American College of Physicians-American Society of Internal Medicine

Is Expanding Medicaid and SCHIP a Viable Way to Reduce the Number of Uninsured?
A Policy Monograph of ACP-ASIM

INTRODUCTION

In the past ten years, several hundred studies have been conducted to document the plight of uninsured Americans. The evidence from these studies contradicts the notion that a lack of insurance is merely an inconvenience as is often supposed by many Americans. These studies confirm that there are real consequences of being uninsured. Uninsured Americans experience generally higher mortality and specifically, higher in-hospital mortality. A staggering 43 million Americans do not have access to health care and suffer poorer medical outcomes simply because they lack health insurance. Lack of insurance is a public health risk that results in poorer health and earlier death. Ensuring that all Americans have health insurance can reduce the total burden of illness. The American College of Physicians-American Society of Internal Medicine (ACP-ASIM) calls upon all elected leaders and policy-makers to focus their attention on the documented problems of uninsured Americans to ensure that all Americans benefit from the provision of health insurance.(1)

With the publication of a series of White Papers on the effects of a lack of insurance, ACP-ASIM advances to the next step, searching for a solution. A number of proposals exist on how to increase the number of insured Americans. ACP-ASIM’s core principles on access, approved by the Board of Regents in October 2000, can serve as a guideline to evaluate these proposals.(2) In this monograph, ACP-ASIM examines the expansion of Medicaid and the State Children’s Health Insurance Program (SCHIP) as a means to increase the number of insured in relation to the core principles.

BACKGROUND

Medicaid

Over 35 million Americans receive Medicaid.(3) Although Medicaid benefits are vital to many of the uninsured, Medicaid is only available to the following categories of people: children, persons with disabilities, pregnant women, and adults with children.(4) While states cover parents under Medicaid, the maximum allowable income is extremely low in many areas. Thirty-two states currently deem full-time employees making minimum wage ineligible for benefits.(5) Low-income, childless adults are completely ineligible unless they are disabled.(5)

Medicaid is an entitlement program that is jointly administered by federal and state agencies. All persons that meet state eligibility requirements are entitled to coverage. Welfare reform laws have contributed to some confusion over eligibility requirements by separating cash assistance and the Medicaid program.(4) In the 15 states with the most uninsured low-income adults, Medicaid coverage for low-income parents declined by 27%, from 1996 to 1999.(6) Children’s coverage was also affected. Children account for two-thirds of those who lost Medicaid coverage due to welfare reform, but their loss of coverage was offset by the increase in the
number of children enrolled in SCHIP. Enrollment of children in Medicaid declined by 8.9% from 1996 to 1999, but combined enrollment of Medicaid and CHIP dropped by 2%.\(^6\) However, states have made an effort to correct the situation and re-enroll those dropped from Medicaid.

The federal government matches state spending under Medicaid and, depending on the state, the federal government pays 50% to 83% of Medicaid expenditures.\(^4\) The Congressional Budget Office projected that 43.1 million people would be covered by Medicaid and that spending would be approximately $115 billion in federal funds and $90 billion in state funds in 2000.\(^4\)

State Medicaid programs vary in eligibility requirements, while remaining within federal laws. The federal government allows some states “waivers” under Section 1115 of the Social Security Act. Section 1115 authorizes research and demonstration programs relating to Medicaid. Although this authority was contained in the original legislation, it was used only for very limited projects covering major medical services until 1993, when the Secretary of Health and Human Services substantially revised the process to allow statewide demonstrations of alternative programs with changes in eligibility, delivery of services, and populations served.\(^7\) Currently, at least a dozen states have Section 1115 waivers, and most waivers are used for managed care programs in an effort to extend coverage to those that would normally not qualify for benefits.\(^4\) ACP-ASIM outlined standards for state waivers in a 1995 Position Paper on reforming Medicaid.\(^7\)

In addition to Section 1115 waivers, Congress enacted a new provision in 1996 to allow states to disregard certain sources of income and assets in determining eligibility.\(^4\) There are no limits on how much can be disregarded, and several states have disregarded all family assets.\(^4\) Therefore, states clearly have some leeway in how they implement Medicaid programs and target funds to the populations in need.

**SCHIP**
The State Children’s Health Insurance Program (SCHIP) was enacted in 1997. The program allows a great deal of flexibility in how states administer the benefits, but generally it applies to low-income, uninsured children under the age of 18. The federal government pays a higher matching rate than under Medicaid in order to enhance state participation.

SCHIP is a block grant, providing capped federal funds to the states, allowing them to expand Medicaid, create a new program, or combine the two programs to cover children up to 200% of the federal poverty level.\(^4\) Twenty-three states expanded Medicaid, 15 created separate state programs, and 18 have combination programs.\(^4\)

SCHIP covers as many as three million children.\(^3\) Before SCHIP was enacted, only four states covered children in families living below 200% of the federal poverty level.\(^4\) Currently, 37 states plan to cover children up to 200% of the federal poverty level; five cover children up to 300%; and one state covers children up to 350% of the federal poverty level.\(^4\)

In January 2001, the Department of Health and Human Services approved three state CHIP waivers to allow New Jersey, Rhode Island, and Wisconsin to offer health insurance to parents of
children eligible under SCHIP or Medicaid. These were the first waivers of their kind to be granted under the federal/state children’s health program. The three states will receive enhanced federal funding to cover low-income families with children whose incomes exceed traditional Medicaid levels but are unable to afford private coverage.

ACP-ASIM CORE PRINCIPLES ON ACCESS

In October 2000, ACP-ASIM approved a set of core principles on health insurance coverage. The principles are not intended to be all-inclusive, covering all problems in the health care system. Rather, they highlight critical issues that need to be addressed by policy-makers as they consider proposals to reform the health care system. ACP-ASIM does not expect that any one particular legislative proposal will satisfy each of the core principles. However, the principles provide a benchmark from which to evaluate specific proposals (e.g., expansion of Medicaid and SCHIP). Several of the principles are relevant to a discussion of the merits of expanding Medicaid and SCHIP to provide coverage to more low-income families.

Principles on Coverage, Enrollment, and Eligibility

Core Principle #1 recommends expanding access to coverage with an explicit goal of covering all Americans by a specified date. The principle also recommends a uniform benefits package for all Americans. It recommends that coverage and benefits be continuous and independent of residence or employment status.

Core Principle #2 states that sequential reforms that expand coverage to targeted groups should be considered but such proposals should identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage; include a defined target date for achieving affordable coverage for all Americans; and include an ongoing plan of evaluation.

Core Principle #3 advocates mechanisms to encourage individuals who otherwise might voluntarily choose not to obtain coverage to participate in the insurance pool, using incentives to participate or disincentives to discourage non-participation. Despite Medicaid’s comprehensive set of services for low-income children, many parents feel deterred by complex eligibility requirements and a lack of basic information about where to enroll. Parents cite as problems limited hours and locations for enrollment and the amount of time needed to apply. Parents are also concerned about the stigma of being attached to the welfare system and the belief that applicants will be treated poorly by Medicaid workers.

The fourth Core Principle suggests that flexibility should be allowed for states to investigate different approaches to expanding coverage, controlling costs, identifying funding sources, and reducing barriers to access and quality. However, state-based approaches should contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to ensure portability and access to a basic benefit package. Medicaid and SCHIP have traditionally provided states with considerable flexibility in setting eligibility, benefits and provider payment levels.
**Recommendation #1:** ACP-ASIM believes that expansion of Medicaid and SCHIP to cover low-income families, both adults and children, represents an acceptable but sequential step toward achieving the goal of affordable health care coverage for all Americans. Expansion of Medicaid and SCHIP should be part of an overall sequential plan that would expand coverage in stages to all uninsured persons, resulting in all Americans having access to health insurance within a defined period of time. Federal and state lawmakers will need to address certain limitations in those programs in order for them to achieve the desired end of making affordable coverage available to all low-income adults:

A. The current eligibility standard for SCHIP and Medicaid, based on a variety of demographic or “categorical” requirements, should be replaced with a federally mandated standard based solely on income. The federal contribution to both programs should be increased to make it affordable for states to provide coverage to all individuals who fall within the national income eligibility level.

ACP-ASIM has proposed that Medicaid eligibility be extended to all adults and families with incomes at or below the federal poverty level, which would be combined with a program of refundable tax credits for persons with incomes between 100-150% of the federal poverty level. Others have proposed extending eligibility for both Medicaid and SCHIP to persons with incomes up to 150% of the federal poverty level. ACP-ASIM believes that further discussion is needed on how best to assure access to coverage for all low-income persons, including where to draw the line on an income eligibility limit for enrollment in Medicaid and SCHIP. We strongly support the concept, however, of establishing uniform and higher income eligibility requirements for both programs.

B. A minimum level of benefits should be mandated for both Medicaid and SCHIP.

Although federal law establishes some broad requirements relating to services that must be covered under Medicaid and SCHIP, there is considerable variation among the states on the specific benefits that are provided under Medicaid and SCHIP. As a result, benefits are not continuous and independent of residence. ACP-ASIM favors the development of an explicit, consensus driven process that would determine a minimum level of benefits for both programs, based on evidence of medical effectiveness. National requirements relating to income and covered benefits would ensure that eligible, low-income individuals are able to move freely, without worrying about qualifying for coverage in a new state or receiving less benefits. In ACP-ASIM’s analysis of the Oregon Health Plan, the College advocated for the identification of a minimum level of services below which a “Basic Health Plan” must not fall. The need for flexibility is outweighed by the need for a basic health plan, as evidenced by recent state activity. Arkansas allows children who may be eligible for Medicaid coverage to enroll in ARKids First, the state’s less generous child health program operated under a Section 1115 waiver, despite the Health Care Financing Administration’s instructions to end this practice. ACP-ASIM opposes giving states the option of waiving participation in Medicaid for a program with less generous benefits.
C. Medicaid/SCHIP outreach efforts to eligible persons should be increased, and Congress should require a simplified application process.

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**Principles on Financing**

Core Principle #6 advocates financing that is adequate to eliminate barriers to care. This Core Principle further advocates adequate and predictable financing for “critical access” institutions and providers, fair reimbursement levels for covered services, funding for the uninsured from the federal budget surpluses, and progressive financing (individuals with higher incomes should contribute more than those with lower incomes).

Physician participation in Medicaid has been hindered by low reimbursement rates. Medicaid fees were only 64% of what Medicare paid in 1998 for similar services. (13) Low payment rates might lead to more doctors opting out of caring for Medicaid patients. This sets a dangerous trend when enrollment in Medicaid has risen in 12 of the 21 states that represent three-quarters of the Medicaid population. (13) However, in response to low payment rates, state medical associations have been lobbying for rate increases. Because of these efforts, California and New York recently raised payment rates for several physician services and a cut in payments in Louisiana was halted. (13)

**Recommendation #2:** Expansion of Medicaid and SCHIP will not be successful in expanding access unless the reimbursement levels for physicians and other health care professionals are at least adequate to cover the costs of providing services to the covered population. This will require a substantial increase in Medicaid and SCHIP reimbursement levels in most states. ACP-ASIM supports increased reimbursement to physicians for services provided under Medicaid and SCHIP.

**Recommendation #3:** ACP-ASIM supports the 1115 waiver process, but urges that renewal requirements for waivers be flexible enough to provide for long-range planning with predictable and sufficient funding.

- **Principles on Patient Rights and Satisfaction**

Core Principle #7 advocates health care reform proposals that address sources of dissatisfaction with current systems, including 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 the physician-patient relationship, unnecessary or excessive administrative burdens in order to get claims paid, excessive documentation requirements, and lack of choice of insurance plans and physicians.

Core Principle #8 calls for proposals designed to reduce administrative and medical liability costs that do not improve access and quality of care. In addition, this Core Principle advocates research on information systems to make administration and financing of health care more
efficient; reforms to limit excessive medical liability costs; reforms that ensure that health care dollars go principally to patient care rather than to administrative costs; physicians devoting as much time as possible to patient care; and administrative and paperwork requirements that are not a barrier to timely care.

Core Principle #9 supports the patient’s right to choice of physician. It states that proposals should respect patient choice of primary care and specialty care physician; maintain patient/physician continuity; provide patients with prompt access to specialty care; make hospitalist use voluntary; require reasonable, but higher co-pay for open-ended access to a physician of the participants’ choice; and research ways to provide patients with quality measurements that will factor into their choice of physician.

Administrative hassles for physicians leave little incentive for physicians to continue seeing Medicaid patients. Medicaid managed care, while expanding access to care, has created a number of administrative obstacles. Patients and physicians must often deal with excessive paperwork, restrictions on access to specialty care, and micromanagement of clinical decision-making when they participate in the Medicaid program. Managed care programs often restrict patients’ ability to choose a provider and make it difficult to obtain specialty care. These barriers make it difficult for patients to form positive, lasting relationships with their physicians.

Recommendation #4: Congress, the Health Care Financing Administration, and state Medicaid agencies should work with the physician community and patient advocates to identify and ease unnecessary administrative and paperwork requirements that restrict choice of physician, micro-manage clinical decision-making, and divert physicians from direct patient care activities to filling out unneeded paperwork. Congress should enact reforms in the medical liability system, including a cap on non-economic damages.

Core Principle #10 states that 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. Each type of non-physician provider should have a defined level of responsibility. Appropriate use of non-physician providers, based on their skills and training and under the direction of a physician, can improve access to care in some cases. A number of non-physician health care providers, such as nurse practitioners and pharmacists, are able to have their services reimbursed directly by state Medicaid programs. Decisions on scope of practice of non-physician health care professionals are often made by state legislatures based on the political clout of the group seeking an expanded scope of practice, not based on evidence that the group members have the requisite training and skills. Expansion of the scope of practice of non-physicians, in the absence of evidence that they have the required skills and experience, can lower quality and increase costs.

Recommendation #5: ACP-ASIM supports the states’ right to determine non-physician scope of practice. However, state legislatures should make such decisions based on scientific evidence that non-physicians have the requisite skills and training to provide the desired scope of services. States should encourage models that emphasize collaboration between physicians and other health care professionals as part of a physician-directed team.
Core Principle #12 advocates reforms that have as a goal the elimination of disparities in the care of patients based on demographic, social, ethnic, racial, sexual orientation or gender differences. Proposals should address barriers to care in inner-city, rural and other underserved communities, and they should recognize that the lack of insurance is in itself a cause of disparities in the quality of care received.

**Recommendation #6**: Because lack of health insurance coverage has been shown to result in poorer outcomes, Congress should support expansion of Medicaid and SCHIP to all low-income individuals as part of a comprehensive strategy to eliminate disparities in the medical care available to such patients. Such expansion would particularly help reduce disparities in the care provided to low-income Latinos, women, African-Americans, inner city, and rural residents that are most at risk of being uninsured—and the ones most likely to benefit from expansion of Medicaid and SCHIP.

**Principle on Accountability**

Core Principle #13 states that health reform proposals should promote accountability at all levels of the system for quality, cost, and access. This Core Principle calls for incentives for physicians to participate in the design of accountability systems and advocates that decisions on medical necessity, coverage, and appropriateness of care be based on evidence of the clinical effectiveness of medical treatments as determined by physicians. It also advocates that all patients should have 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, and the right to be informed about how health plan policies will affect their ability to provide needed care.

The previous administration issued regulations to mandate that all patients enrolled in Medicaid and SCHIP be subject to certain consumer protections. The regulations would implement provisions of the Balanced Budget Act of 1997, which allowed states to enroll Medicaid beneficiaries in managed care plans without consent and without a waiver. However, Congress also included protections for beneficiaries, including restrictions on marketing, a requirement that enrollees have a choice of at least two plans, implementing a prudent layperson standard for emergency care, and assurances of access to specialists and quality of care. President Bush has put a 60-day hold on all regulations issued by Clinton during the last 60 days of his Administration.

**Recommendation #7**: ACP-ASIM recommends implementation of the consumer protection regulations for Medicaid and SCHIP enrollees without further delay.

ACP-ASIM’s final Core Principle (#14) urges the medical profession to embrace its responsibility to participate in the development of reforms to improve the health care system. The tenets of professionalism and the highest ethical standards should guide the medical profession’s approach to reforms. This monograph represents one part of ACP-ASIM’s overall
commitment to participation in the development of reforms to improve the health care system. Over the next year, the College will be issuing further policy proposals for expanding access, controlling costs, and assuring quality and accountability in the health care system.

CONCLUSION

Although Medicaid/SCHIP expansion is costly, it also has great potential to expand coverage to the uninsured. As noted previously, in 1999 ACP-ASIM proposed an incremental package of reforms that included expanding Medicaid to cover all uninsured adults living in poverty. The plan called for enhanced federal Medicaid matching funds; the cost was estimated at $50 billion over five years; and approximately 3.5 million previously uninsured adults were covered. The ACP-ASIM plan also called for refundable tax credits for individuals with incomes between 100 and 150% of poverty, funding for outreach services, and subsidies to help temporarily unemployed workers maintain COBRA coverage.

In a plan outlined in the January/February 2001 issue of Health Affairs it was proposed that Medicaid be expanded to cover an additional 25.4 million uninsured poor and low-income individuals. This plan would entail guaranteeing persons with incomes below 150% of the federal poverty level full access to comprehensive benefits without cost sharing or premium contributions; “almost-full subsidies for almost-full benefits” for those between 150 and 200 percent of poverty; and a gradually reducing subsidy for persons above 200% poverty, but below 300% of poverty.

Ninety-four percent of parents of children enrolled in Medicaid view it as a good program. By building on already existing programs that parents feel good about, coverage can be expanded more quickly and effectively. This would also avoid the creation of new bureaucracies, reduce start-up costs, and avoid further fragmentation of the health care system. Medicaid and SCHIP also already have contracts with providers and managed care organizations and an established method for collecting and matching funds by the federal government. Through careful planning, expansion of Medicaid and SCHIP could potentially reach millions of uninsured Americans. In order for such expansion to be successful, however, it will need to address the limitations on the existing programs described in this paper, particularly the lack of uniform eligibility and scope of coverage requirements, inadequate reimbursement to providers, complex enrollment procedures, excessive administrative hassles, and other program elements that act as barriers to care.
REFERENCES


1. Includes an explicit goal of all Americans being covered by adequate health insurance by a specified date:
   a. Includes a mechanism for determining scope of benefits.
   b. Includes a uniform minimum package of benefits for all.

2. Considers sequential reforms to expand coverage:
   a. A sequential plan identifies the subsequent steps, targeted populations, and financing mechanisms.
   b. A sequential plan identifies a target date for achieving affordable coverage for all Americans.
   c. A sequential plan identifies an ongoing plan of evaluation.

3. Includes strong incentives for participation in the health insurance pool or strong disincentives to discourage non-participation.

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.

5. Creates mechanisms to make prescription drugs more affordable. Does not allow formularies that are determined solely or principally on the basis of cost.

6. Financing should be adequate to eliminate barriers to care:
   a. Highest priority is assuring adequate financing for “critical access” institutions and providers with a higher burden of uncompensated care.
   b. 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.
   c. Substantial portion of federal budget surpluses should provide funds to expand health insurance coverage.
   d. Financing for public insurance programs should be progressive. Explicit means testing should be discouraged.

7. Should address sources of patient and physician dissatisfaction with the 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
### 8. Should be designed to reduce administrative and medical liability costs that do not improve access and quality of care:

- **a.** Public and private research bodies should support research on information systems to make administration and financing more efficient.
- **b.** Reforms should be enacted to limit excessive medical liability costs.
- **c.** Should include a description of mechanisms to assure that health care dollars are directed principally for patient care, not administrative tasks.

### 9. Patients should have a choice of physicians:

- **a.** Should be designed to respect the importance of patients being able to select a primary care and specialty care physician of their choice.
- **b.** Patients should be able to stay with the physician of their choice from year-to-year.
- **c.** Patients should have sufficient and prompt access to specialty care with a real choice of specialist.
- **d.** Use of hospitalists should not be mandated.
- **e.** 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.
- **f.** Research ways to provide patients with meaningful quality measurements that will factor into their choice of physician.

### 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:

- **a.** Should establish a defined level of responsibility, based on skills and training, for each type of non-physician provider.
- **b.** Physician-directed health care teams with sufficient built-in controls.

### 11. Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities.

### 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.

- **a.** Should be designed to address barriers to care in inner-city, rural and other underserved communities.
- **b.** Should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients.
13. **Should promote accountability at all levels of the system for quality, cost, access and patient safety:**
   a. Should include incentives for physicians and other health care professionals to participate in the design systems of accountability. (nonpunitive and educational approaches should be favored)
   
   b. 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.
   
   c. 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.
   
   d. 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.

14. **Medical profession must embrace its responsibility to participate in the development of reforms to improve the US health care system:**
   a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession’s approach to reforms.
   
   b. 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.
### Core Principles on Health Insurance Coverage

Comparison of Medicaid/SCHIP Expansion Proposal with ACP-ASIM Core Principles.

<table>
<thead>
<tr>
<th>Core Principle</th>
<th>Comparison</th>
<th>Concerns or Comments:</th>
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<tbody>
<tr>
<td>1. Includes an explicit goal of all Americans being covered by adequate health insurance by a specified date.</td>
<td>X Consistent: Inconsistent X Does Not Address 0</td>
<td>Targets poor and low-income individuals and families No specified date</td>
</tr>
<tr>
<td>1a. Includes a mechanism for determining scope of benefits.</td>
<td>X Consistent</td>
<td>Varies state-by-state—eligibility standard should be federally mandated based solely on income.</td>
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<tr>
<td>1b. Includes a uniform minimum package of benefits for all.</td>
<td>X Consistent: Inconsistent X Does Not Address 0</td>
<td>Does not provide coverage for all Benefits vary by state and income-level</td>
</tr>
<tr>
<td>2. Considers sequential reforms to expand coverage.</td>
<td>X Consistent: Inconsistent 0 Does Not Address 0</td>
<td>Starts with lowest income and slowly builds to approx. 300% of FPL</td>
</tr>
<tr>
<td>2a. A sequential plan identifies the subsequent steps, targeted populations, and financing mechanisms.</td>
<td>X Consistent: Inconsistent 0 Does Not Address 0</td>
<td></td>
</tr>
<tr>
<td>2b. A sequential plan identifies a target date for achieving affordable coverage for all Americans.</td>
<td>X Consistent: Inconsistent 0 Does Not Address 0</td>
<td></td>
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<tr>
<td>2c. A sequential plan identifies an ongoing plan of evaluation.</td>
<td>X Consistent: Inconsistent 0 Does Not Address 0</td>
<td></td>
</tr>
<tr>
<td>3. Includes strong incentives for participation in the health insurance pool or strong disincentives to discourage non-participation.</td>
<td>X Consistent: Inconsistent 0 Does Not Address 0</td>
<td>SCHIP provides “enhanced” matching funds to states, thereby encouraging participation Medicaid provides complete set of benefits (94% of parents felt it was a “good” program) With easily accessible application process, participation will be enhanced</td>
</tr>
<tr>
<td>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.</td>
<td>X Consistent: Inconsistent 0 Does Not Address 0</td>
<td>Considerable flexibility already in place, with regard to benefits, eligibility and provider payment. However, benefits need to be continuous and independent of residence.</td>
</tr>
<tr>
<td>5. Creates mechanisms to make prescription drugs more affordable. Does not allow formularies determined solely or principally on the basis of cost.</td>
<td>X Consistent: Inconsistent 0 Does Not Address X</td>
<td>Will need more funding in the future; rising prescription drug costs are squeezing states’ budgets.</td>
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<tr>
<td>6. Financing should be adequate to eliminate barriers to care.</td>
<td>X Consistent: Inconsistent X Does Not Address 0</td>
<td>Medicaid reimbursement levels need to be raised to encourage physician participation.</td>
</tr>
<tr>
<td>6a. Highest priority towards assuring adequate financing for “critical access” institutions and with a higher burden of uncompensated care.</td>
<td>X Consistent: Inconsistent 0 Does Not Address X</td>
<td>Need increased reimbursement levels.</td>
</tr>
<tr>
<td>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.</td>
<td>X Consistent: Inconsistent 0 Does Not Address X</td>
<td>Need increased reimbursement levels.</td>
</tr>
<tr>
<td>6c. Substantial portion of federal budget surpluses should provide funds to expand health insurance coverage.</td>
<td>X Consistent: Inconsistent 0 Does Not Address X</td>
<td></td>
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<tr>
<td>6d. Financing for public insurance programs should be progressive. Explicit means testing should be</td>
<td>X Consistent: Inconsistent 0 Does Not Address X</td>
<td></td>
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<tr>
<td>7. Should address sources of patient and physician dissatisfaction with the system:</td>
<td>X Consistent</td>
<td>Does Not Address</td>
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<tr>
<td>Micro-management of clinical decision-making</td>
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<td>Does Not Address</td>
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| 8. Should be designed to reduce administrative and medical liability costs that do not improve access and quality of care. | X Consistent | Inconsistent | Must identify and ease unnecessary administrative and paperwork requirements. |
| Public and private research bodies should support administration and financing more efficient. | Inconsistent | Does Not Address | |
| Reforms should be enacted to limit excessive medical liability costs. | Inconsistent | Does Not Address | Congress should enact reforms in the medical liability system, including a cap on non-economic damages. |

| 9. Patients should have a choice of physicians. | X Consistent | Inconsistent | Proposals should respect patient choice of primary care and specialty care physician. |
| Patients should have sufficient and prompt access to specialty care with a real choice of specialist. | Inconsistent | Does Not Address | Proposals should maintain physician/patient continuity. |
| Use of hospitalists should not be mandated. | Inconsistent | Does Not Address | |
| Requirements 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. | Inconsistent | Does Not Address | |
| Research ways to provide patients with meaningful quality measurements that will factor into their choice of physician. | Inconsistent | Does Not Address | State legislatures should make scope-of-practice decisions based on scientific evidence that non-physicians have the requisite skills and training. |
| 10a. Should establish a defined level of responsibility, based on skills and training, for each type of non-physician provider. | X Consistent | Does Not Address o | 
| 10b. Physician-directed health care teams, with sufficient built-in controls. | o Consistent | o Does Not Address o | States should encourage models that emphasize collaboration between physicians and other health care professionals as part of a physician-directed team. |
| 11. Provide incentives to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities. | X Consistent | o Does Not Address o | o Does Not Address o | 
| 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. | X Consistent | o Does Not Address o | Great flexibility in how states administer benefits, but there is still a need for a basic benefits package for all. |
| 12a. Should be designed to address barriers to care in inner-city, rural and other underserved communities. | X Consistent | o Does Not Address o | 
| 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 | o Does Not Address o | Expansion should help reduce disparities in the care provided to low-income Latinos, women, African-Americans, inner-city and rural residents that are most at risk of being uninsured. |
| 13. Should promote accountability at all levels of the system for quality, cost, access and patient safety. | X Consistent | o Does Not Address o | Consumer protections regulations need to be implemented. |
| 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). | o Consistent | o Does Not Address X | 
| 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. | o Consistent | o Does Not Address X | 
| 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. | o Consistent | o Does Not Address X | 
| 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 | o Does Not Address o | Enact proposed consumer protection principles (ordered by Clinton administration, on-hold by Bush administration). |
| 14. Medical profession must embrace its responsibility to participate in the development of reforms to improve the US health care system. | X Consistent | o Does Not Address o | 
| 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 | o Does Not Address o | 
| 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, economic and other differences. | X Consistent | o Does Not Address o |
ethnic, gender, sexual orientation or demographic differences.