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Senators Bingaman and Corker, I thank you for the opportunity to testify at this Summit on this panel. Your leadership on shaping health policy is commendable. And this Summit’s focus reflects the concerns of Americans across the nation. Addressing health system problems consistently ranks among the top three issues of voters. Business and labor leaders have formed coalitions like “Better Health Care Together” that are seeking change by 2012.¹ Bipartisan efforts have emerged.^{2,3} And the presidential candidates have embraced major health proposals.⁴

This debate is not just propelled by the problems plaguing the health system: It also results from an emerging consensus on the types of solutions that are needed. Reform proposals contain a number of common elements. Most include similar policies to restrain cost growth and squeeze out excessive spending, such as better management of chronic conditions and promoting best practices and information sharing through health information technology. Policies to improve quality follow a similar pattern: A number of discrete, widely accepted policies are included in plans across the political spectrum. Disease prevention and wellness promotion polices have become ubiquitous. Last but not least, all agree that additional public assistance is needed to make health insurance affordable for low-income and high-risk individuals.

However, disagreement persists over the role of public programs in a reformed health system. This is apparent in the presidential campaign plans. Senator John McCain’s (R-AZ) proposal scales back existing public programs like Medicaid and the State Children’s Health Insurance Program, replacing them with tax credits for private insurance. Senator Barack Obama’s (D-NY) plan expands these programs, filling in their eligibility gaps as well as offering all Americans the option of a Medicare-like plan. The rhetoric around this difference is heated: Critics of McCain’s approach call it “privatization,” a “greed-based plan,” based on the “fantasy that the magic of the marketplace can produce cheap health care for everyone.”⁵ The Obama plan would be a “massive government takeover,” “insert government bureaucracy into your medicine cabinet,” and nationalize and “socialize” medicine.⁶

In this testimony, I aim to briefly describe the functions of public programs in our current health system, examine whether and what type of roles they could serve in a reformed system, and discuss the rhetoric versus reality when it comes to public versus private insurance.

Roles of Public Programs

Over the years, a number of public programs have emerged to fill certain cracks in the system. Medicare was created in 1965 to insure the elderly and, soon thereafter, certain people with disabilities. Medicaid evolved from state programs to cover low-income families, seniors, and people with disabilities. The State Children's Health Insurance Program was added in 1997 to cover children in families with too much income to qualify for Medicaid but too little to afford private insurance. The government also provides health benefits to its workers, military personnel, and veterans. Altogether, these programs insure over one-fourth of the population and finance 45 percent of the health system, including the safety net programs that directly pay for services for vulnerable populations.

Public programs serve at least four functions. First, they make health insurance affordable for people with little income or financial resources. Many low-income people can neither afford coverage nor health care. Lacking financial access to health care leads to unmet needs, delayed diagnosis of diseases like cancer, and worse outcomes.⁷ Medicaid and SCHIP offer coverage to income-eligible individuals in federal and state-defined categories at no to low premiums. The coverage itself tends to be generous in recognition that limited benefits and even small copayments could make needed services unaffordable to a person with few resources. Medicaid and SCHIP have proven to significantly improve access and reduce disparities in care.⁸ These programs plus Medicare also support public hospitals, community health centers, and other elements of the health care safety net that directly provide health care to people without health insurance.⁹

Second, public programs insure a disproportionate percent of Americans with disabilities or severe health problems. Medicaid covers individuals who also qualify for Supplemental Security Income due to a disability. States also have options of extending eligibility to certain individuals with disabilities or to people with high medical expenses that erode their income. Medicaid beneficiaries with disabilities account for 16 percent of enrollees but 45 percent of benefit spending.¹⁰ Medicaid's services have adapted to this population's needs, covering home- and community-based long-term care as well as support services like targeted case management, rehabilitation services, and personal care. It also covers long-term care and other services not covered by Medicare for low-income seniors (so-called "dual eligibles"). Medicare itself covers non-elderly people who receive Social Security Disability Insurance after a waiting period. Beyond these explicit eligibility rules, these programs serve as high-risk pools because of the correlation between costs, age, and impoverishment. Often, the reasons for low income are health-related and vice versa: Low income creates stresses that diminish health. In addition, aging is associated with rising cost: The per-capita health cost of seniors is 3.3 times higher than that of other adults and 5.6 times higher than that of children.¹¹

Third, public programs help private insurers manage risk. This is partially achieved because of the profile of people covered by Medicare, Medicaid, and SCHIP. In addition, some states support their own high-risk pools. High-risk pools generally insure people who have been denied coverage by private insurers; insurers typically pay an assessment to partially offset this coverage. In practice, such pools insure only about 200,000 people, usually have waiting lists, and offer limited benefits. Other states use reinsurance to encourage private insurers to cover

people that may be costly. For example, in New York, the state pays for 90 percent of the claims between \$5,000 and \$75,000 for enrollees—lessening the uncertainty for insurers that agree to accept all enrollees.¹² Other ways to balance risk exist as well. Medicare uses risk adjustment to pay private plans more (or less) depending on the likely cost of enrollees—mitigating (but not eliminating) the incentive to avoid enrolling people with health problems. In addition, the drug benefit employs “risk corridors” in which unexpectedly high losses are partially offset by public subsidies. These public subsidies are often used to limit the private cross-subsidies that occur through premiums charge to enrollees. By definition, insurance aims to spread risk across large groups and over time, but too often, individuals and small businesses cannot afford to effectively self-insure, which results when too few people are in a risk pool.

Fourth, some public programs like Medicare offer an alternative to private insurance in covering Americans. This alternative was originally created due to market failures, but has grown in size and popularity as the population has aged and greater numbers of Americans spend more time on the program. Unlike many private insurers, Medicare offers virtually free choice of health care providers, predictable coverage, relatively low administrative costs, and high ratings on access and satisfaction. It has performed as well on cost containment as have private insurers. Medicare has flaws: For example, its payment systems encourage siloed care and specialty over primary and preventive care. However, proposals to “privatize” Medicare have met with public resistance and are not explicitly part of the current policy debate.

What Role Should or Could Public Programs Serve in a Reformed System?

An important question in health reform is: What is the role for public programs in a reformed health system? Some who view them as only gap-fillers answer none: Once reform policy eliminates those gaps through seamless, affordable, value-oriented health coverage, the need for public program disappears. Still others see public programs’ flaws as fatal rather than fixable and, irrespective of the possible need for their continuance, would use reform to eliminate them. At the other end of the spectrum, some view reform as a chance to highlight the inherent limitations of private insurers in meeting our health system goals and support Medicare as a replacement. In my view, the answer to the question, “can private insurers substitute for public programs,” rests in an assessment of whether and how well they will meet the four functions of public programs, just described.

Can private insurers provide low-income individuals with adequate insurance? The answer to this question rests in the current experience. Medicaid and SCHIP may and do use private insurers to cover eligible individuals, mostly children and families. About 60 percent of Medicaid children and parents are enrolled in private plans, with an even higher proportion for children in SCHIP. However, as states have learned, private insurance is not an option for all low-income people. For some, the challenge rests in the larger market: Few insurers operate in some small and rural states, requiring public programs to step in and directly pay for care. For others, the challenge is getting insurers interested in serving this population. Even healthy people with low-income often have other characteristics that differentiate them from typical privately insured populations, such as low education and health care literacy. The insurance industry itself does not advocate for eliminating public programs for low-income populations in its health reform proposals.¹³

Can private insurers manage the health care of people with special needs, such as the frail elderly or adults with serious physical or mental disabilities? Again, options exist in Medicaid and Medicare to contract with private plans. Here, the experience is even more limited. In Medicaid, only a small fraction of people with disabilities and seniors are enrolled in private plans. In Medicare, a growing number of beneficiaries are enrolled in Special Needs Plans, but little evidence exists on whether the extra benefits offered by these plans justify their extra payments.¹⁴ The challenge is that the services needed by this population differ from those of typical private insurance enrollees. Some states have tried to compensate for these service gaps through “carve outs” where a public program supplements private insurance for services like mental health or long-term care. Experience suggests that this approach undermines the goal of care management, leads to cost shifting among multiple plans, and puts vulnerable individuals at risk of falling between the cracks of public and private insurance.¹⁵ Moreover, private plans have no incentive to support safety net providers that care for the uninsured; if public programs were eliminated, the support they provided would have to be recreated to prevent vulnerable people from falling through the inevitable system cracks.

The third function of public programs, to assist in the spreading of risk across the population, could be achieved without them. Some proposals would use regulation to ensure that the uncertainty and high costs of health care are spread across privately insured populations. This would, generally, involve interrelated rules to: (a) set premiums based on the population as a whole rather than individual characteristics; (b) allow all individuals to purchase policies at these premiums; and (c) require people to purchase coverage when they are healthy as well as sick. Sliding-scale premium assistance is also critical. This approach is similar to what was adopted in Massachusetts and proposed by Senators John Edwards (D-NC) and Hilary Clinton (D-NY) during the Democratic primary. Senator McCain opted to insure people with pre-existing conditions through a public program—expanded high-risk pools—rather than private plans via regulation. Senator Obama’s plan used both, including some regulation as well as reinsurance to ensure that the cost of high-risk individuals is spread across society. Simply stated, in the absence of comprehensive rules governing private insurance, the need for public programs to balance risk will persist.

Lastly, in 2008, we have seen a new question emerge: Should non-elderly Americans have the same choice that seniors have: enrolling in a public or private plan? The idea of offering a Medicare-like plan has been proposed by experts as well as all of the major Democratic presidential candidates.¹⁶ Some states like New Jersey and Connecticut have similarly proposed allowing individuals to buy into a state-backed plan like the state employees’ health benefits systems. Research has shown that Medicare has performed as well as private insurance on costs and has exceeded it on satisfaction and access.¹⁷ As such, the questions might be best directed toward opponents: Why should policymakers give private insurers the exclusive right to cover Americans? If private insurers can better meet our goals for the health system, why object to a level competition with public plans?

Conclusion

In summary, public programs serve functions in our health system that cannot be simply replaced by private insurers under reform. The needs of low-income and vulnerable populations have not been universally or sufficiently met by private insurers, and public programs may be preferable to private insurance regulation as a means of fairly spreading risk. In fact, a legitimate case can be made that health reformers should give Americans the choice of replacing private with public plans.

That said, I'd like to conclude with three observations. The first is that the line between "public" and "private" coverage is not simply drawn. "Public" programs run the gamut from the Veterans' Administration, whose providers are public employees, to state-based reinsurance programs that share the costs of claims with private plans. The military and federal employees' health benefits programs are more public than private in terms of payment and risk. Yet the rhetorical debate draws dark lines between the two, and often in the wrong places. On the political right, the term "government-run health care" has not only been misapplied but equated with "bad" while "private" coverage is equated with good—even if it offers no extra value (e.g., private fee-for-service in Medicare¹⁸). Similarly, some on the political left have demonized all private insurers as solely seeking profit at the expense of care and lives. The debate over the nature and extent of the government role in health care is essential but would be improved by less "heat" and more "light" in its terms.

Second, policymakers should focus on the ends more than the means. Most share the goal of providing all Americans with affordable, quality coverage. The best plan to achieve it, in my opinion, is the one that gets us to this goal as quickly and safely as possible. "Safely" means, first, do no harm. Public programs have evolved primarily to help people with the greatest health needs or the least resources. Caution should be taken in changing them to prevent loss of coverage or reductions in access to care among those that need it the most. By definition, this approach will not produce the ideal plan since the reality is so far from perfect. Instead, the successful plan will likely be a hybrid, building on existing, functional public and private insurance. As such, the question is not whether or not there should be a public plan role in health reform, but instead what balance of public and private plans best moves the system toward its goals.

Third, public programs can be effective instruments for systemic change. As can be seen in Medicare's history, its adoption of hospital payment systems and coverage policies set standards that private insurers follow. Its policy toward hospital desegregation and access to language services have transformed access to care for racial and ethnic minorities. The Veterans' Administration was among the first systems to effectively deploy health information technology. Thus, setting the nation's health system on a more sustainable, value-base path may, indeed, depend on having public programs lead the way.

Notes:

- ¹ For a description of the Better Health Care Together principles, see <http://www.betterhealthcaretogether.org/ourvision> (accessed May 26, 2008).
- ² For a description of the Bipartisan Policy Center's project, see <http://www.bipartisanpolicy.org/ht/d/sp/i/600/pid/600> (accessed May 26, 2008).
- ³ R. Marcus, "Health Care Mavericks: Harry and Louise, Meet Ron and Bob," *The Washington Post*, February 27, 2008, p. A17.
- ⁴ S.R. Collins and J.L. Kriss, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals*. (New York: The Commonwealth Fund, February 2008).
- ⁵ For example, see P. Krugman, "John McCain's Greed-Based Health Plan," *Alternet*, April 6, 2008, available at: <http://www.alternet.org/healthwellness/81501/>
- ⁶ M. Cooper and J. Bosman, "Parsing McCain on the Democrats' Health Plans," *The New York Times*, May 3, 2008, available at: http://www.nytimes.com/2008/05/03/us/politics/03check.html?_r=1&oref=slogin,
- ⁷ See for example J. Hadley, "Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintended Injury or the Onset of a Chronic Condition," *JAMA* 297(10) (2007): 1073-1084; Kaiser Family Foundation, "The Uninsured: A Primer, Key Facts about Americans without Health Insurance" (Menlo Park, CA: Kaiser Family Foundation, October 2007); S. Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality" (Washington, DC: The Urban Institute, January 2008).
- ⁸ B. Bloom and A.N. Dey. "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2004," *Vital Health Statistics* 10(227) (2006); A. Davidoff, G. Kenney, and L. Dubay, "Effects of State Children's Health Insurance Program Expansions on Children with Chronic Illness," *Pediatrics* 116 (1) (2005): e34-e42; L.P. Shone, A.W. Dick, J.D. Klein et al., "Reduction in Racial and Ethnic Disparities After Enrollment in the State Children's Health Insurance Program," *Pediatrics*, 115 (2005):697-705.
- ⁹ Public coverage programs have special payments through the Disproportionate Share Hospitals program, for example, that support the safety net. Some safety net facilities also received direct federal and state grant support. Public program, in addition, support other public goods in the health system like medical education. These functions are critical but not explored in this testimony.
- ¹⁰ Congressional Budget Office, *Medicaid Baseline*, 2008.
- ¹¹ Centers for Medicare and Medicaid Services, "Total Personal Health Care Spending, by Age Group," available at: <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/2004-age-tables.pdf>
- ¹² R. Bojbjerg, A.B. Garrett, L. Clemans-Cope, and P. Masi. "Reinsurance in State Health Reform" (Washington, DC: State Coverage Initiative, AcademyHealth, 2008).
- ¹³ America's Health Insurance Plans, "Vision for Health Reform" (Washington, DC: AHIP, 2007), available at: <http://www.ahipbelieves.com/media/A%20Vision%20For%20Reform.pdf>; BlueCross BlueShield Association, "Pathway to Covering America" (Washington, DC: BCBS Association, 2008) available at: <http://www.bcbs.com/issues/uninsured/pathway-to-covering-america/pathway-to-covering-america.pdf>
- ¹⁴ J. Verdier, M. Gold, S. Davis. "Do We Know if Medicare Advantage Special Needs Plans Are Special?" (Washington, DC: Mathematica Policy Research for the Henry J. Kaiser Family Foundation, 2008).
- ¹⁵ See for example National Academy of State Health Policy, "Making Medicaid Work for the 21st Century: Medicare and Medicaid Dual Eligibles" (Portland, ME: NASHP, Issue Brief #6, December 2004); and W.A. Ray et al., "Effect of a Mental Health "Carve Out" Program on the Continuity of Antipsychotic Therapy," *New England Journal of Medicine*, 348(19) (2003): 1885-94.
- ¹⁶ C. Schoen, K. Davis, and S.R. Collins, "Building Blocks For Reform: Achieving Universal Coverage With Private And Public Group Health Insurance," *Health Affairs*, May/June 2008; 27(3): 646-657; J.S. Hacker, "Health Care for America" (Washington, DC: Economic Policy Institute, 2008).
- ¹⁷ K. Davis, C. Schoen, M. Doty, K. Tenney, "Medicare versus Private Insurance: Rhetoric and Reality," *Health Affairs*, Web Exclusive, W311-24, October 9, 2002.
- ¹⁸ M.E. Miller, "Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives: Private Fee-for-Service Plans in Medicare Advantage" (Washington, DC: Medicare Payment Advisory Commission, May 22, 2007).