REPORT 3 OF THE REPORT OF THE COUNCIL ON MEDICAL SERVICE (I-07)
State Efforts to Expand Coverage to the Uninsured (Resolution 136, A-07)
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2007 Annual Meeting, the House of Delegates referred Resolution 136, which asks "that in the development of future American Medical Association (AMA) policy concerning efforts of individual states to reform their health systems, that the following guiding principles be given consideration in the development of a system of metrics that can be used to evaluate specific proposals: (1) Coverage - Health care coverage for state residents should be universal, continuous, portable, and mandatory; (2) Benefits - An essential benefits package should be uniform and include behavioral health; with the option to obtain additional benefits; (3) Delivery system - The system must ensure choice of physician and preserve patient/physician relationships. The system must focus on providing care that is safe, timely, efficient, effective, patient-centered and equitable; (4) Administration and governance - The system must be simple, transparent, accountable, efficient, and effective in order to reduce administrative costs and maximize funding for patient care. The system should be overseen by a governing body that includes regulatory agencies, payers, consumers, and care givers and is accountable to the citizens; and (5) Financing - Health care coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency and efficiency. It should emphasize personal responsibility as well as societal obligations, due to the limited nature of resources available for health care."

Consistent with the comprehensive nature of Resolution 136 (A-07), many state proposals for covering the uninsured are focusing on coverage options, benefit packages, the delivery system, administration and governance, and financing.

Resolution 136 (A-07) provides the framework for the Council's analysis of state reform efforts. This report summarizes state reform efforts to expand coverage to the uninsured; reviews AMA activity on covering the uninsured; provides a comparison of AMA policy with the actions proposed in Resolution 136 (A-07); highlights examples of state reform; and includes a series of principles that are highly consistent with those proposed in the resolution for guiding the evaluation of state efforts to cover the uninsured.

In particular, the Council modified the principles proposed in Resolution 136 (A-07) in accordance with previously established AMA policy for covering the uninsured. In 2007, the AMA embarked on a multi-year campaign, "Voice for the Uninsured," to raise awareness about the uninsured and the AMA health system reform proposal, which is primarily a federal strategy. Nevertheless, the AMA strongly supports state efforts to cover the uninsured. The principles recommended in this report provide guidance to states interested in expanding coverage and patient choice.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - I-07

Subject: State Efforts to Expand Coverage to the Uninsured (Resolution 136, A-07)

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee J (Liana Puscas, MD, Chair)

At the 2007 Annual Meeting, the House of Delegates referred Resolution 136, which was introduced by the New Mexico Delegation and American Association of Public Health Physicians. Resolution 136 (A-07) asks "that in the development of future American Medical Association (AMA) policy concerning efforts of individual states to reform their health systems, that the following guiding principles be given consideration in the development of a system of metrics that can be used to evaluate specific proposals: (1) Coverage - Health care coverage for state residents should be universal, continuous, portable, and mandatory; (2) Benefits - An essential benefits package should be uniform and include behavioral health; with the option to obtain additional benefits; (3) Delivery system - The system must ensure choice of physician and preserve patient/physician relationships; the system must focus on providing care that is safe, timely, efficient, effective, patient-centered and equitable; (4) Administration and governance - The system must be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care; the system should be overseen by a governing body that includes regulatory agencies, payers, consumers, and care givers and is accountable to the citizens; and (5) Financing - Health care coverage should be equitable, affordable and sustainable. The financing strategy should strive for simplicity, transparency and efficiency. It should emphasize personal responsibility as well as societal obligations, due to the limited nature of resources available for health care."

This report summarizes state reform efforts to expand coverage to the uninsured; reviews AMA activity on covering the uninsured; provides a comparison of AMA policy with the actions proposed in Resolution 136 (A-07); highlights examples of state reform and includes a series of principles to guide in the evaluation of state efforts to cover the uninsured that are largely consistent with those proposed in the resolution.

STATE REFORM EFFORTS

In 2007, health system reform has been a major focus for state legislators as evidenced by the consideration of hundreds of bills this year in statehouses across the nation. Several converging factors have contributed to this surge of activity. There is growing attention to the affordability and accessibility of health insurance with no national solution to date. Federal legislation has been introduced encouraging continued state experimentation. As such, states are seeking their own solutions and have models for reform in Massachusetts and Vermont, both of which addressed the issue comprehensively in 2006. Health care reform has emerged as a key topic in the 2008 presidential campaign, with declared candidates from both sides of the aisle publicizing their health care platforms.

State reforms have ranged from incremental to comprehensive. Consistent with the principles outlined in Resolution 136 (A-07), state proposals are focusing on reforming various aspects of the health care system including coverage options, benefit packages, the delivery system, administration and governance, and financing. Regardless of the overall approach, some of the most frequently proposed or used mechanisms include public sector expansion, the provision of public subsidies, insurance market reform, instituting state health insurance exchanges, proposing participation mandates, and exploring various funding sources. Many states have been using the concept of "shared responsibility" in their reform efforts whereby individuals, employers, physicians and other providers, insurers, and the federal government all are expected to share in the cost of coverage.

AMA ACTIVITY AND POLICY ON STATE REFORM EFFORTS

In 2007, the AMA embarked on a multi-year campaign, "Voice for the Uninsured," to raise awareness about the uninsured and the AMA proposal for covering the uninsured. The AMA proposal to expand coverage is primarily a federal strategy that includes revoking or capping the employee tax exclusion for employment-based coverage and providing individuals and families with tax credits to purchase coverage (Policies H-165.920 and H-165.865, AMA Policy Database). Nevertheless, the AMA is also supportive of state efforts and has worked with members of Congress throughout 2007 to reauthorize the State Children's Health Insurance Program (SCHIP). A comparison of comprehensive state approaches to covering the uninsured is available on the Advocacy Resource Center (ARC) page of the AMA Web site. The ARC also regularly issues an "ARC Update" which includes highlights of state legislative activity addressing the uninsured.

The AMA also supports federal legislation authorizing and funding state-based demonstration projects to expand health insurance coverage to the uninsured (Policies D-165.959 and D-165.968[1]). The AMA supports state freedom and financial assistance to develop and test different models for improving coverage for patients with low incomes, including combining advanceable and refundable tax credits to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need. In addition, the AMA advocates for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds. Furthermore, the AMA is committed to working with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons (Policy D-165.966[1-3]).

COMPARISON OF RESOLUTION 136 (A-07) WITH AMA POLICY

Additional policies related to the uninsured are identified in the following sections, which provide a comparison of Resolution 136 (A-07) with AMA policy. Using the elements of reform highlighted in Resolution 136 (A-07), the Council recommends principles to guide in the evaluation of state health system reform proposals. Ultimately, the principles recommended by the Council are highly consistent with those proposed in the resolution. The first principle emphasizes the importance of subsidies when mandating coverage. The second and third principles stress additional choice for patients and physicians regarding benefits and the delivery system. The fourth principle recognizes the challenges of using a governing body to oversee a health system reform health plan, and the final principle addresses financing strategies.

Coverage

The first principle of Resolution 136 (A-07) states that "health care coverage for state residents should be universal, continuous, portable, and mandatory." AMA policy supports these concepts, while urging restraint with mandatory coverage. Patient choice is fundamental to the AMA proposal, as is providing subsidies in the form of tax credits or vouchers for those who need financial assistance obtaining health insurance. Subsidies could be used to help pay for premiums of any available adequate insurance, whether offered through a job, some other group purchasing arrangement, or the individual market. Accordingly, patients would have greater control over the types of benefits and plan features they value, and insurers would be more able and willing to experiment to develop plan designs people find most attractive.

Testimony at the House of Delegates regarding Resolution 136 (A-07) emphasized that a mandatory requirement must take income levels into account and ensure that subsidies are in place to aid those who cannot otherwise afford the health insurance coverage requirement. This sentiment is reflected in Policy H-165.848 which supports an individual responsibility requirement for those families earning less than 500% of the federal poverty level (FPL) only upon implementation of a system of refundable tax credits or other subsidies to help obtain the required health insurance coverage. The policy also supports requiring all individuals and families earning greater than 500% of the FPL to obtain at least coverage for catastrophic health care and evidence-based preventive health care. In addition, Policy H-165.865[1d] states that tax credits should be large enough to ensure that health insurance is affordable for most people.

Accordingly, consistent with the first principle outlined in Resolution 136 (A-07), the Council believes health insurance coverage for state residents should be universal, continuous, and portable. However, coverage should be mandatory only if health insurance subsidies are available for those earning less than 500% of the FPL.

State Examples of Coverage Options: More than half the states are expanding health insurance coverage through existing public sector programs. Many have chosen to build on the foundation of SCHIP and Medicaid to expand coverage to higher thresholds of the FPL for both children and adults. Some states have sought Health Insurance Flexibility and Accountability (HIFA) demonstration waivers to allow experimentation with alternative strategies, such as expanding eligibility to individuals not otherwise eligible for Medicaid. In addition, the Deficit Reduction Act (DRA) of 2005 has provided states with additional flexibility to make significant reforms to their Medicaid Programs.

In the absence of private sector reforms that would enable persons with low incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid and SCHIP (Policy H-290.974[1]). Of importance to physicians, public sector expansions often bring increased caseloads at low payment rates. The AMA has extensive policy advocating for adequate physician payment under Medicaid and SCHIP (Policies H-290.976, H-290.980, H-290.997[4]), which is essential to ensure that state programs have enough physicians to treat beneficiaries.

Given the growing concern about the cost of health insurance, many state reform efforts are including subsidies in various forms. The forerunners to enacting state health reform, Massachusetts, Vermont, and Maine, all provide sliding scale subsidies for those living below 300% of the FPL. Other states are considering proposals that include sliding scale subsidies,

capping the assistance between 100% to 400% of the FPL. A few states are exploring the use of tax credits while some have proposed allowing Medicaid funds to assist with the employee share of employment-sponsored insurance.

As previously noted, the AMA supports subsidies for those living below 500% of the FPL as a requisite for enforcing individual responsibility provisions (Policy H-165.848[2]). However, state proposals have yet to include subsidies up to this income threshold, which raises concerns about the affordability of health insurance under some of these proposals. The AMA supports providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level (Policy H-290.982[8]).

Benefits

The second principle of Resolution 136 (A-07) suggests that "an essential benefits package should be uniform and include behavioral health; with the option to obtain additional benefits." Testimony at the House of Delegates regarding Resolution 136 (A-07) raised concern about the essential benefits package. The House recently rescinded policies that defined minimum and standard benefit packages. These policies had been developed in the context of previous AMA support for an employer mandate, and included detailed recommendations regarding covered services and procedures, benefit levels, and patient cost-sharing. The policies have been superseded with a policy shift emphasizing individual choice and ownership of health insurance.

Although there is widespread agreement that individuals should have access to health insurance coverage, there is little consensus on what criteria should be used to judge an individual plan's adequacy. Consequently, the number and type of mandated benefits vary greatly by state.

At the 2007 Annual Meeting, the House of Delegates adopted the recommendations contained in Council on Medical Services Report 7, "Adequacy of Health Insurance Coverage Options" (Policy H-165.846), which developed a framework for evaluating adequacy that provides enough guidance to minimize the incidence of "underinsurance," and enough flexibility to permit individuals to choose plans that reflect their needs and preferences. These guidelines aim to outline features or benefits that should be included in a health insurance policy to ensure that the policy provides a meaningful level of coverage, both to protect individuals, and to protect society from shouldering the burden of uncompensated care.

Even with such guidelines, the process of determining the benefits that are necessary can be difficult. A comprehensive strategy for ensuring that the chosen benefits cover the necessary and appropriate services would be to promote "value-based decision-making." As described in Council on Medical Service Report 8 (A-07), "Strategies to Address Rising Health Care Costs," (Policy H-155.960) there is an opportunity across the health care system to improve the processes by which decisions are made, so that they take into consideration both cost and benefit – particularly clinical outcomes. Value-based decision-making is an extension of evidence-based medicine, in which a host of private and public decisions are improved through greater availability of information and through incentives. Value can be thought of as the best balance between benefits and costs. This framework could be applied in numerous situations, including the consideration of insurance coverage of particular benefits.

Although Resolution 136 (A-07) requested the inclusion of behavioral health coverage in an essential benefits package, the AMA prefers limiting benefit mandates to allow the market to determine benefit packages and permit a wide choice of coverage options (Policy H-165.856). However, the AMA is a strong proponent of mental health parity and is a member of the Coalition for Fairness in Mental Illness Coverage, advocating for the end of discrimination against people with mental and substance use disorders by requiring equal insurance coverage on par with general health insurance. As a member of the Coalition, the AMA supports pending legislation in the form of the Mental Health Parity Act of 2007 (S. 558).

Accordingly, in lieu of an essential benefits package as called for in Resolution 136 (A-07), the Council believes that state health care systems should emphasize patient choice of plans and health benefits which should be value-based.

State Examples of Benefit Design: States that have enacted or are in the process of implementing comprehensive reforms are offering a range of coverage options and some have mechanisms to educate consumers to make informed choices. Massachusetts' Commonwealth Care Health Insurance Program offers three levels of health insurance options based on price and benefits, with each level offering six plan types. A plan for young adults is available for independent individuals aged 19 to 26. In addition, Massachusetts' Health Care Quality and Cost Council was tasked with establishing a consumer health information Web site to include cost and quality data aimed at helping patients make decisions when choosing providers and plans. Maine's DirigoChoice offers two plan options with varying premiums and levels of cost-sharing. Maine's state reform also included legislation creating the Maine Quality Forum to provide the public with information about the costs and quality of health care along with additional resources.

Delivery System

The third principle of Resolution 136 (A-07) states that "the system must ensure choice of physician and preserve patient/physician relationships. The system must focus on providing care that is safe, timely, efficient, effective, patient-centered and equitable." Existing AMA policy supports the concepts in this principle, while urging the inclusion of additional choice both for patients and physicians. As previously noted, a key pillar of the AMA proposal for reform is individual choice. The rationale for the AMA policy shift away from supporting an employer mandate to supporting individually owned insurance was the overarching goal of ensuring greater patient choice (Policies H-165.881, H-185.954, H-165.856[9b], H-165.920[3], and D-165.996).

Testimony from the House of Delegates regarding Resolution 136 (A-07) expressed concern that physician choice is just as essential as patient choice. Physician choice is embodied in Policy H-385.926, which supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.). In addition, Policy H-385.989[c] states that physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.

Accordingly, consistent with the third principle of Resolution 136 (A-07), the Council concurs that the delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

State Examples of Delivery Systems: State reform proposals vary in the degree to which they offer choice both for the patient and physician. Massachusetts' Commonwealth Choice, as the name implies, offers a choice of comprehensive health insurance options through the Connector, which is a new entity that serves as the point of purchase for competing health insurance plans both for individuals and small businesses. Governor Blagojevich's Illinois Covered has a laudable goal of universal patient access to medical insurance coverage. However, key elements of the Illinois proposal raise concerns as to the level of choice available to patients and physicians alike. The proposal requires that physicians accept the plan as a condition of participating in private sector health insurance plan contracts, allowing no room for individual decision-making on what is best for one's practice or patients.

Administration and Governance

The fourth principle in Resolution 136 (A-07) states that "the system must be simple, transparent, accountable, efficient, and effective in order to reduce administrative costs and maximize funding for patient care. The system should be overseen by a governing body that includes regulatory agencies, payers, consumers, and care givers and is accountable to the citizens." AMA policy supports the concepts in this principle, while emphasizing the inclusion and role of physicians. All health system reform proposals must allow participating physicians to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters without threat of punitive action (Policy H-165.888 [4]). Testimony at the House of Delegates regarding Resolution 136 (A-07) questioned the role of the governing body and whether it would be intrusive. While the Council notes that Policy H-165.888 urges physician representation on the governing board and key committees of health system reform health plans, it recognizes the challenges inherent with an additional layer of bureaucracy.

An example of a governing body in the health care industry is the governing board of a Certificate of Need (CON) program. CONs were enacted at the state level to control health care costs through planning and regulation and to discourage unnecessary investment in facilities and services. However, as some states have experienced, there have been unintended negative consequences as a result of these governing boards. For example, Missouri has reported increased costs and diminished quality of care and considered limiting or repealing certain aspects of its CON program in 2006. Given the possibility of uncertain outcomes with implementing a governing body to oversee health system reform health plans, such as less accountability to stakeholders, the Council cautions against endorsing or outlining the composition of such bodies.

Accordingly, consistent with the fourth principle of Resolution 136 (A-07), the Council believes that the administration and governance system should be simple, transparent, accountable, efficient, and effective in order to reduce administrative costs and maximize funding for patient care.

State Examples of Administration and Governance: Some states are considering mechanisms to serve as clearinghouses, or exchanges, to facilitate the buying, selling and administration of private health insurance coverage. Key functions include availability, portability, standardization, compatibility with federal law, and provision of a uniform payroll withholding system. A prominent example of a purchasing pool being enacted is Massachusetts' Commonwealth Health Insurance Connector. The Connector is overseen by the "Connector Board" made up of representatives from labor, business, and consumers. The Board's success in compromising on major policy decisions indicates strong accountability to the residents of Massachusetts. Following

the experience of Massachusetts, more than a dozen states have considered bills or proposals in 2007 that include a similar mechanism.

Financing

The fifth principle of Resolution 136 (A-07) states that "health care coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations, due to the limited nature of resources available for health care." Existing AMA policy supports the concepts in this principle. The AMA believes that all health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform. In addition, all health system reform proposals should identify specifically what means of funding (e.g., general tax, payroll tax, etc.) will be used to pay for the reform proposal and what the impact will be (Policy H-165.888[3]).

As previously noted, the AMA advocates that those with high incomes have the individual responsibility to obtain health insurance and supports provisions to assist individuals with lower incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations (Policy H-165.848). In 1998, the AMA adopted policy favoring replacing the employee income tax exclusion for employment-based health insurance with tax credits for the purchase of individually owned insurance (H-165.920). Subsequently, consistent with the AMA's philosophical shift toward coverage that is portable and allows for patient choice, the AMA rescinded policy supporting an employer mandate in 2000. The AMA proposal is a federal approach that has been refined over the past decade, always maintaining a focus on patient choice.

Accordingly, consistent with the financing principle of Resolution 136 (A-07), the Council believes that state health insurance coverage should be equitable, affordable and sustainable. The financing strategy should strive for simplicity, transparency and efficiency. It should emphasize personal responsibility as well as societal obligations, due to the limited nature of resources available for health care.

State Examples of Financing Strategies: The financing of state health reforms is often the greatest challenge to ensure successful implementation. States are proposing and using various avenues to secure funding. Many have taken on a "shared responsibility" approach, requesting the participation of a number of stakeholders including individuals, employers, physicians and other providers, and insurers. Some states are able to contribute state funding, while most must rely to some degree on federal funding. Available federal funding streams include public program matching rates, federal waivers and the redirection of Medicaid Disproportionate Share Hospital (DSH) payments into coverage expansions. Proposing and instituting various taxes (e.g. tobacco taxes, provider taxes or gross receipts taxes) is another financing mechanism in state reform. While the AMA supports some of the proposed funding mechanisms, such as using tobacco tax revenue for expansion of health care services, the AMA strongly opposes any attempt on the part of the federal or state governments or other entities to impose user fees, provider taxes, access fees, or bed taxes on physicians and other health care providers to subsidize or fund any health care program (Policies (H-495.987[3] and H-385.941[1]).

Employer-based coverage has long been an expected source of health insurance for the majority of Americans. However, with the availability and affordability of employment-sponsored insurance deteriorating in recent years, some states are proposing employer mandates to ensure that this

stakeholder continues to contribute to the cost of health insurance. While this tactic may seem budget neutral, states must weigh the benefits of the additional funding with the possibility of employers leaving the state. The greatest difficulty for states, however, is the Employee Retirement Income Security Act (ERISA), which prohibits states from imposing state rules on the health plans of multi-state employers that assume the risk of their workers' health costs.

Hawaii is the only state with an ERISA waiver, signed into law in 1982, due to legal challenges to the employer mandate provision of its Prepaid Healthcare Act (PHCA). Although Massachusetts enacted legislation in 2006 containing an employer mandate, it has yet to implement the annual "fair share" fee, to be imposed on employers, of $295 per uninsured employee. In 2006, Maryland's "Fair Share Health Care Fund Act," which required organizations with more than 10,000 employees to spend at least eight percent of their payroll on health benefits or put the money directly into the state's health program for the poor, was deemed to violate federal ERISA law by both the federal district court for Maryland and the Fourth Circuit Court of Appeals. Although the rulings were limited to the Maryland law, they have influenced state legislative approaches that would require employers to provide health insurance coverage for employees. A handful of states have considered bills and proposals in 2007 including employer mandates or assessments, but reservations exist following the Maryland rulings.

DISCUSSION

The Council's comparison of Resolution 136 (A-07) with AMA policy indicates substantial consistency. Where there is inconsistency is on the principle regarding an essential benefits package. While AMA policy emphasizes the importance of limiting benefit mandates in favor of allowing the market to determine benefit packages and permit a wide choice of coverage options, Resolution 136 (A-07) proposes an essential benefits package. The Council believes that Policies H-165.856 and H-155.960, which advocate for choice in a wide variety of coverage options based on value and evidence, continue to be appropriate.

Although Resolution 136 (A-07) was comprehensive, the Council recommends additional key elements to make it more complete. The Council continues to believe that it is important to mandate coverage only for those earning more than 500% of the FPL or, for those earning less, only if health insurance subsidies become available. In addition, health insurance subsidies must be substantial, particularly for those with low incomes to ensure that coverage is affordable.

It is also imperative to ensure that both patients and physicians are provided adequate choices regarding benefits and the delivery system. While the inclusion and role of physicians in administration and governance is key to a successful program, the challenges with using a governing body to oversee health system reform health plans needs to be explored.

With increased activity at the state level to cover the uninsured, the AMA has continued and increased related activity. Several AMA Advocacy Group staff are tracking state legislative proposals to expand health insurance coverage to the uninsured and have developed materials to support state medical association advocacy efforts. The AMA's Advocacy Resource Center regularly convenes meetings and teleconferences with Federation staff to facilitate the exchange of information regarding medical association efforts in this area. These collective activities are part of a larger AMA campaign to expand coverage to the uninsured.

In the absence of federal legislation, the Council believes the AMA should continue to support state efforts to cover the uninsured. The recommended principles for guiding the evaluation of state health system reform proposals are substantively consistent with those proposed in Resolution 136 (A-07).

RECOMMENDATION

The Council recommends that the following be adopted in lieu of Resolution 136 (A-07) and the remainder of this report be filed:

1. That the American Medical Association (AMA) support the following principles to guide in the evaluation of state health system reform proposals:

    a) Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.

    b) The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage.

    c) The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

    d) The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.

    e) Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.

References are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Staff cost estimated to be less than $500 to implement.