Getting to a Single-Payer System Using Market Forces: The CHOICE Program

by Helen Ann Halpin

Overview

The CHOICE program is a new approach to health care reform that very quickly achieves nearly universal access to a single-payer health insurance system for all U.S. residents without any individual mandates or new regulations for employers or health insurers. It accomplishes this goal by offering all U.S. residents a new choice for their health insurance coverage that better meets their preferences as health care consumers, providers and employers. CHOICE offers Americans the option of unrestricted access to nearly all licensed health care professionals and facilities in their state for comprehensive, affordable, high-quality health care without eliminating any of their current health insurance options. The simple beauty of the CHOICE program is that it achieves these goals through economic incentives, competition with the existing system, and ultimately transitioning the entire system as a result of the voluntary choices of individuals, businesses, and health care providers. The result is increased access, equity, efficiency, choice, and security for all.

CHOICE is a shared responsibility between the federal and state governments, with states having flexibility in how they design and administer their programs. CHOICE recognizes the differences in the public programs and delivery systems operating within each state, as well as the varying needs of their populations, and gives states the opportunity to tailor their programs within federal guidelines. Financing is a mix of public and private, and each state contracts directly with private and public health care providers and organized delivery systems in the state to provide covered health care services. All U.S. residents who enroll in CHOICE will have two major options for affordable, comprehensive health insurance coverage:

- *The CHOICE Single-Payer Network:* CHOICE enrollees may receive their medical care from any licensed health care professional or facility that contracts with the statewide CHOICE fee-for-service network to provide covered services. It is anticipated that nearly 100 percent of all health care providers (except those who practice in group- or staff-model HMOs) will elect to contract with their statewide CHOICE Network. All providers in the network will be paid Medicare payment rates for all enrollees, regardless of their sources of financing (for example, employer, Medicaid, Medicare).
- *Organized Delivery Systems:* CHOICE enrollees may select among all state licensed organized delivery systems (ODSs), which include both group- and staff-model HMOs, that elect to contract with the CHOICE program in their state. ODS will be paid an age-, sex-, and risk-adjusted capitation payment for each CHOICE enrollee. In addition, health insurance carriers and health plans will be offered federal tax incentives to develop new partnerships with large multi-specialty groups in exclusive arrangements, creating more ODS options that will compete with each other and

with the CHOICE Network for enrollees.

CHOICE makes coverage affordable by basing the amount that enrollees pay toward CHOICE coverage on their annual wages and family size. Employers contribute by paying a payroll tax of 5.5 percent or 6.5 percent, depending on firm size, which is substantially less than many now pay for coverage. An employer that continues to offer workers health coverage will be credited for the full amount of the tax for each worker enrolled in the employer's plan. States and the federal government will contribute to CHOICE financing when people move from existing state or federally subsidized programs to CHOICE.

Objectives of the CHOICE program

The CHOICE program has five major objectives:

1. To Increase Coverage

The primary objective of the CHOICE program is to guarantee access to affordable, comprehensive health insurance coverage for all non-elderly adult workers (regardless of their immigration status) and their non-working dependents as well as all Americans who are currently eligible for Medicaid, the State Children's Health Insurance Program (S-CHIP), or Medicare. A "worker" is broadly defined to include full-time, part-time, seasonal, contractual, and temporary workers as well as the self-employed.

It is expected that the CHOICE program will increase coverage to at least 95 percent of all U.S. residents within one year of adoption. The CHOICE program will extend eligibility for coverage to nearly all currently uninsured U.S. residents and their families. It also will increase coverage, through mass media campaigns and extensive community outreach, for U.S. residents who are eligible for S-CHIP and Medicaid but are not enrolled, and it will provide for more comprehensive and affordable coverage for elderly Medicare beneficiaries who elect to enroll in the CHOICE program through a federal Medicare Demonstration Program.

2. To Increase Choice

All working, non-elderly U.S. residents and their non-working dependents, as well as Medicaid, S-CHIP, and Medicare beneficiaries, will retain all of their current health insurance coverage options, but they will be offered a new option in the form of the CHOICE program. For example:

- Workers and their families will retain the option of getting their coverage through their employer (if offered), public programs (if eligible), the individual market (if affordable), or the new CHOICE program.
- Elderly Medicare beneficiaries will have the option of getting their coverage through the traditional Medicare program, Medicare+Choice plans, or the new CHOICE program.
- Individuals eligible for Medicaid, S-CHIP, and other state-administered and -financed health insurance programs will have the option of continuing their coverage in these public programs or enrolling in the new CHOICE program.
- Employers will have the option of deciding whether to offer employer-sponsored coverage and will remain free to decide what shape and form that coverage will take without any regulation of the benefits they offer.
- CHOICE enrollees will have the option of choosing from their statewide CHOICE Network of health care providers or enrolling in an organized delivery system (ODS) for their medical care.
- CHOICE enrollees will have the option of choosing their own doctors and hospitals from among all health care providers who contract with the statewide CHOICE Network.
- Health insurance brokers will have the option of offering the CHOICE program to individuals and small firms.
- Health insurance companies and health

plans will have the option of continuing to sell coverage in the group and individual markets and will be offered incentives to partner in new exclusive arrangements with multi-specialty medical groups to form new ODSs.

- Health insurance companies and health plans will also have the option of developing and selling supplemental products that cover services not included in the CHOICE benefits package as well as contracting with the CHOICE program to perform administrative functions.

3. To Increase Equity

An objective of the CHOICE program is to ensure that *everyone pays a fair share of the cost* to support access to comprehensive, affordable coverage for all U.S. residents and their families. The CHOICE program achieves financial equity by requiring all parties (individuals, employers, and state, county, and federal governments) that currently support the health care system financially to continue to do so at a level that is affordable and necessary to provide comprehensive, high-quality health care services. The CHOICE program also increases equity by:

- Making premium contributions affordable for individuals and families by tying them to wage levels up to a maximum annual wage. There is no out-of-pocket premium for individuals and families with annual incomes below 150 percent of poverty. On average, U.S. residents with incomes above 150 percent of poverty will pay 2 percent of their annual income applied up to the maximum wage subject to the Social Security tax (approximately $87,000 per year in 2003) to enroll in the CHOICE program.
- Setting employer contributions to help finance health insurance coverage so that all employers operating in the United States pay into the CHOICE program for any employees who do not take up employer-sponsored coverage. The payroll tax under the CHOICE program is considerably less than what employers now pay to buy coverage in the small- and large-employer group health insurance markets.
- Providing a reasonably comprehensive standard set of benefits to all CHOICE enrollees.
- Providing fair payment to all health care providers in the CHOICE Network through 100 percent Medicare payments, regardless of patients' source of financing.
- Providing each participating ODS with an age-, sex-, and risk-adjusted capitation payment for all covered services for its CHOICE enrollees.

4. To Increase Efficiency

Another objective of the CHOICE program is to increase efficiency in administering health insurance coverage and to purchase greater value with U.S. health care dollars. This means maintaining and improving the quality of health care, while at the same time keeping costs reasonable. This objective will be achieved by:

- Taking advantage of electronic processing capabilities for all administrative functions, including claims processing, auditing, and quality review and improvement.
- Bulk purchasing of pharmaceuticals and medical equipment through the Federal Supply Schedule (FSS).
- Coordinating administration of the CHOICE program with other state-administered health insurance programs.
- Permitting any requirements for enrollment, including residency, work status, family status, and income, to be determined by a self-certification process with random paperless verification.[18]
- Permitting automated enrollment of patients in CHOICE by health care professionals at the site of care.
- Contracting directly with licensed health

[18] Ana Montes. Latino Issues Forum. Memo to Norma Garcia of Consumers Union re: Self-Certification (April 20, 1999).

care professionals and facilities in the statewide CHOICE Network, whose performance will be assessed on quality and value.

- Restricting contracts with ODS to only state-licensed group- and staff-model HMOs, whose performance will be assessed on quality and value.[19]

5. To Increase Security

Ultimately, the goal of the U.S. health care system under the CHOICE program will be to maintain and improve the health of all people living in the United States and to meet their medical care needs. This means preventing disease and disability, promoting health, managing chronic conditions, treating illness and injury, and giving priority coverage to those services that have been demonstrated to be effective in improving health outcomes. This objective will be achieved by:

- Providing coverage for those services and treatments that have been demonstrated to be effective and relatively cost-effective in the prevention, diagnosis, treatment, and management of a medical condition.
- Returning medical care decision making to health care providers and their patients with no preauthorization requirements.
- Holding health care providers accountable for the quality and cost of the care they deliver.
- Increasing the number of insured individuals, thereby providing a reliable source of new revenue for safety net providers and, at the same time, increasing per capita state funding for indigent medical care for persons who remain uninsured.[20]

Coverage/Eligibility

1. Eligibility Criteria

U.S. residents who meet the following criteria are eligible to enroll in the CHOICE program, regardless of their race, age, gender, religion, ethnicity, sexual orientation, legal status, health status, family status, or income.

Non-elderly (0–64 years) U.S. residents who meet *all three* criteria below are eligible to enroll in the CHOICE program:

- Currently reside in the United States with the intent to remain.[21]
- Are not covered by Medicare.
- Meet *one* of the following criteria:
  - —Worked in the United States (or is the non-working dependent[s] of an eligible worker) for at least three months out of the last 12. A "worker" is defined to include full-time, part-time, seasonal, temporary, and contractual workers and the self-employed.
  - —Are eligible for Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefits.
  - —Are receiving state unemployment benefits.
  - —Are eligible for S-CHIP.

Elderly U.S. residents are eligible if they meet the following conditions:

- Are 65 years of age or older.
- Currently reside in the United States with the intent to remain.
- Are eligible for Medicare.

Non-working, non-elderly U.S. residents and uninsured elderly U.S. residents can buy into the CHOICE program by paying the full premium. However, persons enrolled in military/CHAMPUS/Veterans Administration (VA) programs are not eligible for the CHOICE program. In addition, *non-working* adult (18 and older) U.S. residents who are eligible for or enrolled in the Medicaid program will not be eligible in the first phase of implementation to enroll in the CHOICE program, but they will remain covered under Medicaid. Non-elderly Medicare enrollees also will not be eligible to enroll in CHOICE ini-

[19] UC Berkeley Annual Survey of Health Plans (1997).
[20] California LAO analysis (2001).
[21] The language of "present with intent to remain" is used to determine Medicaid eligibility.

tially. Once the CHOICE program is up and running and covering the majority of the U.S. population, the non-working Medicaid and non-elderly Medicare populations will become eligible to enroll in the program. This phased approach avoids adverse selection of these high-risk, high-cost populations into the risk pool too early in the program's development. By first establishing a very large and relatively healthy risk pool, it will be easier to absorb a relatively small but higher-risk population later without substantially changing the average costs of offering coverage to the entire population.

2. Guaranteed Annual Renewal

Individuals and families who elect to enroll in the CHOICE program will have coverage for one full year. Once an individual or family has enrolled, annual renewal is guaranteed, conditional on continued payment of the income-based share of the premium (if any is required).

Subsidies

The CHOICE program offers subsidies to individuals, based on their annual income and their family size, and to firms, based on the number of employees (size of firm). No subsidies are offered to anyone who purchases coverage outside the CHOICE program, with the exception of subsidies offered as part of existing public insurance programs, including Medicaid, S-CHIP, and Medicare.

1. Subsidies for Individuals and Families

For those who enroll in CHOICE, the subsidy for individuals and families is based on both annual wages and family size, gradually increasing as income decreases and family size increases, with limits on out-of-pocket costs capped along both dimensions. Individuals and families who enroll in the CHOICE program pay, at a minimum, nothing toward the monthly premium (for those in families with an annual income below 150 percent of the federal poverty guideline) and, at a maximum, 2.5 percent of their annual income up to the annual wage cap for Social Security taxes (about $87,000 in 2003), or a maximum of $181 per month for a family of any size.

Individuals with incomes between 151 percent and 250 percent of the poverty guideline pay 0.5 percent of their monthly wage toward the premium; those with incomes between 251 percent and 350 percent of the federal poverty guideline pay 1.5 percent; and those with annual incomes above 350 percent pay 2 percent (applied up to the annual wage cap for Social Security taxes). For each non-working dependent who is also covered under CHOICE, an additional 0.5 percent of monthly wages is paid toward the premium, up to a maximum of 2 percent of monthly wages for families with an income between 151 percent and 350 percent of poverty, and up to a maximum of 2.5 percent of monthly wages for families with an income above 350 percent of poverty, again applied only up to the annual wage cap for Social Security taxes. The subsidies are only offered to individuals and families who enroll in the CHOICE program and are not available for any other source of coverage.

2. Subsidies for Employers

Firms are also subsidized relative to their current costs in the group market or as self-insured employers. The subsidy, however, is greater for small firms (1 to 50 employees) than it is for larger firms (more than 50 employees). Under CHOICE, small firms will pay a quarterly tax of 5.5 percent of total payroll, with large firms paying at a marginal rate of 6.5 percent for the 51st employee and beyond. Firms with employees who elect to get their coverage through the firm's plan will receive a tax refund equal to the amount of the payroll tax paid on the wages of those employees.

Financing

The CHOICE program is financed by existing private and public (state and federal) funding for health insurance and new sources of funding.

1. Existing Funds

State Funding

The state will pay its share of cost for:

- workers and their dependents eligible for Medicaid who enroll in the CHOICE program;[22]
- persons eligible for S-CHIP who enroll in the CHOICE program;[23]
- workers eligible for other state-subsidized health insurance programs who enroll in the CHOICE program.

Federal Funding

The federal government will pay its share of cost (federal match) for persons eligible for S-CHIP and Medicaid who enroll in the CHOICE program as well as the Medicare+Choice premium for elderly Medicare beneficiaries who elect to enroll in their state's CHOICE program.

2. New Sources of Funding

Worker's Share of Premium

The CHOICE program does not require workers to take coverage under either their employer's plan (if offered) or the CHOICE program. Thus, workers retain the option of not taking health coverage and not paying a premium, with no individual mandate to buy coverage. All workers and their families, regardless of whether their employer offers health insurance coverage, will have the option of enrolling in the CHOICE program. Persons who take employer-sponsored coverage are responsible for their share of the premium as determined by their employer; it is not subsidized. Workers who take coverage under the CHOICE program pay only the subsidized, wage-based share of the CHOICE premium (if any); they do not pay the premium for the employer's plan.

Table 1 presents the share of the monthly premium each worker who elects to enroll in the CHOICE program will be required to pay as a function of his or her monthly wage relative to the federal poverty guideline and the number of non-working dependents in the family.

Thus, a worker with annual wages of less than $13,000 will be fully subsidized under the CHOICE program and will not be required to contribute anything toward the premium. The same is true for a family of four with an annual income below $26,000. At the other extreme, individual workers who earn more than $87,000 per year will pay $145 per month for themselves, while a family of two or more with an annual income greater than $87,000 will pay a maximum of $181 per month under CHOICE.

Rationale. One of the biggest barriers to health insurance coverage for most uninsured Americans is affordability. Thus, one mechanism for expanding coverage is to tie individual and family premium contribution levels to workers' wages (up to the maximum annual wage subject to Social Security tax), making health insurance affordable for all U.S. residents and their dependents.

Workers who elect to enroll in the CHOICE program will pay a fair share of the cost of the monthly premium, which varies as a function of their monthly wage and the number of non-working dependents in their family. The premium is structured so that those who can afford to pay more are asked to pay a larger share of the premium than those with lower incomes. No individual or family enrolled in the CHOICE program will be asked to pay more toward the annual premium than 2.5

[22] HCFA Final Management Report for FY 2000. Available at hcfa.gov/meidcaid/fmr00.zip.

[23] "State Children's Health Insurance Program Allotments for Federal Fiscal Year." *Federal Register* 65, no. 101 (24 May 2001).

TABLE 1

Worker Out-of-Pocket Monthly CHOICE Premium

WORKER ANNUAL WAGE AS A PRECENT OF THE FEDERAL POVERTY GUIDELINE [1, 2,3]	PERCENT OF MONTHLY WAGE PER WORKER	ADDITIONAL PERCENT OF MONTHLY WAGE FOR EACH NON-WORKING DEPENDENT	MAXIMUM PERCENT OF MONTHLY WAGE PER WORKER
Up to 150% of poverty	0%	0%	0%
151%-250% of poverty	0.5%	0.5%	2%
251-350% of poverty	1.5%	0.5%	2%
Above 350% of poverty	2%	0.5%	2.5%

[1] Individuals enrolled in the CHOICE program who are eligible for Medicaid or S-CHIP will be required to pay only the premium that is required under these programs, if any.
[2] Based on the worker's monthly wage up to the annual wage cap for Social Security payroll taxes (approximately $87,000 annual wage in 2003).
[3] The same rates and restrictions would apply to income of elderly Medicare beneficiaries who voluntarily enroll in CHOICE through the demonstration program of the Centers for Medicare and Medicaid Services (CMS).

percent of total wages, applied up to the maximum annual wage per worker subject to the Social Security payroll tax. Workers with wages below 150 percent of the federal poverty guideline will not be required to pay any out-of-pocket monthly premium.[24] Workers who are eligible for Medicaid or S-CHIP will not be required to pay a premium that exceeds the requirements of those programs in their state. The self-employed pay the worker's share of premium for themselves and their non-working dependents.

Employer Payroll Tax and Tax Refund

All firms operating in the United States will pay a quarterly payroll tax to help finance the CHOICE program based on firm size and total payroll. The self-employed are treated as small firms of one employee for the purposes of the payroll tax. The tax, levied on all wages, tips, and salaries, applies to the total quarterly payroll across all workers. Firms are categorized by size, with smaller firms (those with 1 to 50 workers) paying at a lower rate than larger firms, as shown in Table 2.

State government will pay the payroll tax to cover state employees under CHOICE, and all municipal and county governments will pay the payroll tax for their employees. The federal government will continue to offer Federal Employees Health Benefits Program (FEHBP) plans to federal employees; however, we expect federal workers will do whatever minimizes their costs and meets their needs (either remain in FEHBP or move to CHOICE).[25]

All U.S. employers who hire foreign workers residing in the United States, both documented and undocumented, will participate in financing their health care coverage by in-

TABLE 2

Employer Quarterly Payroll Taxes under the CHOICE Program

FIRM SIZE	MARGINAL TAX RATE
1st to 50th worker	5.5%
51st worker and beyond	6.5%

[24] Individuals/families with incomes below 150 percent of the federal poverty guideline will pay no out-of-pocket share of premium to enroll in the CHOICE program and no co-payment for services or pharmaceuticals. Enrollees in the CHOICE program through no-cost Medicaid will also face no premium cost or copayments if enrolled in the CHOICE program. Premiums and copayments for persons enrolled in the CHOICE program through S-CHIP or share-of-cost Medicaid will not exceed the requirements under these programs.

cluding the wages of these workers in their total payroll, which is subject to the CHOICE employer payroll tax.

While all employers are required to pay the tax, an employer that continues to offer its workers health insurance benefits will be credited with the full amount of the tax for each worker who accepts coverage under the employer-sponsored plan. The tax is also credited for workers with qualified coverage under CHAMPUS or Medicare (for those elderly beneficiaries who do not enroll in CHOICE). However, there will be no recovery of tax payments for other persons not covered under the employer's plan, including workers who are covered under a spouse's employer's health plan.

Rationale. While firms are not required to offer employer-sponsored coverage under the CHOICE program, nor is such coverage regulated by the state, employers are required to pay a modest payroll tax that is significantly less than the average cost of coverage in the group market—on average a 15 percent savings for firms that now offer coverage.[26] Thus, all workers and their non-working dependents in all firms will have the option of enrolling in the CHOICE program when the payroll tax goes into effect or getting their coverage through their employer, if it is offered. This differs significantly from traditional "play or pay" programs, as there are no rules or restrictions on what firms may offer and even if an employer offers coverage, their employees always retain the option of enrolling in the CHOICE program—thus is it not an either/or proposition to the employer.

Most non-elderly Americans with health insurance receive their coverage through their employer (67 percent); yet, in 2002, only 61 percent of smaller firms (with 3 to 199 workers) offered their workers health insurance coverage.[27] In addition, approximately 76 percent of non-elderly adults who were uninsured in 2000 were employed either full- or part-time. While employment is the most important route to coverage, with employers subsidizing on average 84 percent of the premium cost for single coverage and 73 percent of the premium cost for family coverage, employment in the United States certainly does not guarantee coverage.[28] The probability of being offered employer-sponsored insurance varies significantly as a function of firm size, industry, and employment status (full- or part-time, contractual, temporary, seasonal). The CHOICE program seeks to eliminate all of these inequities by guaranteeing all U.S. workers and their families access to comprehensive and affordable health insurance coverage, regardless of their work status or their employers' characteristics.

Recent estimates suggest that, among firms that offer coverage, the employer share of premium is the equivalent of about a 7 percent to 8 percent payroll tax. The payroll tax under the CHOICE program is considerably less costly for nearly all U.S. firms that currently offer coverage (5.5 percent tax for small firms; 6.5 percent tax for large firms). Thus, it is expected that most firms will stop offering their own coverage, pay the tax and encourage their workers to enroll in CHOICE rather than continuing to steer them into employer-sponsored health plans.[29] The firms least likely to pursue this strategy are very-high-wage firms, for whom the payroll tax might represent an increase over their costs of self-insuring or purchasing coverage in the group market.

Lower payroll taxes for small firms recognize the difficulty these firms have in affording coverage in the group market as well as

[26] Ibid.
[27] Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2002

[28] Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2002
[29] A similar idea of a payroll tax low enough to encourage many employers to choose a public coverage option rather than continuing to offer coverage themselves was developed independently in another paper in this series. See Jacob S. Hacker. "Medicare Plus: Increasing Health Coverage by Expanding Medicare." *Covering America: Real Remedies for the Uninsured*, Vol. 1. Economic and Social Research Institute, 2001.

their reported desire to be able to offer health benefits to their workers. Using a marginal payroll tax rate lessens the impact of firm expansions on employer health care costs and reduces the likelihood of negative responses to the payroll tax among firms.

The CHOICE program is also structured to reduce employers' potential to "game" the system. For example, an employer could offer coverage but not contribute toward the cost of it, thus avoiding all costs. Similarly, employers could choose to offer coverage with only minimal benefits to reduce costs (there are no minimum benefits requirements for employer-sponsored coverage under CHOICE). However, if employers make coverage look less attractive than that available under the CHOICE program, and their employees elect not to take that coverage and enroll in CHOICE instead, the employer will still be responsible for the payroll tax for these workers. As a result, the health plans that employers continue to offer to their employees are expected to be similar to those they currently sponsor and to be competitive with the CHOICE program.

Because the payroll tax rates that help finance the CHOICE program are so reasonable, it is expected that most firms will find the cost of the payroll tax to be considerably less than the cost of paying for health insurance for their workers and will encourage their workers to enroll in CHOICE.

Financing for Medicare Beneficiaries

In addition to the federal Medicare+Choice capitation payment from CMS, the premium for elderly Medicare beneficiaries who voluntarily elect to enroll in the CHOICE program will be funded in two ways:

- An income-based share of premium (see worker share of premium above for rates), not to exceed 2.5 percent for a couple in the highest income brackets and applied to an annual income capped at the Social Security tax maximum annual wage.
- For those who have retiree health benefits, the amount the employer pays to purchase retiree health benefits will be paid to the CHOICE program for each eligible Medicare beneficiary who voluntarily enrolls in CHOICE.

Public Health Taxes

Three public health taxes also will be used to help finance the cost of providing health insurance coverage to U.S. residents. They include:

- A federal tobacco tax of $1 per pack of cigarettes, with a proportionate increase on other tobacco products, which will be earmarked exclusively as revenue for the CHOICE program.
- A new federal tax on alcoholic beverages earmarked exclusively as revenue for the CHOICE program.
- A new federal tax of ten cents per 12 ounces of sweetened soda/soft drinks earmarked exclusively as revenue for the CHOICE program.[30]

Rationale. The specific items to be taxed were selected based on analysis of the leading causes of disease and years of life lost in the United States, which include use of tobacco products, alcohol consumption, and obesity.[31]

Safety Net Savings

Under the CHOICE program, 80 percent of per capita state safety net spending on medical care for the indigent and uninsured will be redirected to the CHOICE program for each previously uninsured person who enrolls in the program. The safety net will retain 100 percent of federal disproportionate share hospital (DSH) funds, 100 percent of current per capita safety net spending on medical care for persons who remain uninsured, plus the 20 percent of current per capita spending for

[30] Jacobson MF, Brownell KD. Small Taxes on Soft Drinks and Snack Food to Promote Health. American Journal of public Health. 2000 90(6):854-857.
[31] McGuiness JM, Foege WH. Actual Causes of Death in the US. JAMA 1993;270(18):2007-12.

each previously uninsured person who enrolls in CHOICE.

Rationale. Federal and state governments spend billions of dollars on the safety net each year; however, not all of this funding will be available to help finance the CHOICE program for the previously uninsured. It is critical that funding to DSH facilities be maintained, and that funding is not only maintained but increased as well to pay for health care for the 4 percent to 5 percent of the population who remain uninsured after CHOICE is fully implemented.

The CHOICE program will quickly reduce the number of uninsured people in the United States, and, commensurately, fewer people will need indigent medical care. Under the CHOICE program, Medicare payments will replace indigent care funding for previously uninsured people. This approach will provide the safety net with a much more stable source of financing in the long run by offering higher payments for covered services, and it will enable all safety net providers to deliver more comprehensive, high-quality health care to all of their clients. In addition, the amount the state spends to fund the safety net per uninsured person will be increased under CHOICE by increasing the per capita funding for those who will remain without coverage.

NAFTA Social Integration Fund

Under a new provision of the North America Free Trade Agreement (NAFTA), health insurance for Mexican workers who live and work in the United States will be financed in part by a social contribution from bilateral trade between the United States and Mexico. A bilateral side agreement will be negotiated to create a NAFTA Social Integration Fund that will require a 2 percent contribution on all cross-border transactions. In the United States, the NAFTA Social Integration Fund will subsidize the cost of coverage in the CHOICE program for Mexicans living and working here. The amount of bilateral trade between the United States and Mexico in 2000 was estimated to be $174 billion.[32] Two percent of this would yield $3.5 billion toward financing comprehensive health insurance coverage under CHOICE for all Mexican workers and their families who reside in the United States.

Rationale. NAFTA is the free trade agreement among the United States, Mexico, and Canada to eliminate all tariff and non-tariff barriers to trade by 2005. Under NAFTA, United States-Mexico bilateral trade has more than doubled, growing from $82 billion in 1993, to $130 billion in 1996, to $174 billion in 2000. Before NAFTA was enacted, duty on products and services averaged 10 percent in Mexico; by 1996, this had decreased to less than 6 percent. In the United States, average tariffs fell from 4 percent to about 2.5 percent over this same period.

The reduction in trade barriers and tariffs has allowed many smaller U.S. firms to export their goods. Both the Bush administration and President Fox of Mexico favor "regularizing" Mexicans who are in the United States illegally—that is, taking the steps necessary to make it legal for them to live and work in the United States as citizens of Mexico. Mexico recognizes that its citizens who work in the United States are not only important political constituents, but also that the remittances they send to Mexico constitute the second- or third-largest source of Mexican income.

NAFTA has already negotiated two bilateral side agreements on the environment and safety and labor issues. As part of adoption of the CHOICE program, another side agreement will be negotiated to address social investments, including public health and health care. Adoption of a Social Integration Fund with Mexico will greatly reduce the burden on the United States to subsidize the cost of emergency, maternity, and indigent care for

[32] Personal communication with Joe Kafchinski, U.S. Census Bureau, Foreign Trade Division (Feb. 6, 2002).

Mexicans and their families who live and work here.

This expansion will be modeled on the European Union's Maastricht Treaty developed in 1993.[33] The participating countries developed a strategy that pursues "a high level of human health protection by encouraging co-operation between the member countries" and, if necessary, by lending financial support to their action. In terms of health insurance coverage under European Union regulation, a cross-border worker is entitled to medical care benefits in both the member country in which the worker is employed and the member country in which he or she lives.

Insurance Risk

The federal government will bear the insurance risk for enrollees in the CHOICE Network in each state. State-licensed group- and staff-model HMOs that contract with the CHOICE program in each state will bear the insurance risk for their enrollees.

Administration and Regulation

1. Administration by a Designated State Agency

A state agency designated by each state's governor will administer the CHOICE program and will coordinate with other state agencies to streamline and simplify enrollment in S-CHIP and Medicaid, regulate providers, assess quality, collect and report data, and reach out to the community. The designated state agency will provide or arrange for a centralized electronic clearinghouse for claims processing, benefits coordination, payments to providers, utilization review, quality management, and other administrative functions. Administrative costs for the ODS contracting with the CHOICE program are expected to be about 5 percent, similar to costs for large-group health plans. Program administration for CHOICE is estimated to be 3 percent.

2. Enrollment

Workers will enroll in the CHOICE program through their employer. The wage-based employee share of the monthly premium for workers enrolled in the CHOICE program will be collected through automatic payroll deductions and sent by electronic funds transfer to the designated state agency. The quarterly employer payroll tax will also be collected by the CHOICE program by electronic transfer of funds. Medicare beneficiaries will enroll in CHOICE through the CMS demonstration program or through the employer that administers their retiree health benefits.

3. Self-Certification and Automated Verification

To further reduce barriers to enrollment, all requirements for residency, work, and income will be determined through a self-certification process, whereby individuals verify their information by signature, with a random paperless online verification process. Self-certification with periodic auditing has been found to be cost effective and results in very little fraud. The cost of more extensive verification does not produce enough savings in decreased fraud to make it cost-effective.[34] Implementation of an automated eligibility determination system has the potential to reduce Medicaid and S-CHIP administrative costs by at least 20 percent.[35]

4. Electronic Claims Submissions

All providers in the statewide CHOICE Network will be required to submit all claims electronically. We assume the CHOICE program will not be fully operational until 2005, at which time it is expected that more than 90 percent of health care providers and medical facilities and organizations will have elec-

[33] The European Commission. Communication on the Development of Public Health Policy. Available at http://europa.eu.int/comm/health/ph/grneral/phpolicy2.htm.

[34] Ana Montes, op. cit.

[35] The Lewin Group (March 2002), op. cit.

tronic claims processing capability. Additional federal funding to facilitate adoption of electronic claims processing should be appropriated for the remaining 10 percent of health care professionals and facilities without this capability. Electronic review of claims submission will be ongoing to prevent fraud and identify providers in the CHOICE network with utilization profiles that are statistical outliers. Claims will be reviewed to assess quality and costs as well.

5. Bulk Purchasing

Costs of prescription drugs and durable medical equipment will be significantly lower under the CHOICE program, because they will be purchased using the Federal Supply Schedule (FSS). It is estimated that the savings generated from bulk purchasing using the FSS will amount to about 40 percent for prescription drugs now purchased in the private sector and about 30 percent for drugs now purchased through Medicaid.[36] Similar savings will be realized from bulk purchasing of medical equipment under the FSS.

6. Statewide CHOICE Network

All state-licensed health care providers and health care facilities will be eligible to participate in the statewide CHOICE Network to provide covered services, but as part of their contracts they will be required to provide data on quality and costs and to participate in quality studies. The designated state agency will coordinate regulation of health care providers participating in the CHOICE Network with regulation of providers participating in other state-administered health insurance programs. Enrollees will be covered only when services are received from providers in the CHOICE Network, with the exception of coverage for emergency care by non-network providers.

Rationale. We anticipate that nearly all physicians, other health care providers, medical groups, hospitals, and other health care facilities will elect to contract with the CHOICE Network because of higher payment rates, lower administrative costs, less uncompensated care, and the millions of U.S. residents enrolled in the CHOICE program. We also anticipate that providers will actively encourage their patients to enroll in CHOICE, so providers can receive higher payments than have been available from HMOs and Medicaid. Under CHOICE, providers will be less burdened with paperwork and administration, and they will have the freedom to refer patients to specialists and other ancillary and rehabilitative services as they deem necessary, without any requirements for pre-authorization, approvals, or referrals.

7. Provider Payments

All health care providers and facilities will be paid at rates equal to 100 percent of Medicare payment rates (for example, RBRVS for physicians and DRGs for hospitals). No physicians, medical groups, or hospitals contracting with the CHOICE Network will be paid capitation payments.

Rationale. Providing all providers with 100 percent Medicare payments will result in increased payments to providers for patients now covered under Medicaid and S-CHIP. Uncompensated care for health care providers and facilities will decline, and payments to physicians and hospitals for CHOICE enrollees who are eligible for Medicaid will increase substantially. This approach achieves equity in payment to providers, regardless of patient's source of financing. It will also help to ensure an adequate supply of providers to serve all CHOICE enrollees, regardless of their source of financing, which has been a significant problem under Medicaid.

[36] Ibid.

8. PCP Selection

The CHOICE Network allows enrollees to select any participating provider at any time. Enrollees will be required to select a primary care physician (PCP) who will be held accountable for provision of recommended preventive care and chronic disease management. Enrollees will not be required to obtain a referral/authorization from their PCP to visit a specialist or receive any other covered services. Enrollees may change their PCP at the beginning of each calendar year, and the new PCP must notify the CHOICE program of the change.

9. Contracts with Organized Delivery Systems (ODSs)

Under the CHOICE program, the only ODSs with which a state may contract are group- and staff-model HMOs. Participating ODSs will be required to offer the CHOICE program standard benefits package to CHOICE enrollees, but they may offer additional coverage as well. States also may elect to contract with Medicaid managed care plans operating in their state.

While the CHOICE program will not contract with any independent practice associations (IPAs)/network-model HMOs, point-of-service (POS) plans, or preferred provider organizations (PPOs), all state-licensed U.S. disability insurers or health plans will be encouraged, through federal tax incentives, to create new group- or staff-model HMOs that may contract with the CHOICE program in each state. For purposes of this proposal, a group-model HMO is any health services plan that offers an exclusive multi-specialty network of physicians (who provide services only to that one carrier's enrollees). ODSs will be paid an age-, sex-, and risk-adjusted capitation payment to address any adverse selection in the market. Self-funded employer plans will be exempt under the Employee Retirement Income Security Act (ERISA) from the risk-adjustment process.

Formation of these new partnerships will require time to implement. Carriers and multi-specialty groups that partner to form new group-model HMOs will be required in year one to have at least 30 percent of the multi-specialty group's enrollment be through the partner carrier's plan, increasing to 50 percent at the end of two years, 70 percent at the end of four years, and 100 percent at the end of five years, thereby achieving exclusivity.[37]

We also assume that disability insurers and health care services plans will develop supplemental products to offer additional coverage beyond what is provided in the CHOICE standard benefits package and will try to develop and market low-cost products to compete with the options available under CHOICE. In addition, it is expected that many states will contract with private health insurers to perform administrative functions under CHOICE, including claims processing, benefits coordination, and payments to providers.

Rationale. The ultimate goal of these provisions is to retain the option of organized delivery systems under the CHOICE program and to establish competing exclusive multi-specialty groups of physicians who practice in ODSs and who see only patients who are enrolled in the partner carrier's plan. It is through their ability to increase benefits beyond those offered through the CHOICE Network that ODSs will best be able to compete against each other and the CHOICE Network in the reformed market. To the extent that Medicaid recipients would like to continue to receive their medical care through Medicaid managed care plans, and other individuals and families living in their service areas would like to be able to enroll in them, the CHOICE program will give states this option in designing their programs.

[37] S. J. Singer and A. C. Enthoven. "Structural Problems in Managed Care in the U.S. and Some Options for Ameliorating Them." *The U.S. Management Review 43* (1) (Fall 2000): 50–65.

The CHOICE program will not contract with IPA and network-model HMOs and other forms of managed care because they have been shown to be associated with a number of problems with respect to the efficient delivery of high-quality care.[38] Major efficiency problems with IPA/network-model HMOs include their inability to negotiate with or select high-quality, efficient medical groups; their lack of physician loyalty, cohesion, and leadership; their redundant and often contradictory rules and processes; their lack of investment in the health care delivery system; and the insulation of medical groups from efficiency-enhancing market competition.[39]

A random sample survey of consumer experiences in managed care in California found that individuals enrolled in IPA/network-model HMOs reported significantly more problems in getting needed care than those enrolled in group-model HMOs or PPOs.[40] In another survey of callers to California's Ombudsman Service, consumers in IPA/network HMOs reported problems at a rate three times higher than that for consumers enrolled in group-model HMOs or PPOs. [41] As a result of the problems inherent in IPA/network-model HMOs, there is also substantial dissatisfaction among physicians contracting with these plans.[42]

Under CHOICE, the federal government will use tax incentives to encourage formation of new group- and staff-model HMOs, giving Americans more options for getting their health insurance and medical care through ODSs. These new partnerships between carriers and exclusive multi-specialty groups will relate to one another in a way similar to that of the Kaiser Foundation Health Plan and the Permanente Medical Groups. In this type of arrangement, insurer and the physician incentives are better aligned, so they work in partnership to match resources to the needs of the population served; to offer comprehensive services in the most appropriate setting; to integrate and share information systems; to improve care processes; to conduct evidence-based utilization management, formulary development, and continuous quality improvement; and to manage cost-benefits trade-offs.[43]

The goal of the CHOICE program is not to put insurance companies and health plans out of business but, rather, to try to redesign the system so the products they offer provide accessible, comprehensive, coordinated care as well as to take advantage of the expertise of health insurers in performing specific administrative functions. Both the group and individual health insurance markets will continue to operate and sell their products under the CHOICE program, but they will have to compete with options under CHOICE that will be available to all U.S. residents.

10. Community Outreach

The federal government will develop materials and buy media time for a national mass media campaign on the CHOICE program. In addition, states will conduct extensive community outreach through schools, health care providers, and facilities to enroll eligible persons in Medicaid, S-CHIP, or the CHOICE program. As stated earlier, any uninsured individual may be enrolled in CHOICE at the site of care through an automated verification system; and health care providers will be paid 100 percent Medicare payments for the care they provide. The CHOICE program in each

[38] Ibid.
[39] Ibid
[40] H. H. Schauffler et al. "Differences in the Kinds of Problems Consumers Report in Staff/Group Health Maintenance Organizations, Independent Practice Association/Network Health Maintenance Organizations, and Preferred Provider Organizations in the U.S." *Medical Care 39*_(1) (2000): 15–25.
[41] "Real Problems and Real Solutions: Making the Voices of Health Care Consumers Count." Health Rights Hotline (1999).
[42] Chebab et al. "The Impact of Practice Setting on Physician Perceptions of the Quality of Practice and Patient Care in the Managed Care Era." *Archives of Internal Medicine 161* (2): 202–211.
[43] Singer and Enthoven op cit

state will coordinate with other state-administered health insurance programs in implementing their outreach programs to enroll all U.S. residents in eligible programs. To this end, the CHOICE program will work with employers as well to inform all workers about their eligibility.

The CHOICE program will work with other state-administered health insurance agencies in the state in contracting with hospitals, physician offices, medical groups, and clinics, as well as pre-schools and elementary and secondary schools, to ensure that persons seeking medical care who are eligible for state programs enroll and receive health insurance benefits. All licensed hospitals, clinics, and other health facilities will be prepared to instruct any uninsured patient to apply for the CHOICE program as well as Medicaid and S-CHIP. The individual can self-certify his or her eligibility and may allow an application for enrollment to be submitted while he or she is in the hospital, clinic, or facility. Women who give birth at a hospital, clinic, or facility will be similarly informed and provided an opportunity to submit an application for themselves and their child.

Additionally, pre-schools and public elementary and secondary schools will inform the parent or primary caretaker living with each child at least once each year about the CHOICE program, Medicaid, and S-CHIP. Information will include eligibility requirements, and an application may be submitted at the education facility. There will be a simple, uniform mail-in application and enrollment process as well as an electronic enrollment option for CHOICE, Medicaid, and S-CHIP.

Rationale. The CHOICE program will permit health care providers to make eligibility determinations for a patient using an automated eligibility system. Providers will receive payment for all services provided to patients enrolled in this way, even if the patients are later deemed to be ineligible. Since about 55 percent of uninsured persons seek medical care each year, it is conservatively estimated that half of them will acquire coverage through this process.[44] This would result in a 28 percent reduction in the number of uninsured adults and children in non-working families who are eligible for Medicaid and S-CHIP but are not enrolled.

11. Regulation of Employers and Health Insurers

Regulation of employer-offered coverage will not be affected by adoption of the CHOICE program. Existing state agencies charged with this responsibility will continue to regulate HMOs and disability insurers.

Benefits

1. Initial Standard Benefit Package

The Kaiser Foundation Health Plan standard benefits package in the large-group market in California will be the benchmark for health benefits under the CHOICE program. These benefits include, but are not limited to, coverage of hospital care, outpatient care, prescription drugs, preventive care, chronic disease management, maternity care, mental health care, supplies and supplements, ambulance services, dialysis care, alcohol, tobacco and/or drug dependency treatment, durable medical equipment, emergency care and out-of-area urgent care, family planning, hospice care, vision care, health education, hearing care, home health care, imaging, lab tests and special procedures, ostomy and urological supplies, physical, occupational and speech therapy, multidisciplinary rehabilitation, prosthetic and orthotic devices, reconstructive surgery, skilled nursing facility care, and transplants.

2. Wrap-Around Coverage

To ensure that no one will lose any benefits for which he or she is eligible under current pub-

[44] The Lewin Group, Inc. Analysis of 1998 MEPS data.

lic programs (for example, long-term care under Medicaid and dental care for children under S-CHIP), supplemental or wrap around coverage is provided for anyone who is eligible for a state or federal insurance program with benefits beyond those covered under CHOICE.

3. Payments for Covered Services

Payments for covered services will only be made to health care providers that contract with the Statewide CHOICE Network and to ODSs that contract with the CHOICE program. Payments for out-of-network providers will be made for CHOICE enrollees only for emergency and out-of-area urgent care.

4. Experimental Treatments

The CHOICE program seeks to encourage the development of new treatments and therapies that advance the practice of medicine. As such, it will cover experimental treatments, as long as the treatments are being provided within the context of an Institutional Review Board -approved randomized controlled clinical trial.

5. Pharmacy Benefits

Pharmacy management is a critical aspect of both cost and quality of care. A federal pharmacy and therapeutics committee, comprising independent physicians, pharmacists, consumers, and others, will oversee the CHOICE formulary process. Prescription drugs under the CHOICE program will be purchased through the FSS, which will make them much more affordable compared to current market prices.

6. Copayments

No copayments will be required for receipt of covered clinical preventive services (screening, immunization, or counseling services) in the CHOICE program. There will also be no copayment requirements for enrollees who select the CHOICE Network and whose annual wages are less than 150 percent of the federal poverty guideline. For enrollees in the CHOICE Network whose coverage is financed in part through Medicaid or S-CHIP, copayments will not exceed the requirements under these programs.

Copayments for enrollees who select the CHOICE Network and whose annual wages are above 150 percent of the federal poverty guideline (and whose coverage is not financed by Medicaid or S-CHIP) will be set initially at $10 per outpatient visit.[45] Emergency room copayments will be $35 per visit. There is no copayment, deductible or coinsurance for inpatient care.

Drug copayments for enrollees who select the CHOICE Network and whose annual wages are above 150 percent of the federal poverty guideline (and whose coverage is not financed by Medicaid or S-CHIP) will be $10 per prescription per month. Copayments for those enrolled in CHOICE Network with incomes below 150 percent of the federal poverty guideline will be waived. Participating ODSs may design their own copayment requirements for prescription drugs.

7. Updating Benefits over Time

An independent federal panel of experts composed of physicians representing the major specialties will be established to advise the CHOICE program on coverage for specific interventions, treatments, or drugs that should be added to or removed from the standard benefits package. The panel will meet at least annually to consider new drugs and treatments and to review scientific evidence on their efficacy, effectiveness, relative cost-effectiveness, and impact on the public's health. Only those drugs and devices that have received U.S. Food and Drug Administration (FDA) approval will be eligible for consideration.

[45] Fifty percent of covered workers in HMOs in 2001 had a copayment requirement of $10; see KFF/HRET Employer Health Benefits 2001 Annual Survey.

Rationale. A comprehensive standard set of benefits is one of the keys to the CHOICE program. Health benefit design sits at the center of the debate over trade-offs among access, choice, quality, and costs. Health benefit design is the determination of what is covered by insurance and what is not. The Kaiser Permanente Health Plan group-market benefits package was selected as the initial benchmark because it is relatively comprehensive, was determined through a clinical review process, and was designed to promote the health and meet the medical care needs of the covered population.

One of the primary drivers of improvements in health care quality and growing health care costs is the increasing availability of new technology and pharmaceuticals, including diagnostic and therapeutic interventions. For example, direct-to-consumer advertising has increased patient demand for specific drugs and treatments, as have the actions of political advocates who have pressured state governments to mandate coverage of specific services or prescription drugs for groups with particular conditions.[46] The result is often an irrational process for determining which services and treatments are covered.

CHOICE offers a more rational framework for determining what new technologies and pharmaceuticals will be covered. To preserve affordability and prevent erosion of comprehensive benefits, selection of benefits will be based on evidence that establishes the likelihood that a given procedure, intervention, or drug will produce genuine health benefits. CHOICE also must enable coverage of interventions based on the cost-effectiveness of the procedure, intervention, or drug compared to other comparably effective therapies for the same condition or symptom complex. The decision-making process also needs to exclude from coverage treatments deemed to be inappropriate for insurance coverage because the benefit of including them is limited or is far outweighed by the cost and the effect on the affordability of the benefit package.

The CHOICE program would achieve nearly universal coverage (95 percent) while ensuring stable aggregate risk pools and an evidence-based approach to covered benefits. Under these circumstances, it is feasible to provide broad access to a comprehensive benefits package that is likely to produce desired health outcomes in a cost-effective manner. Such a benefits package would minimize obstacles to receiving effective treatments and would promote access to appropriate health-value-added care, including primary prevention, early disease identification and treatment, and management of chronic conditions.

This approach is highly preferable to using the blunt policy tools of higher and higher deductibles, coinsurance, and copayments. The research shows that these tools do reduce utilization, but they are indiscriminate—reducing the use of both appropriate services and marginal, low-value services to the same degree. The CHOICE program would enable ODSs and health care providers to compete based on effectiveness and efficiency of care delivery and health status improvement, rather than on underwriting, risk avoidance, cost shifting and risk pool manipulation, all of which the current system encourages.

Quality and Data Incentives

1. Patient Care Management

Disease Prevention

The CHOICE program covers all evidence-based clinical preventive services.[47] CHOICE Network providers will agree to implement patient education efforts and reminders to ap-

[46] H. H. Schauffler. "Politics Trumps Science: Rethinking State-Mandated Benefits. *American Journal of Preventive Medicine 19* (2) (2000): 136–137.

[47] US Preventive Services Task Force. Guide to Clinical Preventive Services. Second Edition. (Baltimore, MD: Williams and Wilkins). 1996.

propriate segments of the population (for example, women 18 and older for Pap smears every three years). PCPs in the CHOICE Network, and ODSs that contract with the CHOICE program, will be encouraged to ensure their patients receive all recommended preventive services at recommended intervals and, at a minimum, record that the services were provided. Physicians in the CHOICE Network will be required to submit claims electronically for each preventive service provided, which will enable analysis of claims data for quality assessment. In addition, preventive services utilization will be included in quality performance measures that are linked to provider incentives.

Management of Chronic Conditions

The CHOICE program will notify its enrollees and network providers of those provider organizations that sponsor approved disease management and self-care programs. Patients will be encouraged to participate in disease management programs through reductions in or waivers of copayments. The CHOICE program also will evaluate the option of carve-out disease management programs that have a proven record of success (for example, care for patients with AIDS). The CHOICE program will encourage patient participation in these programs by using similar incentives as those for provider-sponsored disease management programs. Additional incentives may be offered for patients who continue in a given program for a specified period. For example, a patient with cardiac disease who continues to follow a provider group's approved protocol for three years may receive a premium discount.

Centers of Excellence. All enrollment materials will highlight hospital centers of excellence for high-volume, high-cost procedures for which the literature indicates a correlation to quality. The CHOICE program will contract in-network only with those facilities that meet or exceed evidence-based standards for these select services. Where outcomes are not yet available, volume data will be used when appropriate, and network hospitals will be required to participate in any scientific outcome studies. Examples of conditions for which there are existing data for Centers of Excellence include transplants, coronary artery bypass graft surgeries, and neonatal care. Approved trauma centers (for example, burn units) and centers of excellence will also be used for catastrophic care.

2. Provider Performance Measurement and Improvement

Quality Performance and Improvement

High-value providers will be recognized during enrollment, at annual renewal, and throughout the year for their performance on quality performance measures (see below for provision of such information and bonus incentives). In areas for which several years of comparative data are available, high-value providers will be recognized. In the interim, providers will be recognized for improvements as well as for participating in quality measurement programs.

Data and Information

There is a paucity of comparative provider performance information. Such studies often take several years to produce meaningful results and require substantial resources. As a requirement for in-network selection for the CHOICE program, providers will submit relevant electronic data to participate in a study or studies related to their practice.

3. Patient Incentives

Financial Incentives

Plan design is one of the most effective means of influencing patient behavior. Certainly, limiting coverage to in-network providers (except in emergencies) will encourage enrollees to see providers who are willing to provide cost and quality data. As mentioned above,

copayments can be waived or reduced for patients who elect to participate in disease management or self-care programs. Copayments will be waived for all preventive services.

Other Incentives

Additional patient incentives related to quality will include aggressive promotion of educational opportunities. All media, including print, the Internet, phone, and in-person discussions, will be used as appropriate. The patient's condition, language, cultural perspective, health literacy, disabilities, and preferences will be taken into consideration. For example, rather than require a newly diabetic teenager to modify his or her eating habits dramatically, the teen can learn how to count the number of carbohydrates in whatever he or she wants to eat and adjust the level of self-injected insulin accordingly.

Several off-the-shelf, highly regarded educational products will provide patients with evidence-based treatment option comparisons and structured clinical decision support. These include consumer videotapes from the Dartmouth Outcomes Project, condition-specific disease management materials, and commercial software from Healthwise. This type of information can be made available through a nurse advice line, in addition to print and Internet materials.

4. Provider Incentives

Financial Incentives

After the first year of participation, bonus incentives will be paid to providers based on (1) their performance on quality and performance measures, (2) improvement on quality and performance measures, and (3) participation in quality-of-care studies. A bonus scheme will be developed with advice from the provider community and will be paid on top of the Medicare payment rates. It is anticipated that the bonus will reach 10 percent over a three-year period.

Other Incentives

Other incentives include year-round recognition through press releases, an annual recognition event, and publicity during enrollment. This recognition, in conjunction with financial incentives, will strive to provide enrollees with information on "best of class" providers when they need to make decisions about care.

Rationale. Measurement of quality at the physician group, individual physician, and hospital levels is still in its infancy. The quality measurement tools available today across all levels focus on patient satisfaction with care and perceived quality. Physician group measures in the United States include population health status and measures across select diseases/conditions as well as utilization of preventive care. Hospital measures include C-section and perinatal mortality rates, coronary artery bypass graft (CABG) mortality rates, and several Medicare quality indicators. The CHOICE program will work with organizations across the country that provide comparative provider performance information to make such information interactive and available in a variety of media for enrollees all across the country.

The above approach differs from traditional fee-for-service care because of the way cost and quality are factored into the CHOICE program. First, physicians participating in the statewide CHOICE Network will be required to report on both quality and cost measures and to participate in quality studies. Second, the CHOICE Network will include incentives for patients to migrate to relatively high-quality providers and to actively manage their own health. Creation of consumer and provider incentives for both cost and quality—that is, value—as part of the CHOICE Network distinguishes delivery of care in this model from others available in today's U.S. marketplace. In addition, all health plans offered by the CHOICE program will be required to meet any applicable standards issued by the National Committee on Quality

Assurance, to provide quality data, and to participate in quality studies.

Implementation and Transition to the Future

No federal waivers are required to implement the CHOICE program, no ERISA waiver is required to adopt a new federal payroll tax, and there is no individual or employer mandate to have health insurance coverage.

1. Implementation Steps for States

Implementation of the CHOICE program will require each state to:

- Designate a state agency to administer the CHOICE program.
- Contract with licensed health care providers and facilities that elect to participate in the statewide CHOICE Network.
- Contract with ODSs (licensed staff- and group-model HMOs) and develop an age-, gender-, risk-adjusted capitation payment.
- Simplify and coordinate an administrative process for enrollment and eligibility, including self-certification with paperless verification and electronic application.
- Institute a system for collecting the monthly worker share of premium.
- Develop and implement a community outreach strategy to inform residents about CHOICE and how to enroll and to increase enrollment in Medicaid and S-CHIP for those who are eligible.
- Develop an electronic application that will enable providers to enroll patients at the site of care.
- Implement an electronic claims processing and review system.
- Develop a process for review of claims with respect to quality and costs.
- Institute a system for processing claims electronically and a payment system for health care providers in the CHOICE Network.
- Develop a fee structure for licensed insurance brokers who enroll those who are self-employed and small firms (fewer than 50 workers) in the CHOICE program.
- Submit a proposal for review and approval by the U.S. Department of Health and Human Services that demonstrates all of the above conditions have been met.

2. Implementation Steps for the U.S. Department of Health and Human Services

- Develop a national media campaign to increase awareness, knowledge, and understanding of the CHOICE program and how to enroll, including a national media buy over a six-month period on all major network and cable outlets.
- Review and approve a CMS national Medicare demonstration project to permit elderly Medicare beneficiaries to enroll voluntarily in CHOICE and pay their income-based share of premium.
- Appoint a CHOICE National Benefits Panel to review, at least once a year, new treatments, drugs, and technologies that have been demonstrated to be effective and relatively cost-effective in improving health and maintaining and increasing quality of life. Based on this review, update the CHOICE benefit package to reflect the best and most current evidence-based science.
- Institute a system for collecting the quarterly employer payroll tax, distribute each state's revenue to the appropriate administrative agency, and issue tax refunds to eligible firms.
- Collect and distribute the federal taxes from tobacco, alcohol products and soft drinks to the states.
- Develop an age-, sex-, risk-adjusted capitation payment for ODSs.
- Arrange for bulk purchasing of prescription drugs and medical devices through the FSS.
- Review and approve each state's program's regarding its compliance with the provisions of the CHOICE program prior to before releasing federal money to the states, and

monitor state compliance with program rules over time.

Changes to the Existing System

1. Impact on Existing Coverage and the Health Care Market

Adoption of the CHOICE program does not automatically replace any existing coverage. However, it does provide all non-elderly U.S. workers and their non-working dependents, including those who are eligible for S-CHIP and Medicaid, as well as elderly Medicare beneficiaries with the option of replacing their current coverage with the CHOICE program, if they choose.

The CHOICE program leaves in place Medicare, Medicaid, S-CHIP, employer-sponsored coverage, and the private group and individual health insurance markets. However, through the voluntary actions of workers and their families and health care providers, and as a result of outreach to individuals eligible for but not enrolled in S-CHIP and Medicaid, the CHOICE program is likely to increase overall coverage rates to approximately 95% percent of all U.S. residents, regardless of their legal status, within one year of implementation. At the same time, the CHOICE program offers employers strong economic incentives to move much of their covered population into the CHOICE program.

We anticipate that following the implementation of the CHOICE program, the number of persons covered by commercial PPOs and IPA/network -model HMOs will decline, and the number of employers who offer health benefits will decline. Within a year of implementation, it is estimated that the number of persons receiving their health insurance through their employer in the group market will decline dramatically. In addition, the number of U.S. residents purchasing private health insurance in the individual market will also decline, as individuals understand that coverage under CHOICE is both more affordable and more comprehensive, with a much broader choice of providers. The individual health insurance market will try to compete with the CHOICE program, but it may not be able to do so effectively unless the health plans can develop and sell a product that is less expensive than and competitive with the benefits, out-of pocket monthly premium costs, and co-payments under the CHOICE program. It is estimated that enrollment in Medicaid and S-CHIP will also drop as well (although financing through these programs will continue), as individuals eligible for these programs move into the CHOICE program.

In addition, the CHOICE program offers federal tax incentives to health insurance carriers and health plans to partner with multi-specialty groups in exclusive arrangements to create new group-model HMOs in the United States. It is likely that the group-model HMO market will grow through the formation of new ODSs to compete with the existing group- and staff-model HMOs in each state. Commercial health plans will also have the opportunity to develop and market supplemental products for coverage that exceeds the standard CHOICE benefits package.

2. Impact on the Safety Net

Safety net providers will be less dependent on direct state subsidies for indigent care, because they will be providing services to a predominantly insured population. They will also be paid at a higher rate for indigent care for the remaining uninsured population. Each state will maintain its commitment to safety net providers through continued state and federal funding for indigent care programs for those who remain uninsured. In addition, safety net providers will be strongly encouraged to participate in the CHOICE Network in their state. Those who do so will be reimbursed at Medicare payment rates, which are more than 50 percent higher than rates currently paid by Medicaid and considerably

higher than is currently available through indigent care funding.[48] In addition, states have the option of permitting Medicaid managed care plans to contract with the CHOICE program. Thus Medicaid recipients now enrolled in managed care plans could stay in them, and the plans would be newly accessible to others in the areas they serve. In addition, they would receive risk-adjusted capitation payments that are significantly higher than Medicaid payment rates.

Political Feasibility

Like any proposal that seeks to accomplish major reform of the U.S. health care system, there will be winners and losers. Though the potential losers can be expected to oppose the CHOICE proposal, it may be unique in that it is likely to find much broader support than previous proposals because of its voluntary approach and the absence of restrictions on individuals, employers, health insurers, and health care providers. However, it will face strong opposition from at least two very powerful interests—the private health insurance industry and the pharmaceutical and medical device industries, whose profit margins are likely to be negatively affected once the CHOICE program is fully implemented.

There is probably nothing that can be done about opposition by the health insurance industry in particular because, even though it will still be able to sell its products in both the individual and group markets, it will lose substantial market share to the CHOICE program in both markets. However, there will be new opportunities for industry members to partner with large multi-specialty groups to form new ODSs as well as opportunities to develop and market supplemental products that offer coverage beyond that included in the CHOICE standard benefits package. In addition, health insurers will have the opportunity to contract with states to serve as third-party administrators in processing claims and payments, coordinating benefits, and performing other administrative functions. However, none of this is likely to temper the industry's opposition to the CHOICE program. In defending CHOICE against attacks, proponents need to stress that it offers Americans much broader access to choose any doctor or hospital they want, with much more comprehensive benefits, at a cost that is affordable and reasonable, and their health care providers will be compensated at a fair rate and will be able to practice medicine without interference by managed care administrators. It is a win-win situation for them and their doctors.

However, health care providers may be split in their support of CHOICE. While many may welcome a single administrative structure and single set of rules for providing services and receiving payments, as well as the freedom to make their own medical decisions about what is in the best interests of their patients, others may be concerned that a single payer may reduce their payments over time. Instead, most health care professionals, particularly physicians who serve Medicaid patients and currently serve a substantial proportion of managed care enrollees, will be much better off, not only financially, but also in terms of reduced administrative burden, as a result of returning medical decision making to their hands and eliminating prior approval, authorizations, or appeals of denied services. In addition, reporting requirements, particularly for quality measures, will be simplified enormously as a result of fee-for-service payments and electronic claims processing. Not only are Medicare payments likely to be much higher for many of their patients, but bad debt and uncompensated care will be virtually eliminated.

There is likely to be some opposition among health care providers who fear the federal government will have too much power in determining Medicare payment schedules.

[48] The Lewin Group (March 2002), op. cit.

However, historically, Medicare has been a much more generous payer than the state-run Medicaid programs. In addition, the political coalition of consumers likely to develop as a result of adopting the CHOICE program is expected to be even more powerful than AARP, which developed following enactment of Medicare, and should be able to exert a tremendous amount of political pressure, along with the health care provider interest groups, to keep Medicare payment rates reasonable and equitable.

Most hospitals are also likely to look favorably on the CHOICE program because they will receive higher payments for Medicaid-eligible patients, will not receive any capitation payments, will have nearly all bad debt and uncompensated care eliminated, should see drastic reductions in the use of emergency rooms for non-emergency conditions, will be able to finance operation of their trauma centers, and will be recognized for the acute care areas where they excel. In addition, hospitals will face less of an administrative burden because they will be working primarily with a single payer in submitting claims and receiving payment, and quality assurance and assessment will be easier as a result of electronic submission of claims data, facilitating review of quality and costs. In addition, public hospitals will greatly benefit because the vast majority of their clients will be insured under CHOICE, and they will have a stable source of revenue to meet their patients' medical care needs.

Academic medical centers are likely to favor the CHOICE program because it will cover experimental treatments, as long as they are conducted within the context of an IRB-approved randomized controlled clinical trial. Thus, a substantial new source of revenue to support research and innovation in medical care will be available following adoption of the CHOICE program.

Opposition by the pharmaceutical and medical device industries is likely to be strong because all covered prescription drugs and medical devices will be purchased through the FSS. However, it may be possible to soften some of this opposition if the prices paid under CHOICE still enable these industries to make a reasonable profit. Since the quantity of products purchased under the CHOICE program is likely to increase substantially given nearly universal coverage, it does not seem unreasonable that their margins should decline commensurately. The key to gaining their support will be to set prices in such a way that they will continue to deliver a return on investment to their shareholders.

The vast majority of the business community is also likely to favor the CHOICE program. Those who currently offer coverage may continue to do so, but the CHOICE program gives them the opportunity to get out of the business of administering health benefits and bearing the associated financial risks. In most cases, the CHOICE program will offer a firm's employees an option for comprehensive health insurance coverage with much greater choice, with coverage as rich as, if not richer than, that they currently have, and with much lower patient cost sharing, at a reasonable price. The coverage is also a bargain for the employer.

However, there may be substantial opposition from the Chamber of Commerce and the National Federation of Independent Businesses with respect to imposition of a payroll tax on small firms. Even though the majority of U.S. firms, including small firms, offer their workers health benefits, and the CHOICE program will enable these firms to provide more comprehensive benefits for their workers at a lower cost than they pay now, organizations representing small-business interests are likely to view any scheme that imposes new taxes on firms as unacceptable. Under the CHOICE program, small firms will be subject to a 5.5 percent tax on total payroll, but it is not clear how this will play out. Many small employers would like to offer their workers

health insurance coverage but cannot afford the prices. The payroll tax is substantially less than the cost of coverage in the small- and large-group markets. In addition, as previously mentioned, high-wage firms are likely to continue to offer their workers health benefits that are more attractive than the CHOICE program to avoid paying more through the payroll tax for health care than they do now through self-insurance or purchasing group products. Firms also may worry that as costs increase, the payroll tax will creep up, but their costs are likely to increase regardless of how they participate in employer-sponsored health benefits. Their premiums in the group-health insurance market are increasing now at double-digit rates. In addition, any increased costs imposed on employers under CHOICE will be tempered by the ability to spread them across the many different sources of revenue for the CHOICE program, including the employee share of the premium and the state and federal sources of revenue as well as new sources of revenue, including new public health taxes. Under the current system, when health insurers increase group premiums, there is no way for employers to share the burden of increased costs except to shift them onto employees.

Compared to a uniform federal program, a federal-state model of shared responsibility in achieving universal coverage is much more likely to be politically acceptable both to state legislators and to Congress. The success of S-CHIP suggests that the federal government can play an important role in defining the framework and options for broad expansions and reform of the health care system, including eligibility determination, outreach, and enrollment, leaving the details regarding administration, interagency coordination, regulation, and quality assessment and assurance to each state. In fact, individual state programs might look quite different under CHOICE. In some states, the CHOICE program, once fully implemented, may resemble a single-payer plan, where the state contracts with all private and public providers in the state as part of the CHOICE Network with no ODS options. This scenario is particularly likely to occur in states where there are no staff- or group-model HMOs and no large multi-specialty groups facilitating their creation. In other states, once fully implemented, the CHOICE program may resemble Alain Enthoven's original vision of managed competition[49], with many organized delivery systems made up of exclusive groups of providers in partnership with an insurer competing against each other for enrollment of the population living and working in their service area, with the majority of providers in the state participating in one ODS. Most state programs probably will fall somewhere in between these extremes, with a choice of several ODSs, but with the majority of the health care providers contracting with the CHOICE Network.

Many states are likely to welcome the program because it enables them to solve an enormous problem without requiring that they raise any new state revenue, and to streamline administration and reduce costs associated with existing public insurance programs. In addition, states will be eligible for considerable amounts of federal revenue generated from the payroll tax, public health taxes, and the NAFTA Social Integration Fund to solve what has been an intractable problem—reaching near-universal health insurance coverage and offering comprehensive and affordable coverage to all residents in their state. However, states also will face a number of new administrative challenges, which some states will be able to meet better than others.

It is unlikely that any comprehensive national health care reform proposal will be enacted in the foreseeable future, despite the fact that the number of uninsured is growing,

[49] Enthoven, AC. Health plan : the only practical solution to the soaring cost of medical care. (Reading, Mass: Addison-Wesley Pub. Co.) 1980.

health care is becoming more expensive, and the issue is increasingly on the public agenda. However, given the current revenue shortfalls at the federal and state level and the attention being given to fighting terrorism at home and abroad, Congress is unlikely to tackle the problem of the uninsured and underinsured, with perhaps the exception of working to pass some kind of pharmacy benefit under Medicare. While it is likely that comprehensive national health care reform will become a more dominant issue in the 2004 presidential election, until the U.S. economy improves and there is a change in leadership at the national level, the problem of the uninsured is likely to continue to worsen and to be excluded from the formal policy agenda. However, this political reality does not mean that we should stop working on new proposals to solve this ongoing problem. One of the important lessons from the failed Clinton health care reform effort was that there was not a viable and acceptable policy solution ready to go with a broad base of support when the policy window opened.[50] In addition, strategies for responding to opposing interests and framing the debate were not well developed, and the battle to win public opinion was ultimately lost. Understanding where is the most likely a strong base of support on which to build a broad-based coalition and anticipating the sources of opposition and how they will try to reframe the debate will be key in winning this war.

Acknowledgements

The following people made significant contributions to this proposal: Sylvia Guendelman, Ph.D.; Joyce Lashof, M.D.; Sharon Levine, M.D.; Sara McMenamin, Ph.D.; Patricia Powers, M.P.P.; and Sara Singer, M.B.A. Contributions do not imply endorsement of the full proposal. ■

[50] Kingdon, JW. *Agendas, Alternatives and Public Policies.* (New York. NY: Harper Collins) 1984.

Helen Ann Halpin

Helen Ann Halpin has proposed a program that emphasizes voluntary choice but which includes incentives that are likely to produce a state-based, single-payer system over time. It has the following elements:

A CHOICE PLAN THAT WOULD CONTRACT with all willing (presumably most) licensed providers and group model or staff model HMOs and offer comprehensive coverage to most of the population should they choose to enroll.

CONTINUATION OF MEDICAID, S-CHIP, MEDICARE, EMPLOYER-BASED PLANS, and private insurer plans as alternatives to CHOICE for those who prefer to stay with current forms of coverage.

A REQUIREMENT THAT EMPLOYERS EITHER OFFER COVERAGE (though neither the type of plan nor the amount of premium contribution would be regulated) or pay a payroll tax of no more than 6.5 percent for each employee not covered under the employer's health plan.

SUBSIDIES AVAILABLE ONLY TO PEOPLE ENROLLING IN CHOICE that would limit premium payments to a maximum of 2.5 percent of annual income, depending on income and family size.

FINANCING FOR CHOICE from individuals (premiums), states (replacing some current public program subsidies), the federal government (some new "sin" taxes), employers (payroll taxes), and a new assessment on cross border transactions between Mexico and the United States.

About the Author

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