



University of Connecticut Health Center

TESTIMONY

Public Health Committee

January 31, 2007

**SB 1, An Act Increasing Access to Affordable, Quality Health Care
HB 6332, An Act Increasing Access to Health Care**

Senator Handley, Representative Sayers, members of the Public Health Committee, my name is Peter Deckers, Executive Vice President, University of Connecticut Health Center (UHC) and the Dean of the School of Medicine. Thank you for the opportunity to speak with you today in support of **SB 1, An Act Increasing Access to Affordable, Quality Health Care and HB 6332, An Act Increasing Access to Health Care.**

As you undertake the vital task of increasing access to affordable quality health care, I want you to know you have a resource in the University of Connecticut Health Center (Health Center).

The Health Center is comprised of the Schools of Medicine and Dental Medicine and the Graduate School in Bio Medical Sciences, the UConn Medical Group (our faculty practice) and John Dempsey Hospital (JDH). We are the only public academic medical center in the state and we operate the only public acute care hospital in the state; our primary mission is education and research. Each year our graduates help populate Connecticut's legions of physicians and dentists. Researchers conduct more than \$90 million per year of innovative basic science, clinical, epidemiological and bio-behavioral research that is translated into advances in patient care—advances such as ovarian cancer vaccines, hormone therapies for osteoporosis and stem cell research. We are host to more than 600 residents in training every year who practice and train in local hospitals. We have much in common with community hospitals, but our education and research mission also makes us different. Each of our components contributes in a special way to our goal of teaching, creating new knowledge and translating that knowledge from the laboratory to patient bedside.

As a body of health care professionals housed in your public academic medical center, we believe in the power of quality and accessible health care to all residents. We believe in health promotion and disease/injury prevention as critically necessary to any successful healthcare plan that is adopted. A health care system, which does not address opportunities to prevent disease and injury, will not improve the health of our populations and will ultimately be unaffordable. Through UConn's Center for Public Health and Health Policy we serve as founding members of the BeHealthy Connecticut Coalition, where prevention is a key principle. The University provides expertise in

primary, secondary, and tertiary prevention, supporting policy for clean environments and healthy workplaces, promoting early detection programs for treatable conditions such as high blood pressure and cancer, and developing systems of care for chronic disease that improve health and quality of life. From birth to the end of life, our faculty seeks to optimize health, health care, and performance of patients, families, and communities.

As your public academic medical center, you have a cadre of extremely talented faculty whose expertise can be of tremendous value as you determine how to increase access to affordable, quality health care. Through the UConn Center for Public Health and Health Policy, we have developed a matrix of principles and issues you may want to consider along with a worksheet that can be used as a means to evaluate different proposals that come before you. (A copy of the matrix and worksheet has been shared with Senator Handley and Representative Sayers and is attached to my testimony). I hope you will find the matrix a useful tool during this process. It is a checklist with 10 key principles that include, eligibility, participation, affordability, scope of benefits, cost sharing and equity, access to care, financing, quality, continuity of coverage and evaluation that can be measured by any plan you are considering. The document and matrix tool do not take positions as to which choices will best serve Connecticut, but rather they help in assessing the competing proposals and serve as an easy to use comparative tool.

You have a daunting task ahead of you as you consider the numerous proposals that are now and will be under consideration. As researchers we know that no matter how well designed, getting something right out of the box, may just not be the case. We strongly believe that whatever proposal is considered and ultimately approved to increase access to affordable, quality health care, it is critical to include in the design rigorous data-tracking and an objective evaluation component that will support monitoring of results and continuous improvement in the 10 key areas outlined in our matrix. The evaluation would serve as necessary data for you as policy makers and for administrators who will need data on a regular basis to document successes and failures of the systems in place and to inform decisions as to the future allocation of resources. We would be happy to discuss how the University of Connecticut and the University of Connecticut Health Center might be of assistance in evaluating whatever plan is ultimately adopted.

We support your efforts and again stand ready to assist you as you work to increase access to affordable, quality health care to residents statewide. Thank you for your attention.



DOMAIN	KEY FEATURES	PRINCIPLES/CONCERNS
Eligibility	<ul style="list-style-type: none"> Degree of inclusiveness—pre-existing condition, age, income, residency or other exclusions Number and kind of documentary requirements 	<ul style="list-style-type: none"> Potential for coverage gaps based on eligibility determinations: income, immigration/residency status.
Participation	<ul style="list-style-type: none"> Process of enrollment: relative ease or difficulty Amount and kind of effective marketing and outreach 	<ul style="list-style-type: none"> Disincentives for participation: high out-of-pocket costs, burdensome documentation, cultural barriers. Potential for fraud/abuse and administrative burden in income disclosure and verification process
Affordability	<ul style="list-style-type: none"> Premium assistance: low income, disability & health status. Range of plans/ degree of choice Measure of affordability for employers and individuals. 	<ul style="list-style-type: none"> More comprehensive plans may impact affordability and cost containment efforts Lack of clear evidence of cost-effectiveness of some prevention activities, although most result in improved quality of life.
Scope of Benefits	<ul style="list-style-type: none"> Comprehensiveness: physician, hospital, prescription drugs, durable medical equipment, rehabilitation services, home health services, etc Incentives for primary care and for integration of care Oral Health (prevention and treatment) Mental health and substance abuse treatment parity Degree of focus on prevention, health promotion, early detection of disease, and chronic disease management 	<ul style="list-style-type: none"> Significant co-pays and deductibles can cause insured to avoid or delay treatment Employer costs may stifle economic development and job growth
Cost Sharing & Equity	<ul style="list-style-type: none"> Equitable cost sharing among individuals, employers, and governments based on ability to pay, economic incentives, and social welfare Incentives for lifestyle choices proven to prevent or slow development of disease 	<ul style="list-style-type: none"> De facto multi-tiered system from lack of incentives for providers to participate, resulting in limited options for persons in poverty or with special needs Cultural barriers to timely and effective care Will universal coverage result in an increase in demand for health services that is beyond current resource capacity?
Access to Care	<ul style="list-style-type: none"> Adequate provider participation incentives Simplification of administrative burden on providers Reduced language/cultural barriers Ease of navigating the health system Support for health education and literacy Transportation and care coordination available as needed 	<ul style="list-style-type: none"> Administratively burdensome and costly revenue collection methods
Financing	<ul style="list-style-type: none"> Sustainable, reliable, and predictable financing mechanisms Continued/enhanced federal participation Cost controls that include long-term population health 	<ul style="list-style-type: none"> Health information technology is effective for error reduction and quality measurement, but requires significant up-front capital investment Many methods of dissemination of EBM to providers are ineffective
Quality	<ul style="list-style-type: none"> Provider incentives to follow standards of care and practice evidence-based medicine (EBM) Error monitoring and feedback Program evaluation components for efficiency in program operation, cost-effectiveness, and continuous quality improvement. 	<ul style="list-style-type: none"> Administrative complexities may increase overall system costs
Continuity of Coverage	<ul style="list-style-type: none"> Continuous, affordable coverage regardless of employment status, retirement, change in health status, or change in income, assets or personal circumstances. 	<ul style="list-style-type: none"> No program of universal health care coverage, no matter how well designed, can anticipate all unintended consequences. Essential program design elements include monitoring through rigorous data-tracking and comprehensive evaluation in support of continuous program improvement.
Evaluation	<ul style="list-style-type: none"> Ongoing data collection systems related to broad range of cost, quality, and access variables Analytic capacity to process data and produce clear information on system performance related to cost, quality and access Policy development capacity to generate evidenced-based recommendations for system modification 	



Universal Health Insurance Coverage Key Principles Matrix --- December 2006

DOMAIN	CRITERION	RESULTS
Eligibility	<ol style="list-style-type: none"> 1. Age range accepted: 2. Immigration Status accepted: <ol style="list-style-type: none"> a. Citizen or Alien resident b. Visa- work or tourist c. Undocumented 3. Income limitations: 4. Asset limitations: 5. Residency requirements: 6. Exclusion/ limitations on preexisting conditions: 7. Documents required: 	<ol style="list-style-type: none"> 1. 2. <ol style="list-style-type: none"> a. b. c. 3. 4. 5. 6. 7.
Participation	<ol style="list-style-type: none"> 8. Process of enrollment: relative ease or difficulty 9. Marketing proposed: 10. Outreach proposed: 	<ol style="list-style-type: none"> 8. 9. 10.
Affordability	<ol style="list-style-type: none"> 11. Premium assistance: <ol style="list-style-type: none"> a. low income b. disability c. impaired health 12. Range of plans 13. Measure of affordability for employers <ol style="list-style-type: none"> a. By size of business/ # of employees b. By % of wages 14. Measure of affordability for individuals/ families <ol style="list-style-type: none"> a. By % of income and absolute cost b. Subsidy of low income individuals by high income c. Subsidy of the chronically ill by the healthy 15. Cost-shifting Analysis <ol style="list-style-type: none"> a. Subsidy of low income individuals by high income b. Subsidy of the chronically ill by the healthy c. Subsidy of unemployed by the employed 	<ol style="list-style-type: none"> 11. <ol style="list-style-type: none"> a. b. c. 12. 13. <ol style="list-style-type: none"> a. b. 14. 15. <ol style="list-style-type: none"> a. b. c.
Scope of Benefits	<ol style="list-style-type: none"> 16. Comprehensiveness of included services: <ol style="list-style-type: none"> a. Physician/ prescriber b. Hospital c. Prescription drugs d. DME e. Rehabilitation services f. Home health services g. Other: _____ 17. Incentives for primary care 18. Incentives for vertical integration of care 19. Oral Health (prevention and treatment services) 20. Mental Health treatment parity 21. Addictive Disorder treatment parity 22. Degree of focus on prevention, health promotion, early detection of disease, and chronic disease management 	<ol style="list-style-type: none"> 16. <ol style="list-style-type: none"> a. b. c. d. e. f. g. 17. 18. 19. 20. 21. 22.



Center for Public Health and Health Policy

<p>Cost Sharing & Equity</p>	<p>23. Individuals a. Premium structure b. Copays for MD, hospital, medications</p> <p>24. Employers a. Premium costs b. Economic incentives</p> <p>25. Government a. # covered at what cost b. Benefit to social welfare, reduced emergency room care</p> <p>26. Incentives for lifestyle choices proven to prevent or retard development of disease</p>	<p>23. a. b.</p> <p>24. a. b.</p> <p>25.</p>
<p>Access to Care</p>	<p>27. Provider participation incentives a. % Fee schedule compared to Medicare b. Other non-financial benefits</p> <p>28. Administrative burden a. estimated time per patient visit b. estimated office staff requirements</p> <p>29. Language/cultural barriers addressed in what way?</p> <p>30. Ease of navigating the health system</p> <p>31. Support for health education and literacy a. Part of the health care system b. Optional or incentivized?</p> <p>32. Transportation to appointments available if needed?</p> <p>33. Care coordination available if needed?</p>	<p>26. a. b.</p> <p>27. a. b.</p> <p>28. 29. 30.</p> <p>31. 32.</p> <p>33.</p>
<p>Financing</p>	<p>34. Financing mechanisms a. Sustainable? b. Reliable and predictable?</p> <p>35. Continued/enhanced federal participation?</p> <p>36. Cost controls that include long-term population health?</p>	<p>34. 35.</p>
<p>Quality</p>	<p>37. Provider incentives to follow standards of care and practice evidence-based medicine (EBM) a. Which criteria set proposed?</p> <p>38. Error monitoring and feedback a. Mechanism for data collection and feedback</p> <p>39. Program evaluation components for efficiency in program operation, cost-effectiveness, and continuous quality improvement a. Mechanism for data collection and feedback b. Mechanism for choosing CQI initiatives</p>	<p>36.</p> <p>37.</p> <p>38.</p>
<p>Continuity of coverage</p>	<p>40. Continuous, affordable coverage a. Changing jobs b. Loss of job c. Retirement d. Change in health status e. Change in income f. Change in assets.</p>	<p>39. a. b. c. d. e. f.</p>



Universal Health Insurance Coverage Key Principles Matrix --- December 2006

DOMAIN	CRITERION	RESULTS
Eligibility	1. Age range accepted: 2. Immigration Status accepted: a. Citizen or Alien resident b. Visa- work or tourist c. Undocumented 3. Income limitations: 4. Asset limitations: 5. Residency requirements: 6. Exclusion/ limitations on preexisting conditions: 7. Documents required: 8. Process of enrollment: relative ease or difficulty 9. Marketing proposed: 10. Outreach proposed: 11. Premium assistance: a. low income b. disability c. impaired health 12. Range of plans 13. Measure of affordability for employers a. By size of business/ # of employees b. By % of wages 14. Measure of affordability for individuals/ families a. By % of income and absolute cost 15. Cost-shifting Analysis a. Subsidy of low income individuals by high income b. Subsidy of the chronically ill by the healthy c. Subsidy of unemployed by the employed 16. Comprehensiveness of included services: a. Physician/ prescriber b. Hospital c. Prescription drugs d. DME e. Rehabilitation services f. Home health services g. Other: _____ 17. Incentives for primary care 18. Incentives for vertical integration of care 19. Oral Health (prevention and treatment services) 20. Mental Health treatment parity 21. Addictive Disorder treatment parity 22. Degree of focus on prevention, health promotion, early detection of disease, and chronic disease management	1. 2. a. b. c. 3. 4. 5. 6. 7. 8. 9. 10. 11. a. b. c. 12. 13. a. b. 14. 15. a. b. c. 16. a. b. c. d. e. f. g. 17. 18. 19. 20. 21. 22.
Participation		
Affordability		
Scope of Benefits		



Cost Sharing & Equity	<p>23. Individuals</p> <ul style="list-style-type: none"> a. Premium structure b. Copays for MD, hospital, medications <p>24. Employers</p> <ul style="list-style-type: none"> a. Premium costs b. Economic incentives <p>25. Government</p> <ul style="list-style-type: none"> a. # covered at what cost b. Benefit to social welfare, reduced emergency room care <p>26. Incentives for lifestyle choices proven to prevent or retard development of disease</p>	<p>23. a. b.</p> <p>24. a. b.</p> <p>25.</p>
Access to Care	<p>27. Provider participation incentives</p> <ul style="list-style-type: none"> a. % Fee schedule compared to Medicare b. Other non-financial benefits <p>28. Administrative burden</p> <ul style="list-style-type: none"> a. estimated time per patient visit b. estimated office staff requirements <p>29. Language/cultural barriers addressed in what way?</p> <p>30. Ease of navigating the health system</p> <p>31. Support for health education and literacy</p> <ul style="list-style-type: none"> a. Part of the health care system b. Optional or incentivized? <p>32. Transportation to appointments available if needed?</p> <p>33. Care coordination available if needed?</p>	<p>26. a. b.</p> <p>27. a. b.</p> <p>28. 29. 30.</p> <p>31. 32.</p> <p>33.</p>
Financing	<p>34. Financing mechanisms</p> <ul style="list-style-type: none"> a. Sustainable? b. Reliable and predictable? <p>35. Continued/enhanced federal participation?</p> <p>36. Cost controls that include long-term population health?</p>	<p>34. 35.</p> <p>36.</p>
Quality	<p>37. Provider incentives to follow standards of care and practice evidence-based medicine (EBM)</p> <ul style="list-style-type: none"> a. Which criteria set proposed? a. Mechanism for data collection and feedback <p>38. Error monitoring and feedback</p> <p>39. Program evaluation components for efficiency in program operation, cost-effectiveness, and continuous quality improvement</p> <ul style="list-style-type: none"> a. Mechanism for data collection and feedback b. Mechanism for choosing CQI initiatives 	<p>37. 38.</p> <p>39. a. b.</p>
Continuity of coverage	<p>40. Continuous, affordable coverage</p> <ul style="list-style-type: none"> a. Changing jobs b. Loss of job c. Retirement d. Change in health status e. Change in income f. Change in assets. 	<p>39. a. b. c. d. e. f.</p>

Key Principles of Universal Health Care

Multiple calls for new solutions to the health care crisis facing Connecticut and the nation will lead to an active debate in the Connecticut General Assembly regarding Universal Health Care. This document, prepared by The Center for Public Health and Health Policy (CPHHP) at the University of Connecticut, outlines the core principles that should be addressed in any proposal to provide universal health care to all residents of Connecticut.

The CPHHP was formed in 2004 by the University to bring together faculty across the University's campuses who work in public health-related fields and to be the focal point for public health research at the University. It has been asked to provide this framework to assist in deliberations at the Capitol.

Background

Connecticut is one of the wealthiest states in the United States, based on per capita income. It also has one of the highest percentages of residents with health insurance. However, approximately 12.9% of its residents have no health insurance. Studies have shown that lack of insurance causes people to postpone or forgo health care, even for serious conditions. The uninsured are less likely to have a regular provider of medical care and are more likely to use more expensive emergency care. They are also less likely to be able to comply with recommended treatments when they do seek care, because of lack of prescription drug coverage. They are less likely to receive timely preventive care and are more likely to be hospitalized for avoidable health problems. (Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*. October 2006).^{1,2} The National Academy of Sciences estimates that nationally, 18,000 excess deaths each year can be attributed to a lack of health insurance.

The many calls for universal health care today are based on the premise that the availability of health insurance will result in better access to health care; better compliance with treatment recommendations; dollar savings due to provision of care in a more effective, more efficient and less costly manner; and ultimately, better health status for Connecticut's residents. The various proposals for providing universal health care should be evaluated against these goals.

In order to evaluate universal health care proposals, it is first important to define what is meant by universal health care. It is here defined in relation to its ultimate goal, which is the improved health status for those who are covered by it. The means to achieve this goal necessarily includes creating better and continuous access, quality, and affordability of medical care.

Most existing universal health care programs or proposals focus on making some form of health insurance available to all or most residents. This can be done through a single payer (e.g., Medicare and Medicaid), through the competitive insurance market, or through a combination

(e.g., Husky). However, the availability of an insurance card does not necessarily guarantee access to medical care (as is evident with some aspects of Medicaid in Connecticut), nor does it guarantee the quality, efficacy, or efficiency of the medical care obtained.

Several recent studies and reports have addressed the elements required for successful universal health coverage plans. The Institute of Medicine (IOM), in its recent report, *Insuring America's Health* (January 2006),³ set forth five principles for the assessment of universal coverage proposals and made it clear that any effort to provide universal coverage will require balance and trade-offs between competing goals. The IOM said that coverage should be: **universal** (cover everyone who lives in the United States); **continuous** (allows for early detection of disease and uninterrupted treatment); **affordable for individuals and families** (including financial assistance for low-income individuals and families); **affordable and sustainable for society** (including cost and inflation controls and incentives for use of most efficacious and cost-effective services); and it should **enhance the health and well-being** of those it covers (including preventive services, health screenings, prescription drug benefits, and mental health services). This last element requires a system that will strive to achieve the six elements of quality health care outlined by the IOM Committee on Quality of Health Care in America: effectiveness, efficiency, safety, timeliness, patient-centeredness, and equity.

The Citizens Health Care Working Group (CHCWG) was established under the Medicare Prescription Drug Improvement and Modernization Act of 2003, and charged to research and report to Congress the health care benefits the American people want, how such health care should be delivered, what insurance coverage they want, and how they are willing to pay for it. The CHCWG's report⁴, issued in September 2006, sets forth six goals for health care for America. These include **universal coverage, protection from catastrophic health care costs and improvement of the current system of health care**, both in terms of accessibility and quality.

The Kaiser Commission on Medicaid and the Uninsured (Kaiser Commission) issued its report, *Health Coverage for Low-Income Americans* in October 2006.⁵ This report outlines what the Kaiser Commission sees as the key elements of any program to provide health insurance to the low-income uninsured. These elements are: **eligibility, participation, affordability, scope of benefits, use of cost-sharing, access to care and financing** of the insurance.

Principles

We have integrated the recommendations of these national reports to develop the attached matrix of key principles for evaluating proposals for universal health care in Connecticut. The key principles included are not listed in order of priority. Each principle is important in a comprehensive scheme of universal health care coverage.

Eligibility

Eligibility criteria of any universal health care proposal should be reviewed to determine if there are significant gaps in those who would be covered. For example, current Medicaid eligibility is defined by categories as well as income. To be eligible for Medicaid, an individual must be a member of a covered group (children, pregnant women, elderly or disabled) and have income and assets at or near the poverty level. The requirements leave out many of the working poor, who earn too much to be eligible for Medicaid, but whose employers do not provide health insurance or require cost-sharing that the worker cannot afford. Medicaid also excludes non-disabled adults without children, regardless of income level. Consequently, we have a patchwork of coverage, with many gaps. The IOM, the CHCWG and Kaiser Commission have all recommended that coverage be available to all Americans (or, as the IOM states, to everyone who lives in America).

Proposals for universal health care should be evaluated for their inclusiveness of populations in Connecticut.

Participation

Universal health care proposals should be evaluated for ease of and barriers to participation. The IOM report found that more than half of the children who are eligible for the State Children's Health Insurance Program (SCHIP) coverage are not enrolled. Burdensome documentation requirements, complicated enrollment procedures, or significant premiums or cost sharing can make it difficult or impossible for those who need the coverage most to obtain it. In addition, Connecticut's experience with Husky A and B has shown that extensive outreach and marketing, as well as the removal of cultural barriers, are necessary to achieve significant participation in the program. Enrolling those who are eligible to participate is important, because, otherwise, they are likely to delay care, ultimately seeking acute care from emergency rooms and other more costly venues.

Proposals for universal health care should be evaluated for the likelihood that they will optimize participation.

Affordability

This element encompasses both affordability for participants and affordability for society. Low-income participants have little or no disposable income with which to pay health insurance premiums, deductibles and co-pays. Costs that are beyond their means will act as a barrier to participation. This is the case presently with many of the uninsured working poor. Low-income participants will likely need financial assistance in order to afford the uncovered costs of health care. At the same time, as the IOM report points out, universal coverage must be affordable for society, or it risks constant revision and/or discontinuance, which threatens the continuity of

coverage that is necessary for good health outcomes. The principle of affordability for society encompasses the means both to control health care cost inflation and to encourage efficacious, cost-effective services.

Proposals for universal coverage should be evaluated for their affordability, both for covered participants and for society.

Scope of Benefits

The CHCWG report takes the position that a consensus on a standardized core set of benefits and services that are both affordable and sustainable must be developed for universal coverage. Individuals could purchase private coverage for non-covered services (much as Medi-gap policies function today for Medicare beneficiaries). However, the Kaiser Commission report makes the point that, to the extent that such coverage will be the safety net for people with low incomes, the covered services should be comprehensive in order to maximize health status. Low-income individuals often have poorer health status than those with private insurance and have a greater need for comprehensive medical services, prescription drugs, durable medical equipment, rehabilitative services, and long-term care services (e.g., personal care assistance). This is particularly true of Medicaid beneficiaries with disabilities, who often need rehabilitative and long-term care services. The IOM report argues for a basic benefit package that includes preventive and screening services, outpatient prescription drugs, and mental health care, in addition to outpatient and hospital services. At a minimum, the CHCWG report argues for catastrophic coverage as necessary to protect Americans against very high health care costs. Another important issue is coverage for oral health (prevention and treatment).

Proposals for universal coverage should be evaluated for the extent of covered services, which must be balanced against the need for affordability.

If a basic benefit package is developed, consideration should be given to the development of other means to provide more comprehensive services needed by discrete low-income populations, such as people with disabilities and the elderly.

Cost Sharing

The IOM report takes the position that all members of society benefit from universal coverage and so all members should contribute to its cost through taxes, premiums, and cost sharing. However, cost sharing requirements should be proportionate to the income of the insured person and should not discourage people from seeking needed care. People living at or near the poverty level often have to choose between food, rent, other necessities, and medical care. If there are

significant deductibles or co-pays for services, even those who have coverage may postpone or avoid treatment if they cannot afford the cost sharing.

Proposals for universal coverage should be evaluated for the level of cost sharing required, and the extent to which such cost sharing is proportionate to the income of the insured.

Access to Care

Universal health insurance means little to an individual if he or she cannot obtain needed medical services on a timely basis, or does not understand the care plans developed by his or her providers. Inadequate access can result from lack of providers, lack of transportation, refusal of providers to participate in the plan, language or other cultural barriers, lack of time off from work, low health literacy, and/or lack of care coordination. Any universal health care proposal should be evaluated for the manner in which it addresses such issues.

Both the IOM and the CHCWG reports address the need to improve the quality and delivery capacity of the current system of health care. CHCWG recommends the development of integrated community health networks, which provide local access, continuity of care, coordination of services, and the ability to combine several funding systems. These closely mirror the elements of a “medical home,” which are viewed by the IOM as important to quality health care. The elements of a medical home are accessibility (local and available), continuity, cultural competence, patient-centeredness, coordination, and compassion for the individual patient.

Proposals for universal coverage should be evaluated for the extent to which they are likely to encourage provider participation and enhance access to care.

Financing

Financing is the issue that gets the most attention in proposals for universal health care. Whatever financing mechanism is used, it must be sustainable and reliable. Financing mechanisms include at least two distinct components: 1) development of revenue streams and 2) predictability and control of costs. The experience with Medicaid is that participation, and therefore cost, is at a maximum during bad economic times, when states are experiencing reduced revenue streams and looking for ways to restrain spending. Capping expenditures, whether on the individual or the program level, provides cost predictability, but the overall spending level may not be sufficient to accommodate the needs of all beneficiaries.

Uncontrolled costs, on the other hand, threaten to make universal coverage unaffordable for society and can lead to efforts to reduce benefits and eligibility.

Proposals for universal health care must be evaluated for the extent to which the method for collecting revenue is capable of being administered efficiently and fairly and is likely to generate sufficient revenue to pay for covered services.

Proposals should also be evaluated for the method(s) used to control costs and to ensure both the efficiency and the efficacy of the health care obtained.

Quality

Quality control and program evaluation are critical components of any universal health care program. Such programs must not only provide mechanisms for accurately predicting costs, but also for ensuring that the money is spent on services that are effective and appropriate. A number of studies have been published in the last twenty years suggesting that quality improvement and cost control can be accomplished together.^{6, 7, 8} The IOM has developed six criteria for the evaluation of quality health care.

A proposal for universal coverage should be evaluated for the extent to which it supports these six elements of quality of care: effectiveness, efficiency, safety, timeliness, patient-centeredness, and equity¹.

Continuity of Coverage

Continuity of coverage is important to the ultimate goal of achieving improved health status for all Americans (or people who live in America). Gaps in coverage often result in delayed care for the sick and the lack of preventive care or health screening, both of which lead to lower health status. Gaps in coverage make compliance with medical providers' recommended plans of treatment and control of chronic diseases more difficult. Guaranteeing continuity of coverage may also help to level out the peaks and valleys of demand for health care services that make it difficult to predict costs and staffing needs. The lack of continuity of coverage has significant economic impact. Job mobility is reduced by approximately 30% due to the lack of portability of health insurance coverage.⁹

Proposals for universal coverage should be evaluated for the extent to which they ensure continuity of coverage.

Ongoing Evaluation

No program of universal health care coverage will get everything right at the beginning, no matter how well designed it is. Therefore, it will be critical to include in the design a rigorous data-tracking and evaluation component that will support monitoring of results and continuous improvement in the nine key areas outlined above. The University of Connecticut, through its Center on Public Health and Health Policy, is ready to assist in the evaluation phase of this endeavor.

Proposals for universal coverage should be evaluated for the adequacy of their ongoing data collection and analysis capacity.

Matrix Tools

The attached matrix of key principles puts these principles in a graphic form, with key features and concerns noted for each one. The placement of each criterion listed under the principles is somewhat arbitrary, as many criteria apply to more than one principle. Furthermore, the criteria interact in complex ways, and it may be necessary to consider the impact of each criterion on multiple other criteria. We have also attached a second matrix listing criteria under each key principle, which can serve as a checklist for the evaluation of individual proposals.

We would be happy to answer any questions you may have about the content of this memo at any time. Thank you for the opportunity to address this important issue.

1. The Uninsured: A Primer, Kaiser Commission on Medicaid and the Uninsured. Oct 2006
2. Care Without Coverage: Too Little, Too Late. National Academy of Sciences. 2002
3. Insuring America's Health, Institute of Medicine. Jan 2006
4. Health Care That Works for All Americans, Citizens Health Care Working Group (CHCWG). Sept 2006
5. Health Coverage for Low-Income Americans, Kaiser Commission on Medicaid and the Uninsured. Oct 2006
6. Bodenheimer, T. And A. Fernandez (2005). "High and rising health care costs. Part 4: can costs be controlled while preserving quality?" Ann Intern Med 143(1): 26-31.
7. Chaiken, B.P. and M.A. Thompson (1997). "Enhancing quality and controlling costs: using Internet technology to apply workflow to health care." Healthc Inf Manage 11(3): 73-80.
8. Berwick, D.M. and M.G. Knapp (1987). "Theory and practice for measuring health care quality." Health Care Financ Rev Spec No: 49-55
9. Scott J. Adams. Employer-Provided Health Insurance and Job Change. Contemporary Economic Policy, July 2004.