ACP

American College of Physicians

INTERNAL MEDICINE | *Doctors for Adults®*

Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists, Updated 2008

American College of Physicians

A Position Paper

2008

Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists, Updated 2008

A Position Paper of the
American College of Physicians

This paper, written by Naomi Senkeeto, MA, was developed for the Health and Public Policy Committee of the American College of Physicians: J. Fred Ralston, MD, FACP, Chair; Molly Cooke, MD, FACP, Vice Chair; Charles Cutler, MD, FACP; Andrew A. Chang, Student; David A. Fleming, MD, FACP; Brian P. Freeman, MD, FACP; Robert Gluckman, MD, FACP; Mark Liebow, MD, FACP; Robert McLean, MD, FACP; Kenneth Musana, MB, ChB; Mark Purtle, MD, FACP; P. Preston Reynolds, MD, FACP; and Kathleen Weaver, MD, MACP with contributions from David C. Dale, MD, FACP (ACP President, ex officio); Joel S. Levine, MD, FACP (Chair, ACP Board of Regents), and Joseph W. Stubbs, MD, FACP (Chair, ACP Medical Service Committee). It was approved by the Board of Regents in January 2008.

How to cite this paper:

American College of Physicians. Achieving Affordable Health Insurance Coverage for all Within Seven Years: A Proposal from America's Internists, Updated 2008. Philadelphia: American College of Physicians; 2008: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

For questions about the content of this Position Paper, please contact ACP, Division of Governmental Affairs and Public Policy, Suite 700, 25 Massachusetts Avenue NW, Washington, DC 20001-7401; telephone 202-261-4500. To order copies of this Position Paper, contact ACP Customer Service at 800-523-1546, extension 2600, or 215-351-2600.

Executive Summary

The American College of Physicians (ACP) 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 according to the core principles.

This updated position paper, based largely on ACP's 2002 position paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists*, offers a framework for reform policies that would enable all Americans to have access to affordable health insurance coverage within the seven years. The College has reviewed the key reforms recommended in the 2002 paper and believes that they remain, with only modest revisions, a viable approach to making health insurance coverage available to all Americans. ACP also believes that reforms to expand coverage should be done in concert with changes in health care financing and delivery to improve outcomes and efficiency of care, such as the Patient-Centered Medical Home. The framework outlined in the paper represents a logical series of reforms necessary to achieve universal coverage. The recommended elements of reform are as follows:

Recommendation 1: The federal government should provide dedicated funding to states that have requested federal support for efforts to redesign their health care delivery programs to achieve measurable expansions of health insurance coverage, and to redesign health care financing and delivery systems to emphasize prevention, care coordination, quality, and use of health information technology through the Patient-Centered Medical Home.

Recommendation 2: States should have the option to expand Medicaid coverage to all residents up to 100% of the federal poverty level, with the additional cost of such expansion to be paid for by a dollar-to-dollar increase in the federal matching program. States should also have the option to unify SCHIP and Medicaid coverage so that families are covered under a single program.

Recommendation 3: Advance, refundable, and sliding scale tax credits should be made available to uninsured working Americans with incomes up to 200% of the federal poverty level. The tax credit should provide a premium subsidy equal to what the federal government now provides to its own employees.

Recommendation 4: Tax credit recipients should have the options of buying coverage through state purchasing group arrangements modeled after the Federal Employees Health Benefits Program, giving them the same types and variety of health plan options now available only to federal employees, or from qualified nongroup insurers. Plans that participate in the purchasing group would be required to agree to uniform new federal rules on risk-rating and renewability as a condition of participating in the program.

Recommendation 5: Small employers should have new options for obtaining coverage, including access to the variety and types of health plans offered to federal employees.

Recommendation 6: Once coverage is affordable and available, national and/or state-based health plans should ensure that all individuals participate in the plan by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.

Recommendation 7: An expert advisory commission should be created to recommend a core set of benefits that participating health plans will be encouraged to offer, as well as ways to expand coverage to those with incomes above 200% of the federal poverty level.

Through this framework, ACP believes that all Americans would have access to affordable coverage from Medicaid or SCHIP if they are within the qualifying income levels, from health plans that meet the purchasing groups' qualifications established under our proposal or from an approved state-based 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 not to obtain coverage.

This policy monograph is intended to be a conceptual and analytical framework that would serve as the basis for further analysis, debate, and action. ACP encourages further analysis of the framework proposed in this policy monograph, 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, sustainable financing.

This policy monograph acknowledges that expanding health insurance coverage will not by itself ensure that individuals have access to high-quality medical care. Other reforms to break down barriers to high-quality medical care will be required; however, this policy monograph focuses 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 prerequisite for individuals to be able to have access to quality medical care. ACP 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.

This policy monograph makes the case that reforms that build on existing sources of coverage can achieve affordable coverage for all. Rather than being half-measures, as some have suggested, the reforms recommended in this policy monograph represent a dramatic change in the way that individuals obtain coverage. For the first time, everyone who needs coverage but does not have access through their employer would have access to a subsidized health insurance program; every participating health plan would be required to offer a "benchmarked" package of benefits, including preventive services; every participating 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 Americans would have a much greater choice of health plans and more continuity of care than is typical in today's fragmented health care system.

Introduction

The American College of Physicians is the largest medical specialty society in the United States, with over 124,000 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 to all Americans.

There were roughly 47 million Americans without health insurance in 2006 (15.8%), up from roughly 43.5 million (14.9% of the population) in 2004 (1). The number of uninsured has exceeded the cumulative population of 24 states plus the District of Columbia. The percentage of Americans with employer-based health coverage has also decreased to 59.7% in 2006 from 63.6% in 2000, continuing a recent trend (1). As the numbers rise, lack of health insurance is beginning to affect middle- and higher-income Americans. Over the past few years, the increase in uninsured persons has primarily occurred among young adults, whites, and native-born Americans, demonstrating that lack of insurance is not exclusively affecting racial and ethnic minorities or noncitizens, as previously thought.

The situation looks even worse in light of a 2005 study by The Commonwealth Fund that found that nearly 16 million Americans are underinsured, meaning that their insurance did not adequately protect them from catastrophic health care expenses. Underinsured adults are almost as likely to go without necessary medical care or to take on medical debt as those who are uninsured.

The U.S. has historically tolerated having large numbers of people without health insurance. This is in stark contrast to virtually every other developed country, in which guaranteed health insurance is provided either by the state or through employers, with government backup for the unemployed. Options for decreasing the number of uninsured persons continue to be debated in the U.S., with little consensus on the best and most affordable strategy. Proposals at both national and state levels emphasize making the individual insurance market more affordable. Some would expand eligibility for public programs, and others propose a combination of private and public approaches. Difficult economic times and soaring health care costs have further compromised significant health care reform.

ACP's proposed framework for expanding access to health insurance coverage, as originally published in a 2002 position paper *Achieving Affordable Health Insurance Coverage for All Within Seven Years: A Proposal from America's Internists*, has garnered widespread support (2). In both 2003 and 2007, Representatives Marcy Kaptur and Steven C. LaTourette introduced the Health Coverage, Affordability, Responsibility and Equality (HealthCARE) Act, which they noted is based in large part on the College's proposal. Additionally, in January 2007 the Health Coverage Coalition, a coalition of 16 health care organizations, announced a two-phase proposal that has many of the elements that are also in the College's health coverage expansion framework. The proposal would expand health care coverage for low-income Americans, the first for children and the second for adults, by increasing enrollment in public programs and providing tax credits. If fully enacted, the proposal would cover up to one half of the country's uninsured residents. Coalition members include the American Association of Retired Persons, American Hospital Association, American Medical Association, America's Health Insurance Plans, Families USA, Pfizer Inc., Johnson & Johnson, U.S. Chamber of Commerce, and the United Health Foundation. A key element of the coalition's proposal is a competitive grant program that would enable states to experiment with new,

innovative approaches to expand health coverage. States awarded the grant would receive new funding, over and above federal funds currently given to the states for Medicaid and SCHIP. The second phase of the proposal would allow states to expand Medicaid eligibility to cover all adults with incomes below the federal poverty level (FPL) ($15,769 in 2006 for a family of three with one adult under age 65 years and two children) (2). Family status would be eliminated as an eligibility requirement, and coverage decisions would be based solely on financial need. Additionally, adults with incomes between 100% and 300% of the FPL would receive a tax credit to help them buy insurance, either through an employer-sponsored or state-sponsored insurance system. The proposal would also provide federal grants to states to cover high-risk populations.

ACP Core Principles on Access

The framework proposed in this policy monograph is 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 several 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. 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 policymakers as they consider proposals to reform the health care system. ACP 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, such as expanding access to coverage, and serve as a foundation for recommending legislative initiatives on the subject.

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 and 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 that such proposals should 1) identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage; 2) include a defined target date for achieving affordable coverage for all Americans; and 3) 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 for non-participation.

Core Principle 4 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. State-based approaches should contribute to the overall goal of providing all Americans with access to affordable coverage.

Core Principle 6 states that reimbursement levels for covered services must be fair and adequate to reduce barriers to care and enhance participation of physicians (3).

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. A detailed discussion of implementation strategies and the rationale for the recommended reforms follow the summary.

> **Recommendation 1: The federal government should provide dedicated funding to states that have requested federal support for their efforts to redesign their health care delivery programs to achieve measurable expansions of health insurance coverage, and to redesign health care financing and delivery systems to emphasize prevention, care coordination, quality, and use of health information technology through the Patient-Centered Medical Home.**

States should have the ability to opt out of any national framework for universal coverage by establishing their own programs for expanded coverage and to redesign health care delivery and financing to emphasize prevention, care coordination, quality, and use of health information technology through the Patient-Centered Medical Home (PCMH), subject to federal guidelines and standards. States should be required to show that they can achieve enrollment in state-approved coverage (private health plans or public programs) that is at least equal to the coverage that would occur without a waiver, taking into account the number of insured individuals, covered benefits, access to participating health care providers, and costs to the consumer. In addition, a state should have to show that, compared with state policy without a waiver, no Medicaid or SCHIP beneficiary would lose services or eligibility or be subject to increased costs, using procedures employed to identify less restrictive methodologies under Sections 1931(b) and 1902(r)(2) of the Social Security Act.

It is widely believed that the current method of health care delivery in the United States, which emphasizes episodic treatment for acute care through private health insurance and governmental programs, is not optimally meeting the health care needs of patients with chronic diseases.

In January 2006, the College proposed a fundamental change in the way that primary care is delivered and financed (4). The PCMH model envisions physicians in practices that provide comprehensive, preventive and coordinated care centered on patients' needs, using health information technology and other process innovations to ensure high-quality, accessible, and efficient care. Practices would also be accountable for results based on quality, efficiency, and patient satisfaction measures. In the PCMH, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the principles of the PCMH. Rather than being a "gatekeeper" who restricts patient access to services, a personal physician leverages the key attributes of the PCMH to coordinate and facilitate the care of patients and is directly accountable to each patient. Personal physicians advocate for and provide guidance to patients and their families as they negotiate the complex health care system. Studies of the medical home model indicate that a medical home provides better effectiveness, increased efficiency, and more equitable care to individuals and populations while lowering the overall costs of care (4).

The College's PCMH model includes a series of recommendations for reforming payment policies, including new models for paying physicians for coordinating care for patients with chronic diseases; increased payment for office visits and other evaluation and management services; separate payment for e-mail consultations for nonurgent health issues to reduce the need for

face-to face visits; and additional payments to physicians who use electronic health records to improve quality.

The use of Health Information Technology plays an essential role for a successful PCMH model. Such support systems have been shown to offer the most effective way to keep track of patients' health care needs, communicate with patients effectively and efficiently, and provide evidence-based clinical approaches to medical care. The College strongly believes that linking care coordination with support systems will result in overall quality improvement and enhanced communication access.

States approved for federal grant support to design their own health care reforms would receive federal contributions equal to anticipated federal expenditures, on behalf of state residents under age 65, through Medicaid, SCHIP, and other provisions of this legislation, including federal grants under this legislation and the premium subsidy program that otherwise would have applied to the state. In addition, a state would be able to choose to open its waiver program to Medicare beneficiaries under age 65. In a state exercising this option, when a beneficiary voluntarily elects to participate in the state system, the state would receive a federal contribution equal to the expected Medicare expenditure for that beneficiary.

Further, the Secretary of Health and Human Services should negotiate a contract with each waiver state specifying state coverage objectives, which should include (but need not be limited to) the number or percentage of state residents without health insurance, the benefits and costs of health coverage received by state residents under the waiver, and the access to care received by state residents under the waiver. The Secretary would have the ability to withhold up to 2% of each state's allotment for a given year, pending the state's demonstration that it has met its objectives for the year. If the state has not met its objectives, the withheld allotment would be provided promptly to the state after it and the Secretary agree on an action plan for meeting coverage objectives in the future. In addition, the Secretary would have the ability to award a bonus payment, up to 2% of the state's grant amount, if the state exceeds its objectives for the year. Such bonuses could be spent for any health-related purpose.

Recommendation 2: States should have the option to expand Medicaid coverage to all residents up to 100% of the federal poverty level, with the additional cost of such expansion to be paid for by a dollar-to-dollar increase in the federal matching program. States should also have the option to unify SCHIP and Medicaid coverage so that families are covered under a single program.

States should have a new option to provide "need-based" Medicaid eligibility. A state exercising this option should cover residents based simply on household income below a percentage of the FPL chosen by the state, which may not exceed 100%. The standard federal matching program for a state's entire Medicaid program should increase through multiplication by a number above 1, determined as described below, if the state does all of the following: extends need-based Medicaid to 100% of the FPL; applies standard streamlining and outreach measures to all need-based eligibles, applicants, and beneficiaries; and maintains eligibility categories for residents under age 65 that were in effect under state law as of July 1, 2003.

- Amount of enhanced FMAP. The Secretary should set the number for enhanced FMAP at a level above 1 that, in the Secretary's judgment, would compensate states as a whole for the increased program costs that would result from full implementation of this option nationwide up to 100% of the FPL.

- Standard streamlining and outreach measures should include application and retention procedures (such as short forms that can be mailed in) used by the majority of state SCHIP programs during the preceding year and outreach efforts proportional in scope and reasonably expected effectiveness to those used by the state during a similar stage of implementing its SCHIP program.
- Partially enhanced match. If a state meets all the requirements for enhanced FMAP, except that needs-based Medicaid is extended to a percentage of FPL below 100, then the state should have a proportionate enhancement to its standard FMAP. For example, a state extending needs-based Medicaid to 66% FPL would receive two thirds of the maximum possible increase to its FMAP.

In addition, states should have the option to receive matching funds at the SCHIP rate without any federal cap that applies to nonwaivered SCHIP coverage. A state exercising this option should be required to provide all eligible children who apply for coverage with services described in the state SCHIP plan when medically necessary. To exercise this option, a state should also agree not to deny children eligibility under SCHIP for reasons forbidden by Medicaid (such as residence in a particular part of a state, enrollment caps, waiting lists, or application for coverage after a particular date). Federal caps should continue to apply to SCHIP coverage furnished pursuant to waivers issued under either Section 1115 or Title 21. The Secretary should set such caps for a state on the basis of the expected proportion of which waivered spending would have comprised the state's allotment if its SCHIP program had remained capped. Because a state that would exceed its allotment could then opt for uncapped federal funds, a state's unspent SCHIP allotments should no longer be redistributed for one year to other states before such allotments revert to the Treasury.

Recommendation 3: Advance, refundable, and sliding scale tax credits should be made available to uninsured working Americans with incomes up to 200% of the federal poverty level. The tax credit should provide a premium subsidy equal to what the federal government now provides to its own employees.

Premium subsidies should be made available to uninsured individuals and families under age 65 for whom all of the following are true: 1) Family income is at or below 200% of the FPL; 2) they are ineligible for Medicaid and SCHIP coverage; 3) they either lack access to insurance offered by a current employer or could enroll in such employer-sponsored insurance for a cost to the worker that exceeds 5% of household income; 4) they have applied for subsidies within 60 days of receiving notice (provided pursuant to procedures developed by the Secretary) of potential eligibility for premium subsidies; and 5) they are not enrolled in Medicare, the Federal Employees Health Benefit Program (FEHBP), or health care systems for members of the U.S. military or veterans.

The premium subsidy should be delivered as an advanced, refundable tax credit, in a manner similar to that provided in the Trade Adjustment Assistance (TAA) bill that passed the Congress in 2002. As with TAA credits, advance amounts should be subtracted from credit amounts determined at the end of the tax year, but such year-end credits would not be reduced below zero under any circumstances. The Secretary of the Treasury would be authorized to develop appropriate measures to deter, detect, and punish fraudulent efforts to obtain advance credits for which households are ineligible, which should include (but

need not be limited to) information returns for insurers and households receiving advance payments.

The tax credit should cover the standard percentage of premiums funded by the federal government for federal employees who enroll in the FEHBP, in coverage that is not subject to the FEHBP premium subsidy cap. As with FEHBP, the credit would increase proportionately as premiums rise, as long as the premium remained below a capped level. The cap for each state should be set by its pool operator (see Recommendation 4 below) and should equal or exceed the premium charged by the most highly subscribed plan among federal employees. As with FEHBP, subsidy recipients enrolling in a plan with a premium above the capped level should pay the full balance of the premium. These credit percentages, amounts, and caps would apply, regardless of which mechanism is used by the tax credit recipient.

Ineligibility for Medicaid and SCHIP should be established using screen and enroll requirements used under SCHIP for Medicaid-eligible children. However, such procedures should not apply to tax credit applicants whose income and household characteristics make them ineligible for their state's Medicaid and SCHIP programs. In addition, application procedures from SCHIP (rather than Medicaid) should initiate the screening and enrollment process and be for the remainder of that process to the extent possible.

The Secretary should provide a supplemental subsidy for tax credit beneficiaries with incomes at or below 150% of the FPL, using amounts, percentages, and delivery and allocation mechanisms that compensate for such beneficiaries' reduced purchasing power, relative to average federal employees. Mandatory funding for supplemental subsidies should equal the sum of five percentage points of additional premium subsidy for each individual who uses the tax credit to enroll in coverage.

Eligibility for advance payments of credits and supplemental subsidies should be established by issuance of certificates by any agency that determines income eligibility for SCHIP. If an applicant's prior year income (as reported on federal income tax forms) qualifies for the credit, the applicant should be income-eligible for the credit. If an applicant's prior year income does not qualify, the certificate-issuing agency should determine income eligibility using standard SCHIP procedures in that state. Federal grants should fully compensate such agencies for reasonable administrative costs incurred in issuing certificates, issuing findings with respect to supplemental subsidies, or making income determinations that exceed their usual duties. As with most SCHIP programs, income-eligibility should be granted for a continuous period of 12 months, without regard to changes in household income taking place after eligibility is determined.

Certificate-issuing agencies should determine eligibility for advance credits promptly, without delays based on pending screen and enroll procedures. Individuals initially enrolled in plans offered to tax credit recipients who are later found eligible for Medicaid or SCHIP, based on screen and enroll procedures, should move to the applicable Medicaid or SCHIP plan. To prevent states from shifting costs into this new tax credit system by eliminating previously available Medicaid and SCHIP coverage, a state's residents should qualify for tax credits only if their state maintains Medicaid and SCHIP eligibility for persons under age 65.

Recommendation 4: Tax credit recipients should have the option of buying coverage through state purchasing group arrangements modeled after the Federal Employees Health Benefits Program, giving them the same types and variety of health plan options now available only to federal employees, or from qualified nongroup insurers. Plans that participate in the purchasing group would be required to agree to uniform new federal rules on risk-rating and renewability as a condition of participating in the program.

Insurance pools should be established through which premium subsidy recipients would have the option to purchase private or group coverage. Each state should be allowed to choose whether to run a pool or to contract with the Office of Personnel Management (OPM) or its designee to run the pool for state residents. The purchasing pools should have defined statutory functions similar to the way that the federal government serves as a purchasing group for the FEHBP. Such functions should include offering one-stop shopping for group health insurance, and limiting participating insurers to those that are able to negotiate bids and terms with insurers, provide consumers with comparative information on plans, assist in enrolling individuals into plans, collect and process premiums, reconcile each plan's aggregate premium payments and claims costs from year to year, and offer customer service to enrollees. A state should be able to contract with a private entity to operate its pool, provided that the entity meets requirements established by the Secretary.

To participate in such a pool, a health plan should be licensed in the applicable state (or be a FEHBP-participating national indemnity plan exempt from state regulation under FEHBP); should provide requested information, described below, to pool operators; and should offer coverage in one of the following three categories:

1) Benchmark coverage. Such coverage should have benefits not less than, and out-of-pocket cost-sharing not greater than, one of the following:
   a) The most highly subscribed FEHBP plan among federal employees during the prior year
   b) Nonwaivered Medicaid or SCHIP coverage in the state *or*
   c) The most highly subscribed plan in the state among either state employees or commercial, non-Medicaid HMO enrollees during the prior year.
2) Benchmark-equivalent coverage. To qualify as benchmark-equivalent, a plan should:
   a) Have an aggregate actuarial value not less than a benchmark plan *and*
   b) Cover the most recent set of essential benefits recommended by an expert Commission and adopted by Congress.
3) Alternative coverage should offer benefits not less than, and out-of-pocket cost-sharing not greater than, an FEHBP fee-for-service or HMO plan that does not provide benchmark coverage.

As with FEHBP, premiums should not be risk-rated for pool enrollees, and participating plans should not decline coverage for subsidy recipients enrolling through the pool. The Secretary should develop, and pool operators should use, age-based and/or other specific risk adjustment mechanisms that, without affecting enrollee premium payments, effectively compensate plans for higher-

cost enrollees. Under such an approach, the tax credit enrollee's premium share should be based on the state's total risk distribution, including both pool participants and other state residents. If a plan's tax credit enrollees depart from that state average, federal tax credit premium payments to the plan should rise or fall accordingly.

Pool operators should offer each tax credit beneficiary a choice of at least two benchmark or benchmark-equivalent plans with a premium at or below the cap and coverage of essential services and cost-sharing. Premium payments to such plans that are needed to keep out-of-pocket cost-sharing for individuals with limited ability to pay within applicable limits should not be taken into account in determining premiums paid by enrollees or in determining the pool's cap. To encourage plan participation, permitted profit margins should be 2% (nearly twice the standard 1.1% FEHBP profit margin) during the first three years of each pool's operation. After that, pool operators should be allowed to revise profit margins, which may not fall below margins for FEHBP plans and may not exceed a multiple of standard FEHBP profit margins established by the Secretary. Pool operators should be authorized and federally funded to encourage plan participation, if necessary, with stop-loss coverage and reinsurance above levels otherwise offered in the state.

Federal grants to states should pay other necessary pool administrative expenses. If a state elects to have OPM administer a pool for the state's residents, OPM should receive the federal grants that would have gone to the state for pool administration. OPM should take all steps needed to ensure that FEHBP beneficiaries under current law do not have their coverage affected by new enrollees under this Act. Such steps should include (but need not be limited to) separate risk pools, separate contracts with plans, and separately negotiated premiums. ("Separate" means separate from current FEHBP enrollment categories.) FEHBP plans that do not opt out should participate in this new program. OPM should also be allowed to contract with plans that do not participate in FEHBP, but only if necessary to offer tax credit beneficiaries the above-described choice of plans covering essential benefits. OPM should promulgate, subject to Administrative Procedure Act notice and comment procedures, a standard set of terms and conditions that applies to states that contract with OPM for this purpose.

To be eligible to receive tax credits in the individual market, a health plan should be required to abide by applicable state regulation of the individual market as well as conditions of participation developed by the Secretary to eliminate barriers to affordable coverage. Such conditions should include, but need not be limited to, guaranteed renewability without premium increases based on changed individual risk; and limits on risk rating. In addition, the Secretary should develop conditions of participation for plans in the individual market that ensure that plans provide to pool operators, and consumers receive from pool operators, the information described below before selecting a plan; and detect, deter, and punish marketing fraud by insurers.

In a family with one or more members enrolled in a capitated Medicaid or SCHIP plan and one or more members qualifying for tax credits, the family should have the option to enroll all family members in the Medicaid or SCHIP plan. The premiums charged to tax credit recipients should be based on the Medicaid or SCHIP program's capitated payments for adults and children, whichever applies, plus reasonable administrative costs.

To serve tax credit beneficiaries using the mechanisms described above (pools, individual market, Medicaid, and SCHIP), plans should, in a uniform and easily comprehensible manner that allows for informed comparisons by consumers, provide or make it possible for pool operators to provide information

about covered benefits, costs, provider networks, and quality; the amount and proportion of health insurance premium payments that go directly to patient care; and the plan's coverage rules (including amount, duration, and scope limits) and out-of-pocket cost-sharing (both inside and outside plan networks, including estimates of balance billing liabilities for non-network care) for all essential services included in the benefits package, which should be prominently identified as such to the consumer. To the extent possible, consumer information should be based on the model FEHBP uses with federal employees.

Subsidies should be allowed to be used to enroll persons in employer-sponsored insurance (ESI) in two different contexts. First, credits could purchase ESI offered by a current employer of the tax credit recipient or a family member of such recipient. In that case, credit amounts should be based, not on the full premium, but on the worker's share of the premium. For example, someone qualifying for a 60% tax credit could use the credit to cover 60% of the worker's premium share for ESI. Second, subsidies could be used to purchase ESI from former employers who volunteer to provide coverage not legally required or who offer coverage through COBRA or state mini-COBRA laws. With former employers, subsidies should be based on the full premium amount charged by the volunteering former employer or permitted under such laws.

Recommendation 5: Small employers should have new options for obtaining coverage, including having access to the variety and types of health plans offered to federal employees.

During annual open enrollment periods, small firms with 2 to 100 employees should have the option of purchasing group coverage for their workers and dependents, including persons ineligible for tax credits, through the market-based health insurance pool applicable to their state. Premiums should be the same amount as those for tax credit recipients. As with tax credit recipients, plans participating in the pool should not be allowed to decline coverage to small business enrollees. If small business employees who do not receive tax credits and who enroll in a particular plan have a collective risk level that exceeds the statewide average, the Secretary should provide the plan with small business bonus payments needed for pool operators to compensate for such increased risk, using risk-adjustment methods described above. Pool operators correspondingly should reduce payments to plans with such a risk level that falls below the statewide average. The Secretary should develop guidelines for pool operators to use in serving small employers, modeled after existing, successful, longstanding small business purchasing cooperatives, including administratively simple methods for small employers and licensed insurance brokers to participate.

The Secretary should establish and conduct, directly or through one or more public or private entities (which can include licensed insurance brokers), a health insurance information program to educate small businesses about the option to participate in market-based health insurance pools. Such program should also educate small firms about the benefits of health insurance to small employers, including tax benefits, increased productivity, and decreased turnover; small employers' current rights in the marketplace under Federal and State health insurance reform laws; and the tax treatment of insurance premiums. Such sums as may be necessary for the small business health information program and small business bonus payments should be authorized.

Within one year of adoption of this legislation, the Secretary should send to Congress a report with recommendations for permitting affinity groups that are not employment-related to participate in the pool.

Recommendation 6: Once coverage is affordable and available, national and/or state-based health plans should ensure that all individuals participate in the coverage plan by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.

Short of a single-payer system sponsored by either the federal government or the state, the only way to cover all Americans is by applying individual mandates, employer mandates, or a combination of both. Without mandates, the College believes that achieving universal coverage nationally or in a state is unlikely.

Ideally, the federal government, states, employers, and individuals should share financial responsibility for the cost of health insurance; however, Congress and/or each state should decide the best approach for its residents. Employer mandates could include either requiring employers to provide insurance to their employees or taxing employers who do not provide coverage and having their employees participate in insurance pools or public plans.

Individual mandates should not cause financial hardships to residents. Congress and/or states should supply affordable premiums and adequate public subsidies to offset costs for low-income residents. Purchasing pools may be necessary to dilute the burden for those with a chronic or debilitating condition.

Recommendation 7: An expert advisory commission should be created to recommend a core set of benefits that participating health plans will be encouraged to offer, as well as ways to expand coverage to those with incomes above 200% of the federal poverty level.

Congress should establish a National Advisory Commission on Expanded Access. The advisory commission should have several major charges: 1) to assess the effectiveness of programs designed to expand coverage or make coverage affordable to the otherwise uninsured, identifying both program accomplishments and needed improvements; 2) to make periodic recommendations about benefits and cost-sharing to be included in health coverage for various groups, taking into account the special health care needs of children and of people with disabilities, differential ability to pay for services out of pocket among various populations, incentives for efficiency and cost-control, preventive care, disease management services, and other factors; 3) to recommend mechanisms to discourage individuals and employers from voluntarily opting out of insurance coverage; 4) to recommend mechanisms to expand coverage to uninsured individuals with incomes above 200% of the FPL; 5) to recommend automatic enrollment and retention procedures and other measures to increase coverage among those eligible for assistance; 6) to review the relationship between federal and state roles and responsibilities with respect to health coverage and recommend improvements; and 7) to analyze the size, effectiveness, and efficiency of current tax and other subsidies for health coverage and recommend improvements.

The Commission should be tasked with producing the following: 1) annual reports to Congress and the President addressing the above topics, plus others the Commission deems relevant; 2) biennial reports with recommendations concerning essential benefits and maximum out-of-pocket cost-sharing (for the general population and for individuals with limited ability to pay, the latter of which may not impose costs in excess of those permitted under SCHIP) for coverage options, including statutory language, which would be subject to approval or rejection by Congress without amendment, using the procedures for

recommendations of military base-closing commissions; and 3) by no later than four years after the creation of the commission, a report recommending policies to cover uninsured individuals with incomes above 200% of FPL and changes to the policies enacted through this legislation, both of which should include automatic enrollment and retention procedures. The latter report should include statutory language that would move directly to the House and Senate floors, where the language could be amended. Commission decisions about the contents of these reports should require votes in favor by at least 60% of all Commission members.

The House and Senate majority and minority leaders should each appoint four members to the commission, and the Secretary of HHS should appoint one member, to include consumers, state officials, economists, health care professionals and providers, consumer advocates, other stakeholders, and experts on health insurance and the uninsured. The Commission should choose its own chairman. Funding should be authorized and appropriated for staff and Commission members.

Impact of ACP's Recommendations

According to a 2004 analysis of the College's health care reform proposal by Kenneth E. Thorpe of Emory University, The Health Coverage, Affordability, Responsibility and Equity Act, which is based on the above-outlined recommendations, was estimated to expand coverage to approximately 14 to 21 million out of the 45.8 million uninsured persons at the time he prepared his analysis (5). Through fully federally funded state expansions of Medicaid to all individuals with incomes at or below 100% FPL, states would have strong incentives to enroll as many eligible uninsured persons as possible. As states would generate substantial financial savings for each previously uninsured adult who enrolls in Medicaid (through reduced state and local taxes levied to support health care for the uninsured), over time Medicaid enrollment could reach 90% of all eligible adults (5). Additionally, transitioning SCHIP from a capped entitlement program to an entitlement program similar to Medicaid would enable states to enroll all eligible children without concern about federal caps or funding limits. Finally, the tax credit premium subsidies proposed by ACP would enable lower-income persons to buy into a purchasing program modeled on the FEHBP.

Dr. Thorpe's analysis confirms that these steps would cover most of the most vulnerable persons—low-income people (below 200% of the Federal Poverty Level) who do not meet SCHIP and Medicaid eligibility requirements and do not have access to affordable coverage through an employer. Although these measures would fall short of the College's goal of insuring *all* persons, ACP's proposal, as noted above, includes a recommendation for an Advisory Commission to recommend additional legislative steps that Congress could take to extend coverage for persons with incomes above 200% of the FPL, with the goal of extending coverage to all remaining uninsured persons. The College's proposal, as updated in this monograph, also includes a new recommendation to bring all persons into the coverage pool through individual mandates, employer mandates, automatic enrollment in a public program, or some combination of these approaches, as well as new options for states to expand coverage to the uninsured. The College believes that these combined approaches will make affordable coverage available to almost all persons who currently lack coverage.

Conclusion

The American College of Physicians firmly believes that a health care system that provides affordable, high-quality, patient-centered health care to all Americans is within reach, provided that the will to explore new ideas and strive for consensus exists. ACP is confident that the framework outlined in this policy monograph can succeed where other health reform proposals have failed. ACP's framework offers robust incentives and relies on choices, competition, and financial incentives for states, small employers, insurers, and individuals to make affordable health insurance coverage available to all Americans.

References

1. **US Bureau of the Census.** Income, Poverty, and Health insurance Coverage in the United States: 2006. U.S. Dept. of Commerce (P60-233), August 2007. Accessed on August 29, 2007 at www.census.gov/prod/2007pubs/p60-233.pdf.
2. **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, 2002.
3. **Providing Access to Care for All Americans: A Statement of Core Policy Principles.** American College of Physicians–American Society of Internal Medicine, 2001.
4. **The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care.** American College of Physicians. 2006.
5. **Thorpe, Kenneth E.** Estimated Federal Costs and Newly Insured Associated with the HealthCARE Act of 2003 (S.1030/H.R.2402). 2004.

ACP

American College of Physicians

internal medicine | *Doctors for Adults®*

Product #501281200