, rather than proposing enactment of a single payer plan. We received several comments from individuals and organizations that reviewed the College's discussion draft of this paper arguing that incremental approaches have not and will not be effective. Instead they propose that ACP-ASIM call for immediate action to implement a single payer system.[5] [6] They argue that because health care is a right, the same moral imperative should be applied to enacting a single payer plan as was the case with the struggle to guarantee other rights, such as women's right to vote.

ACP-ASIM respects the sincerity and commitment of those who advocate such an alternative, although we have chosen a different course. We too believe that access to affordable health care is a right. *Defining health care as a right, however, does not necessarily lead to a conclusion that a particular method of financing care and providing coverage--such as a single payer plan—is necessarily superior to other methods that provide access to affordable health care.* There are a variety of options to assure the right to affordable care that merit consideration. Further, unlike other rights—such as women's right to vote, or the right of all Americans to be free of discrimination in housing or education—the problem of the uninsured is not due to discriminatory laws that explicitly deny certain groups of Americans equal protection under the law *because* of their race, religion, gender or ethnicity. (Even though it is demonstrably true that the uninsured are over-represented in certain ethnic and racial groups). Rather, the uninsured are people who are unable to obtain coverage, through public or private programs, *because such coverage is unavailable or too costly for them to obtain or the eligibility requirements are too restrictive.* Because some demographic groups, such as Latinos, are more likely to work in low-wage jobs that do not offer health insurance coverage, they are more likely to be uninsured.[7]

Therefore, the right to affordable health care represents a different kind of challenge than the struggle for other rights that involved repealing discriminatory laws. The comparisons to other civil rights struggles may be appropriate in terms of defining the moral

imperative of making health insurance coverage available to everyone. Saying that health care is a right does not by itself lead to a pre-determined conclusion on how best to provide access to affordable health care, however. Nor should defining health care as a right limit consideration to only one type of solution.

Advocates for single payer often discount the effectiveness of existing incremental approaches to expanding coverage. However, there is evidence to support the view that building upon existing sources of health insurance coverage can be effective in making coverage available to previously uninsured people. The number of children covered by Medicaid, S-CHIP and other government programs increased by 500,000 from 1999 to 2000. Thirty-eight states and the District of Columbia cover children in families with household income at or above 200 percent of the federal poverty level. The increases in the number of children covered by public programs more than offset the decline in the number of non-elderly adults who were covered by the public programs during the same period.[8] Although the S-CHIP program is far from perfect, it is an example of a successful incremental approach to expanding coverage to children who otherwise would be uninsured. Those children are clearly better off than they would have been had S-CHIP never been established.

The challenge now is to build upon what is working, fix what is not working, and create a new national framework to make coverage affordable for everyone.

A new national framework for coverage must be *effective* in expanding coverage *and viable.* Viability means how likely it is that Congress will agree to enact the desired laws, how much support or opposition there will be to a proposed change, how a change will be affected by public perceptions of, and confidence, in the role of government, and most importantly, how willing the American people are to support the recommended changes. Although advocates for various approaches will make assertions about how much support they will have from the public, it is beneficial to look to the history of previous health reform efforts for lessons on how proposals will likely fare today.

A recent analysis of the lessons learned from this nation's experience in the 20th Century in failing to achieve universal coverage, from a long-time and respected advocate for universal coverage, concludes that "incremental changes that expand coverage but do not change the organization and delivery of services have fared better than more sweeping health care proposals . . . Given that the uninsured are unable to afford coverage on their own, *viable* options for expanding coverage will require financial contributions toward premiums from government or employers." (emphasis added). Four general strategies for providing and financing coverage for the uninsured are suggested by the author: federal tax subsidies, federal health insurance programs, federal/state health insurance programs, and expanded employer coverage.[9]

Like the author, the College has concluded that the approaches that will be the *most viable and effective* will involve some combination of financial contributions toward premiums from government and employers—the framework proposed in this paper. We recognize, however, that there is a role for states to consider and experiment with

alternative frameworks for providing health coverage to their residents. Consequently, we are proposing that a waiver program be created that would allow states to opt-out of the national framework for coverage, so that they could develop and implement their own plan for coverage, with a re-direction of federal dollars to support such efforts.

By proposing the framework in this paper, ACP-ASIM hopes to stimulate a discussion of the necessity of achieving universal coverage and the timeline and methods for doing so. We call on physicians, patients, non-physician health professionals, business leaders, government and others to join with us in achieving universal coverage by the end of this decade. Although some will argue that this goal will never be achieved, we disagree. "With the will and the right resources, the United States can attain the goal of universal coverage early in this century. Indeed, to be strong, just, and prosperous in the 21st century, our nation depends on it."[10]

IV. SOURCES

Throughout this paper, ACP-ASIM makes references to two sources that presented a wide variety of thoughtful options for expanding health insurance coverage: Covering America: Real Remedies for the Uninsured, published by the Economic and Social Research Institute, June 2001, under a grant from the Robert Wood Johnson Foundation, and Challenges and Options for Increasing the Number of Americans With Health Insurance, Sherry A. Glied, Task Force on the Future of Health Insurance, January, 2001, under a grant from the Commonwealth Fund. The College appreciates the work of the Economic and Social Research Institute, the Robert Wood Johnson Foundation, the Task Force on the Uninsured, and the Commonwealth Fund in making these analyses available.

Although the prescriptions offered by the authors differ considerably, the common theme in most of the papers summarized by the Economic and Social Research Institute and the Commonwealth Fund was one of providing financial assistance—through premium subsidies and tax credits—to make affordable health insurance coverage available to more Americans. Many of the authors also advocated that tax credits and premium subsidies be coupled with expansion of public programs, particularly Medicaid and S-CHIP. There also was considerable support for linking tax credits and premium subsidies to establishment of purchasing groups and individual insurance market reforms.

The principal areas of disagreement between the authors concerned how much emphasis should be placed on expanding coverage in the private sector compared to expansion of public programs; the feasibility and design of the tax credits; the role of the government in regulating the insurance industry and guaranteeing (mandating) coverage and benefits, limits on the tax-exclusion for employer-paid health insurance, and financing.
Of the papers published by the Economic and Social Research Institute, individual health insurance tax credits were key features of the plans proposed by Butler, Pauly,Wicks/Meyer/Silow-Carroll, and Singer/Garber/Enthoven. In their paper, authors

Feder/Levitt/O'Brien/Rowland explore the use of tax credits to individuals or employers, combined with expansion of the Medicaid and S-CHIP programs [11]

Individual or employer tax credits were also supported by many of the authors cited in the Commonwealth Fund papers, with tax credits being key features of the plans authored by Zelenak; Weil; Curtis/Neuschler/Foreland; Fuchs; Merlis; and Meyer/Wicks.[12] Although the authors differ on how best to apply tax credits toward the purchase of health insurance, the broad support for tax credits and other forms of premium subsidies suggests that they should be central feature of a sequential plan to make affordable health insurance coverage available to all Americans.

There is also considerable support among the authors cited in the two reports for expanding public programs. Expansion of Medicaid and S-CHIP are key features in the plans proposed by Feder/Levitt/O'Brien/Rowland, Holanan/Nichols/Blumberg; Weil; and Rosenbaum/Borzi/Smith.[13] Several authors propose expansion (buy-ins or automatic enrollment) in the Medicare program (Short/Shea/Powell; and Hacker).[14]
There is also considerable support for combining tax credits and other forms of premium subsidies with purchasing groups and individual insurance market reforms. Several of the authors propose a program that is similar to the Federal Employee's Health Benefits Program (FEHBP) of premium contributions to federal employees. Authors that propose some form of premium subsidies, purchasing groups, insurance market reforms, and increased choice of health plans in a competitive market include Butler, Gruber, Pauly, Singer/Garber/Enthoven, Wicks/Meyer/Silow-Carroll;Holahan/Nichols/Blumberg, Fuchs, and Swatz. [15]

Based on a review of the referenced papers and the College's own policies and core principles, ACP-ASIM concludes that a combination of premium subsidies, purchasing groups, insurance market reforms, and expansion of the Medicaid and S-CHIP programs may be the most viable way to make affordable health insurance coverage available to all Americans. In the next section of this paper, we offer for further discussion a series of sequential policy steps to make affordable coverage available to all Americans within the next seven years.

It should be noted that the steps proposed in this paper, like those of the referenced authors, focus principally on expanding coverage, rather than addressing other needed areas of improvement in the health care system. The fact that most of the emphasis in this paper and supporting references is placed on expanding coverage does not mean that the ACP-ASIM believes that it is acceptable to neglect other areas of improvement. Systems will need to be put into place to bring about more accountability for costs, effectiveness of medical treatments, quality, and patient safety. Disparities based on gender, race or ethnicity need to be eliminated. Inadequate reimbursement for covered services and excessive administrative costs and barriers need to be confronted. The supply and distribution of the health professions workforce and health care infrastructure need to be adjusted to provide accessible services. For the purposes of this paper, however, the College chose to address the most critical need to make health insurance coverage

available to the 39 million Americans who have no coverage, rather than attempting to solve all of the problems in the health care system.

V. THE COLLEGE' S PROPOSED FRAMEWORK

Presented in **bold type** below is a description of the College's proposed framework for making affordable health insurance coverage available to all uninsured Americans within the next seven years. (Appendix A illustrates how all uninsured Americans would have access to affordable coverage through the steps outlined below). A detailed discussion of implementation strategies and the rationale for the recommended reforms follows the summary.

ACP-ASIM believes that Congress should enact legislation to establish a framework of a step-by-step plan to make affordable coverage available to all Americans within seven years:

STEP ONE: Congress adopts a resolution establishing the goal of making health insurance coverage available to all within seven years: "It will be the policy of the United States to make affordable health insurance coverage available to all people in the United States no later than January 1, 2009." *Resolution to be enacted by December 31, 2002.*

Although a sense of the Congress resolution is non-binding, it could have significant symbolic and political value. A Sense of the Congress resolution on access could be the equivalent of President Kennedy's historic speech committing the United States to having a manned lunar landing by the end of the 1960s. For the first time, Congress would clearly establish that it will be the policy of the United States to make affordable health insurance coverage available to all Americans—with a target date for delivering on this commitment. It would serve as a benchmark for holding Congress accountable for meeting its commitment by enacting subsequent legislation to expand coverage, as discussed below. Since the resolution does not specify any particular policies to reach the desired goal or call for specific levels of funding, it should have broad support from legislators from all political parties—most of whom are on record as agreeing on the necessity of making affordable coverage available to all Americans, even if they disagree on the policies needed to achieve the goal.

There already is an effort being made in Congress to enact a non-binding resolution, similar in some respects to the language advocated by ACP-ASIM in this paper. House Concurrent Resolution 99 was introduced in Congress on April 4, 2001 with 24 co-sponsors. The resolution calls for Congress to" guarantee" universal access by a defined date. It also includes a series of policy pre-requisites and an earlier timeline for guaranteed coverage than the simple declarative resolution suggested above.[16] It may be better to ask Congress to adopt a simpler resolution that would commit to the goal of making coverage available to all by a defined date, as ACP-ASIM has proposed, than to

use the resolution to set certain pre-conditions that could undermine support for the resolution.

STEP TWO: Congress creates an advisory commission to report annually on the effectiveness of measures to expand coverage and how successful they are in making progress on the goal of achieving affordable coverage for all within seven years. The National Commission on Expanded Access is also charged with developing a basic benefits package that will be required of qualified health plans under the subsequent steps. Implementation details:

Composition of the Commission: **consumers, health care professionals, state government officials with responsibility over access programs, economists, hospitals, and other stakeholders, to be appointed by the Majority Leader of the Senate and the Speaker of the House of Representatives.**

Charge of the Commission: **to assess the effectiveness of programs designed to make affordable health insurance coverage available to all Americans, with an annual report to Congress and the President on needed improvements, and to recommend the benefits to be included in a basic benefits package for health plans that would qualify for premium subsidies (see next step).**

Implementation dates: **Legislation to be enacted by December 31, 2002. Commission to be appointed by July 1, 2003. First report to Congress: September 30, 2003. Recommendations on benefits package to be submitted by September 30, 2004.**

The lack of an independent evaluation mechanism has been a shortcoming of past efforts for reform, such as the Children's Health Insurance Program and Health Insurance Portability and Accountability Act (HIPAA). Although evaluations of both programs by consultants have been commissioned by Congress and the Center for Medicare and Medicaid Services (CMS), an independent commission would have more stature and "buy in" from stakeholders, and therefore would be more likely to be successful in persuading Congress to make necessary improvements in health coverage programs. ACP-ASIM believes that creation of a new advisory Commission would result in smoother and more effective implementation of the policy changes recommended in this paper. However, we would not favor the creation of another Commission to study the problems of the uninsured. The advisory Commission should be directed toward monitoring implementation of specific policies to expand coverage, rather than being created for the purpose of studying the problem in a manner that could delay action.

STEP THREE: Congress enacts legislation to make affordable coverage available to all people with incomes up to 200% of the Federal poverty level. Reforms will include: uniform national income eligibility for Medicaid; converting S-CHIP to a federal-state entitlement program; federal contribution to Medicaid increased to fully cover the costs of the expanded enrollment; premium subsidy program for individuals with incomes from 100-200% of the federal poverty level, to be applied to Medicaid or S-CHIP "buy in" or toward purchase of individual or employer coverage. Implementation details:

Uniform income eligibility for Medicaid. **The federal government will mandate that eligibility for Medicaid be expanded to all uninsured individuals with incomes up to 100% of the federal poverty level. This would replace the current practice of allowing each state to establish its own income eligibility based on income and family status.**

Conversion of S-CHIP to an entitlement program. **S-CHIP would be converted to a federal-state entitlement program, as with Medicaid, rather than the current practice of leaving the S-CHIP program dependent on annual appropriations from state legislatures.**

New costs to be borne by the federal government. **The costs of the expanding Medicaid to all uninsured individuals with incomes up to 100% of the federal poverty level, and converting S-CHIP to an entitlement program, will be completely borne by the federal government, rather than through an enhanced match rate.**

Premium subsidies for individuals with incomes from 100-200% of the federal poverty level. **Uninsured individuals with incomes between 100% and 200% of the federal poverty level, who are not eligible for coverage under a state's Medicaid or S-CHIP program, will be given an income-related premium subsidy. The premium subsidy could be applied to the following coverage options: a "buy into" the S-CHIP or Medicaid program, *or* purchase of insurance in the individual insurance market *or* as a contribution towards the individual's share of employer-based coverage.**

Continuation of existing state options. **States shall continue to have the option of maintaining coverage through Medicaid and S-CHIP for families above 100% of the federal poverty level, without requiring that they pay an additional premium, as is permitted under current law.**

Options for design of the premium subsidy. **The premium subsidy shall be designed in one of two ways: refundable tax credit or direct dollar subsidy (voucher) from the federal government. (Congress will choose between the two options).**

Requiring a sufficient subsidy to make coverage affordable. **The premium subsidy, whether in the form of a tax credit or a direct dollar subsidy, would be established at a level that will make the purchase of health insurance *affordable* to low-wage workers. For individuals in the specified income brackets, this would likely require a contribution of 80-90% of the cost of the average cost of a health insurance policy that provides a required basic benefits package, as determined below.**

Implementation date: **Legislation to be enacted by December 31, 2003; expanded Medicaid enrollment, premium subsidies, and buy-in programs to be implemented as of January 1, 2005.**

Expanding Medicaid to cover all uninsured Americans with incomes up to 100 percent of the federal poverty level would by itself make coverage available to the single largest group of uninsured Americans: 34.7 percent of the total uninsured population.[17]

Feder, Levitt, O'Brien and Rowland argue that expansion of Medicaid and S-CHIP to low-income Americans is more effective than premium subsidies or tax credits. Many of the low-income uninsured do not have any income tax liability and would need a subsidy provided in advance to purchase coverage. Any credit, therefore, would need to be refundable, payable in advance, and not reconciled for income changes over the course of the year, adding considerable complexity to the use of tax credits for low-income people. Since 70 percent of the uninsured lack access to employer-based health insurance, they would be forced into the non-group market, which they note is riddled with problems. They also believe that the size of the proposed tax credits would be insufficient to cover the costs of buying insurance. Relying on expansion of Medicaid and S-CHIP as the principal source of coverage for low-income individuals would have the virtue of relying on existing delivery, outreach and eligibility determination systems, rather than having to create new administrative structures. Finally, they express a preference that eligibility for S-CHIP be made an entitlement, rather than being dependent on state appropriations.[18]

The College concurs with the views of Feder et al that expansion of Medicaid and S-CHIP is the most feasible way of extending coverage to the poorest Americans who lack health insurance coverage. We also concur that S-CHIP should be made an entitlement, rather than being subject to annual appropriations. (Annual discretionary appropriations place those enrolled in S-CHIP at the risk of having their coverage terminated if budgetary priorities change in the state in which they reside).

Our proposal differs by offering individuals with income between 100 and 200% of the federal poverty level the option of buying into Medicaid and S-CHIP or obtaining coverage from the individual insurance market or employers. States would continue to have the option of covering such individuals under S-CHIP or Medicaid without a premium contribution, but it would be the state's option and not mandated by federal law.

Making coverage available through multiple sources, rather than requiring that they obtain coverage from Medicaid, would provide a greater degree of choice to such individuals than making Medicaid and S-CHIP the only choices available to them.

Although we agree that a premium contribution in the form of a tax credit would be complex, the College believes that it is possible to design a refundable tax credit with an advance payment option that would be effective for individuals with incomes between 100 and 200% of poverty level. The credit would need to be available on an advance payment basis, so that the subsidy is available at the time that insurance is purchased. It would need to be refundable, so that individuals with no federal income tax liability would still qualify for a subsidy.

Most importantly, the credit would need to be high enough to make the purchase of health insurance affordable for low-wage workers. In 1999, ACP-ASIM developed a plan for a refundable tax credit, with an advance payment option, and proposed that the tax credit be high enough to fund 90% of the actuarial equivalent of the Blue Cross/Blue Shield standard option health plan offered under the Federal Employees Health Benefit Plan. We set the tax credit at this level based on the advice of a prominent health economist that worked with us on developing the proposal. At that time, it was estimated that the value of the credit would be $2800 per adult for those living at the federal poverty level and $2400 per adult at 150 percent of the federal poverty level[19]. We recognize that the value of the credit would need to be updated based on current costs of obtaining health coverage in the individual insurance market. Current proposals in Congress for refundable tax credits do not provide a high enough subsidy; the credits should be increased be to make coverage truly affordable for low-wage workers.

The concerns about the individual insurance market, although valid, are addressed in the next step of the College's proposed framework through creation of purchasing pools and conditions of participation for qualified health plans. Eligible individuals who qualify for the tax credit would be able to participate in the purchasing groups, as discussed in the next section. At least one option offered by the purchasing groups would cost no more than the maximum tax-credit (or voucher) amount. We recognize that until the purchasing groups and conditions of participation for qualified health plans are established, availability of coverage in the individual insurance market may be limited. The Medicaid and S-CHIP buy-in, and the option of applying the premium subsidy toward the employee's share of employer-sponsored coverage, would provide a source of coverage in the interim even in markets where affordable individual insurance may not be available. The College's policy monograph on tax credits provides more details on how a tax credit could be structured to be effective in extending coverage to this population group.[20]

Although the College supports the use of tax credits as a way to subsidize coverage, we concur with those who argue the tax code is not the most efficient way to subsidize the purchase of health insurance coverage. It may be the most viable approach, however, in the current political environment.

As an alternative to tax credits, we recommend that consideration be given to providing eligible individuals with a direct income-related premium subsidy, in the form of a dollar grant (voucher) that could be used only for the purchase of qualifying insurance plans or for buying into the Medicaid and S-CHIP programs. The Commonwealth Fund notes that voucher programs do not benefit from the automatic elements of tax filing. They also require the establishment of a new administrative structure. However, these programs do have much more flexibility in setting the amount of the voucher, determining income, and making timely payments. Further, states could adjust the amount of the voucher to track state health care costs. Voucher programs could also provide incentives to non-filers through a different administrative mechanism. They could also adjust payments for monthly changes in income, and make non-reconciled advance payments, depending on federal rules.[21]

Tax credits will be more effective if combined with expansion of Medicaid and S-CHIP. The Commonwealth Fund analysis supports the view the expansion of public programs can be a viable mechanism for making coverage available to low-income Americans. Existing public programs offer a well-developed administrative infrastructure. They already regulate plans, educate consumers, and facilitate plan enrollment. They have substantial bargaining power to obtain good rates from insurers, enabling them to lower costs and offer more complete coverage to qualifying beneficiaries than in the non-group market.[22]

ACP-ASIM's monograph on expansion of the Medicaid and S-CHIP programs provides additional recommendations on how such expansions should be structured to assure that they meet the desired objective of improving access to care for vulnerable populations. The monograph addresses not only coverage issues, but also reimbursement and administrative barriers to access under the Medicaid and S-CHIP programs. [23]

STEP FOUR: Congress expands the income-related premium subsidy program to all uninsured individuals with incomes above 200% of the federal poverty level. Legislation also authorizes the creation of purchasing groups to facilitate the purchase of qualified health plans; and establishes conditions of participation for qualified health plans, to include basic benefits requirements and market reforms, modeled after the Federal Employees Health Benefits program. *Legislation to be enacted by December 31, 2004; new coverage options and requirements to go into effect on January 1, 2007.* Further details:

***Income-based premium subsidy.* All eligible individuals shall be provided an income-related premium subsidy, with the amount of the subsidy declining as income increases.**

***Eligibility:* all uninsured individuals with incomes above 100 percent of the federal poverty level (i.e. those with incomes between 100-200% of the federal poverty level who are already eligible for a premium subsidy proposed under step three, as well as individuals with incomes above**

200% of poverty who are not already covered by private insurance, Medicare, Medicaid, S-CHIP, CHAMPUS, VA or other programs)

Design of the premium subsidy. **The subsidy would be in the form of either a refundable individual tax credit or in the form of a direct dollar contribution (voucher). Congress will choose between the two options.**

Sources of coverage. **The subsidy shall be applied to purchasing coverage from *qualified* plans in the private insurance market *or* towards the individual's share of the cost of coverage from a qualified health plan offered by an employer.**

Basic benefits package for qualified health plans. **A basic benefits package, as recommended by the National Commission on Expanded Access, shall be submitted to Congress under legislative rules that would provide for an up or down vote without amendment ("base closing commission model"). Once enacted by Congress, health plans would be required to offer the minimum package of benefits in order to be a qualified plan for the premium support subsidies. Plans would be allowed to compete by offering additional benefits.**

Purchasing pools. **Purchasing pools shall be established through which those eligible to receive the premium subsidy would purchase coverage. The purchasing pools will be established on a state or regional basis, be funded by the federal government, and have certain defined statutory functions similar to the way that the federal government serves as a purchasing group for the Federal Employees Health Benefits Program. Such functions shall include: offer one-stop shopping for health insurance; limit the number of participating insurers to those that meet the requirements for participation, negotiate terms with insurers, provide comparative information on the cost and quality of plans, assist in enrolling individuals into plans, collect and process premiums, and offer customer service to purchases. At least one coverage option offered by the purchasing groups would cost no more than the maximum tax-credit (or voucher) amount.**

Qualifying conditions for health plan participation. **Health plans that wish to be eligible for the premium assistance/tax credit subsidies would be required to abide by federally-mandated conditions of participation to eliminate barriers to affordable coverage in the individual insurance market, including guaranteed renewability and modified community rating. They would also be required to disclose the amount of the health insurance premium that goes directly to patient care compared to administrative and operational costs in a uniform manner that allows for informed comparisons by consumers. Qualified plans would be required**

to offer the basic benefits package recommended by the Commission and approved by Congress.

Establishment of state based re-insurance programs. **State based re-insurance programs would be established to guard against adverse selections.**

Participation by small employers. **Small employers should have the option of purchasing coverage from qualified health plans offered by the purchasing group.**

Implementation date: Legislation to be enacted by December 31, 2004; new coverage options and requirements to go into effect on January 1, 2007.

One model for administering a premium support program through arrangements with purchasing pools is described in the Commonwealth Fund paper. Curtis, Neuschler, and Forland propose a system of purchasing pools that would operate in conjunction with a tax credit or premium assistance program. They recommend that the federal government fund the development of private purchasing pools in each state. Each pool would have to meet federal criteria and the number of federal start-up grants would be limited in each state, according to the numbers of potential eligible beneficiaries.

In order to mitigate adverse selection, and to give the pools enough buying power to operate effectively, they recommend that all individuals eligible for premium assistance (tax credits or vouchers) be required to purchase coverage through the pools. These pools would have the power to contract with a limited number of health insurers. In general, they would be required to offer at least three different health plans with different benefit packages. At least one option would cost no more than the maximum tax-credit (or voucher) amount. The plans would offer coverage to subscribers, charging age-related (but not health-related) premiums.[24]

Another variation of this approach is to use the Federal Employees Health Benefits Plan as a model. FEHBP offers its members a choice of plans, including a fee-for-service option. Under Fuchs' proposal, a parallel program to the existing FEHBP, called the extended-FEHBP program (E-FEHBP), would be established. All plans that participate in the FEHBP would be required to participate in the E-FEHBP, but could price their plans at a new community rate that reflected the costs to the newly enrolled insured population. In order to avoid adverse selection, high-risk qualifying individuals who signed up for the E-FEHBP would be diverted to a separately funded reinsurance pool. Fuchs argues that such a pool could substantially reduce premium costs. By removing some of the selection risk, it would be easier for plans to participate in E-FEHBP and to remain in FEHBP as well. This option would give qualifying beneficiaries coverage at much lower cost and offer them a much greater choice of high-quality plans, at least in some markets, than they would otherwise obtain in the non-group market.[25]

ACP-ASIM's proposal borrows elements from each of the arrangements discussed above. The purchasing groups would be established on a state or regional level, funded by the federal government and subject to federal criteria for funding. They would offer a choice of plans, including one that cost no more than the maximum premium subsidy amount. They would offer the approved basic benefits package for qualified health plans, as determined below, but could compete by offering additional benefits. In function and design, the purchasing groups would operate along the lines of the extended FEHBP program, including the establishment of separately funded reinsurance pools. The College's monograph on the FEHBP model as a way of expanding coverage elaborates on the issues that need to be considered in the design of such a system.[26]

ACP-ASIM believes that all qualified insurers should be required to offer a basic benefits package, including preventive and screening procedures that have been shown to be effective, and a limit on total out-of-pocket expenses in a calendar year. Plans could compete by offering additional benefits. A basic benefits package would reduce the problems with individuals being "under-insured" for the primary and preventive services or being at risk for catastrophically high expenses. It would also facilitate the ability of individuals to make an informed choice of plans, since they would be assured that all plans provided at least a basic core of comparable benefits.

We propose that the National Advisory Commission on Expanded Access develop the recommendations for covered benefits, for an up or down vote by Congress without amendment (base closing model). The reason for having the Commission develop the package, while having Congress vote on it as a whole without amendment, is to depoliticize (to the extent possible) the process of determining benefits and the risks of benefits being added based on which groups are most effective in lobbying Congress, not which benefits have been shown to be medically effective. The Commission would also develop the proposed cost-sharing (co-payments, coinsurance and deductibles) for the benefits package. It would also determine if Medical Savings Accounts or other high deductible health plans could be offered as an exception to the required package of preventive and screening services.

The American Academy of Family Physicians (AAFP) has developed a basic benefits package, which includes a package of assured services with no co-payments, including evidence-based periodic evaluation and screening services, and assured services with 20 percent co-payment, including outpatient physician services and visits. The AAFP basic benefits package would not include the inpatient hospital care, except for prenatal and maternity benefits. The availability of services not included in the AAFP basic benefits package would be determined through market competition. [27]

ACP-ASIM suggests that the AAFP basic benefits package could be one model that merits consideration by the Commission on Expanded Coverage, although we believe that the benefits package should include coverage for inpatient hospital services. AAFP's proposal for assuring health coverage for all, of which the basic benefits package is one element, has similar goals as the framework proposed by ACP-ASIM in this paper.

Areas of agreement include: all Americans must be assured coverage of a health plan that has a uniform minimum package of benefits; an evidence-based approach should be used to determine benefits; financial barriers to basic care should be removed; and public financing is essential. AAFP proposes a different method of assuring that all people are guaranteed coverage by a qualified health plan, however.[28] ACP-ASIM commends the AAFP for publishing a thoughtful proposal for universal coverage, and believes that the public will benefit from discussion of the AAFP plan and the framework proposed in this paper.

Any system of premium support or tax credits has the potential of eroding the existing employer-based model. Some proposals are designed explicitly to accomplish this objective. Proponents of moving away from an employer-based model, to one in which individuals purchase their own coverage, argue that employer-based health insurance distorts consumer choice, inhibits competition, and disadvantages individuals who cannot obtain coverage through an employer. Others argue that it would be a mistake to demolish the employer-based system, since it is the system that provides coverage to the vast majority of Americans, is relatively easy to administer since enrollment and premium contributions and deductions all occur automatically at the work site, and enjoys the support of most working Americans.

ACP-ASIM believes that a premium support or tax credit system should be designed to maintain a key role for employer-based coverage, particularly during the initial years of implementation when the effectiveness of a system that relies on subsidies to purchase coverage in the non-group market—with the assistance of a purchasing group—is still being tested. Abrupt erosion of employer-based coverage could increase the number of uninsured Americans. It will take time to determine if the non-group market can demonstrate that it can provide affordable coverage to all or most Americans in the absence of employer-based insurance. It will also take time to establish the purchasing groups, negotiate terms with qualified health plans in the non-group market, and develop the infrastructure to administer a premium support or tax credit system.

The College's policy monograph on expansion of individually-owned insurance, as a strategy to expand access, elaborates on the changes that are needed in the small group market before individually-owned insurance can be considered to be a viable alternative to employer-based insurance. The monograph cautions against instituting changes that could erode employer-based coverage, and lead to more uninsured Americans, until or unless it is shown that the individual market can be sufficiently reformed to make it a viable option for providing health insurance coverage to most Americans.[29]

To reduce the risk of erosion of employer-based coverage, ACP-ASIM proposes to permit beneficiaries to use tax credits or premium support (voucher) programs to buy coverage through their employers.

Merlis proposes to allow individuals without access to employer-sponsored coverage to use their tax credits in the non-group health insurance market. However, the Merlis proposal would also allow the credits to be used to finance the employee share of group

insurance premiums. He suggests that the "take up" rate of an insurance tax credit would be increased by allowing beneficiaries to use the nearly automatic enrollment mechanisms of employer-sponsored health insurance. If tax credits could only be used for individual coverage, employer-sponsored insurance would likely erode. Permitting credits to be used to purchase employer-sponsored coverage would encourage many of the eligible workers and their employers to remain within the employer-sponsored system.[30] The report of the Task Force on the Future of Health Insurance notes that the Merlis approach has important advantages. It provides a way to make tax credits portable—available to those working for an employer as well as those working on their own. It offers, on average, less public money to employees of firms that offer employer-sponsored coverage than it does to employees of firms that do not offer such coverage. As a result, public funds could lead some firms and worker to drop employer-sponsored coverage in favor of non-group coverage. Nevertheless, the Task Force notes that this approach has important merits: It would take advantage of the fact that coverage available through employers is usually cheaper and enrollment is nearly automatic. Furthermore, this step would reduce the degree to which the employer market would disintegrate, compared to a system in which credits could only be used in the individual insurance market. Subsidies for employer-based insurance might encourage employees in firms that do not now offer such insurance to demand such coverage.[31] ACP-ASIM concurs with the analysis of the advantages of allowing individuals to apply the premium subsidy to the employee share of group insurance offered by an employer, as Merlis proposes.

STEP FIVE: Congress enacts legislation to authorize states to request a waiver to opt-out of the national framework for coverage, so that they have the option of establishing their own programs for universal coverage, subject to federal guidelines. States that meet the federal guidelines would be able to have federal funding for existing programs re-directed to support the state program. Further details:

***Eligibility for a waiver*: states could apply for a waiver to design and administer their own health care financing systems to provide coverage for all residents.**

***Conditions for a waiver:* states would have to show that the can achieve enrollment in state-approved sources of coverage (private health plans or public programs) that is at least equal to the coverage that would occur under Medicaid, S-CHIP and the premium subsidy program proposed in this paper, and that the sources of coverage provide benefits at least equal to the basic benefits package required of qualified health plans. States would also have to show that they had made arrangements for coverage for residents when traveling outside the state.**

***Redirection of federal funding:* states approved for a waiver could apply to receive a federal contribution equal to federal expenditures per**

resident of the state for existing public programs (Medicaid, S-CHIP), purchasing groups and the premium subsidy program that otherwise would have applied to the state. Additional financing if required would come from the state itself.

Implementation date: **Legislation to be enacted by December 31, 2005; state can begin requesting waivers as of January 1, 2007.**

Kronick and Rice propose that all legal U.S. residents would have a "right" to comprehensive health insurance coverage. Health insurance would be a social insurance program, not a means-tested program. States would be responsible for designing and administering the health care financing systems, allowing them the flexibility to create systems that meet the needs of their residents. To receive federal funding, states would need to assure that nearly all legal residents would be covered and have access to at least one zero-premium plan that includes a federally defined standard benefit package. The current health care financing system, which relies principally on employer-based health insurance, would be replaced by one relying on a payroll tax levied on employers and employees, supplemented by federal general revenues, state revenues, and possibly individual contributions.[32] The Kronick and Rice proposal is not a single payer proposal, since it would leave it to each state to determine how it wanted to provide coverage: through public programs, subsidies for private coverage, or other means. It would not preclude a state from implementing a program administered and financing solely by the government, however.

Others have similarly advocated that states be allowed to develop their own systems for universal coverage, rather than depending on enactment of a federal program or incremental expansion of existing programs. Organizations have been established in several states to advocate for enactment of state programs for universal coverage.[33] [34]

A central tenet of the American federal system is that states should be given the freedom to experiment with ways to meet the needs of their residents, with little interference from the federal government. States have often shown that they are more likely than the federal government to initiate bold plans to assure health care coverage—Hawaii, which guarantees that all residents have access to coverage, and Oregon, which pioneered priority-setting as means to re-direct resources to the uninsured, are two examples. However, states have also shown that they can be regressive in their approaches to the uninsured, often cutting back on programs to provide coverage in times of economic difficulty and budget constraints. States also vary greatly in how generous they are in providing optional coverage under the Medicaid and S-CHIP programs.

Therefore, ACP-ASIM believes that states should have the freedom to design their own systems for coverage, *provided* that they meet certain federal requirements for federal funding, including guaranteed enrollment and coverage by plans that offer benefits at least equal to the basic benefits package that would otherwise be available to their residents. ACP-ASIM believes that once a waiver is approved, the specific method for financing coverage, including the roles of public and private insurance, should be left to

the state decide. We do not believe that it should be pre-determined that the program should operate as a social insurance program funded by payroll taxes, as Kronick and Rice propose. Nor should any particular option be automatically excluded from consideration. Although many of the advocates for allowing states to design their own plans for universal coverage are also advocates of single payer plans, we believe that states that wish to obtain a waiver should have the freedom to choose from a wide range of options for assuring coverage, including ones that rely on programs administered and financed by the government as well as those that maintain a strong role for private insurance and employer-sponsored insurance.

STEP SIX: National Commission on Expanded Access submits a recommendation to Congress on mechanisms to discourage individuals from voluntary opting out of insurance coverage. Options that would be considered would include: automatic enrollment in Medicaid, S-CHIP, or Medicare, with a tax surcharge imposed on the individual to cover a portion of the costs of enrollment. Further details:

Availability of affordable coverage: **the Commission will assess whether or not the framework established through the previous steps has resulted in adequate access to affordable health insurance coverage for all uninsured people nationwide, and if necessary, steps that need to be taken to increase voluntary enrollment.**

Mechanisms to provide coverage for remaining uninsured: **if the Commission determines that affordable health insurance coverage is available nationwide, it proposes policies to provide coverage for those who have chosen not to obtain it on their own. The Commission will specifically consider the feasibility of automatic enrollment of individuals who voluntary refuse in Medicaid, Medicare or S-CHIP.**

Creation of financial incentives to obtain coverage: **The Commission will make a recommendation on ways to create financial incentives to obtain coverage, including consideration of a federal tax surcharge to be collected from individuals who choose not to obtain coverage on their own to offset the costs of enrolling the individual in a public program and to make it more cost-effective for individuals to obtain coverage on their own (i.e. the tax surcharge would be higher than the cost of obtaining subsidized coverage on their own through other sources).**

Implementation dates: **Commission reports its recommendations by September 30, 2006; Congress enacts legislation to provide coverage for individuals who otherwise would opt-out by December 31, 2007; implementation of programs to provide coverage to such individuals and financial incentives to obtain coverage to be effective January 1, 2009.**

The problem of individuals "opting out" of buying health insurance needs to be addressed under any plan that has as its goal making health insurance available to all Americans. Particularly if the individuals who opt out are healthy and sufficient financial means to buy health insurance, they distort the risk pool of those who obtain health insurance by siphoning off the lowest risk individuals. Further, individuals who choose to "go bare" will still expect access to medical care should they become ill, thereby shifting costs onto insured Americans. Until a system of affordable health insurance is in place, however, it is premature to subject individuals who "opt out" of insurance to mandates or financial penalties. Once a premium assistance/tax credit program is in place—combined with expansion of Medicaid and S-CHIP—there should be strong disincentives created for individuals to opt out of obtaining coverage.

Holohan/Nichols/Blumberg propose that after five years of implementation of a system of subsidized coverage, states should be allowed to mandate that everyone be covered.[35] (It is unclear, however, how coverage could be mandated in a way that would not violate the rights of sick Americans. Denying them health care would be morally unacceptable and illegal. Subjecting individuals who refuse to obtain health insurance to civil or criminal penalties would also be unacceptable. Therefore, a mandate for coverage is only realistic to the extent that it can truly be enforced in a way that would be acceptable to the American people and not violate the right that every American has to obtain health care).

Wicks/Meyer/Slow-Carroll propose that every individual and family would have to have health coverage at least as comprehensive as Medicare's, plus prescription drugs and child care. Those who fail to show proof of purchase would pay a premium plus a penalty for Medicare back-up coverage for every month without coverage.[36]

Butler proposes making the tax credit conditional on individuals or families buying a health plan that included a minimum set of benefits. Although coverage would not be mandated, he expects high-level compliance among most workers since under his proposal, employees would be required to tell employers which health plan they wished to join.[37]

ACP-ASIM believes that policies that pressure or mandate that individuals obtain coverage on their own, or that penalize them financially if they choose not to obtain coverage, or that automatically enroll them in a public program without their consent, will likely be necessary to achieve universal coverage. However, the necessity of such policies will be diminished if affordable sources of coverage are available nationwide, with relatively simple selection and enrollment procedures. Most individuals, given the opportunity to obtain coverage, will do so if it is available, affordable, and administratively simple to enroll. Policies that may be viewed as being coercive should be implemented only once it is certain that affordable sources of coverage are available nationwide, and that such measures are required to assure that nearly everyone is covered. Further, the most effective ways of bringing the remaining uninsured into the pool, in a way that respects the rights of the individual, and is administratively feasible, requires more thought. The ideas proposed by the studies discussed above merit

consideration, but it is premature for ACP-ASIM to endorse a particular mechanism at this time. The National Commission on Expanded Access would be the appropriate forum to study this issue and make a recommendation to Congress.

VI. WHO WOULD BE COVERED . . . AND WHEN?

The steps described above would increase the availability of health insurance coverage, through a step-by-step expansion each year, so that all would have access to affordable coverage within seven years:

STEPS ONE, TWO AND THREE:

Who is covered: Individuals up to 200% of FPL
Percentage of uninsured: 65% of total uninsured (Source: Commonwealth)
Sources of coverage: Covered by Medicaid (uniform national eligibility up to 100% of FPL); income-related premium subsidy to buy coverage through S-CHIP, Medicaid or through private insurance
Effective date: 1/1/05

STEP FOUR:

Who is covered: Individuals with incomes above 200% of FPL
Percentage of uninsured: 200-299%: 16.7% of uninsured
300-399%: 10.6% of uninsured
400%+: 6.3% of uninsured (Commonwealth)
Sources of coverage: Income-related premium subsidy to buy coverage through purchasing pools modeled after FEHBP
Effective date: 1/1/07

STEPS FIVE AND SIX:

Who is covered: All remaining uninsured, regardless of income
Sources of coverage: Medicaid expansion and S-CHIP buy-in, premium subsidies to purchase coverage through FEHBP model (see steps 1-4) or through state programs for universal coverage (waived programs); or through automatic enrollment in public programs for individuals who otherwise would opt out of coverage.
Effective date: Sources of coverage from steps 1-4 will all be implemented by 1/1/06; state waiver program becomes effective 1/1/07; provisions to discourage opt-out become effective 1/1/09

By January 1, 2009, *everyone* would be covered through Medicaid, S-CHIP, premium subsidized individual or employer-based insurance purchased through program modeled after FEHBP or through a state program authorized under a federal waiver; provisions to cover those who otherwise would opt-out would close remaining gaps.

VII. ADMINISTRATIVE ISSUES

The respective roles of the federal and state governments in administering the framework proposed in this paper requires further discussion. One person who commented on ACP-ASIM's discussion draft recommended that a federal waiver process be established for states, counties, or metropolitan areas that are already have the capability to implement purchasing groups and subsidized "buy ins" for Medicaid and S-CHIP to move ahead with those programs at an accelerated timeframe from what is proposed in this paper. He also recommended that the federal government allow direct contracting during the 7-year development period among public entities for utilizing the most advanced existing public administrative infra-structures for enrollment, claims billing, cost accounting, an clinical data management. He suggests that direct contracting be encouraged among interstate, county/metropolitan governments, municipal departments, federal departments and their health programs, to benefit from each other's best and lowest cost systems. For example, he notes that many states have third-generation information systems for public insurance that could bring other states and their expansion programs up to speed. [37]

ACP-ASIM's plan of February, 1999 for refundable tax credits for individuals with incomes up to 150% of the federal poverty level, combined with expansion of Medicaid to all individuals with incomes up to 100% of the federal poverty level, provides one model for dividing administrative responsibilities between federal and state authorities. The plan proposed that eligibility for the refundable tax credit be administered by the states. The Internal Revenue Service would reconcile the credit when enrollees file their income tax. Annual adjusted gross income would be used to establish eligibility. The credit could be claimed a part of the income tax filing process or on an advanced payment option. Under the advanced payment option, enrollees would receive a monthly voucher to purchase coverage, or alternatively, the enrollee could direct the voucher directly to the health plan. Expansion of the Medicaid program would be administered by the states within federal guidelines. [38] Although the framework proposed in this new paper is more ambitious than what we proposed in 1999, the sharing of responsibilities for administering the tax credit may still be a useful model to consider.

Although the College recognizes the importance of better defining the roles of the federal and state governments, and in describing the administrative structures that would need to be created, it is beyond the scope of this current paper to provide such details. This paper is intended as a conceptual framework for discussion, rather than a detailed plan of implementation.

VIII. FINANCING AND COST

The papers reviewed by the College in developing this proposal offer several options for financing a program of affordable health care coverage for all Americans. Options include: a phased in cap on the amount of employer contributions to the purchase of health insurance that represent tax-free income to the employee; elimination of the tax exclusion of employer-provided health insurance; general revenues; income-based premium payments from individuals who can afford to contribute to the purchase of coverage for themselves and their families; requirements that individuals who buy more expensive coverage pay for the difference out-of-pocket; payroll taxes; increased federal matching contributions to Medicaid and S-CHIP; taxes on tobacco and other harmful products; value added taxes, and savings from increased competition between health plans and lower administrative costs.

The College has not endorsed a specific method of financing at this time, but invites further discussion of ways to fund a system that would provide affordable coverage for all Americans. Methods that merit consideration include: a tax on the amount of the amount that the employer can deduct as a business expense and that is treated as tax free benefits for the individual, pegged at the median cost of a qualified health plan; a designated payroll tax that increases with income; and taxes on tobacco and other harmful products. It should also be noted, however, that a reduction in the number of uninsured Americans may by itself result in savings: reduced hospitalizations and higher health care costs associated with treating uninsured individuals at a later stage of disease, decreased costs shifting, reduced use of hospital emergency rooms as an initial point of contact with the health care system; a more productive workforce with fewer days off due to illness, and most importantly, saved lives.

We recognize that cost and financing are critical issues that will need to be addressed. However, until there is agreement on the need to provide coverage to everyone, and on the framework for doing so, we believe that it is premature and possibly counterproductive to propose a specific method of financing. We are concerned that if a specific method of financing is proposed now, discussion would focus on the methods of paying for the program—for instance, whether a tax increase would be required, what kind of tax, and how high a tax—rather than on the value of providing coverage and the viability of the mechanisms that are proposed. Similarly, if a price tag is assigned to the reforms that are proposed, discussion would likely focus on the cost of providing health insurance coverage to everyone—not on the necessity and moral imperative of doing so.

Further, the College's proposed framework is by design and intent a work in progress. Complex issues relating to the interaction of the various elements, the role of state and federal governments in administering the program, how individuals will respond to the proposed program, methods of controlling the costs of care, methods to assure adequate reimbursement for covered services—all of these and more will need further discussion

and refinement and will affect the price tag for the proposed framework. Further, until a basic benefits package is determined, it is impossible to develop an accurate price tag. Our goal in publishing this paper is to propose a conceptual framework for reform, not a detailed plan for implementation that covers all issues, although we have attempted to provide just enough detail on how the plan would work to facilitate further discussion.

RECOMMENDATION:

ACP-ASIM encourages further analysis of the framework proposed in this paper, including discussion and modeling of the interaction of the various elements, the role of state and federal governments in administering the program, how individuals will respond to the proposed programs, methods of controlling costs, and methods to assure adequate reimbursement for covered services. The College also encourages discussion of methods of financing coverage. Such methods should be progressive and result in predictable and sustainable financing.

IX. ADDITIONAL REFORMS

As noted previously, the recommendations in this paper are designed with the specific purpose in mind of expanding health insurance coverage. However, health insurance coverage will not by itself guarantee access to high quality, affordable health care—although lack of health insurance is clearly an unacceptable barrier to obtaining such care.

As noted in the College's CORE PRINCIPLES ON ACCESS, further reforms will be required to create a health care system that provides every American with access to quality, affordable care. Issues that will need to be addressed include: establishing better systems of accountability for quality and cost; reducing administrative barriers; assuring adequate reimbursement levels for covered services; and reducing disparities in treatment based on race, ethnicity or gender. The College will continue to offer proposals to address the further needed reforms, although such proposals are beyond the scope of this paper.

RECOMMENDATION

ACP-ASIM encourages discussion of further reforms that will be required to make affordable health care available to all, including: establishing better systems of accountability for quality and cost; reducing administrative barriers; assuring adequate reimbursement levels for covered services; and reducing disparities in treatment based on race, ethnicity or gender.

X. NEXT STEPS

ACP-ASIM believes that the framework proposed by this paper has the potential of offering an effective and viable roadmap for providing all Americans with access to

affordable health insurance coverage by January 1, 2009. Further, we believe that the recommended steps will have strong support among the American people. The conceptual framework that is proposed:

- *Builds upon the strengths of the current pluralistic system*—combining the benefits of public health plans such as Medicaid and S-CHIP with a more competitive and affordable market for private insurance.
- *Provides more choice*, since individuals will be able to choose from a variety of health coverage options.
- *Makes affordable coverage available to everyone*—through expansion of public programs combined with premium subsidies and tax credits, competition between health plans, reforms in the small group market, and purchasing groups that would facilitate the purchase of affordable coverage.
- *Allows for increased "portability"*—since eligible individuals would be able to purchase coverage from a variety of health plans that would not be as contingent on their place of employment or geographic locale.
- *Improves continuity of care*, since eligible individuals would be less likely to be faced with having to terminate a relationship with a personal physician because their employer switches health plans. Instead, most individuals would be able to choose a plan that allows them to continue to see their own personal physician from the menu of plans offered by the purchasing group,

Further, by providing a recommended timetable for enactment of authorizing legislation and implementation, the College hopes to show that it is realistic to make the necessary changes to make coverage available to all Americans—through phased in expansions of coverage in a step-by-step fashion over the next seven years.

We wish to thank the authors who contributed their ideas for publication in the Task Force on the Future of Health Insurance and the Economic and Social Research Institute Report, since it was their ideas that served as the basis for many of the recommendations in this report. It should be noted that the College adapted and combined their ideas with our own thinking—producing a report with recommendations that may differ substantially from the proposals of the individual referenced authors. We also thank all of those who commented on the discussion draft of this paper—those who are specifically mentioned in this report, as well as the many others who also submitted comments that influenced our thinking, and we hope, resulted in a better paper.

The College considers the conceptual framework recommended in this paper to be a work in progress. We encourage further discussion from physicians, patients, business leaders, other health care professionals, government officials, economists, and other stakeholders. Do you agree with the conceptual framework? Why or why not? Are there ways that it can be improved?

We recognize that some will argue that the College's proposed reforms do not go far enough to problems with the current health care system. Others will likely argue that they go too far and are not realistic in the current political environment. Some will question the political feasibility of the specific recommendations in the paper.

ACP-ASIM welcomes such comments, but requests that those who disagree with our conceptual framework present an alternative plan of action—one that could achieve affordable coverage for all Americans within the next seven years. Debate should no longer center on whether all Americans should have access to affordable coverage, but on the means to achieve that end within a reasonable period of time.

ACP-ASIM also recommends that the ideas in this paper, as well as alternative proposals to achieve the same objective, be discussed in community forums throughout the country. History has shown that health care reform cannot be a top down proposal emanating from Washington, D.C. Rather, the changes that are needed must be understood, guided, and supported by citizens in communities throughout the country.

XI. CONCLUSION

America's internists believe firmly that achieving a health care system that provides affordable coverage to all Americans is within reach, provided that there is the will to explore new ideas and strive for consensus. It is our hope that this discussion paper contributes in a meaningful way to consideration of options for achieving affordable coverage--within the next seven years--and that it helps bring about a long overdue consensus for reform. "With the will and the right resources, the United States can attain the goal of universal coverage early in this century. Indeed, to be strong, just, and prosperous in the 21st century, our nation depends on it."[39]

Appendix A
Illustration of Proposed Steps, Target Groups, and Timetable for Making Affordable Coverage Available to All

Individuals up to 100% of FPL

34.7% of total uninsured (Source: Commonwealth)

Covered by Medicaid (uniform national eligibility)

Effective date: 1/1/05

Individuals from 100 to 200% of FPL

30.3% of total uninsured (Source: Commonwealth)

Income-related premium subsidy to buy coverage through S-CHIP, Medicaid or through private insurance and FEHBP-type buy-in

Effective date: 1/1/05

Individuals with incomes above 200% of FPL

200-299%: 16.7% of uninsured
300-399%: 10.6% of uninsured
400%+: 6.3% of uninsured
(Commonwealth)

Income-related premium subsidy to buy coverage through FEHBP-type buy-in

Effective date: 1/1/07

All remaining uninsured, regardless of income

Implementation of rules to create financial disincentives for individuals to voluntarily opt-out of health insurance coverage. At this point, virtually all previously uninsured Americans would have access to affordable coverage, at which point strong disincentives would be needed to discouraging individuals from opting out

Effective date: 1/1/09

Appendix B

COMPARISON OF IMPLEMENTATION OF ACP-ASIM'S SEVEN YEAR PLAN FOR ACHIEVING AFFORDABLE COVERAGE FOR ALL WITH THE ACP-ASIM'S CORE PRINCIPLES

Core Principle	Comparison	Concerns or Comments:
1. Includes an explicit goal of all Americans being covered by adequate health insurance by a specified date.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	The plan provides a specific series of actions to provide affordable health insurance to all Americans by 1/1/2009.
1a. Includes a mechanism for determining scope of benefits.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, to be recommended by new advisory Commission and ratified by Congress. Health plans would be required to offer the standard benefits as a condition of being eligible for the premium assistance program.
1b. Includes a uniform minimum package of benefits for all.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, see (1a) above.
1b. Coverage and benefits should be continuous and independent of place of residence or employment status.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	For qualified participants, individuals would be able to choose from a menu of eligible health plans or could buy into Medicaid and S-CHIP, without regard to residence or employment. Income eligibility would be standardized for Medicaid and S-CHIP.
2. Considers sequential reforms to expand coverage.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, proposes a series of sequential steps to cover everyone within seven years.
2a. A sequential plan identifies the subsequent steps, targeted populations, and financing mechanisms.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, identifies each step and the population that would be covered and how they would be covered. Comments are solicited on several financing options.
2b. A sequential plan identifies a target date for achieving affordable coverage for all Americans.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, target dates are established for each step in the plan, with 1/1/09 being the target date for covering all Americans.
2c. A sequential plan identifies an ongoing plan of evaluation.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, an independent advisory Commission would be created to provide Congress with an independent, ongoing evaluation of the effectiveness of the reforms.
3. Includes strong incentives for participation in the health insurance pool or strong disincentives to discourage non-participation.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, seeks comments on several different options for discouraging individuals from opting out.

Core Principle	Comparison	Concerns or Comments:
4. State flexibility to investigate different approaches that contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to assure portability and access to the basic benefits package.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Seeks comments on option of allowing states to establish their own programs to cover everyone within federal guidelines.
5. Creates mechanisms to make prescription drugs more affordable. Does not allow formularies determined solely or principally on the basis of cost.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Depends on whether or not prescription drug coverage would be among the evidence-based benefits recommended in the standard benefit package by the advisory commission. Even without such a mandate, greater choice of health plans should allow more individuals to purchase plans that have prescription drug coverage. Medicaid and S-CHIP buy-in for individuals with incomes between 100 and 200% of poverty would allow those individuals to buy into plans that cover prescription drugs.
6. Financing should be adequate to eliminate barriers to care.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Paper calls for an adequate premium subsidy/tax credit. Also mentions need for reforms that address inadequate reimbursement levels, administrative barriers, health care treatment disparities, and other obstacles to high quality care.
6a. Highest priority towards assuring adequate financing for "critical access" institutions and providers with a higher burden of uncompensated care.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Expanded HI coverage would reduce the demands placed on institutions to provide uncompensated care. The plan does not include specific measures to improve financing of critical care institutions.
6b. Reimbursement level for covered services must be fair and adequate to reduce barriers to care. Mechanisms to improve ease of administration should be included to enhance physician participation.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Paper mentions the need to assure that reimbursement levels are adequate, but does not propose specific reimbursement reforms at this time.
6c. Congress should dedicate a sufficient commitment of budgetary resources to expanding health insurance coverage for the uninsured, particularly for those must vulnerable."	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	The paper explicitly calls for Congress to adequately fund expansion of health insurance coverage, particularly for those most vulnerable.
6d. Financing for public insurance programs should be progressive. Explicit means testing should be discouraged.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Yes, proposes that the amount of the premium subsidy be inversely related to income. Participation in Medicaid and S-CHIP would be means-tested, but all individuals with incomes of more than 100% of the federal poverty level would be eligible for income-related premium subsidies to purchase coverage.

Core Principle	Comparison	Concerns or Comments:
7. Should address sources of patient and physician dissatisfaction with system: • Micro-management of clinical decision-making • Diversion of health care dollars away from patient care to administrative inefficiencies • Excessive pressure on physicians to reduce time spent with patients • Duplicative and inconsistent coverage and payment policies by payers • Lack of continuity of care • Erosion of physician-patient relationship • Unnecessary or excessive administrative burdens • Excessive documentation requirements • Lack of choice of insurance plans and physicians	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	The College's proposal addresses some of the sources of dissatisfaction: --continuity of care will be improved by allowing individuals to have a wider choice of health plans, including fee-for-service, and by not making those plans contingent on place of employment --choice of physician and health plans would be increased --standard benefit package would reduce inconsistent coverage policies by payers --amount of money that insurers spend on administrative costs versus patient care would be disclosed. Other sources of dissatisfaction are not specifically addressed, although the paper mentions the need for additional reforms to address costs, quality and administrative barriers.
8. Should be designed to reduce administrative and medical liability costs that do not improve access and quality of care.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Insurance market reforms and the requirement that insurance be obtained from purchasing groups would substantially reduce the administrative costs of obtaining insurance in the small group market. Expanded Medicaid and S-CHIP enrollment would result in more Americans being covered in plans with generally lower administrative costs. Medical liability reforms are not addressed in this paper.
8a. Public and private research bodies should support research on information systems to make administration and financing more efficient.	❑ Consistent ❑ Partially consistent ❑ Inconsistent **X** Does Not Address	Not specifically addressed.
8b. Reforms should be enacted to limit excessive medical liability costs.	❑ Consistent ❑ Partially consistent ❑ Inconsistent **X** Does Not Address	Not specifically addressed.
8c. Should include a description of mechanisms to assure that health care dollars are directed principally at patient care, not administrative tasks.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Requires that health plans divulge the percentage of the premium that is spent on administrative costs versus patient care in a way that allows for informed comparisons by consumers.

Core Principle	Comparison	Concerns or Comments:
9. Patients should have a choice of physicians.	**X** Consistent Partially consistent ❑ Inconsistent ❑Does Not Address	Individuals would have greater choice of health plans, including plans that allow greater choice of physician. Disruption of the doctor-patient relationship when employers switch plans would be reduced due to portability requirements.
9a. Should be designed to respect the importance of patients being able to select a primary care and specialty care physician of their choice.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as 9 above.
9b. Patients should be able to stay with the physician of their choice from year-to-year.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as above for (9).
9c. Patients should have sufficient and prompt access to specialty care with a real choice of specialist.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as above for (9).
9d. Use of hospitalists should not be mandated.	❑ Consistent ❑ Partially consistent ❑ Inconsistent **X** Does Not Address	Does not address.
9e. Requiring a reasonable but higher level of patient co-payments for open-ended access to a physician of their choice is an acceptable mechanism to control costs while providing patients with greater choice of physician than would be available through closed network or staff model health plans.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Wider choice of health plans would give patients the option of selecting point-of-service plans that allow access to out-of-network physicians.
9f. Research ways to provide patients with meaningful quality measurements that will factor into their choice of physician.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Purchasing group(s) would have the authority to require that health plans provide meaningful quality information to consumers. The paper also calls for further discussion of ways to develop systems of accountability for quality.
10. Decisions on expansion of the scope of practice of non-physician health care professionals should be based on evidence that they have the requisite skills and training.	❑ Consistent ❑ Partially consistent ❑ Inconsistent **X** Does Not Address	Not addressed. Coverage of non-physicians' services would be determined by state law.
10a. Should establish a defined level of responsibility, based on skills and training, for each type of non-physician provider.	❑ Consistent ❑ Partially consistent ❑ Inconsistent **X** Does Not Address	Same as above for (10).

Core Principle	Comparison	Concerns or Comments:
10b. Physician-directed health care teams, with sufficient built in controls.	❑ Consistent ❑ Partially consistent ❑ Inconsistent **X** Does Not Address	Same as above for (10).
11. Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	To the extent that new health insurance coverage provides incentives for individuals and families to meet regularly with a physician, it may encourage them to be more responsible about their own health. Evidence-based coverage of preventive and screening procedures would be included in the standard benefits package.
12. Should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation and demographic differences.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	To the extent that a lack of health insurance is, in itself, a reflection of health care disparities, expansion of coverage would reduce disparities. The paper calls for additional discussion of ways to reduce health care disparities based on race, ethnicity or gender.
12a. Should be designed to address barriers to care in inner-city, rural and other underserved communities.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as above for (12). By placing the highest priority on providing coverage to low-income Americans, the proposal would particularly benefit those who live in underserved communities.
12b. Should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as above for (12).
13. Should promote accountability at all levels of the system for quality, cost, access and patient safety.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Health plans would be required to meet certain quality and consumer protection standards in order to qualify for the premium support programs. The paper calls for additional discussion of ways to assure accountability throughout the system.
13a. Should include incentives for physicians and other health care professionals to participate in the design systems of accountability (non-punitive and educational approaches should be favored).	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Does not specifically address, although the paper reaffirms the College's commitment to develop systems of accountability.
13b. Decisions on medical necessity, coverage and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Qualified plans would have to meet consumer protection principles, including a definition of medical necessity as proposed by the College.

Core Principle	Comparison	Concerns or Comments:
13c. Should foster innovation and improvement, including innovation in use of Internet technologies with safeguards to protect the confidentiality of medical information that is transmitted electronically.	❑ Consistent **X** Partially consistent ❑ Inconsistent ❑ Does Not Address	Although not specifically addressed, health plans would be required to meet federal confidentiality protections. Competition between health plans should foster innovation.
13d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a particular problem or perceived problem should be based on evidence of clinical effectiveness and pre-determined benefits.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as (13) above.
14. Medical profession must embrace its responsibility to participate in the development of reforms to improve the US health care system.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Publication of this paper is part of the College's continued commitment to the development of reforms to improve the U.S. health care system.
14a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as above for (14). The reforms proposed in this paper meet the highest standards of ethics and advocacy for patients.
14b. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation or demographic differences.	**X** Consistent ❑ Partially consistent ❑ Inconsistent ❑ Does Not Address	Same as above for (14). Publication of this paper is part of the College's continuing effort to partner with other stakeholders to improve access and quality.

REFERENCES

[1] No Health Insurance? It's Enough to Make You Sick. American College of Physicians-American Society of Internal Medicine, 2000.
[2] Final Report, Decision 2000/Hidden Epidemic Campaign. American College of Physicians-American Society of Internal Medicine, June 2001.
[3] Alliance for Health Reform. An Update on the Uninsured, January 2002.
[4] Core Principles on Access. American College of Physicians-American Society of Internal Medicine, 2000.
[5] Young, Quenten. Physicians for National Health Program, letter to ACP-ASIM, January 2002.
[6] Society of General Internal Medicine, letter to ACP-ASIM, January 2002.
[7] No Health Insurance? It's Enough to Make You Sick: Latino Community at Great Risk. American College of Physicians-American Society of Internal Medicine, 2000.
[8] Alliance for Health Reform. An Update on the Uninsured, January 2002.
[9] Davis, Karen. Universal Coverage in the United States: Lessons from Experience of the 20th Century. Commonwealth Fund, December 2001.
[10] Ibid.
[11] Economic and Social Research Institute. Covering America: Real Remedies for the Uninsured, June 2001.
[12] Glied, Sherry A. Challenges and Options for Increasing the Numbers of Americans with Health Insurance. Commonwealth Fund, Task Force on the Future of Health Insurance, January 2001.
[13] ECSRI, Commonwealth Fund.
[14] Ibid.
[15] Ibid.
[16] Health Care Access Campaign, letter to ACP-ASIM, December 12, 2001.
[17] Commonwealth Fund.
[18] ECSRI.
[19] Redirecting Budgetary Priorities to Help the Uninsured: A Call to Action from America's Internists. American College of Physicians-American Society of Internal Medicine, February 10, 1999. (Kenneth E. Thorpe, Ph.D. assisted in the development of the proposal.)
[20] Health Insurance Tax Credits: Can Implementation Reduce the Number of Uninsured Americans? American College of Physicians-American Society of Internal Medicine, 2001.
[21] Commonwealth Fund.
[22] Commonwealth Fund.
[23] Is Expanding Medicaid and SCHIP a Viable Way to Reduce the Number of Uninsured? American College of Physicians-American Society of Internal Medicine, 2001.
[24] Commonwealth Fund.
[25] Commonwealth Fund.
[26] Federal Employee Health Benefits Program (FEHBP) Buy-In with a Defined Contribution to Qualified Participants: Will This Strategy Reduce the Number of Uninsured Americans? American College of Physicians-American Society of Internal Medicine, 2001.
[27] Assuring Health Coverage for All: A Plan by the American Academy of Family Physicians, October 2001.
[28] American Academy of Family Physicians, Comments on the ACP-ASIM discussion paper on access to health insurance, January 7, 2002.
[29] Individually Owned Health Insurance. American College of Physicians-American Society of Internal Medicine, 2001.
[30] Commonwealth Fund.
[31] Commonwealth Fund.
[32] ECSRI.
[33] Maryland Citizen's Health Initiative, letter to ACP-ASIM, January 2002.
[34] Universal Health Care Action Network of Northwest Ohio, letter to ACP-ASIM, January 2002.
[35] ECSRI.
[36] Ibid.

[37] Holcomb, Lee. Comments on ACP-ASIM discussion paper on access to health insurance, January 7, 2002.
[38] Re-Directing Budgetary Priorities to Help the Uninsured: A Call to Action from America's Internists. American College of Physicians-American Society of Internal Medicine, February 10, 1999.
[39] Davis, Karen. Universal Coverage in the United States: Lessons from Experience of the 20th Century. Commonwealth Fund, December 2001.