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Public Options Will Improve Health Equity Across the Country

By Nicole Rapfogel and Maura Calsyn May 5, 2021

The COVID-19 pandemic has exposed and exacerbated health inequities—particularly those along racial and ethnic; rural and urban; and socioeconomic lines.[1] While these inequities have been long-standing, the disproportionate impact of the coronavirus crisis on underserved communities has recently driven public momentum to meaningfully address the social determinants of health.[2] Doing so requires commitment and intention from all levels of government and a collaborative approach in which community members direct and contribute to these plans and conversations.

State and federal policymakers have the power to address the full scope of health disparities—both by increasing coverage and access to affordable care and by addressing the social, economic, and structural roots of inequity that drive health disparities. Achieving universal coverage and lowering consumer costs are key elements of meaningful change, and mindful policymakers can also use public options to address an even broader range of health inequities. A public option for health insurance—a reform that would give people the option to enroll in publicly backed health insurance plans instead of private insurance—has been proposed at state and federal levels. Not only is a public option an important tool to negotiate lower prices that will reduce out-of-pocket costs, but it can also be used to create significant and sustainable equity improvements.

Health care industry groups opposed to public options have argued that reforms could decrease coverage options in rural areas, leading to a two-tier health system—one public, one private—and worsening health disparities.[3] What these critiques seem to miss is that the current health system is riddled with health inequities and unaffordable care for those who are not healthy and wealthy.[4] From the ubiquity of people turning to crowdfunding to afford care, even when privately insured, to affluent Americans securing COVID-19 vaccines ahead of low-income, Black, Hispanic, and Native communities who have faced the brunt of the pandemic, health care access and optimal health outcomes under the current system are unattainable privileges for many Americans.[5] Yet these analyses of service provision and unmet needs mask one of the biggest beneficiaries of the

U.S. health care system: powerful health care industry leaders.[6] In spring 2020, a time of the greatest job loss since 1975, some of the largest insurers doubled their earnings from the year prior.[7]

Public option and other similar reforms can improve health equity by bringing down care costs and ensuring that those savings reach consumers and underserved communities. A public option would introduce more competition into the health insurance market, and it would use its market power to negotiate lower payment rates, driving down costs for its public plans as well as private commercial plans. These cost savings can be passed to consumers through lower premiums and cost sharing and reinvested in broader equity initiatives to address social determinants of health. Public options that make health care more accessible and affordable and that invest in dismantling the underlying conditions that contribute to health inequities can be key to creating a more equitable nation—one in which all Americans are able to learn, grow, and thrive.

Many factors drive health disparities and inequities

Many noncoverage factors—called social determinants of health—play a critical role in whether a person is likely to remain healthy.[8] Discrimination in and out of the medical system has driven health inequities for centuries—ranging from discrimination in housing and job opportunities to challenges accessing culturally competent health care.[9] Crowded conditions, unstable housing, access to nutritious food, and environmental dangers put underserved populations at increased risk.[10] Disparate access to education, employment, and paid leave, as well as income and wealth gaps, also contribute to health inequities.[11] These deeply rooted problems must be addressed through policies that seek to foster health equity beyond bolstering health care coverage and affordability.

Nevertheless, lack of adequate coverage does affect access to affordable, quality health care and reinforce these insidious inequities. Despite the Affordable Care Act's (ACA's) narrowing of racial and ethnic coverage disparities, Black, Hispanic, and American Indian and Alaska Native communities remain far more likely than non-Hispanic white people to be uninsured.[12] For example, in 2018, Hispanic people were more than 250 percent more likely to be uninsured than non-Hispanic white individuals.[13]

Even those who have insurance struggle with affordability. According to the Kaiser Family Foundation, at least 1 in 4 adults report each of the following measures: difficulty affording routine health care costs, not taking prescriptions as prescribed due to cost, and struggling to pay medical bills.[14] In 2018, people with incomes below 250 percent of the federal poverty level—$30,000 for a single person and less than $63,000 for a family of four at the time—were twice

as likely to feel unconfident about their health insurance helping them afford care.[15] Tragic stories about delaying treatment or inability to take leave from work have proliferated in recent years,[16] and unaffordable health care costs continue to burden Americans. In 2020, 27 percent of insured nonelderly adults reported problems with medical bills or debt.[17]

Compounding coverage and financial disparities, many U.S. residents struggle to access high-quality, culturally competent care.[18] People living in rural and low-income communities have limited access to hospital care. In fact, half of low-income communities do not have any intensive care unit beds—a problem with devastating consequences during the COVID-19 crisis.[19] Both a history of racist policies and spending cuts and the contemporary closure of hospitals in rural and low-income communities have led to so-called health care deserts, disproportionately limiting access to care for Black and Hispanic families in particular.[20]

Intersections between identities make it increasingly difficult to access identity-affirming care. LGBTQ individuals often face health care discrimination, which can decrease their likelihood of seeking care. Due to discrimination in health care settings, 15 percent of LGBTQ individuals, including nearly 30 percent of transgender individuals, have postponed or avoided medical treatment.[21] One in 4 transgender people reported a provider refusing to see them due to their gender identity.[22] Nationally, physician workforces do not reflect the diverse populations they should be serving, lack cultural competency, and will continue to reinforce these inequities and discriminatory practices if left unchecked.[23]

Building on the successes of the Medicaid program, public options can provide comprehensive benefits that meet the needs of their most at-risk enrollees and begin to address key inequities.[24] Black, Hispanic, and American Indian/Alaska Native families are more likely than non-Hispanic white people to be covered by Medicaid, as are LGBTQ individuals compared with their non-LGBTQ counterparts.[25] The Medicaid program has been a lifeline for low-income and other underserved communities: It covers half of all births, nearly half of children and adults with disabilities, and more than 60 percent of nursing home residents.[26] Critically, Medicaid offers benefits that reflect the needs of its diverse populations. For example, Medicaid programs cover speech and occupational therapy for children with autism and other disabilities and prenatal and delivery costs for pregnant people.[27] A public option can similarly meet the needs of its enrollees.

States are considering public options

While various public option proposals carry different features, this issue brief discusses the public option as an umbrella term that includes plans to improve coverage and bring down costs through greater competition.[28] Common

characteristics of state public option reforms include a state-backed public option that competes with private plans in the individual market for health insurance; government-regulated rates for provider payments; and income-based financial assistance in addition to that currently available through federal subsidies. There are also federal public option variations, such as President Biden's proposal, of similar design.[29]

Several states are developing public options or taking other steps to make health plans more affordable.[30] Washington state launched its Cascade Care public option for the 2021 enrollment period, through which private carriers offer affordable, standardized plans that "provide more services with reduced cost-sharing" than nonstandardized plans and offer lower deductibles and more pre-deductible services.[31] The state has set aggregate payment caps at 160 percent of Medicare rates for all medical services, accounted for differences in service types and shortage areas, and projected 5 percent to 10 percent premium cost savings. However, Washington has not met its premium savings goal in its first enrollment period.[32] While public and nonpublic standardized plans—both new additions to the state's marketplace for 2021—were more expensive than nonstandardized plans that are not beholden to the same rigorous quality standards, public option standardized plans were less expensive than nonpublic option standardized plans in all but one county in which they were offered.[33]

In 2019, Colorado lawmakers passed legislation that directed state agencies to develop a public option proposal. The state recently introduced another bill that[34] would require private insurers to offer individual and small-group market standardized benefit plans in every county in which the insurer offers other, nonstandardized individual and small-group market plans and that would set premium reduction goals over three years.[35] A previous iteration of the legislation called for a state-run public option contingency in the case of unmet premium reduction goals. Under the most recent text, if insurers fail to meet the premium reduction goals, the Colorado Division of Insurance will hold a public hearing and, based on evidence offered at the hearing, may set provider payment rates if necessary to reach the premium reduction target or meet network adequacy requirements. The legislation would also set a floor based on a percentage of Medicare payments, below which the state could not lower payment rates.[36]

Efforts to enact a public option are also gaining momentum in several other states. The Oregon Legislature received study results evaluating three public option proposals in December 2020 and is considering a bill that would direct the Oregon Health Authority to develop a public option implementation plan, although additional legislation would be needed to enact the public option.[37] Nevada enacted a resolution to study public option possibilities in 2019.[38] Similar in design to Washington state's Cascade Care, Nevada legislators recently introduced a new bill that would require private insurers that bid to operate Medicaid plans in

the state to offer public option plans and require providers that accept Medicaid and the Public Employees' Benefit program to participate in the public option program.[39] With increased market power and competition, the Nevada bill plans to lower premiums by at least 15 percent over five years.[40] Connecticut legislators have introduced two public option bills previously and plan to bring another bill up for consideration this year.[41] Several other states, including Delaware, Massachusetts, and New Mexico, have initiated or completed studies of pursuing public options in their states.[42]

Public option reforms can improve health equity and disparities

Public options or other related reforms would drive competition and efficiency into the existing health care market, lowering prices within the public option plan with ripple effects of lowered prices in the private market. These savings can be passed on to consumers and reinvested into equity initiatives that target social determinants of health. Governments have a ripe opportunity when designing state-backed plans to integrate benefits, services, and community investments that tackle insidious inequities into their public option plans.

Bringing down prices for care while bolstering access

A key element of the projected success of the public option is lowering payment rates for both public option and private plans. This provision would be particularly salient in hospital settings. Recent trends of hospital consolidation and diminished competition have added to health systems' market power, allowing hospitals to take in large profits and set high prices for commercial insurers.[43] Indeed, according to an analysis by the RAND Corp., commercial issuers pay nearly 2 1/2 times as much as Medicare does for hospital care.[44] Not only does high-priced hospital care drive countless stories of medical debt and sky-high bills, but it also results in higher premiums.[45]

A public option drives competition into the insurance market. With a significant number of enrollees and state pressure, the public option can use market power to negotiate provider reimbursement levels below current commercial rates. Knowing that enrollees can switch to the public option, commercial insurers would have an incentive to negotiate lower payment rates to stay in competition. The savings from lower rates could be passed on to enrollees in both the public option and commercial insurance plans through lower premiums and reduced cost sharing.

This downward pressure on prices could help make universal coverage sustainable under a public option. A public option that itself offers lower premiums could also drive down premiums for competing private insurance plans. These lower costs would also generate potential savings for the federal government because ACA subsidies are pegged to plan premiums. Using federal Section 1332 waivers,

states could apply to receive pass-through funding to put expected savings toward policies to expand coverage to the uninsured or improve affordability for those covered through the individual market.[46]

Bringing down costs for care does not have to be at the expense of struggling providers and hospitals; payments can be adapted to meet the needs of safety-net providers and others that need it. For instance, policymakers could offer higher or additional payments to community health centers—key to providing care to underserved populations—to improve access to care.[47] Washington state's Cascade Care plan sets a payment floor of 135 percent of Medicare rates for primary care services to prioritize access to and sustainability of primary care.[48]

Policymakers must also consider hospitals and providers on the front lines of the pandemic and ensure that payment rates are adequate to keep those providers afloat. Since the onset of the coronavirus crisis, 60 percent more rural hospitals have been at risk of closure.[49] Coverage expansion has been key to sustaining rural hospitals: From 2013 to 2017, rural hospital closure rates were double previous rates in non-Medicaid expansion states, while expansion states experienced little change in rural hospital closures.[50] Even at Medicaid payment rates—which are well below those of private insurers, at an average of 72 percent of Medicare rates for common procedures—greater coverage plays a large role in improving the vitality of rural hospitals.[51] Washington's Cascade Care plan sets a payment floor for rural hospitals at 101 percent of Medicare rates, suggesting expanded coverage will continue to improve the financial vitality of struggling hospitals.[52]

By overseeing provider contracting, state and federal governments can ensure that public option payments support providers that provide care to underserved, at-risk community members. Providing higher payment rates for these providers would incentivize them to continue providing this care and augment their ability to stay afloat.[53] Using this payment system to equitably distribute resources would require upfront analysis of which providers serve at-risk communities. As the Massachusetts Office of the Attorney General describes, states can use cost-growth benchmarks, modified global budgets, and grant funding for patients receiving no-cost coverage to support safety-net hospitals and health centers.[54] States could also offer add-on payments to certain providers, such as those that meet certain thresholds of treating low-income or uninsured patients. Finally, these equitable payments would require ongoing monitoring to ensure that the additional funding is reaching the right providers and adequately supporting health care resources.

Improving affordability for individuals

As detailed above, a significant proportion of U.S. residents struggle to afford their health care, especially those in historically marginalized communities, including Black, Hispanic, Native, and LGBTQ individuals and people living in poverty.[55] By regulating provider payment rates, governments can pass on savings to

consumers through lower premiums, deductibles, and other forms of cost sharing. States can also play a more active role in benefit design. Using data from public health agencies, the public option could offer certain services that would improve population health at no out-of-pocket cost or pre-deductible. For example, following Washington state's lead, pre-deductible coverage for services such as primary care and behavioral health and no-cost prescription drugs for chronic conditions could benefit underserved communities.[56]

The government could also design plans to include nonclinical services that address barriers to accessing care. Numerous studies point to lack of transportation as a driver of delayed care, missed appointments, and missed prescription refills, especially among low-income individuals.[57] In a 2013 study, 1 in 4 lower-income patients reported missing or rescheduling health care appointments due to transportation constraints.[58] These barriers are felt unequally; people of color are more than twice as likely as white people to live in a household without access to a vehicle.[59] A public option could include nonemergency transportation as a benefit and apply the same framework to address similar barriers.

Applying savings to other equity initiatives

By creating a more efficient and high-value health insurance system, the government can reinvest savings to address social determinants of health. Targeted investments in key nonclinical drivers of inequity, such as housing, transportation, and education, would not only reduce health inequities but also potentially decrease health care expenditures, as these initiatives improve health outcomes and encourage people to seek care before conditions become acute.[60] For example, under the Super-Utilizer Pilot Project in rural Montana, community health workers and nurses contacted people using hospital care at high rates; identified barriers to health and health care; and connected participants with services and resources, collaborative care plans, and other supports.[61] The program saved more than $1.8 million in hospital costs by serving just 36 participants.[62] The savings from addressing broader barriers and inequities can be both passed to consumers and reinvested in further equity initiatives.

Effectively addressing social determinants of health requires coordination and collaboration between community stakeholders. Some local nonprofit hospitals and public health departments already assess community needs; bringing together independent groups and organizations to identify shared community priorities and needs is key to creating a meaningful impact.[63] With additional funding, local health departments can serve as the epicenter for community-based equity initiatives, working with other agencies and community organizations with specific expertise on particular social determinants.

Prioritizing equity before and after implementation

State and federal policymakers designing public options must prioritize equity at every opportunity. From the very beginning of idea generation, meaningful community engagement—especially with communities of color and other high-risk populations—is integral to designing plans that will prioritize interventions in the ways affected communities find most valuable and urgent. Rather than just serving as approvers or endorsers, representatives from underserved communities must be welcomed as decision-makers throughout the entire process. To accomplish this, public health departments and other government actors must publicize opportunities for community involvement and invest in engaging at-risk and underserved individuals.[64]

Federal and state governments developing and implementing public options must dedicate resources to thinking through data collection, monitoring, and evaluation. Public option plans can best address inequities with data that accurately assesses community needs. As these programs are implemented, government actors will need to evaluate improvements in access and other measures of equity. Disaggregated data will be key to ensuring that equity initiatives reach in-need communities. Meaningful community engagement is as necessary to evaluating initiatives as it is to developing them—patient reported measures are some of the most critical data to evaluate.[65]

Conclusion

The coronavirus pandemic has made it clear that the status quo of health coverage is not working for everyone. To reimagine the United States as a country with affordable and accessible coverage for all, policymakers need to make significant investments—not only to achieve universal coverage but also to address inequities in nonclinical factors that contribute to poorer access and worsening health disparities. Public options designed with equity in mind can be an important part of creating a healthier nation in which basic needs are met and opportunities to thrive are abundant.

Nicole Rapfogel is a research assistant for Health Policy at the Center for American Progress. Maura Calsyn is the managing director of Health Policy at the Center.

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