Appendix A

Summary Assessment of Prototypes Based on IOM/CCU Principles

Principles	Status Quo (Current U.S. Health Care System)	Prototype 1: Major Public Program Expansion and Tax Credit	Prototype 2: Employer Mandate, Premium Subsidy, and Individual Mandate	Prototype 3: Individual Mandate and Tax Credit	Prototype 4: Single Payer
Coverage should be universal	Not universal; *43 million uninsured*	*Would not achieve universality because voluntary,* but would reduce uninsured population	*Coverage likely to be high:* depends on enforcement of mandates	*Depends on size of tax credit, enforcement,* and cost of individual insurance	*Likely to achieve universal coverage*
Coverage should be continuous	*Not continuous;* income, age, family, job, and health-related gaps in coverage	Family- and job-related *gaps in coverage*	*Brief gaps* related to life and job transitions	*Minimal gaps*	*Continuous* until death or age 65
Coverage should be affordable for individuals and families	*Private coverage unaffordable* to many moderate- and low-income persons	*More affordable than current system* for those with low or moderate income	*Yes for workers,* assuming adequate employer premium assistance; *public program designed to be affordable* for all enrollees	Subsidy based only on income and family size leaves *older, less healthy, and those in expensive areas with less affordable coverage*	*Minimal cost sharing,* but could be problem for lowest income
Strategy should be affordable and sustainable for society	*Not affordable or sustainable for society*	All participants contribute; *aggregate expenditures not controlled; new public expenditures for only the public program expansion and tax credit;* sustainability of public program depends on revenue sources and political support; size of credit depends on political support	All participants contribute; *basic package less costly than current employment coverage;* revenue from patients in public program; sustainability depends on revenue sources for employers' premium assistance and public program	No limit on aggregate health expenditures or on tax expenditure, though federal costs relatively predictable and controllable through size of credit; *sustainable through federal income tax base;* size of credit depends on political support	Nearly all participants contribute; *aggregate expenditures controllable,* utilization not directly or centrally controlled; *high cost to federal budget;* administrative savings; sustainability depends on revenue source and political support.
Coverage should enhance health through high-quality care	*Quality of care* for the population *limited* because one in seven is uninsured	Opportunities to promote quality improvements *similar to current system*	*Could design quality incentives in expended public program and basic benefit package; current employer incentives for quality remain*	*Similar incentives to current private insurance system;* consumer could choose quality plans	*Potentially yes;* depends on proper design

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