Federal Health Coverage Programs:

Building Blocks for Coverage of the Uninsured

By Diane Rowland and Adele Shartzer

As the 2008 presidential campaign gears up, health care reform is ranked just below Iraq as a public priority. Thus, it has become a top issue for candidates to address. Filling the gaps in coverage that leave millions uninsured, constraining rising health care costs, and improving the quality of care are the goals of reform efforts.

The health care system in the United States is under a lot of pressure. In 2006, 47 million Americans lacked health insurance coverage. Health care costs continue to rise faster than inflation and wages, with premiums increasing 78 percent since 2001. Roughly half (54 percent) of all Americans get their health coverage through their employers, and a smaller share purchase coverage directly. Together Medicare and Medicaid provide publicly-sponsored coverage to one in four Americans who are elderly, disabled or low-income (income less than twice the poverty level, roughly $40,000 for a family of four). Building on this coverage to assist the 16 percent of Americans who are uninsured is a key component of reform. This article reviews the role of public programs as building blocks for coverage of the diverse group of people that are uninsured.

Medicare

Medicare, a federal entitlement program that began in 1965, provides health insurance coverage to 14 percent of Americans, including 37 million adults age 65 and older and 7 million younger people with permanent disabilities. Most people who have paid social security taxes for at least ten years are automatically eligible for Medicare once they turn 65, and younger people can get Medicare after they have been disabled for two years.

Medicare has four parts (A, B, C and D) that cover different Medicare benefits. Beneficiaries can enroll in "traditional" Medicare Parts A and B for their inpatient hospital, outpatient physician care, and other medical services, or they can choose to enroll in private managed care companies (Part C) to receive the benefits covered under Parts A and B. Medicare Part D is the voluntary outpatient prescription drug benefit, provided through private plans or as part of a managed care plan. Medicare covers most medical services, but beneficiaries face both deductibles and cost-sharing for covered services. As a result, most of them depend on employer retiree benefits or purchase private supplemental insurance to help with costs.

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Medicare Part A is funded by a tax on earnings paid equally by employers and workers, while Parts B, C and D are funded with general tax revenues, beneficiary premiums and state payments. As the population ages and health care costs continue to rise, health spending for Medicare is expected to put increasing financial pressure on the federal budget.

Medicare is both a model for broader health reform through a single-payer approach as well as a vehicle for extending coverage to the 9 percent of the uninsured in the 55–64 age group who are currently too young for Medicare. As policymakers look to build upon the popular Medicare program for coverage expansions for the nonelderly population, the program is featured in some proposals of Democratic presidential candidates. Proposals have been advanced to make a public plan modeled after Medicare available to the public as one choice for health coverage, allow early retirees to buy into Medicare, and provide universal coverage through a "Medicare for All" plan.

Assessing how Medicare would fit into broader health reforms raises several issues: what the appropriate role for private insurers is in Medicare and how much Medicare should pay these plans, and whether the premiums and cost-sharing requirements in Medicare would be affordable for the low-income uninsured. Moreover, because Medicare is an entitlement based on contributions from individuals who have paid into the system during their working years, extending it to the broader population would require revisiting the social insurance nature of the system and the financing.

Medicaid and the State Children's Health Insurance Program (SCHIP)

Medicaid is a joint federal-state entitlement program providing health insurance coverage to low-income families and people with disabilities that also helps low-income Medicare beneficiaries with cost-sharing and long-term care services.

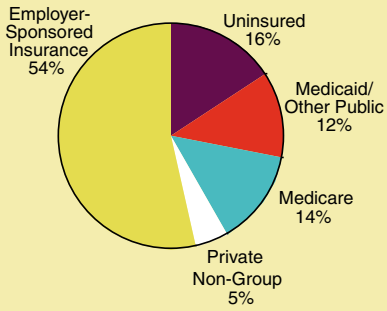
Medicaid provides health coverage to 58 million low-income children and parents, pregnant women, elderly, and people with disabilities. States design their Medicaid programs within broad federal guidelines, and the federal and state governments share in paying for costs for eligible groups. Federal statute does not provide Medicaid funds for states to cover some groups of people, such as non-disabled adults without dependent children, regardless of how poor they are.

Medicaid benefits vary from state to state but generally cover the comprehensive services low-income children, elderly and disabled people need such as hospital and physician care, prescription drugs, mental health and substance abuse treatments, and long-term care services.

SCHIP was enacted in 1997 to assist states in providing health coverage to low-income children with family incomes too high to qualify for Medicaid but too low to afford private insurance. Today it provides coverage to 6 million children. Federal funds to states for SCHIP are a fixed allocation each year unlike Medicaid where the federal government matches state spending. In SCHIP, states have more flexibility to cap enrollment, impose waiting lists and determine benefit design—some services covered by Medicaid may not be available in SCHIP, and states can charge premiums and higher copayments than allowed in Medicaid.

Because Medicaid and SCHIP already provide coverage to low-income children and some adults in all the states, these programs are a central building block in most health reform proposals. With two-thirds of the nation's 47 million uninsured in families with incomes below 200 percent of the poverty level, these public programs offer a vehicle to subsidize coverage for the low-income uninsured. Increasing enrollment for those currently eligible but not enrolled (especially the 20 percent of the uninsured who are children) can be achieved. Improved outreach and simpli-

Health Insurance Coverage in the U.S., 2006



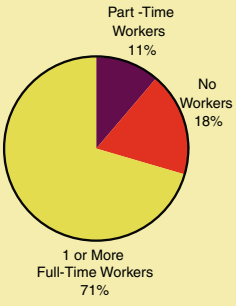
Total = 296.1 million

NOTE: Medicaid/Other Public includes Medicaid, SCHIP, other state programs, and military-related coverage. Those enrolled in both Medicare and Medicaid (1.8% of total population) are shown as Medicare beneficiaries.

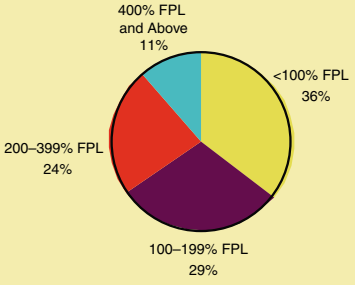
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

Characteristics of the Uninsured, 2006

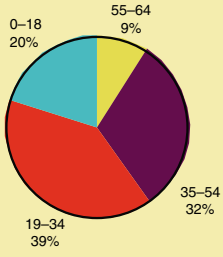
Family Work Status



Family Income



Age



Total = 46.5 million uninsured

The federal poverty level was $20,614 for a family of four in 2006.
SOURCE: KCMU/Urban Institute analysis of March 2007 CPS.

fication of enrollment procedures as well as broadening eligibility for low-income adult parents and enabling childless low-income adults to enroll would allow more of the uninsured to gain coverage.

The Massachusetts health reform plan and proposals being considered in other states build on public programs as a way to make coverage both accessible and affordable. The reform plans of several Democratic presidential candidates couple public program expansions for the low-income population with strategies to make coverage more available to higher-income individuals through the workplace or purchasing pools.

Federal Employees Health Benefits Program (FEHBP)

FEHBP is a health insurance program for about 8 million federal workers, retirees and their dependents, making it the largest employer-sponsored health plan in the country. As federal employees, members of Congress can get their health coverage through FEHBP. It is an example of a large purchasing pool giving federal employees access to a range of private group health plan options. In 2007, enrollees could choose between 284 national and regional fee-for-service plans, health maintenance organizations (HMOs), point-of-service plans, or high deductible health plans. The Office of Personnel Management (OPM) contracts with insurance companies and negotiates the rates and benefits, which include medical services and prescription drugs.

The FEHBP model provides a way to offer group coverage with a choice of plans to those who are without employer-sponsored coverage. Among the uninsured, 81 percent are from families with a full- or part-time worker without coverage through the workplace. As costs grow, fewer employers—especially small businesses—are offering health benefits to their workers. Health coverage through the individual market can be unaffordable for some people who do not have access to coverage through their employer or a union. Insurers in the individual market can charge higher premiums for older, overweight and sicker people; they can exclude coverage for pre-existing conditions.

Allowing the uninsured to purchase group coverage through FEHBP would give them access to group-rated premiums with greater consumer protections. As a result, major state health reforms as in Massachusetts and candidate proposals at the national level create an FEHBP-like purchasing arrangement to enable small businesses or individuals without access to employer coverage or public coverage to obtain coverage. This type of group approach would provide a place to shop for insurance for some of the more tax-based proposals being advocated as a way to promote consumer choice.

How Voters Can Affect Health Care Policy

- Find out more specifics about each presidential candidate's plans. Information is available on the candidates' Web sites or at www.health08.org.
- Tell your story—the campaigns and the media may want to hear from you if you've got an interesting story about health care in the U.S.
- Talk about health care with your friends and family.
- Be prepared for lots of advertisements from interest groups as the health care reform debate unfolds. Ask questions, do your research, and think critically about what you're seeing and hearing.
- Health care reform is also important at the local level—find out what your state and local candidates are saying about health care, and let them know it's an important issue to you.

Veterans Health Administration (VHA)

Although not directly health insurance, the Veterans Health Administration (VHA) is the nation's largest integrated health system and provides access to health services for 7.7 million of the nation's 24 million living veterans. The VHA emphasizes managed care through a network of 163 hospitals, more than 800 community-based clinics, 135 nursing homes and other facilities. In order to receive health services through the VHA, veterans must enroll in the system and are placed in one of eight priority groups. Many of the users of the VHA system are older; over half (55 percent) have Medicare to supplement their VA care. However, nearly one in five VHA enrollees is uninsured and depends on care delivered at VHA facilities.

Access to the VA is limited to veterans and prioritized based on service injury and income. Given the new demands being placed on the VHA from returning Iraq veterans, the system is already stressed, and coverage is unlikely to be broadened as part of health reform. However, many of the recent innovations in the VHA delivery system such as electronic health records have led the way for quality improvements and innovative health practices that both Republicans and Democrats support in health reform.

Putting the Pieces Together

Many of the presidential candidates with health reform plans propose to combine strategies and build upon these existing federal programs to expand coverage to the uninsured. The uninsured population in the United States is a diverse group including children, early retirees without employment-based coverage, poor adults who do not qualify for public programs, veterans who rely on care through the VHA, and people who cannot find an affordable non-group health plan. These existing federal programs already provide coverage to millions of Americans. Utilizing the strengths and features of these programs could make further inroads in reducing the number of uninsured. ■

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VOTER LINKS

- *www.kff.org*
- *www.health08.org*
- *www.kaisernetwork.org*