Changing Nature of Public and Private Health Insurance

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BACKGROUND

While approximately 42 million Americans lack health insurance coverage (Kaiser Commission on Medicaid and the Uninsured, 2001), the vast majority of Americans are covered for their health care expenditures by a complicated array of public and private programs. Private health insurance coverage grew rapidly during World War II as employers provided coverage as a fringe benefit to their employees in response to Federal Government wage controls. Today, many individuals continue to receive their coverage through their employers.

It was not until 1965 that Congress passed historic legislation to establish the Medicare and Medicaid Programs as Title XVIII and Title XIX, respectively, of the Social Security Act. When first implemented, the Medicare Program covered most persons age 65 or over. The program was subsequently expanded by Congress in 1972 to include persons entitled to Social Security or Railroad Retirement Disability Benefits for at least 24 months and most persons with end-stage renal disease. In 2001, the Medicare Program provided coverage to 40 million aged and disabled beneficiaries (U.S. Department of Health and Human Services, 2001).

The Medicaid Program was first implemented as an extension of federally-funded programs providing cash assistance to the poor. Within broad guidelines established by Federal statutes, States develop and administer their own Medicaid policies for eligibility, services, and provider payments. Over the years, eligibility has been expanded incrementally to additional populations including low-income pregnant women, poor children, and some Medicare beneficiaries with low income and limited resources (Rowland and Garfield, 2000).

In 1997, Congress established the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. SCHIP is designed to encourage States to extend Medicaid eligibility to a greater number of uninsured children. In 2001, approximately 34 million Americans received health insurance coverage in any given month through the Medicaid Program and as many as 4.6 million additional children got assistance from SCHIP (U.S. Department of Health and Human Services, 2001; Centers for Medicare & Medicaid Services, 2002).

Both public and private health insurance coverage continue to evolve rapidly not only in response to the health care needs of the covered population and the development of new treatments and technologies to address these needs, but also in response to economic conditions affecting the affordability of the coverage. A mix of public and private solutions such as tax credits for low-income uninsured and Federal funding for State high-risk pools are currently being proposed to make private health insurance more accessible and affordable. The articles in this issue of the *Review* address the interactions of public and private coverage for Medicare

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beneficiaries and the expansions of State programs through the Medicaid Program, waiver authorities, and SCHIP.

MEDICARE SUPPLEMENTAL COVERAGE

While the Medicare Program is a stable source of health insurance coverage for the elderly and disabled, there are substantial cost-sharing requirements for basic benefits such as inpatient hospital care and physician services. There are also important gaps in coverage, most notably outpatient prescription drugs and long-term care (LTC) services. As a result the vast majority of Medicare beneficiaries obtain supplemental coverage from a variety of public and private sources. Routine Medicare administrative data collected by CMS do not, however, contain information on beneficiaries' private supplemental coverage and have incomplete information on their public supplemental coverage. Additional data sources must be used to understand beneficiaries' sources of supplemental coverage.

The Medicare Current Beneficiary Survey (MCBS), sponsored by CMS, is a continuous, multipurpose survey of a representative sample of the Medicare population. An important feature of the MCBS is that it combines information from Medicare administrative files with information that can only be obtained from the beneficiary such as supplemental health insurance, utilization on non-covered services, health status and functioning, access to and satisfaction with care. Using this unique combination of data, the MCBS highlights the critical role that supplemental coverage plays in beneficiary access to care.

In 1997, the Medicare Program was the source of payment for 55.7 percent of personal health care expenditures for Medicare beneficiaries. While some personal health care expenditures are for services not covered by Medicare such as LTC, dental and prescription drugs, non-institutionalized beneficiaries also face substantial financial barriers to care for Medicare covered services. For example, among community dwelling beneficiaries, the Medicare Program was the source of payment for 67.26 percent of physician and supplier services (Sharma et al., 2001). Concern over the cost of services can contribute to beneficiaries delaying care and this concern is likely to be most acute among beneficiaries with no coverage for Medicare cost-sharing requirements. In 1999, 19.83 percent of beneficiaries with no supplemental coverage reported delaying care due to cost compared with 7.58 percent of all non-institutionalized beneficiaries (Shatto, 2001).

Two articles in this issue use the MCBS to profile supplemental coverage for Medicare beneficiaries. In the first article, Murray and Eppig track the sources of supplemental coverage from 1991 to 1999. The sources they track include Medicare risk plans, Medicaid, employer-sponsored plans and individually purchased Medigap plans. They describe dramatic changes over the decade in the number of beneficiaries enrolling in Medicare risk plans. As the decade progressed, many beneficiaries joined managed care plans to avoid Medigap premium increases and to get prescription drug coverage. In 1991, only 3 percent of Medicare beneficiaries were enrolled in these plans. By 1999, they report that 17 percent of Medicare beneficiaries were enrolled in these plans.

However, as Murray and Eppig discuss, the Medicare risk program, currently called Medicare+Choice (M+C), has experienced considerable turmoil in recent years. Since 1998, over 170 plans have left M+C with many others reducing their service areas. As a result, 2.2 million

Medicare beneficiaries have been involuntarily disenrolled from their M+C plan. Among those plans remaining in the program, many of them have ceased offering a zero premium product and have dropped or reduced prescription drug coverage. All these changes suggest that there will be continuing changes in the sources of supplemental coverage for Medicare beneficiaries during the upcoming decade.

In the second article, McCormack, Gabel, Berkman,Whitmore, Hutchison, Anderson, Pickreign, and West supplement data from the MCBS with data from the Kaiser Family Foundation/Health Research Educational Trust (Kaiser/HRET) survey of firms to examine trends in employer-sponsored retiree health insurance coverage. While the commitment of employers to provide coverage to employees often extends into retirement, the authors document an erosion of this type of supplemental coverage over the past decade. Firms responding to the Kaiser/HRET survey report declines in the availability of retiree coverage and Medicare beneficiaries responding to the MCBS report lower rates of enrollment in employer-sponsored plans.

Despite this erosion, the percentage of Medicare beneficiaries with no supplemental coverage did not increase over this period. The decline in employer-sponsored coverage is offset by a shift towards other types of coverage, namely M+C plans and non-Medicaid publicly-sponsored health insurance. McCormack et al. conclude that the future of employer-sponsored supplemental coverage is uncertain and speculate that the erosion in coverage is likely to continue in the upcoming decade. Declines in the availability of employer-sponsored retiree coverage and continuing increases in the cost of individually purchased supplemental coverage will undoubtedly lead to pressure on policymakers to ensure the viability of the M+C program and to add an outpatient prescription drug benefit to Medicare.

STATE APPROACHES AND SOLUTIONS

Providing Health Insurance to the Uninsured

Over the last decade, various laws have been passed to increase the likelihood that lower income individuals and families would have access to health insurance coverage. Through the Health Insurance Premium Payment Program enacted in 1990, States could use their Medicaid funds to pay the employer-sponsored health insurance premiums of Medicaid eligible individuals and families. Under the unlinking of Medicaid from welfare eligibility that was part of the Personal Responsibility and Work Opportunity Act of 1996, States could raise the income and assets thresholds in order to provide coverage to the working poor. Most notably, though, through the enactment of SCHIP, States' efforts to initiate and expand health insurance coverage to uninsured, low-income children were greatly improved.

SCHIP enables States to insure children from working families with incomes too high to qualify for Medicaid, yet too low to afford private insurance. Through SCHIP, States have sought to implement new and innovative approaches to expanding insurance coverage. States receive enhanced Federal matching for SCHIP expenditures up to a fixed allotment. These funds can be used to cover the cost of insurance and program administration, which includes outreach. To maximize the number of covered children, funds can only be used to cover uninsured children, and the statute includes a mandate that children eligible for Medicaid must be enrolled in Medicaid.

Cost-sharing protections also were established to reduce the burden on families of unaffordable out-of-pocket expenses.

Under the statute, States are given broad flexibility in tailoring their SCHIP programs. States can create a separate child health program, expand Medicaid, or implement a program that combines both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, or seek permission from the Secretary to use a State-defined benefit package.

The next three articles in this issue of the *Review* address the successes and challenges faced by States as they implement their SCHIP programs. The lessons from the experiences of these States are clearly useful to other States as they modify and refine their approaches to providing insurance coverage to low income children and families. The first article describes the unique and comprehensive approach used by Massachusetts to reduce the number of uninsured in that State and the other two articles examine the enrollment and disenrollment experiences of selected States.

In the article by Mitchell and Osber, they describe the innovative program adopted by the Commonwealth of Massachusetts. According to these authors, many individuals who work full time do not have health insurance for themselves or their families. Not surprisingly, since over one-half of the working uninsured earn less than 200 percent of the Federal poverty level (FPL), these individuals, and their employers, are frequently unable to afford the premiums (Hoffman and Schlobohm, 2000). Unlike most other States, Massachusetts implemented a program to address the premium issue for both employers and low-income employees. Using both Medicaid and SCHIP funding for the premium subsidy program, the State has adopted a two-pronged approach. Through the Insurance Partnership Program, the State provides a premium subsidy to qualified employers. Similarly, through the Premium Assistance part of the Family Assistance Program, the State provides a health insurance premium subsidy for low-income employees. While the State faced many challenges along the way, the unique approach adopted by Massachusetts has clearly had an impact on the number of individuals with insurance. At the time the article was written, nearly 3,500 employers were participating, and 10,000 adults and children had health insurance coverage. Of the 10,000 individuals with coverage, 70 percent had been previously uninsured.

Having continued access to health insurance is an important element in sustaining the health of individuals. Sporadic health insurance coverage, or coverage for only short periods of time, may negatively impact the quality of care provided to children. Initially, the focus for States was on increasing enrollment of SCHIP eligible children. While this is still a focus, there is increasing attention on retention of eligible enrollees.

Shenkman, Vogel, Boyett, and Naff examine the impact of four major policy changes that were made to an existing subsidized children's health insurance program in Florida as they transitioned into a Title XXI program. The four policy changes included: (1) expansion of eligibility coverage to children in families with incomes below 200 percent of the FPL; (2) a reduction in the family share of the monthly health insurance premium; (3) expansion of the mental health benefit; and (4) implementation of the 60-day waiting period to re-enroll for those families whose children involuntarily disenrolled due to non-payment of premium. Using enrollment and claims data from October 1997-

September 1999, the authors found that program changes do significantly impact enrollment and disenrollment rates, with for example, a higher likelihood of re-enrolling and of not disenrolling when premiums are reduced.

Similar to the Shenkman et al. article, Dick, Allison, Haber, Brach, and Shenkman examine the impact of various State policies on enrollment in and disenrollment from SCHIP programs. Focusing on Florida, Kansas, New York, and Oregon, they examined the impact of presumptive eligibility, the extent of disenrollment during periods of continuous eligibility, the relationship between disenrollment and recertification, and the impact of passive recertification. Under presumptive eligibility, applicants are provided with immediate coverage while eligibility is determined. Under continuous enrollment, children retain coverage in SCHIP even if income changes. Under passive recertification, forms are sent to enrollees to update, but children retain coverage in SCHIP regardless of whether the forms are returned.

Several key findings are suggested by Dick et al. First, they suggest that presumptive eligibility appears to be associated with higher disenrollment rates. Conceivably, individuals are enrolled who are later found to be ineligible. Second, the impact of continuous eligibility on preventing the loss of coverage due to slight increases in income appears to be limited. Many individuals disenroll prior to recertification despite the protection afforded by continuous enrollment. Third, the authors state that there is a strong and large association between disenrollment and recertification. In States without passive recertification, disenrollment rates at recertification were higher. According to the authors, the incomes and family compositions of many enrollees change prior to recertification, making them eligible for Medicaid at recertification.

Providing Home and Community-Based Services

It has been projected that the number of aged with some form of activity limitation will grow from 12 million in 1994 to 28 million by 2030 (Rice, 1996). In the recent past, the LTC needs that often resulted from these activity limitations were provided in institutional settings and paid for by Medicaid. Both in response to consumer pressure and the U.S. Supreme Court's *Olmstead* decision, States are seeking to design alternatives to institutional care through their Medicaid programs.

Under the Section 1915(c) waiver authority of the Social Security Act, States have substantial flexibility in designing their LTC delivery systems. The home and community-based services that make up the non-institutional LTC delivery system can include case management, homemaker and home health aide services, personal care, adult day care, habilitation, non-medical transportation, home modifications, and respite care. According to Wiener, Tilly, and Alecxih in their article, non-institutional LTC services accounted for 10 percent of Medicaid LTC expenditures in 1988, but increased to 25 percent by 2000. Little is known, however, about the effects of these home and community-based services on quality of care, quality of life, and costs. The authors describe how States address the supply, administration, organization, and financing of these home and community-based services for older people and younger adults with physical disabilities. To address these issues, they conducted extensive case studies in seven States: Alabama, Indiana, Washington, Wisconsin, Maryland, Michigan, and Kentucky. These States were specifically

chosen because they represent both those with well developed systems and those in the developing stages of their home and community-based services programs. They also address six major issues of policy importance. First, what are the roles of Medicaid and State-funded programs in the financing of home and community-based services; and within Medicaid, what are the roles of mandatory, optional, and waiver services? Second, how do States administratively coordinate the various funding streams, and what is the role of local entities, such as area agencies on aging, counties, development agencies, waiver agents, and home health agencies? Third, given the growing demand for services, how do States use financial and functional eligibility criteria to allocate resources? Fourth, what services are provided through home and community-based services programs? Fifth, how do States control expenditures? Finally, how do States ensure the quality of care provided through these programs?

CONCLUSION

State responsibilities in the health care arena have grown significantly in recent years with expansions of Medicaid eligibility criteria, development of SCHIP programs, and increased activity in meeting the LTC needs of aging populations. The problems of the uninsured continue to be of special concern to State governments. States have much to learn from each other as they experiment with methods of addressing their common problems. This is particularly true of SCHIP because these programs are relatively new and their characteristics vary considerably among States. This issue of the *Review* offers important lessons to be learned from attempts by various States to develop and improve their health care programs.

Several articles in this issue highlight the changing relationship of private and public health insurance, particularly Medicare. These relationships are important for policymakers to understand, particularly as they contemplate various options for Medicare reform. The role of private insurance is a critical factor in the evaluation of proposals to raise the eligibility age for Medicare, provide coverage for prescription drugs, and to increase beneficiary cost sharing.

As public and private health insurance programs evolve, the relationship between them will continue to change. Their effects on each other will continue to be significant. A role for future research will be to evaluate how effectively the private and public health insurance sectors can operate together to insure health care for their clients.

REFERENCES

Centers for Medicare and Medicaid Services: *The State Children's Health Insurance Program*. Annual Enrollment Report. Internet address: www.hcfa.gov March 2002.

Dick, A.W., Allison, R.A., Haber, S.G., et al.: Consequences of States' Policies for SCHIP Disenrollment. *Health Care Financing Review* 23(3):65-68, Spring 2002.

Hoffman, C., and Schlobohm, A.: *Uninsured in America*. The Henry J. Kaiser Commission on Medicaid and the Uninsured. Washington DC. 2000.

Kaiser Commission on Medicaid and the Uninsured: *The Uninsured and Their Access to Health Care*. The Henry J. Kaiser Family Foundation. Washington DC. January 2001.

McCormack, L., Gabel, J., Berkman, N., et al.: Retiree Health Insurance: Recent Trends and Tomorrow's Prospects. *Health Care Financing Review* 23(3):17-34, Spring 2002.

Mitchell, J.B., Osber, D.S.: Using Medicaid/SCHIP to Insure Working Families: The Massachusetts Experience. *Health Care Financing Review* 23(3):35-45, Spring 2002.

Murray, L., and Eppig, F.: Insurance Trends for the Medicare Population, 1991-1999. *Health Care Financing Review* 23(3):9-15, Spring 2002.

Rice, D.: Beneficiary Profile: Yesterday, Today, and Tomorrow. *Health Care Financing Review* 18(2):23-46, Winter 1996.

Rowland, D., and Garfield, R.: Health Care for the Poor: Medicaid at 35. *Health Care Financing Review* 22(1):23-34, Fall 2000.

Sharma, R., Chan, S., Liu, H., and Ginsberg, C.: Health and Health Care of the Medicare Population: Data from the 1997 Medicare Current Beneficiary Survey. Westat. Rockville, MD. September 2001.

Shatto, A.: *The Characteristics and Perceptions of the Medicare Population*. Data from the 1999 Medicare Current Beneficiary Survey. Health Care Financing Administration. Baltimore, MD. 2001.

Shenkman, E., Vogel, B., Boyett, N., and Naff, R.: Disenrollment and Re-enrollment Patterns in a SCHIP. *Health Care Financing Review* 23(3):47-63, Spring 2002.

U.S. Department of Health and Human Services: *2001 HCFA Statistics* HCFA Pub. No. 03427. July 2001.

Wiener, J.M., Tilly, J., and Alecxih, L.M.B.: Home and Community-Based Services in Seven States. *Health Care Financing Review* 23(3):89-114, Spring 2002.

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