EXPANDING PUBLIC PROGRAMS TO COVER THE SICK AND POOR UNINSURED

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EXECUTIVE SUMMARY

Strengths of Public Programs

- One in four Americans is covered by Medicare (39 million) or Medicaid/CHIP (another 31 million)
- More than 35 years experience covering the sickest and poorest
- Allow pooling of risk across large groups
- Economies of group purchasing lower costs of health care services
- Scale of operations makes for low administrative costs
- Unlike public programs, non-group health insurance works least well for those who have limited incomes or serious health problems because of its high premiums, high loading factors, and inadequate benefits

Medicaid/CHIP Expansions

- Cover parents in Medicaid/CHIP where children are covered
  - Simple to administer, easy to reach eligible parents, facilitates family coverage
  - Improves health and health care of children to have parents insured, healthy
- Expand Medicaid to uninsured family members of Medicaid-disabled adults and special needs children

Medicare Expansions

- Medicare is preferred and trusted by older uninsured adults
- Medicare is lower cost for older, sicker adults than non-group coverage
- Provide premium assistance to cover:
  - Uninsured adults age 55 to 64 – 3.4 million
  - Dependents of elderly Medicare beneficiaries (spouse; dependent children) – 600,000 uninsured dependents
  - Uninsured family members of Medicare-disabled
  - All uninsured sick and disabled under age 55 – 3.7 million
    - Eliminate two-year waiting period – already qualified for SSDI
    - Working disabled unable to obtain or afford private coverage
    - "Insurer of last resort" for chronically ill who can't obtain or afford private coverage

Improving the Link between Public Programs and Employer Coverage

- Employer coverage important, works well for 158 million people, important to build on this positive experience which is the mainstay of American health insurance
- Fixation with "crowd-out" counterproductive – makes administration of public programs complex
- Encourage employer coverage by:
  - Providing premium assistance and permitting small businesses and low-wage employers not now offering coverage to buy coverage through public programs (Medicaid/CHIP, Medicare, FEHBP) – cover 5-13 million uninsured

- Providing premium assistance administered by employers to increase participation of low-wage workers in employer plans – 6 million uninsured
- Providing greater flexibility for public programs funds to be combined with employer contributions to finance employer coverage

- Increasing flexibility for employers to cover early retirees under Medicare

Conclusion

- Public programs are an important base on which to build and are best designed to assist poorest and sickest
- Need to design options that work best for different groups of uninsured
- Public programs work and they help the private market work
- Family coverage is important
- Public programs can be designed to stimulate more employer coverage and premium contributions rather than less

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Karen Davis

Thank you, Mr. Chairman, for this invitation to testify regarding the expansion of existing public health insurance programs to cover the sickest and poorest of our nation's uninsured. As this Committee well knows, Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) today cover one of four Americans. There are 39 million elderly and disabled Medicare beneficiaries and another 31 million people enrolled in Medicaid and CHIP. These programs have improved access to health care for many of our most vulnerable citizens, and warrant serious consideration as a base from which to begin to expand health coverage to America's 42.6 million uninsured people.

Strengths of Public Programs

Public insurance programs have several important strengths. Most importantly, both Medicare and Medicaid pool risk across large groups of individuals. Under Medicare, the sick are automatically cross-subsidized by the healthy. In addition, because they cover large numbers of people, they are able to set prices for hospitals, physicians, and other health care providers at a discount to the normal market price, yet continue to experience high provider participation rates. Finally, Medicare and Medicaid's administrative costs average less than 2 percent, while large employer plans expend 8 to 12 percent and nongroup plans 30 to 50 percent.

It is also important to note that public insurance programs work hand-in-hand with and not to the exclusion of the private market. While funded by the government, Medicare and Medicaid use private insurers when it is efficient to do so. Medicare and Medicaid purchase services from private managed care plans and make extensive use of private insurers as administrative claims payment agents. By utilizing the private market, public programs are able to offer beneficiaries a wide array of options. Only 47 percent of privately insured American workers have a choice of two or more managed care plans, as compared with most Medicare and Medicaid beneficiaries.[1]

Medicare and Medicaid/CHIP have more than 35 years' experience covering the sickest and poorest beneficiaries. Two-thirds of the uninsured have incomes below twice the poverty level or are in only fair or poor health. With the exception of Medicare's lack

[1] Lisa Duchon, Cathy Schoen, Elisabeth Simatov, Karen Davis, and Christina An, *Listening to Workers: Findings from The Commonwealth Fund Survey of Workers' Health Insurance*, The Commonwealth Fund, January 2000.

of prescription drug coverage, public programs provide benefit packages well-suited to their needs. By contrast, private nongroup health insurance plans apply underwriting techniques to screen out applicants with serious health problems or charge higher premiums for higher-risk individuals.

Public programs lower the cost of private coverage because they enroll everyone who meets statutory age or income criteria, regardless of health status. A recent study for The Commonwealth Fund found that if the sickest 2 percent were excluded from the nongroup private insurance market, the average cost of coverage would drop by more than 20 percent.[2] Clearly, Medicare and Medicaid help private markets work by covering the elderly, disabled, special needs children, persons with HIV/AIDS, and those with serious mental illnesses. Expanding public programs to cover the sickest and poorest of the uninsured would help ensure affordable private insurance premiums for many of the remaining uninsured. By reducing bad debt and the burden of charity care, expanding public programs would also enhance the financial stability of rural and inner city hospitals, academic health centers, community health centers, and other safety net providers—many of which have experienced an increased uninsured patient load in recent years.

Nongroup health insurance coverage is the smallest, weakest, and most poorly performing sector of the U.S. health insurance system. It works least well for those who have limited incomes or serious health problems. Nongroup premiums are 20 to 50 percent higher than employer plan premiums and, as noted, as much as half of total premiums go toward administration, marketing, sales commissions, underwriting, and profits. Premiums typically climb steeply with age. For an unmarried 60 year old, a plan with a deductible of $250 exceeds $8,000 per year in major urban areas and is often available only if the individual is healthy and stringent underwriting conditions are met.[3] Benefits are often inadequate, and premiums and risk selection practices are difficult for states to regulate. By design, underwriting practices discriminate against the sick and disabled, making coverage often unavailable at any price, or only at a substantially higher cost than incurred by healthier individuals.

The provision of tax credits for the purchase of individual insurance is particularly problematic. A $1,000 tax credit toward an $8,000 premium for a 60-year-old woman earning less than $35,000 a year is hardly sufficient to make such coverage affordable. It

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[2] Sherry A. Glied, *Challenges and Options for Increasing the Number of Americans with Health Insurance*, The Commonwealth Fund, January 2001.

[3] Commonwealth Fund Task Force on the Future of Health Insurance staff survey of lowest-cost premium rates quoted in 15 U.S. cities across the country on www.e-healthinsurance.com as of February 2001.

is difficult to adjust tax credits to take account of variations in individual health insurance premiums by age, geographic location, and health status.

Medicaid/CHIP Expansions

The most straightforward way to cover low-income adults would be to expand Medicaid and CHIP benefits to parents. The Kaiser Commission on Medicaid and the Uninsured estimates that 5.3 million parents of Medicaid/CHIP eligible children are uninsured—nearly 30 percent of all low-income parents.[4] Expanding coverage to parents would add 3.2 million low-income parents, including 2.2 million who are currently uninsured. These uninsured are least able to afford private health insurance coverage, even if there were tax credits that reimbursed families in April for part of premiums paid for private coverage during the prior year. Nor does it require complex mechanisms to advance tax credits and make end of the tax year reconciliation of amounts owed.

Medicaid offers the kinds of benefits needed by many low-income parents, who often have serious health problems, require ongoing treatment, and cannot afford deductibles and copayments. Without an automatic mechanism such as payroll deduction, even low premiums can act as a barrier to participation in private coverage.[5]

As a practical matter, enrolling the parents of children covered by Medicaid and CHIP would be relatively easy, since their children are already registered and participating. Extending Medicaid/CHIP to low-income parents would also cover many more people than the provision of tax credits to buy non-group health insurance, which would require low-income adults—many with limited education or English-language skills—to navigate the complexities of the private insurance market.

Expanding public programs to the family members of those already covered by Medicaid/CHIP would be an effective way to reach and enroll uninsured members of partially insured families. A recent study for The Commonwealth Fund found that 4.5 million families—or 14 percent of all families with children—are only partially uninsured.[6] Experiences in various states (Wisconsin, for example) indicate that allowing parents to participate would also increase the participation rate of children overall by making it possible for the whole family to be insured under the same program.

Expanding public insurance programs would also increase the stability of coverage for low-income families. Circumstances for low-income families change

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[4] Diane Rowland, et al. Kaiser Commission on Medicaid and the Uninsured, "Building on Medicaid to Cover the Low-Income Uninsured," forthcoming, Spring 2001.

[5] Mary Jo O'Brien et al., *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions*, The Commonwealth Fund, May 2000.

[6] Karla Hanson, "Patterns of Insurance Coverage within Families with Children," *Health Affairs*, 20:1 January/February 2001.

frequently—jobs are found or lost, wages and hours fluctuate. Currently, public programs contribute to the instability of coverage by linking eligibility to family structure or health, rather than to income alone. For example, pregnant women with incomes below 185% of poverty are covered by Medicaid in many states, but coverage is lost 60 days after childbirth. Today, 15 percent of women who lose Medicaid coverage do so because their pregnancy has ended.[7] But the health needs of mothers do not end with pregnancy. Allowing people to stay on as long as income remains low would avoid this type of instability and would allow continuous coverage as jobs and hours change.

Covering low-income families under Medicaid/CHIP makes for healthier families. Healthy parents are important for healthy children. A mother's health, including mental health, is particularly important if she is to provide the nurturing and support that children need. Expanding Medicaid/CHIP to cover low-income parents as well as children would promote family-based insurance coverage and improve the continuity of coverage. Improving continuity of Medicaid coverage would in turn permit managed care plans and safety net providers to continue serving this low-income population. Continuity of care facilitates better quality care, for example, reducing hospitalization and emergency room use by children as parents better understand and follow physician recommendations for care.

Medicaid could also be expanded to cover the uninsured family members of low-income disabled adults and children with special needs, providing much-needed relief and peace of mind to those fulfilling this important caregiving role. Those who care for disabled family members are often in poor health themselves, suffer from stress and anxiety, and struggle with the financial burdens of uninsured medical expenses and lost income.

Medicare Expansions

Most of the uninsured, especially older adults, view Medicare favorably. A Commonwealth Fund survey of adults ages 50 to 64 found that 86 percent of uninsured adults in that age group are interested in early coverage under Medicare.[8] Medicare is highly trusted by older adults—surpassing even employer-based coverage as a preferred option.

Two groups of uninsured are prime candidates for coverage under an expanded Medicare program: older uninsured adults and sick disabled adults not currently covered. There are 3.4 million uninsured adults age 55 to 64 and 3.7 million uninsured sick and

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[7] P. F. Short, *Medicaid's Role in Insuring Low-Income Women*, The Commonwealth Fund, 1996.

[8] Cathy Schoen, Elisabeth Simatov, Lisa Duchon, and Karen Davis, *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70*, The Commonwealth Fund, July 2000.

disabled persons under age 55. The uninsured disabled include those receiving Social Security Disability Insurance (SDDI) for less than two years. Current law provides for a two-year waiting period that makes little sense given the limited options for alternative coverage. It also includes those who are still able to work, thus failing to qualify for SSDI and Medicare coverage as permanently and totally disabled. Finally, it includes those chronically ill or high-risk individuals who are rejected for private health insurance coverage.

While expensive to insure, disabled and chronically ill adults have the greatest need for assistance and are most at risk in the absence of coverage. They typically require extensive treatment to maintain functioning or slow the progression of disease and disability. Research indicates that uninsured chronically ill people are far less likely than their insured counterparts to have their conditions properly managed. Consequently, they have worse health outcomes. The sick and chronically ill are also at greatest risk of incurring major medical expenses and financial hardship.

Family coverage is also an important goal. Coverage could be extended to dependents of Medicare beneficiaries and family caregivers of the disabled covered under Medicare. Based on recent Current Population Survey data, there are 600,000 uninsured dependents of elderly Medicare beneficiaries—primarily spouses under age 65 but also some dependent children. Coverage of uninsured family members of Medicare disabled beneficiaries would also provide much needed assistance to those family caregivers whose own health and financial security are often at risk.

Unlike the current Medicare program that covers all the elderly – both healthy and sick, opening Medicare to uninsured older adults on a voluntary basis could be expected to be most attractive to sicker and higher-risk older adults. A new study for The Commonwealth Fund found that among uninsured adults ages 62 to 64, almost one-third are in only fair or poor health—contrasted, for example, with 15 percent of those covered by employer plans.[9] The disabled who would be newly eligible could also be expected to have above-average medical expenses. Premiums would need to be based on a community rate of all older adults, with reinsurance or subsidies to offset adverse risk selection. Such premiums, though high, would be less expensive than premiums in the nongroup market. Average Medicare community rated premiums would be approximately $3,000 to $4,000 irrespective of health status, compared with premiums of $8,000 or more for otherwise healthy 60-year-old adults in many nongroup, private insurance markets.

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[9] John Sheils and Ying-Jun Chen, *Medicare Buy-in Options: Estimating Coverage and Costs*, The Commonwealth Fund, March 2001.

Expanded Medicare coverage would provide financial protection and access to health care for adults at high risk of serious illness or disability. It would also obviate the need to change programs upon reaching age 65. Premium assistance applied to Medicare coverage rather than tax credits for individual health insurance would: promote continuity of coverage; assure the availability of adequate coverage; and avoid the empty promise of coverage under individual private health insurance that is neither affordable nor genuinely open to high-risk individuals.

Strengthening the Link Between Public Programs and Employer Coverage

Employer health insurance coverage is the mainstay of the American health insurance system. Over 158 million American workers and their family members are covered by insurance offered by employers. Employers help make such coverage affordable by picking up on average 86 percent of worker-only premiums or 73 percent of family coverage premiums.[10] Almost one-third of all health expenditures—$300 billion—is financed through employer plans.[11]

Employer coverage forms a natural risk pool—covering large groups of people automatically upon employment rather than those seeking insurance because they anticipate needing health care. This and other benefits of group coverage assure that employer coverage provides good value, with low loading factors, and adequate benefits. Administration is easy for workers, with automatic enrollment, premiums that are automatically deducted from paychecks, and an employer to navigate the complexities of the marketplace. Employment-based coverage is the preferred option for most workers, both those with and without such coverage. Three-fourths of workers with employer coverage think employers do a good job selecting plans.[12]

Employer coverage is essential to the smooth functioning of America's health care system. It is important that we build on this positive experience and not design policies that contribute to its deterioration. The way to do this is to provide incentives for employers to offer and expand coverage. We should not institute rules that prevent low-wage working families from participating in public programs in a misguided effort to avoid "crowding out" private coverage. For example, CHIP programs typically have

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[10] The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits, 2000 Annual Survey*, 2000.

[11] Author's estimate based on John Sheils and Paul Hogan, "Cost of Tax-Exempt Health Benefits in 1998." *Health Affairs*, 18:2. March/April 1999. pp. 176-181.

[12] Cathy Schoen, Erin Strumpf, and Karen Davis, *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance*, January 2000.

waiting periods of 9 months to a year without private coverage. This creates unnecessary hardship for families, and confusion about why an application for coverage is denied.[13]

Policies that strengthen the link between employer coverage and public programs should be designed to increase the availability of employer coverage and participation in public programs by eligible families. Two strategies could strengthen this link. Small businesses and low-wage employers could be encouraged to buy coverage through public programs such as Medicaid/CHIP,[14] Medicare, and the Federal Employees Health Benefits Program.[15] Secondly, employees who would be eligible for public programs could receive premium assistance to participate in their own employer's plan.[16] The goal should be greater flexibility for public program funds to be combined with employer contributions to finance coverage of working families. Such initiatives could be expected to make a major dent in the numbers of uninsured, almost 80 percent of whom are in families with at least one worker.

Today, 12 percent of uninsured workers decline employer coverage largely because it is unaffordable.[17] An estimated 6 million of these uninsured workers and their family members would be covered if premium assistance were available to offset their portion of employer premiums. Participation would be particularly high if employers took on the administrative task of collecting such premium assistance (or tax credits) for low-wage workers and automatically enrolling them in employer plans.

Opening public programs to small businesses and low-wage employers is also an important step toward making high-quality plans at reasonable premiums accessible to this market. An estimated 5 million to 13 million working uninsured could be expected to benefit from such options. For firms with large concentrations of very low-income workers, buying into Medicaid/CHIP coverage would help assure continuity of coverage and care as low-income families moved in and out of poverty. For small businesses with a mix of employees, the option of purchasing coverage under the Federal Employees Health Benefits Program—perhaps administered separately via the Internet—could

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[13] Mary Jo O'Brien et al., *State Experiences with Access Issues Under Children's Health Insurance Expansions*, The Commonwealth Fund, May 2000.

[14] Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith, *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs*, The Commonwealth Fund, December 2000.

[15] Beth C. Fuchs, *Increasing Health Insurance Coverage Through an Extended Federal Employees Health Benefits Program*, The Commonwealth Fund, December 2000.

[16] Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs*, The Commonwealth Fund, February 2001.

[17] Lisa Duchon, Cathy Schoen, Elisabeth Simatov, Karen Davis, and Christina An, *Listening to Workers: Findings from The Commonwealth Fund Survey of Workers' Health Insurance*, The Commonwealth Fund, January 2000.

induce more small businesses to offer coverage, particularly if premium assistance were available to pay a portion of the premiums for low-wage workers. Firms with older workers or large numbers of early retirees under age 65 might be attracted to the option of purchasing coverage under Medicare.

Flexibility to purchase coverage privately or through public programs, and picking an alternative best suited to the needs of different workforces, could make a significant difference. It would reduce the numbers of uninsured, extend the benefits of large group coverage to the self-employed and small businesses, make coverage more affordable, increase the quality of coverage, and reduce the turnover and instability of coverage.

Conclusion

In summary, public programs serve as a good foundation from which to begin building a comprehensive policy to cover our nation's uninsured. They are most well-suited to assisting the poorest and sickest uninsured. They have a long track record of providing efficient and effective coverage to those with the most serious health problems. They are the insurance coverage of choice for many uninsured, particularly older adults looking forward to coverage under Medicare.

Expanding public programs does not exclude tapping the private market. Medicare and Medicaid/CHIP both make extensive use of private insurers. In addition, by assuming the risk for the sickest and poorest, public programs free private insurers to cover those they are best able to cover: healthier working families. Expanding public program coverage to the neediest uninsured would provide a stable source of financing to rural and inner-city hospitals, academic health centers, community health centers, and other safety net providers, thus promoting a high-quality health care system available to all Americans.

In American health care, one size does not fit all. Different strategies should be employed to cover different groups: a low-income family with young children has different needs than an older adult with heart disease or cancer who can no longer work. Individual choice is also an important value, and preferences vary. Medicare is popular with older adults; uninsured low-wage workers prefer what high-wage workers have, health benefits through their job. Families with special needs children or a disabled adult value the comprehensive benefits that Medicaid assures, yet family caregivers often struggle without health insurance of their own.

Providing choices and honoring preferences are important. But coping with a serious illness or struggling to make ends meet leave little time and energy for navigating a complex health care and health insurance system alone. Making coverage automatic

and affordable without creating administrative hurdles is key to reaching those currently uninsured. Providing tax credits or vouchers without guaranteed access to proven established mechanisms assuring high-quality, affordable coverage is an empty promise—unlikely to make a significant reduction in the number of those who are uninsured, underinsured, or unstably insured. Public program expansions are an important strategy to reach the sickest and poorest of the uninsured.

Specific options for targeting public program expansions include:

- Cover uninsured parents under Medicaid/CHIP (2.2 million under 200% of poverty)
- Expand Medicaid to uninsured family members of disabled special needs children and disabled adults on Medicaid
- Provide premium assistance under Medicare to cover uninsured adults age 55 and over (3.4 million)
- Cover uninsured dependents of elderly Medicare beneficiaries (600,000 people) and uninsured family members of disabled Medicare beneficiaries
- Expand Medicare coverage of the sick and disabled (3.7 million uninsured under age 55), including eliminating the two-year waiting period, and broadening eligibility to those able to work though disabled or suffering from a serious chronic illness that precludes private coverage
- Improve the link between public programs and employer coverage, including giving small businesses and low-wage employers the option of purchasing coverage with low-wage premium assistance through Medicaid/CHIP, Medicare, and the Federal Employees Health Benefits Program, and using funds under Medicaid/CHIP to provide premium assistance to employer coverage of low-wage working families (5 million to 13 million uninsured)
- Increase low-wage worker participation in employer health plans through low-wage premium assistance administered by employers (6 million uninsured workers and family members not currently participating in employer plans)

By designing options that work for families in different circumstances, and favoring family coverage through a single mechanism, participation rates will increase and continuity of coverage and care will be improved. Most importantly, making health insurance coverage of the sickest and poorest the highest priority will help assure that all Americans have access to quality health care.

We are at a propitious and historic moment. We have the luxury of a substantial 10-year budget surplus—at least $1 trillion of which was generated by economies in Medicare and Medicaid achieved in the last part of the 1990s.[18] It is an ideal time to reinvest a significant share of those savings in improved health care for those left behind.

[18] Karen Davis, Cathy Schoen, and Stephen C. Schoenbaum, "A 2020 Vision for American Health Care," *Archives of Internal Medicine*, 160: Decmeber 11/25, 2000.