HOW SHOULD PUBLICLY SPONSORED HEALTH INSURANCE BE STRUCTURED?

Policymakers considering how to structure a program of publicly sponsored health insurance for low-income Americans face a set of fundamental issues about its design. This section addresses seven core elements that play a large part in determining the scope, shape, impact, and sustainability of a publicly financed health coverage program. In the following pages, we outline the issues and present the evidence relevant to these defining policy dimensions:

- **Eligibility**
- **Participation**
- **Use of Premiums**
- **Scope of Benefits**
- **Use of Cost-Sharing**
- **Access to Care**
- **Financing**

Scope of Benefits

The issue

The low-income population is diverse, including newborns, young and older children, working adults, people with disabilities, and seniors. Because of their limited means, low-income people face particularly steep financial barriers to obtaining care that is not covered by insurance. If they do not obtain needed care, they may experience adverse health consequences that may, in turn, have wider public health and economic implications.

On the other hand, budget pressures at the federal and state level, concern that comprehensive benefits could lead to inappropriate utilization and spending, and equity issues have been raised as reasons to offer limited benefits in the nation's public health insurance programs. Also, some have argued that leaner benefits can be justified in the context of efforts to expand coverage with constrained resources.

The evidence

An abundance of evidence shows that low-income people tend to be in worse health than others. It also confirms that people with worse health status have greater needs for care and report more unmet need. Many low-income Americans, particularly seniors and adults and children with severe physical and mental disabilities, need rehabilitation and long-term care as well as acute medical care. The low-income population enrolled in Medicaid is both poorer and sicker than the low-income population with private insurance. Nearly half of uninsured adults report having at least one chronic condition.

Commercial insurance often does not cover the scope of benefits needed by many low-income people. Experience in some states with Medicaid waivers indicates that limited benefit packages may leave enrollees with significant unmet needs. And Medicaid's large role in supplementing Medicare for low-income Medicare beneficiaries reveals the magnitude of the gaps in Medicare-covered benefits.

Medicaid provides more comprehensive benefits than private insurance. However, researchers have shown that when differences between the health and disability status of the two insured populations are adjusted, utilization of basic services by adults in Medicaid is similar to utilization by low-income privately insured adults. That is, higher utilization in Medicaid is due to the lower health status of the Medicaid population. Other research shows that Medicaid spending is highly concentrated among Medicaid's sickest and most disabled beneficiaries, and that their intense consumption of care, not high use of Medicaid services in general, drives the program's high total spending.

States use an array of available strategies, such as managed care, prior authorization, drug formularies, and disease management to manage utilization in Medicaid. In some cases, states also set limits on the "amount, duration, and scope" of the Medicaid benefits they cover.

Because states have discretion both to define the scope of required Medicaid benefits they will cover and to offer optional benefits, there is wide variation in the content of Medicaid coverage nationally, especially for adults, and a variety of benefit gaps and disparities persist. Currently, because the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit entitles children to the full range of services permissible under federal law to treat all diagnosed

The diverse health needs and limited resources of the low-income population point to a need for a benefit package that is comprehensive in scope, including rehabilitation and long-term care, as well as acute health services. Experience from Medicaid does not support claims that broad benefits are associated with over-utilization of care; in fact, the research documenting unmet need in Medicaid suggests barriers to access and under-utilization in the program. Clinically sound management of health care use is critical to assure the receipt of appropriate, high-quality care.

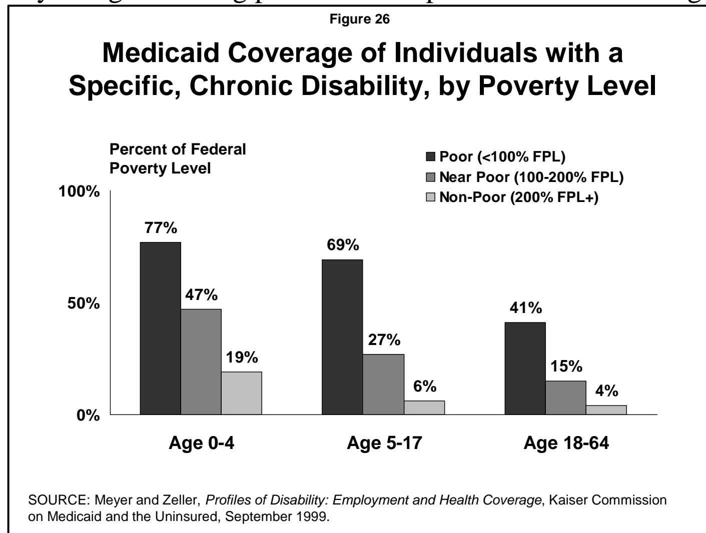
When fiscal realities constrain the capacity to expand coverage of the uninsured, offering a limited benefit package to previously uninsured individuals may result in important gains in access while laying a foundation for broader benefits when resources permit. However, reducing benefits for already-covered groups to finance slim benefits for a new group can result in reduced access and more unmet need in the previously covered population, as well as inadequate access for those who are newly insured.

Key Evidence

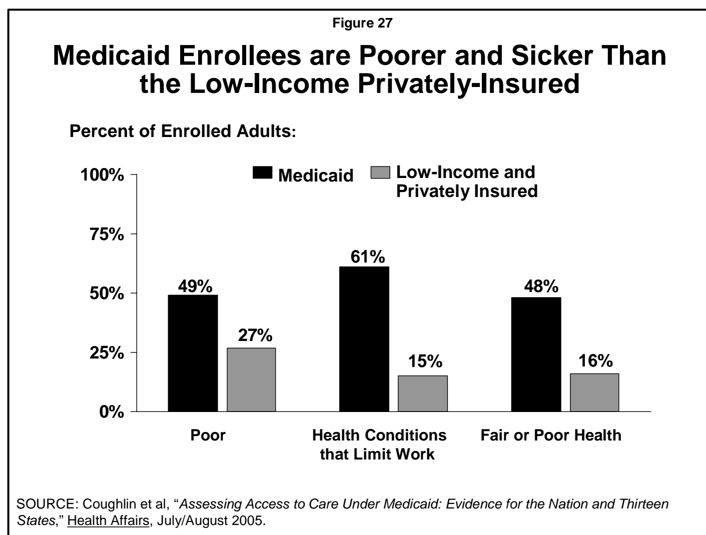
Low-income people are in worse health, have more health needs, and report more unmet need than others. People with disabilities tend to have lower income and greater medical needs than others. Many of the uninsured have chronic conditions.

- Low income is strongly correlated with poorer physical and mental health. Further, income has been shown to have a strong and significant relation to mortality; as income declines, mortality rates rise.[1 2 3 4 5]

- The prevalence of major chronic illnesses (e.g., hypertension, asthma, diabetes, depressive symptoms) and physical disability is higher among poor and near-poor adults than among the non-poor, and much higher among working-age adults covered by Medicaid than among their privately insured counterparts. Disparities by income and insurance status also exist among children. Medicaid covers a large proportion of both children and working-age adults with disabilities who are poor, and it covers a substantial portion of children with disabilities who are near-poor (Fig. 26).[6 7 8]



- Working-age adults enrolled in Medicaid are much poorer and more likely to have health problems than either low-income working adults with private coverage or uninsured adults. Almost half (49%) of adults enrolled in Medicaid are poor, compared with just over one-quarter (27%) of low-income adults with private insurance. Also, nearly half (48%) of Medicaid-enrolled working-age adults describe their health as fair or poor, while 16% of privately insured low-income adults do so. Over 60% of working-age adults with Medicaid report that they have health conditions that limit their work, compared with 15% of their low-income counterparts who are privately insured (Fig. 27).[9 10]



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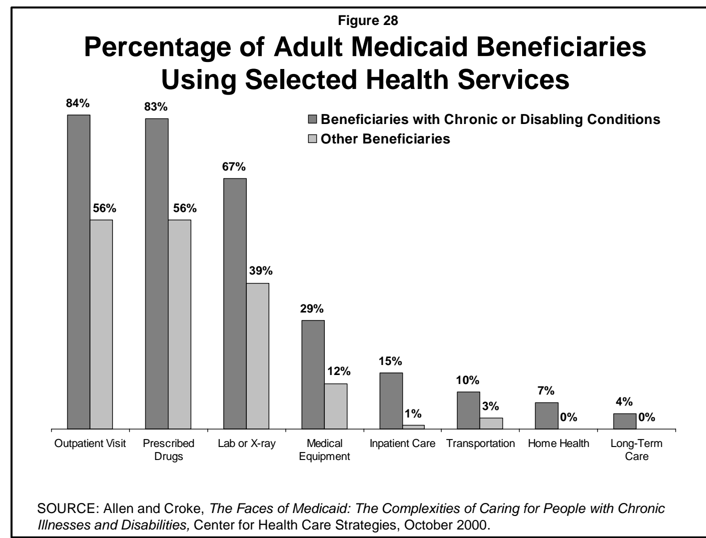
- Medicaid beneficiaries use a diverse array of health and long-term services (Fig. 28).[11] [12] [13]



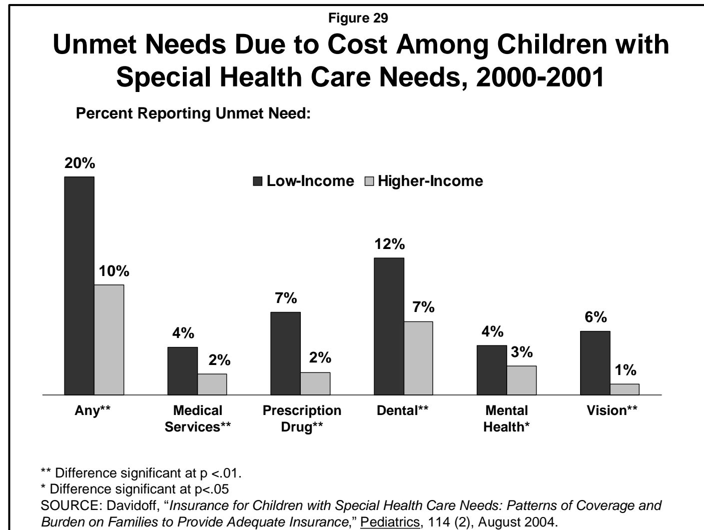
- Adults with mental and/or physical disabilities are lower-income and in much poorer health than the general non-elderly adult population. Among working-age adults, nearly 40% of those with disabilities have family income below 200% of the poverty level, compared with 22% of the non-disabled. The range of disabilities is extremely wide, including traumatic injuries, blindness, severe mental illness, developmental disabilities, HIV/AIDS, mental retardation, Down Syndrome, epilepsy, Parkinson's Disease, and many other conditions.[14] [15]

- Close to half (45%) of uninsured adults report having at least one chronic condition.[16]

- People in fair or poor health are almost three times more likely than those in good or excellent health to report having an unmet need (11.9% versus 4.1%).[17]

- Children with special health care needs (CSHCN) use many more services than other children. A recent analysis found that they had about four times as many hospitalizations as other children, more than twice as many physician visits, and seven times as many visits to non-physician health professionals, including nurse practitioners, psychologists, physical therapists, and others. They used five times as many prescribed medications per year as other children.[18]

- Holding other factors constant, low-income CSHCN are much more likely than higher-income CSHCN to report having unmet needs. One study found that 20% of low-income CSHCN experienced some unmet need, compared with 9.9% of higher-income CSHCN (Fig. 29). Another study found that nearly 1 in every 3 poor CSHCN has unmet needs for one or more kinds of health care, including primary and specialty care, ancillary services, and supplies and equipment; over a quarter of near-poor CSHCN had unmet needs. CSHCN who are uninsured are more likely to face access problems and to report unmet medical, dental, prescription drug, vision, and mental health care needs than insured CSHCN. Underinsured CSHCN are disproportionately represented in low-income families and are significantly more likely than fully insured children to have unmet health needs. Their families are also more likely to report difficulty in obtaining a specialty referral and to experience financial problems.[19] [20] [21] [22] [23] [24]



Most private health plans, as well as Medicare, do not cover the range of services needed by many low-income people.

- Private health insurance often excludes or limits coverage of several categories of care that are critical for many in the low-income population, including but not limited to people with disabilities. To illustrate, the Blue Cross/Blue Shield Standard PPO, the dominant insurer under the Federal Employees Health Benefits Program, provides no coverage of institutional care for people with mental retardation, home and community-based services, case management services, personal care services, or non-emergency transportation. The plan's coverage of many other benefits – including nursing home care, home health care, mental health care, dental and vision care, and physical, occupational, and speech therapy – is limited.[25] [26] [27]

- A national survey of working-age adults with physical disabilities, mental disabilities, or both found that the privately insured were significantly more likely than those with Medicaid to report postponing care because of higher cost-sharing and more limited benefits. For the same reasons, the adults covered by Medicare only (i.e., no supplemental coverage) were more than 12 times as likely to have postponed care and more than seven times as likely to have skimped on medicine due to cost than the adults with Medicaid only.[28]

- Among low-income children, those with private insurance but no dental benefits are as likely to report unmet dental needs as uninsured children. Children with dental coverage, whether public or private, are about half as likely to have unmet dental needs as privately insured children who do not have dental benefits, and they are significantly more likely to receive preventive dental care.[29] [30]

- While private health plans typically cover some services important to children with disabilities, such as mental health care, home health care, and physical, occupational, and speech therapy, these benefits are usually limited and designed for short-term rather than chronic care. A study of utilization by children with special health care needs found that, controlling for many demographic and health status variables, privately insured children had significantly lower odds than publicly insured children of using therapeutic services, social work services, non-medical care coordination, transportation, and housing modifications. Although the lower odds may reflect unmeasured differences between the two groups of children, the authors cite research indicating that the scope of benefits covered by private health insurance may not be adequate for children with special health care needs.[31 32]

- Under private health insurance, coverage of mental health care, home health care, physical, occupational, and speech therapy, and other benefits may be conditional on a determination that the medical condition is expected to improve. This restriction may preclude children with disabilities from obtaining services important to preserving or maximizing their function.[33]

- A study of the adequacy of private insurance for children with special health care needs found that the most commonly sold HMO and PPO products covered most basic medical services, and nearly all covered preventive care, immunizations, and behavioral health services. However, audiology, optometry, partial hospitalization for mental health/substance abuse, nutrition counseling, and medical supplies were not covered in at least 25% of the plans. Most plans limited mental health visits, and some excluded or limited coverage for certain mental disorders.[34 35 36]

- The breadth of benefits appears to play a role in medical debt. A recent study examining medical debt and access to care among privately insured working-age adults found that medical debt is a common problem. In 2003, about 1 in 6 privately insured working-age adults had medical bills they described as being very difficult to pay and/or that had a major impact on their lives. Nearly a fifth of the adults with medical debt had income below $20,000. While almost all the insured had prescription drug coverage, those with medical debt were less likely than the others to have dental, vision, maternity, mental health, and preventive care coverage. Insured adults with medical debt often skimped on their care much as adults who had no insurance at all did.[37]

- Medicare, which covers the nation's elderly and non-elderly individuals with severe disabilities, includes very limited long-term care benefits and until recently, no outpatient prescription drug benefits. Disabled Medicare beneficiaries without supplemental coverage through a private source or Medicaid are significantly more likely than those with such "wrap-around" coverage to report having postponed care, gone without equipment or items, and skimped on medicine due to cost. As one measure of the magnitude of Medicare's gaps, Medicaid's share of total spending on "dual eligibles"– low-income Medicare beneficiaries who also qualify for Medicaid – is almost as large as Medicare's.[38 39]

The scope of covered benefits affects low-income people's ability to access needed care and their financial burdens. Limited Medicaid benefits have left individuals with significant unmet needs and reduced access to care.

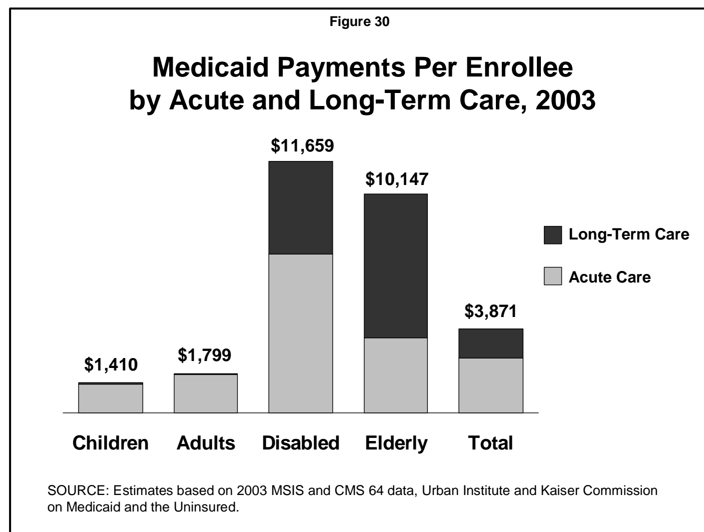
- In a national survey of non-elderly adults with disabilities, close to one-third said that prescription drugs and dental care were a cause of serious cost problems for them. Close to half (46%) reported they went without needed items such as glasses and equipment due to cost, and 17% of those with a mental disability said that they had serious problems paying for mental health services.[40]

- Following Massachusetts' elimination of most dental coverage for adults in MassHealth, the state's Medicaid program, 100,000 fewer MassHealth adult enrollees received dental services reimbursed by MassHealth than in the previous year. Both beneficiaries and providers reported an increase in untreated dental problems and a reduction in corrective and restorative treatments for MassHealth enrollees, and beneficiaries described living with pain, diminished self-esteem, and negative effects on employment and their families' finances due to dental problems.[41]

- When Utah reduced Medicaid benefits for extremely poor adult beneficiaries to finance a primary care-only benefit for additional adults, both groups experienced access problems and financial hardship. A majority of both groups reported using or needing services that were not covered. The limited coverage or cost associated with services led one-third of the newly insured people to miss or postpone care, and over half reported difficulty paying for medical expenses. Among those with reduced benefits, nearly a quarter missed or postponed care, and over a third reported difficulty paying medical expenses. Likewise, studies in other states that have used waivers to limit Medicaid benefits have found that individuals have difficulty obtaining needed care due to the limits on benefits.[42 43 44 45 46]

- Researchers studying the impact of Medicaid caps on the number of prescription drugs that can be covered have found that the use of clinically essential medications declines markedly, particularly for people with mental health problems or chronic pain. Exacerbations of chronic illness increase and the use of emergency services and admissions to nursing homes rise sharply.[47 48 49 50]

- Medicaid per capita spending varies widely by eligibility subgroup. The much higher per capita costs associated with disabled and elderly enrollees reflects their much greater use of acute care, as well as their use of institutional long-term care and other long-term services and supports (Fig. 30).[51]



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Medicaid benefits are comprehensive to address the diverse health and long-term care needs of its beneficiaries.

- Federal Medicaid law mandates a wide range of acute as well as long-term care benefits, and states can cover many other services at their option. Medicaid benefits span the spectrum of care needed by a low-income population with diverse health needs, including – in addition to the benefits typical of commercial insurance – many services for which private health coverage tends to be limited or excluded. These services include nursing home care, community-based long-term care, rehabilitation services, mental health and substance abuse services, dental and vision care, non-physician practitioner services, and medical equipment and supplies.[52 53]

- Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit requires states to cover all federally authorized Medicaid benefits for children under age 21, including benefits that, for adult beneficiaries, states cover on an optional basis. Congress designed EPSDT to be comprehensive, encompassing early intervention services to identify the needs of children at elevated risk, as well as the full range of acute and long-term care services and case management services often needed by children with chronic conditions and disabilities. Research provides evidence that EPSDT has provided for preventive and well-child care and treatment of illness and disability for low-income children who would have gone without it in the absence of this Medicaid benefit.[54 55 56 57 58]

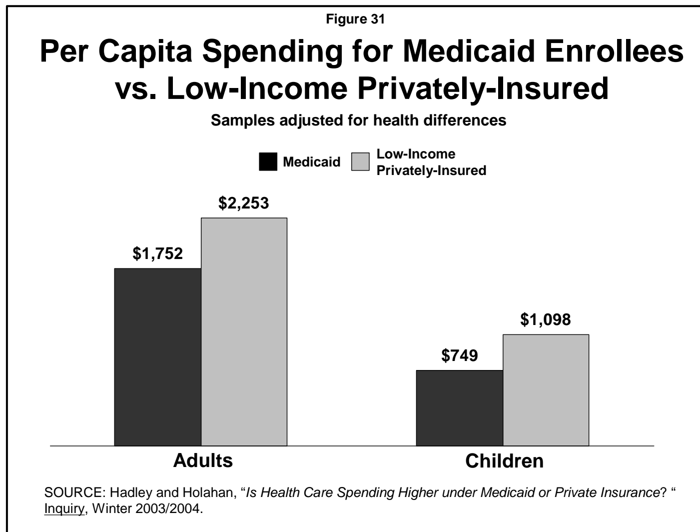
- For children in Medicaid, the expectation that a service will lead to improved function is not a criterion for coverage of the service; Medicaid also covers services on the basis that they enable children to maintain their existing level of function.[59]
- Medicaid is the nation's main source of coverage for people in nursing homes and individuals in intermediate care facilities for individuals with mental retardation (ICF/MR). Coverage of institutional care by other insurers is very limited.[60]

- Medicaid supplements Medicare for almost 7.5 million low-income Medicare beneficiaries, including more than 5 million seniors and 2 million individuals with disabilities. Medicaid fills key gaps in Medicare benefits for these "dual eligibles," particularly for nursing home care, and it also subsidizes their Medicare premiums and out-of-pocket costs.[61]

Although Medicaid benefits are comprehensive, Medicaid-covered adults are no more likely to use a service than comparable low-income adults with private coverage. Medicaid-covered children are more likely than privately insured low-income children to use services.

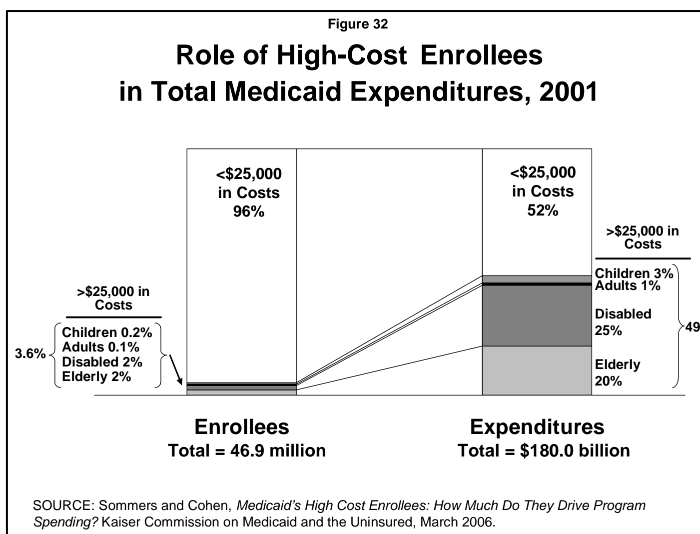
- When the greater poverty, worse health, and higher prevalence of disability in the Medicaid population are taken into account, adults in Medicaid are no more likely to use doctor visits, hospital days, and other broad categories of service than low-income adults with private insurance. Though their per capita spending is lower than that for low-income children with private insurance, children in Medicaid are more likely than their privately insured peers to use a service, perhaps due to the program's emphasis on assuring care for children.[62]

- Dental and other optional services, often associated with controversy about the breadth of the Medicaid benefit package, have been found to account for a small proportion of Medicaid per capita spending – generally less than 15%. These services account for a significantly larger proportion of per capita spending for the low-income population with private insurance.[63]



- Medicaid per capita spending is low relative to per capita spending among the low-income privately insured, once health status differences between the two groups are adjusted. This finding holds for both adults and children (Fig. 31).[64]

- A small share of Medicaid beneficiaries account for a large share of Medicaid expenditures (Fig. 32). In federal fiscal year 2001, nearly half of Medicaid spending was attributable to the 3.6% of Medicaid beneficiaries whose spending exceeding $25,000 in that year. Those with spending under $5,000 represented more than 85% of Medicaid enrollees but accounted for only 23% of all spending. More than half of all enrollees had spending of less than $1,000 in 2001, including more than 1 in 10 Medicaid enrollees who had zero spending.[65]



The content of Medicaid benefits for adults varies widely from state to state.

- Because of broad state discretion – both to determine which optional services to cover and to place limits on the amount, duration, and scope of all services – the content of Medicaid benefits for adults depends on where they live. To illustrate, although inpatient hospital care is a mandatory service, many states cap the number of inpatient days allowed for adults. Similarly, while all states have elected the option to cover prescription drugs, adults in some states face sharp limits on the number of prescriptions Medicaid will cover (e.g., three or four per month). Dental coverage for adults tends to be extremely limited in all states that cover it, and, in six states, adults have no dental coverage at all.[66] [67]

Medicaid provides a range of institutional and community-based long-term services, and it has focused increasingly on improving the integration of beneficiaries with long-term care needs in the community.

- Because of the diverse array of services needed by people with disabilities, Medicaid covers a comprehensive package of services, including rehabilitation, habilitation, mental health, and other long-term services. These services, not commonly offered by private insurance, assist people with disabilities in maximizing their independence, living in the community, and working.[68]

- Federal law requires all state Medicaid programs to cover institutional services but they are generally not required to provide home and community-based services. Most states have used the flexibility allowed under law to provide community-based care. However, since states most often provide home and community-based long-term care services as optional benefits or through waivers, funding and eligibility have been limited. Despite substantial growth in home and community-based care, many states have waiting lists for services.[69]

States have adopted strategies in their Medicaid programs to foster appropriate utilization of services.

- Federal law stipulates that Medicaid benefits are covered subject to "medical necessity." The law defines the medical necessity standard applied to EPSDT, but states have discretion in defining medical necessity otherwise. Within broad federal guidelines, states also determine the amount and duration of services offered under their Medicaid programs. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, states may place a reasonable limit on the number of covered physician visits or may require prior authorization to be obtained prior to service delivery.[70] [71]

- While evidence on the impacts of managed care arrangements on access for the low-income population is mixed, numerous studies have found that Medicaid managed care is associated with a variety of improvements in utilization and outcomes, including increased use of preventive and primary care, lower unmet need, lower emergency department use, and reduced preventable hospitalizations. More targeted strategies, such as disease management, also appear to offer potential to promote more appropriate utilization of services by the low-income population.[72] [73] [74] [75] [76] [77] [78] [79] [80] [81] [82] [83] [84] [85] [86] [87] [88] [89]

- States can and do use a variety of tools to manage utilization of prescription drugs in Medicaid. A 2005 survey of state Medicaid prescription drug policies found that nearly all of

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the 37 responding programs impose limits on the quantity of a drug that can be dispensed per prescription. When dispensing limits are hit, most programs subject beneficiaries to some form of prior authorization, rather than deny them drugs that may be medically necessary. More than two-thirds of the programs operate preferred drug lists (PDL). States are relying increasingly on prior authorization to control use of brand-name drugs.[90]

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