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Universal Coverage, Universal Responsibility
A ROADMAP TO MAKE COVERAGE AFFORDABLE FOR ALL AMERICANS

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According to the most recent census numbers, 43 million Americans were uninsured in 2002 — and nearly one-third of the non-elderly population were uninsured during some portion of the preceding two years.[1] Studies show that people without health insurance delay needed care, have poorer health outcomes, and die prematurely. When the uninsured do get care, it is more likely to be inappropriate and they are often charged much higher prices than those with insurance. Victims of this discriminatory pricing either end up in financial ruin or are simply unable to pay, shifting the cost of their coverage onto those with insurance. Americans who have insurance are increasingly nervous about losing that insurance, a fear that has been exacerbated by a sluggish economy and a health care system where losing a job usually means losing health insurance.

While most Americans agree that something must be done to cover the uninsured, there is little agreement about how to move forward. Ten years ago, President Clinton made health care reform a centerpiece of his administration's policy goals, but was unable to reach a consensus with Congress on a plan. Since that time, some incremental steps have expanded coverage, particularly the creation of the State Children's Health Insurance Program (SCHIP) in 1997. Nevertheless, the overall health coverage gap has grown wider, even among the middle class. Eight out of each ten uninsured Americans are in working families and an estimated 60% of uninsured wage earners own or work for a business that has fewer than 100 employees.[2] Premium costs are rising again at double-digit rates, employers are increasingly passing these costs on to their employees, and the number of uninsured Americans keeps climbing.

While the majority of Americans support the concept of universal coverage, there is little agreement on how best to achieve that goal. While this is a difficult puzzle to solve, it is not an intractable problem. The most promising and politically feasible route to universal coverage, we believe, is to make an adequate level of health insurance mandatory *and* affordable for all individuals, a system that could build on the various structures that already exist. The grand bargain underlying compulsory health insurance should be ***universal coverage in exchange for universal responsibility***. Insurance should be required, but in exchange, it should also be affordable. By making both the insurance mandate and subsidy *citizen-based*,[3] the nation can achieve universal coverage, expanded choice among private plans, and continuity of coverage and care regardless of employment status.

The key features of the proposal described in more detail below include:

- All Americans would be required to maintain an adequate level of coverage with a fixed, maximum contribution based on ability to pay. Individuals who wish to purchase more comprehensive coverage could do so.
- Americans who have employer-based insurance could keep that insurance. Individuals without employer-sponsored coverage would be able to access affordable insurance through community insurance pools that states would establish to offer every American a choice among competing private insurance plans. In both cases, health insurance would be portable and employees would no longer have to fear that losing a job means losing health care. The insured would also see their costs stabilized and choice expanded.
- Contributions and subsidies would flow from a combination of mandatory employer contributions, individual payments not to exceed a modest percentage of family income, and a refundable federal tax credit payable directly to health plans

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(including to employer plans) to make up the difference.

- Insurers offering coverage through the pools would be required to offer a core benefits package. Individuals could purchase more comprehensive coverage with their own funds or with additional employer contributions.
- Medicaid and the State Children's Health Insurance Program (SCHIP) would be modified to fit within this proposal, but would continue to ensure access to the lowest income and most vulnerable individuals.

GOALS OF REFORM

Universal Coverage and Responsibility

The most fundamental goal of this proposal is to achieve universal health insurance coverage. It is premised on the belief that the best and most politically feasible route to universal health insurance coverage is to require all Americans to have insurance and for the government, employers, and insurers to help make that insurance affordable. Just as drivers are required to have insurance, the responsibility to avoid imposing the burden of uncompensated health care costs on society must be elevated from a voluntary to a mandatory duty of citizenship.

Affordability Regardless of Job Status

A second key reform goal is to make access to a choice of affordable health plans available regardless of job status — that is, to make coverage fundamentally *citizen-based* rather than *job-based*. At its inception more than forty years ago, the employer-based system was based on the premise that there was one full-time earner in the family who was provided with coverage for himself and his dependents, generally an at-home spouse and children. This notion of the American workforce is terribly outdated today and, as a result, excludes large percentages of working Americans from coverage. Millions of Americans today work one or two part-time jobs, are independent contractors or are self-employed, and they are all excluded from employer-based coverage. Millions more — 60 percent of the uninsured — work full-time[4] and they too are not immune from this phenomenon. They are uninsured either because their employers do not offer coverage or because they cannot afford their share of the premiums.

The current system also creates significant labor market distortions, burdening families and decreasing economic efficiency. In many two-income families, one worker has difficulty accessing health benefits and instead relies on dependent coverage offered through the spouse's employer — a form of cost shifting that encourages yet more firms to drop coverage or to increase the worker premiums.[5] Employees are deterred from reducing their hours or switching jobs if it means losing their health insurance.

This proposal for mandatory insurance de-links coverage from employment and expands the advantages of group insurance to all Americans by giving every individual and adult access to a choice of competing private plans through a Community Insurance Pool (CIP). Every individual would have guaranteed access to basic coverage at a cost that does not exceed a fixed share of household income, and all but the lowest-income would have a responsibility to contribute a reasonable, fixed amount to the cost of coverage.

Expanded Choice, Portability, and Continuity of Coverage

Another vexing by-product of the employer-based system is the inability for individuals to take their health plan and doctors with them when they change jobs. This lack of portability is frustrating to consumers and has serious consequences for the quality and cost of health care. According to a recent study in the *Annals of Family Medicine,* 20 percent of people with insurance change plans each year, resulting in lower quality care and higher costs.[6] And even those with short spells of uninsurance have health outcomes more similar to the long-term uninsured rather than to the insured.[7] By enabling individuals to stay with a single insurer, a system of portable and continuous coverage would increase insurers' incentives to invest in disease prevention and long-term preventive care, investments that decrease the cost of care over time.

This system would be a major improvement for those who currently purchase health insurance through their employer. While those with employer-based insurance could keep that insurance, workers would no longer need to worry that losing a job means losing health insurance coverage. They would always have access to a variety of affordable plans through the Community Insurance Pools and be able to choose the plan that best suits their needs.

Improved Incentives for Cost Containment

A fourth goal of the system of universal coverage proposed here is to reduce the rate of increase in health insurance premiums, which have risen at double-digit figures over the past three years. The increasing and unpredictable cost of health insurance undermines the ability and willingness of employers to offer and pay for coverage.

There are many reasons for these cost increases. One is uncompensated care that to a large degree is passed along in higher prices to private payers. Another is the inefficient use of hospital emergency room services as a

means of primary care among the uninsured. In addition, companies offering good family coverage subsidize family members who work at other firms, but who are not offered or who decline coverage from their own employer. Requiring everyone to maintain and contribute to the cost of coverage will minimize this cost shifting and lower the average cost of coverage, particularly for individuals and small employers. Finally, there has been an explosion in information available to Americans about health care, such as the increasing prevalence of direct-to-consumer advertising for pharmaceuticals. This phenomenon, when coupled with Americans who are well insured and relatively prosperous, has contributed significantly toward skyrocketing health care costs.

Another costly side effect of America's fragmented health coverage policy is related to high turnover. Individuals typically switch plans and medical providers when they change (or lose) their job. Insurers would have a greater incentive to encourage preventive care and disease prevention if policyholders could remain with the same plan provider for the long-term. Policy churning is also a major contributor to the more than $110 billion spent nationally on private insurance and government administrative costs last year. This does not even include the administrative costs absorbed by employers, or the cost of lost productivity due to preventable illness and "job lock."

Individual consumer choice among competing private health plans could also better align supply with demand. Because workers typically have little choice over the scope or price of their health insurance benefits at work, individuals often end up with more or less coverage than they need or are willing — or able — to pay for. These choices are further distorted by excluding employer-paid health benefits from taxable income, since the tax subsidy encourages discretionary health care consumption far in excess of what individuals might choose to purchase with after-tax dollars. By subsidizing only basic but adequate coverage — and requiring that supplemental coverage and services be offered and priced separately — individuals would make more economically rational choices about health care.

Reduced Administrative Burden on Business

Another important objective of the self-insurance mandate and tax credits proposed here is to shift much of the cost of subsidizing basic health coverage for low-wage workers from employers to society as a whole. Because health insurance can represent 25 percent or more of a low-wage worker's total compensation, firms with a predominantly low-wage workforce have a strong disincentive to pay for health coverage. In addition, below median-wage workers receive little if any tax benefit from the exclusion of health benefits from taxable income.

The approach proposed here eliminates this disincentive by requiring employers to contribute toward the cost of all their employees' coverage, including those that are low-wage. Because employer-sponsored plans would be eligible to receive the tax credits that would subsidize insurance for low-income individuals and their dependents, low-wage workers would become relatively *less* expensive to cover rather than more. Moreover, employers that choose to continue offering health insurance benefits would see their costs reduced as uncompensated care and other schemes that shift costs to employers and private purchasers would be eliminated. In addition, by creating insurance purchasing pools and making all individuals eligible for coverage irrespective of their employment status, employers could choose to relinquish their role as administrators of complex health plans without reducing their employees' after-tax compensation. And since all employers would be required to offer or contribute toward the cost of coverage, the number of workers who receive health coverage from an employer other than their own would shrink.

Features of the System

Individual Insurance Mandate

The essential starting point for achieving universal coverage is a new social bargain: guaranteed access to affordable, adequate coverage in exchange for personal, employer, and societal responsibility. Maintaining an adequate level of health insurance should be a duty of citizenship. In turn, the government should assume the responsibility to subsidize coverage for those who need it and to maintain public programs such as Medicaid to cover the lowest-income families.

There are several reasons to make a self-insurance mandate the centerpiece of a universal coverage system. First, while many of the uninsured cannot afford coverage, more than 30 percent of the uninsured earn more than $50,000 a year, suggesting that they could afford to contribute to the cost of their own health insurance. These individuals fully expect society to provide them with first-rate health care if they become sick or are injured, as they should. But they should not expect others, particularly those who are paying to be insured, to bear the risk of paying for that care.

Second, there are eight million 18- to 24-year-olds without health insurance, and this age group is the fastest growing demographic of the uninsured. Their absence from the individual insurance market exacerbates adverse selection. Risk is unevenly distributed in the private

insurance market in part because there is a higher percentage of people who are already sick, or who are slightly older and perhaps more risk averse than the adult population as a whole. Bringing the younger and healthier population into the health insurance market will spread the risk more evenly, bringing down costs over time for everyone.

Third, it is critical that the public perceive the subsidies necessary to achieve universal coverage as part of a reciprocal obligation and not as welfare for the uninsured. A central purpose of the new system is to ensure individual choice and to protect workers who currently have coverage from losing it. Decoupling coverage from employment guarantees continuity of coverage for everyone, while also greatly reducing the cost to employers of covering low-wage workers.

Employer Contribution

Employers contribute roughly $350 billion every year toward their employees' coverage, a third of overall health care spending. Withdrawing this contribution would be disastrous for the market and unfair to employees, since health benefits are a basic component of employee compensation. At the same time, employers who wish to get out from under the burdensome administration of health care benefits should be given that option.

This leaves two roles for employers, one mandatory and one voluntary. The required role is to contribute toward the cost of all employees' health insurance; the voluntary role, as it is today, is to administer a company-sponsored health plan. Employers can either maintain coverage at least as comprehensive as the required minimum level of coverage, *or* they can make a premium contribution equal to a low and fixed percent of payroll. Like current contributions for Medicare and Social Security, the contribution would apply to all wages, including wages paid to part-time and contingent workers not otherwise eligible for coverage under the employer's own benefits plans. It is essential that these non-standard workers, who represent a disproportionate number of today's uninsured, accumulate automatic contributions to offset the cost of their coverage in proportion to their work effort and earnings.

Employers who are already providing coverage should welcome the option of a low, fixed percent contribution, since private firms that offer health insurance are currently spending at least 7 percent of payroll, on average, depending upon firm size.[8] Health benefit costs would become fixed and predictable, and there would be no burden of administering a plan. And since all employers would be required to contribute in some way, the practice of some firms shifting the costs of health insurance to others would end. Many firms that do not offer coverage to their low-wage workers today would be required to do so under this plan, and these workers would be subsidized, as we propose below. Although many small and low-wage employers would need to adjust their compensation mix to absorb this cost, they would face no competitive disadvantage, since every employer would contribute at the same rate.

Limit the Mandate to Basic Coverage

To create a basic benefits package, there must be a clear distinction drawn between medically necessary (and hence required) coverage and discretionary health care "consumption." Considering the enormous public expenditure associated with an entitlement to health insurance, we believe it is most practical to require (and subsidize) an adequate, but basic, level of coverage. The required basic benefits package could mirror the Blue Cross Blue Shield Standard Benefit offered to federal government workers through the Federal Employees Health Benefits Program (FEHBP). All available public subsidies should be targeted to make this basic coverage as affordable as possible—and to make discretionary purchase of coverage beyond the required coverage compete equally with other consumer demands. Employers and individuals should have the option to purchase supplemental coverage or services above the core package, but these offerings should be priced separately and not be subsidized.

Enforcement

Every adult would be required to maintain, individually and on behalf of his or her dependents, health insurance coverage at least as comprehensive as the required benefits package. As part of the annual income tax filing process, the government could verify coverage. Individuals who fail to certify coverage could be randomly assigned to a private plan offered through the CIP that is priced at or below the average for that region. The lowest-income individuals, who are not required to file an income tax form, would be required to submit the proof-of-insurance form (or equivalent) each year to maintain their qualification for subsidies. Although the tax credit vouchers would be paid directly to qualified plans, all individuals (including non-filers) would need to annually report their total household income to maintain eligibility.

Individual Contributions

Contributions to the cost of health insurance would be divided among the three current sources of today's private employer-based health insurance system: federal tax subsidies (described below), an employer contribution, and individual payments that would never

exceed a modest share of a family's adjusted gross income. The total individual and employer responsibility would be capped at a fixed percentage of an employee's adjusted gross income, with employers contributing a larger share than employees, as most do today.

Tax Credits

Insurance should only be mandatory if it is affordable. Subsidies would be available to bridge the gap between the personal responsibility requirement and the cost of adequate health insurance. If the cost of a basic plan exceeds the individual's required contribution, the difference would be made up by a federal tax credit (in the form of a voucher) paid directly on behalf of the subsidized household to the household's health plan or self-insured employer. The tax credits would be refundable, advanceable, and calculated on a sliding-scale basis according to income.

The premium contributions for the basic level of coverage, whether paid by employers or individuals, would be excluded from taxable income, as employer-paid health benefits are today, but any additional health benefits compensation would be reported as income. This has the overall effect of preserving the current tax exclusion for employer-paid health benefits, but capping its cost. Today's unlimited exclusion of health benefits compensation from both the payroll and income tax subsidizes both medically necessary care and discretionary medical consumption and is a major contributor to rising health care costs.

The tax credit would be attached to the individual, regardless of whether coverage was obtained through the employer's health plan or purchased directly through the CIP. The subsidy would greatly reduce the cost to employers of covering low-wage workers and their families, who receive no assistance today. The subsidy is therefore neutral with respect to the choice of health plans and promotes horizontal equity among households with similar ability to pay.

Community Insurance Pools

Today, individuals and small groups face significant barriers when they try to find affordable, high-quality health insurance. Small employers cannot adequately spread the risks of high medical claims, achieve economies of scale in administration, offer choices among health plans to their employees, or manage competition among health plans. They typically face substantially higher premium charges than large firms. Individuals seeking coverage are in an even more vulnerable position, particularly if they have a potentially costly pre-existing condition. Not surprisingly, the uninsured rate among wage earners who are self-employed or work in firms employing fewer than 25 employees is roughly double the uninsured rate for wage earners in medium and large firms.[9]

Perhaps the biggest challenge for a mandatory insurance system is to create a market mechanism to replicate the benefits of large employer-based risk pools for individual citizens. Making basic coverage mandatory for individuals necessitates making such coverage available and affordable to all. One potential remedy to the dysfunction of the small group and individual insurance market is to facilitate health insurance purchasing cooperatives that duplicate, or even improve on, the advantages of a very large and sophisticated employer group. By pooling small groups into larger ones, health insurance purchasing cooperatives (HIPCs) could bargain for lower premiums, increase access to coverage, and offer choice to employees of small firms.

Two key barriers have stymied the growth and success of purchasing pools in the small-employer market: the inability to reach a critical mass, which creates greater purchasing power and lowers administrative costs, and the presence of adverse selection, which concentrates risk and increases costs. The approach proposed here takes direct aim at these barriers by requiring and subsidizing health insurance for everyone so that low-risk individuals must also join the pool, funding states to create large scale purchasing pools, and requiring and providing incentives for employers to offer or contribute toward the cost of coverage.

To achieve this, each state would receive an initial federal grant to establish and operate one or more Community Insurance Pools. Participating insurers would be required to offer and separately price the nationally mandated benefits package on the basis of guaranteed issue and guaranteed renewability. Participating insurers, to be eligible to receive tax credits as payment, would be required to offer and separately price the mandatory benefits package on a community-rated basis. These basic ground rules would make the average cost of coverage as low as possible, reduce public subsidy expenditures, and avoid the costly administrative process of risk rating. Since the sliding-scale tax credits ensure that nobody pays more than a modest share of income for the mandatory level of coverage, concerns of younger and healthier populations who likely prefer risk rating should be mitigated.

Integrating Medicaid into the Mainstream

Our proposal would provide a guarantee that all Americans have access to affordable health insurance. As such, Medicaid and the State Children's Health Insurance Program (SCHIP) would continue to play a

critical role in providing coverage to the lowest-income individuals. Specifically, Medicaid would serve three roles in this proposal: (1) assuring affordability for the lowest income people by subsidizing premiums and cost-sharing and filling in benefit gaps for some individuals getting coverage through the state-sponsored purchasing pools; (2) serving the special health and long-term needs of people with disabilities and chronic health problems; and (3) coordinating eligibility for benefits across populations and programs.

Savings that states receive from the new progressive tax subsidy system should be reinvested to extend these protections to all low-income Americans, eliminating Medicaid's current categorical approach to coverage, and basing eligibility on need rather than category. Medicaid would be modernized to fit within the new construct, but its role would be as important under the new system as it is today in ensuring access to needed care among the lowest income and most vulnerable individuals as well as protecting them from the potentially devastating costs of uncovered health services.

Financing

Under this proposal, the cost of health insurance would be a shared responsibility between individuals, employers, and government. However, there would be several significant changes in the distribution of the financial burden, primarily because all employers and all but the lowest-income individuals and families would be expected to contribute to the cost of the required level of coverage.

While overall health spending by the federal government would increase,[10] the net cost would be reduced by at least three changes: first, by capping the tax exclusion for employer-paid premiums at the cost of the mandated benefits package; second, by requiring all employers not providing coverage to contribute a fixed percent of each worker's wage toward the cost of their employees' coverage; and, third, the insurance mandate would minimize uncompensated care, spreading the costs of care more evenly among all insured individuals. Finally, although making basic coverage affordable should increase the demand somewhat for primary and preventive health care, the mandatory nature of the system would help to reduce the *average* cost (and subsidy) for a basic plan by bringing in premium dollars from the uninsured who are able to pay. For example, the nearly 7 million uninsured adults living in households earning more than $75,000 would add $15 billion or more to the private insurance premium pool.

Incentives for Cost Containment

The system of mandatory self-insurance proposed here does not anticipate any form of rationing, premium caps, or other mechanisms that would force cost control directly. It does, however, include a number of features that should help to reduce administrative costs, make consumers more cost conscious, and encourage insurers to place more emphasis on preventive care.

Most important, a truly *citizen-based* model of universal coverage enables continuity of coverage and care. Unlike today's system, distinguished by the enormous waste and discontinuity of policy churning, individuals would be able to remain with the plan and doctors of their choice as they move from job to job. Insurers and health care providers spent $112 billion on administrative costs in 2002, a large portion of which is attributable to individuals moving in and out of plans and changing their medical providers frequently.[11] While continuity of coverage and the economies of scale inherent in a large Community Insurance Pool would reduce administrative costs, over the longer term enabling individuals to remain with a single plan should increase insurers' incentives to focus more on preventive care and disease management.

Second, the incentives to purchase coverage through the Community Insurance Pool would greatly increase competition in the small-group and individual insurance market. There would be more choice among more plans offering a standardized benefits package that would be easier for consumers to compare and to match more closely to their needs.

Third, the open-ended tax subsidy for health care consumption would be capped at the cost of the mandated benefits package. Although guaranteeing the affordability of coverage for all Americans would, by itself, increase utilization, removal of today's sizable tax subsidies for non-medically necessary services would place these additional health benefits on a level playing field with other types of compensation and consumption preferences. Eliminating the tax subsidy for coverage beyond the required level of coverage would save money and should encourage employers to increase wages or pension benefits (which have fallen steadily as a share of compensation as health care costs have risen).

Finally, the approach here anticipates substantial administrative savings for both insurers and employers. In addition to the significant savings from reduction in policy churning mentioned above, employers opting to simply enroll their workforce through the CIP would save considerable sums on overhead, administration, and internal benefits management and consulting services.

CONCLUSION

In the decade since the derailment of the Clinton plan, the American health care system has continued to deteriorate and nobody — not the insured or the uninsured — is

immune to its effects. Those with insurance are paying more every year for less coverage and are increasingly vulnerable to losing coverage altogether. The number of uninsured continues to grow with no end in sight. The cost borne by taxpayers increases steadily as federal and state Medicaid rolls continue to grow. Employers are being socked with large, unpredictable increases in their health insurance premiums, and fewer employees have health insurance coverage today than ten years ago.

The benefits of universal coverage for the uninsured, for whom the system has already collapsed, are obvious. But there are also significant benefits for insured Americans, whose anxiety about the future of their health insurance coverage is undermining their faith in their elected representatives. Not only will their costs go down, but they will have continuous coverage that is no longer tethered to their job, nor will they need to fear that losing a job or having a pre-existing medical condition will push them into the ranks of the uninsured.

We are at a critical juncture in the quest for universal coverage. Nearly every Democratic presidential candidate has proposed comprehensive reforms to the health care system. While all the proposals would increase coverage, none would cover all Americans and those that come closest are far more costly. Our approach of mandatory insurance is universal without the sticker shock and without a radical change in the current system. It is achievable and politically feasible and would make great strides toward improving our nation's health.

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[1] Robert Wood Johnson Foundation, "Going Without Health Insurance: Nearly One in Three Non-Elderly Americans," prepared by Families USA for Cover the Uninsured Week, March 2003.

[2] Institute of Medicine, "Coverage Matters: Insurance and Health Care," National Academy of Sciences, 2001.

[3] "Citizen" is used here in a generic sense; we assume that all permanent legal residents would be covered under the new system. Emergency medical costs imposed by uninsured foreign visitors and illegal residents would be reimbursed through a Default Payment Fund maintained by each state's insurance purchasing pools.

[4] Glied, Sherry, Jeanne Lambrew, and Sarah Little, "The Growing Share of Uninsured Workers Employed by Large Firms," The Commonwealth Fund, October 2003.

[5] Between 1979 and 1998, the share of private-sector employees receiving health coverage from their own employer fell from 66 percent to 54 percent, a drop of 12 percentage points. Most of this decline occurred after 1988, when 64.6 percent of all employees received coverage as a benefit at work. Medoff, J, M. Calabrese, *et al*, "The Impact of Labor Market Trends on Health Coverage and Inequality," The Commonwealth Fund, 2001.

[6] Franks, Peter, Colin Cameron, and Klea Bertakis, "On Being New to an Insurance Plan: Health Care Use Associated With the First Years in a Health Insurance Plan," Center for Health Services Research in Primary Care and Department of Family and Community Medicine, University of California, Davis, *Annals of Family Medicine*, September/October, 2003.

[7] Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America," National Academy of Sciences, 2003.

[8] Bureau of Labor Statistics, United States Department of Labor, "Employer Costs for Employee Compensation," data extracted on October 27, 2003. It should be noted that this data averages in the benefit expenditures of all employers, even those not offering health benefits. As a result, the percentage of payroll that a typical employer offering health benefits spends for this coverage is actually larger than the overall average, especially among smaller firms.

[9] Among uninsured wage earners, nearly half (46 percent) are self-employed or work for private-sector firms with fewer than 25 employees. The uninsured rate among this group is 28 percent, while the uninsured rate for wage earners employed at medium and large firms ranges from 12 percent to 16 percent. *See* Fronstin, Paul, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey," Issue Brief No. 228, Employee Benefits Research Institute, 2000.

[10] Two comparable proposals released during 2003 by The Commonwealth Fund and by Blue Shield of California estimated the net additional cost to the federal government at $70 billion and $75 billion, respectively. Both would insure virtually all Americans on a mandatory basis and rely on a combination of individual, employer, and federal tax credit contributions for financing; see Davis, K. and C. Schoen, "Creating Consensus on Coverage Choices." *Health Affairs* Web Exclusive (April 23, 2003); Thorpe, Kenneth E, "An Analysis of the Costs and Coverage Associated with Blue Shield of California's Universal Health Insurance Plan for All Americans," Emory University, June 11, 2003.

[11] See Davis, Karen, "American Health Care: Why So Costly?" Testimony before Senate Appropriations Subcommittee on Labor, Health and Human Services, June 11, 2003.