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The Health Care Safety Net We Want and Need

First in the Series on the U.S. Health Care Safety Net System

One of the most vexing public policy problems is how to ensure that people have access to affordable health care. Currently, the U.S. health care system relies on a patchwork of funding mechanisms. Most Americans get their health insurance through the private sector, but millions are covered by an ad hoc safety net.

Two problems emerge from this patchwork system:

- There are millions of Americans who should be in the safety net but are not;
- And there are millions who have no business being in the safety net but are.

Such problems make the safety net both inefficient and very costly. The public policy challenge facing the U.S. and its elected representatives is to develop a safety net that provides quality and timely care for those who need it most, and allow the market to work for everyone else.

Two Safety Net Philosophies. There are two different safety net philosophies: The U.S. (along with South Africa and Singapore) holds one view, and just about every other country takes the other.

Historically, the U.S. has held that individuals should be responsible for obtaining their own health care and health insurance, but there should also be a government-supported safety net for those who are too poor, elderly or sick to access the system. Medicare and Medicaid — the two largest safety net programs — were intended for the elderly and poor because it was thought they had limited funds to pay for care.

Most other countries do not believe that markets work in health care, nor do they believe that individual responsibility and accountability can or should play a significant role. Thus a safety net isn't just part of their system; it IS the system. Everyone is entitled to a rich package of health benefits. These countries have, in effect, *turned the safety net into a hammock.*

Over the past four decades, U.S. politicians have frequently expanded the Medicare and Medicaid safety net programs so that they too look like a hammock. But the government also has been

cutting reimbursement rates so that people in these programs are increasingly experiencing access problems as health care providers limit or reduce participation, and costs are shifted to the private sector.

U.S. Health Insurance Coverage. Most Americans with health insurance get it through the private sector.¹

- 159.2 million Americans (workers and dependents) have employer-provided coverage;
- Another 17 million buy their own policies in what is known as the individual market.

But the U.S. also has an extensive public sector health care system — accounting for about 45 percent of all U.S. health care spending.² [See the Sidebar.] Despite all of these private and public sector options, there are still some 45 million uninsured Americans.³

Public Hospitals and Clinics. Historically, states and local communities have filled in the cracks for the uninsured, largely by funding public hospitals and clinics that will take the poor, the uninsured and the uninsurable.

The Public Sector Safety Net*

- Medicare covers about 35 million seniors and 6 million disabled people (2003).⁴
- Medicaid covers 42.4 million Americans, of whom 4.3 million are aged and also participate in Medicare, and 7.9 million are blind or disabled and may participate in Medicare. That leaves about 30.2 million mostly low-income Americans who rely on Medicaid for insurance coverage.⁵
- In addition, there are nearly 7 million Americans in Tricare (a program run by the Department of Defense for military retirees or the dependents of those on active duty and others) or CHAMPVA (for low-income and disabled veterans).⁶
- The State Children's Health Insurance Program (SCHIP) is the federal-state partnership program designed to expand health insurance coverage to children whose families earn too much money to be eligible for Medicaid but not enough money to purchase private health insurance coverage. For 2003, there were 5.8 million children enrolled in SCHIP at some point during the year.⁷

* Some of the figures are derived from separate sources and so populations may be in more than one safety net and therefore counted more than once.

According to the Institute of Medicine (IOM), of the \$34 billion to \$38 billion in uncompensated charity care delivered to the uninsured (but not paid for) in 2001, the public sector is estimated to have financed up to 85 percent of the cost.⁸

However, providing that care is straining government budgets, a situation exacerbated by the fact that many states expanded Medicaid eligibility limits in the 1990s — in some cases to solidly middle-income families — when most state coffers were overflowing. For years, education was the states' biggest spending item. But by 2004, 23 states spent more on Medicaid (when federal subsidies were included) than education.⁹

Tax Breaks for Health Insurance. Another way government provides a safety net, at least indirectly, is by providing a tax break for the purchase of health insurance — a significant benefit for those who get health insurance through an employer and for the self-employed. The journal *Health Affairs* estimates that the government “spends” — that is, forgoes — about \$188 billion each year on such tax breaks.¹⁰

However, individuals working for employers who don't provide health insurance get no similar tax relief. They must pay their taxes first and buy a policy with what's left over.

High-Risk Pools. High-risk pools act as a safety net for people who are uninsurable, or whose premiums cost more than the standard. Established more than 25 years ago, high-risk pools operate in 33 states and covered more than 181,000 people as of June 2004, according to *Communicating for Agriculture*.¹¹

In most states with high-risk pools, applicants have a choice among HMOs or PPOs, and most offer a range of deductibles and copays. Applicants can purchase a plan that meets their needs and budget. State high-risk pools are usually funded by assessing health insurers operating within a state, based on the amount of business the insurer writes. Some states have relied on broad-based funding sources such as lotteries or general tax revenues.

However, in 2002 Congress passed legislation that provided federal “seed” money (through 2004) to be used for start-up costs in states where no high-risk pool existed or was closed to new applicants. The legislation further provided funds for states that already had operational high-risk pools, so long as existing pools were consistent with regulatory guidelines.

Congress should continue to provide federal funding and remove legal barriers to states' efforts to broadly fund their pools, which are the most efficient way to provide a safety net for the uninsurable while letting the private sector work for most other Americans.

Returning to a Real Safety Net. One goal of any U.S. health care reform effort should be to ensure that the safety net system is just that: a safety net that actually helps those who need help most. For example:

- Even though the Congressional Budget Office documented that about 75 percent of seniors on Medicare had some type of prescription drug coverage, Congress passed a new entitlement that will include even the richest seniors.

- Some states have expanded SCHIP eligibility beyond the 200 percent of the Federal Poverty Level (FPL) limit and some are also covering entire families and not just children.
- Middle- and upper-income families routinely “spend down” or hide the assets of a family member who must go to a nursing home, thus qualifying for Medicaid coverage.
- And, as mentioned above, those with employer-provided coverage tend to be higher-income workers, yet they get an unlimited tax break; those without employer coverage tend to have lower incomes, but get no tax subsidy.
- Local governments may also provide other safety nets that are not coordinated with any of the federal or state programs discussed above, resulting in confusion as well as overlapping coverage.

For a safety net to be both effective and affordable, it must provide sufficient help to the poor, the uninsured and the uninsurable, but let the market work for the vast majority of Americans who are willing and able to take responsibility for their own actions. It should also encourage individuals to eventually take care of and help themselves, not make them dependent on the program forever, unless their physical health necessitates it. Such a safety net would:

- Build on a free market system, not detract from it;
- Attempt, as much as possible, to “mainstream” those in the safety net so that if and when the day comes that they can move back into the private sector, the transition will be as seamless and painless as possible;
- Fund it with public dollars, rather than trying to impose those costs on business;
- Provide reasonable incentives within the programs to encourage people to spend the money as though it was their own, while providing the ability to receive timely and high quality care; and
- Ensure that only those who really need help are in the safety net.

If the U.S. can implement these health care reform principles, it will fundamentally restructure the health care system so that all Americans have access to affordable, quality health care.

Note: Endnotes are available at http://www.cahi.org/cahi_content/resources/pdf/n128safetynet.pdf.

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Endnotes

¹Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey," Employee Benefit Research Institute, Issue Brief No. 276, December 2004, p. 5, Figure 1.

²Organization for Economic Cooperation and Development, "OECD Health Data 2004," 1st Edition (<http://www.oecd.org/dataoecd/13/12/31963479.xls>).

³Ibid.

⁴Centers for Medicare and Medicaid Services, "Medicare Enrollment: National Trends, 1996-2003" (http://www.cms.hhs.gov/statistics/enrollment/natlrends/hi_smi.asp).

⁵Centers for Medicare and Medicaid Services, "Medicaid Enrollment for Beneficiaries, Selected Fiscal Years," November 2003.

⁶Fronstin, Ibid.

⁷See <http://www.cms.hhs.gov/schip/>.

⁸See Institute of Medicine, "A Shared Destiny: Community Effects of Uninsurance," March 6, 2003. <http://www.iom.edu/report.asp?id=5404>.

⁹See National Association of State Budget Officers, "2003 State Expenditure Report," 2003.

¹⁰John Sheils and Randall Haught, "The Cost of Tax-Exempt Health Benefits in 2004," Health Affairs, Web Exclusive, February 25, 2004.

¹¹"Comprehensive Health Insurance for High-Risk Individuals — A State-by-State Analysis," Communicating for Agriculture, Inc., Eighteenth Edition, 2004/2005, November 4, 2004.