

Toward Universal Insurance Coverage: A Primer for Sexual and Reproductive Health Advocates

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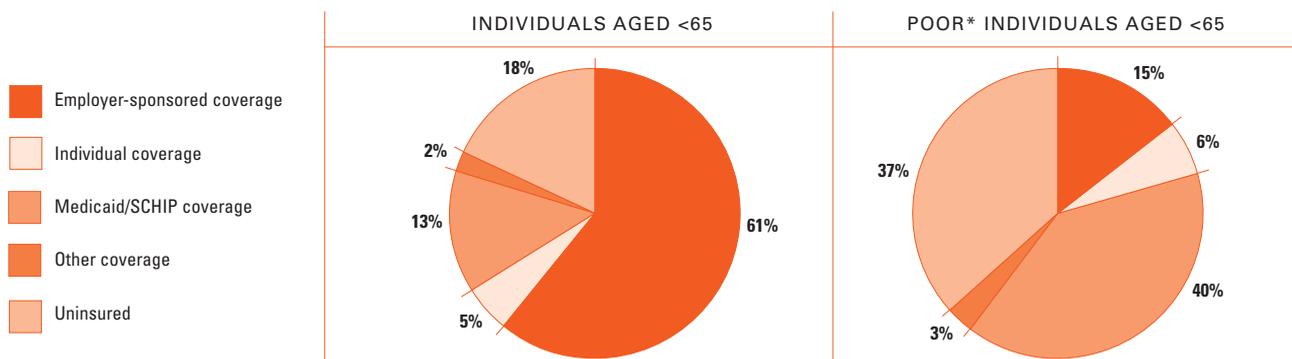
After simmering for more than a decade following the failure of the Clinton administration's health care reform plan in 1994, the issue of expanding health insurance coverage with the goal of achieving "universal coverage" has reemerged as a central one in the American political debate. National polls place concerns about health care near the top of voters' list of domestic priorities. First and foremost, these concerns reflect the large and ever-rising number of uninsured Americans. In 2006, 46.5 million people—18% of the U.S. population younger than 65—were uninsured (see chart). That figure includes 16.6 million who were in families with an income below the federal poverty level (\$16,600 for a family of three in 2006). But even many people who have insurance are concerned: about the possibility of losing their coverage, its adequacy for their needs, and the high and rising cost of using it.

The free-market conservatives in charge in the Bush administration and, for most of the past decade, in Congress have been disinclined to take concerted action. As a result, whatever progress has been made has been made at the state level. In the past several years, three northeastern states—Maine, Massachusetts and Vermont—have enacted legislation aimed at achieving at least near-universal coverage for their residents. Governors and legislators in a number of other states, including California, Illinois and Pennsylvania, have made similarly ambitious proposals, but have experienced less success to date.

At the national level, all of the major presidential candidates have presented plans to expand coverage and rein in health care costs. The fundamental direction and thrust of these plans has clustered substantially by party, with Democratic

A PATCHWORK OF COVERAGE

One in six U.S. residents younger than 65 were uninsured in 2006—including more than one-third of those living in poverty.



*Individuals in families with incomes under the federal poverty level (\$16,600 for a family of three in 2006). Source: Urban Institute/Kaiser Commission on Medicaid and the Uninsured tabulations from Current Population Survey, 2007.

and Republican leaders promoting radically different models. Much depends, therefore, on the outcome of the 2008 presidential election. Equally important is the extent to which one party dominates the other in Congress. The political battle in 2007 over attempts to expand the State Children's Health Insurance Program (SCHIP) demonstrates the obstacles to even incremental health care reform when Congress is closely divided. The shape of the U.S. government next year and the health reform proposals that thereby gain traction will have substantial implications for coverage and accessibility of sexual and reproductive health services, including family planning, abortion, testing and treatment for sexually transmitted infections (STIs), and pregnancy-related care.

The Current System

For Americans younger than 65, the U.S. system of health care coverage today is a decentralized patchwork of private and public efforts, with three major components: generally high-quality private health insurance offered and subsidized through employers, especially the largest ones; the country's public insurance programs, Medicaid and SCHIP, which provide a broad package of benefits to selected groups of low-income Americans; and a largely dysfunctional private insurance market for small businesses and individuals, typically a market of last resort for those without access to the other pieces of the system.

Although its role has gradually deteriorated over the past several decades, employer-sponsored health insurance is still at the heart of this system, accounting for six in 10 Americans younger than 65. Premiums are lower—and thus coverage is more common—under large than small employers, because the risk of an expensive health care crisis can be spread out over many enrollees. In part for this reason, 80% of workers with employer-sponsored insurance are in firms with 50 or more employees.

Many of the lowest income Americans, who rarely have access to employer-sponsored insurance, instead have access to Medicaid or SCHIP. The programs currently provide coverage for 13% of U.S. residents younger than 65, including

40% of those who are poor. For those who have it, public coverage provides a generous package of services. But many poor Americans are excluded from the programs, and eligibility varies widely from state to state. Congress has set some floors for Medicaid, so that all states must cover pregnant women and children at or near the poverty level. Most states provide coverage for both groups at higher income levels, often to 200% of poverty or higher. Yet, there is no eligibility floor for parents, and in several states, those with incomes at only one-third of poverty are ineligible for Medicaid. Adults who are not pregnant and have no children are generally barred from public coverage entirely. Most recent immigrants, and those who entered the country illegally, are barred as well (related article, Winter 2007, page 7).

For Americans who do not work for a large employer and who are not eligible for Medicaid or SCHIP, the remaining options are limited. About 12% of Americans younger than 65 have coverage through small employers. The smallest U.S. firms are most likely to pay low wages and are least likely to offer coverage: Forty-five percent of companies with 3–9 employees offer coverage, compared with 95% of firms with 50 or more employees. Only 5% of nonelderly Americans—14 million people—have purchased coverage on their own in the individual market. Even when it is available, premiums for the smallest employers and individuals are high, because of insurers' costs for marketing, enrollment and "underwriting"—determining whether to offer coverage to an applicant and, if so, under what terms and at what cost. When an insurer does offer someone coverage, it often excludes important health care services and, for individual coverage, preexisting health problems. In fact, most states exempt these markets from many of their regulations, including some benefit mandates, in an attempt to keep coverage affordable.

The last piece of the U.S. health care patchwork is a motley system of federal and state funding streams that sustain a nationwide network of health clinics. These clinics, which may provide a broad set of primary care services or focus on specific areas such as family planning or STI

screening and treatment, are relied upon heavily by Medicaid recipients and by the uninsured and underinsured. For a variety of reasons, this is likely to be the case in the future as well, regardless of what happens with health care reform (related article, page 6).

The Public-Private Partnership Approach

Among the numerous options available in theory, the venerable idea of a single-payer, government-run, universal system—common in many industrialized nations and essentially tantamount to “Medicare for all”—is not considered a major contender in the projected upcoming round of health care reform, even under the most optimistic of scenarios. Instead, most Democratic leaders, including the major presidential candidates, have coalesced around a very different approach, one that has been embraced on a bipartisan basis in a handful of states, including Massachusetts.

Underpinning this approach is the premise that it is best to minimize change. Rather than tearing down the current system and starting anew (as many perceived the 1994 Clinton plan to be about), proponents of what could be termed a public-private partnership approach have deemed it more politically, financially and administratively feasible to buttress the current patchwork, despite its flaws, and knit it together into a more comprehensive system that closes the current gaps in coverage and ensures that insurance coverage is meaningful. The details of this model vary in important ways among various individual proposals, but they include three important components: funding and legislative changes, designed to encourage employers to continue to offer and subsidize private insurance coverage; shoring up Medicaid and SCHIP; and finding new mechanisms to make insurance accessible and affordable to individuals and small employers.

Policymakers and experts promoting this model have proposed a variety of measures to ensure the continued participation of employers in providing insurance and thus minimize disruptions for currently insured Americans. Typically, the model would require some or all employers to provide coverage or to help finance their employ-

ees’ coverage in some other manner—often referred to as a “play or pay” mandate. A second, related piece of many proposals is a subsidy to employers as an incentive to provide coverage, either through a new tax break or by offsetting some of employers’ catastrophic health costs. Another provision would require insurers to sell and renew plans to any willing employer.

In terms of Medicaid and SCHIP, all of the Democratic proposals for universal coverage would expand the scope of who is covered. Some proposals look to fill in the gaps in the current system that leave out many Americans living in poverty, particularly childless adults and, perhaps, immigrants. Other proposals would expand the programs to encompass lower-middle-class working families—to income levels as high as 250% or 300% of poverty—who often struggle to afford employer-sponsored insurance or work for small employers that do not offer coverage. None of the proposals include major changes to how these programs work or to the benefits they provide.

The prominent innovations and most important political battleground within the Democratic approach are in the third component, which aims to create an alternative or a replacement for the individual and small employer insurance markets. A consensus seems to have formed around establishing a new mechanism, sometimes called a “connector” or an “exchange,” for gathering individuals—on their own and, in some proposals, through employers—into a large insurance pool and providing them a choice of private insurance plans and perhaps a publicly run competitor. Some policymakers and experts would like to use the Federal Employees Health Benefits Program (FEHBP) as this pool, or to set up a parallel program. The FEHBP, in which dozens of private plans compete over government employees and their families, is widely commended as providing choice, quality and affordability.

The public-private approach includes a variety of provisions designed not only to make coverage universally available but also to ensure that the coverage Americans obtain is coverage that truly works. Potential reforms would limit insurers’

ability to vary and raise premiums and exclude coverage for preexisting conditions, common tactics that make the individual market today effectively worthless for Americans with health problems. Other reforms would set a minimum benefit package within any new purchasing pool, and would require private insurance coverage to include preventive health services, or provide incentives for plans to do so. In addition, an exchange or connector would serve as a way to help Americans compare and choose from among competing plans, by making clear their costs, benefits and restrictions.

One contentious question that crosses all three layers of the proposed new system is whether all Americans should be required to have insurance coverage (an “individual mandate”). Many analysts believe this requirement to be necessary to ensure not only that everyone is covered but also—because it would spread risk over the entire population, minimize expensive emergency care and prevent people from waiting until they get sick to purchase coverage—that coverage is affordable. Other analysts, who are concerned about the affordability of coverage and the problem of enforcing a mandate, would exempt certain low-income individuals and families or forgo a mandate entirely. Related to that question is whether and how to include a tax subsidy or system of sliding-scale costs to ensure that coverage remains affordable.

Perhaps the greatest potential obstacle to such a public-private partnership is the issue of cost. Many experts argue that such a plan will actually save money and that universal coverage, indeed, is necessary to effectively constrain costs. The various proposals should also reduce administrative expenses by reforming the individual and small employer markets and reduce medical expenses by promoting the use of preventive care. Most include other cost-control provisions, such as promoting electronic medical records, reforming medical malpractice and expanding the use of health care quality measures. Nevertheless, many policymakers and analysts assert that hundreds of billions of new government dollars will be necessary to fund a universal care system. The debate over whether such

revenue is needed—and if so, how to obtain it—is certain to be heated.

The Free-Market Approach

The public-private partnership approach to health care expansion seeks to create a coherent system out of the existing national patchwork. In contrast, national Republican leaders have coalesced around a free-market approach that would compete with and likely undermine over time both employer-sponsored insurance and public programs such as Medicaid and SCHIP. Proponents of this approach insist that it will contain health care costs and expand coverage, although none purport it would achieve universal coverage.

The key idea behind these proposals is that individual consumers purchasing insurance in a free market will make better, more cost-conscious choices than today’s third-party purchasers (employers and the government). To promote this type of free-market thinking, Republicans have pushed for the expansion of a new type of private insurance, which they call “consumer-directed” plans (related article, February 2005, page 8). These plans combine high-deductible coverage (which only kicks in after an individual has paid several thousand dollars out-of-pocket) with a tax-sheltered health savings account dedicated to medical expenses.

A second, related idea is that the current tax system improperly favors employer-sponsored insurance—a form of insurance that, conservatives argue, affords less choice and portability than the individual insurance market. President Bush and other Republicans have proposed that a tax deduction be made available for anyone purchasing health insurance, through an employer or on their own, and that this deduction be capped to discourage the purchase of the most expensive health plans. (Currently, only employer-sponsored insurance is eligible for a tax deduction, and that deduction is not capped.) Free-market proponents insist these changes will “even the playing field” and make the individual market more viable, without the need for government regulation, and some believe that employer-sponsored insurance, without its tax advantage, will atrophy.

Finally, free-market proponents assert that regulation is a major driver of health care costs and that deregulation will provide consumers with more and more-affordable choices. To this end, they have worked to limit or eliminate state and federal regulation, particularly state benefit mandates (related article, Spring 2006, page 7). These proposals include “limited-benefit” plans for small employers and individuals that are exempt from some or all benefit mandates and designed as a money-saving alternative; “Association Health Plans,” formed across state lines by groups of small businesses, bypassing state regulation in the process; and a national market for individual coverage, allowing Americans to purchase insurance plans in any state—presumably in states with the least regulated and therefore least expensive (and least comprehensive) coverage.

Republicans have also attempted to apply these free-market principles to Medicaid and SCHIP. The Deficit Reduction Act of 2005, for example, allows states to provide limited benefit packages to certain groups of Medicaid enrollees, including parents and pregnant women, and provides states with greater power to impose the cost-sharing at the heart of the “consumer-directed” health care movement (related article, Spring 2006, page 2). Furthermore, the Bush administration has given its blessing to experiments in Indiana and South Carolina that bring the concept of health savings accounts to Medicaid.

Opponents of the free-market approach assert that it has serious limitations that will leave many Americans worse off than they are now. First, they emphasize that the individual market that this approach seeks to expand is simply too expensive for millions of individuals and families, because of its high administrative costs. In response, free-market proponents have promoted tax credits for the purchase of insurance in this market; whether these credits will be large enough and easy enough to use may depend on the details. Even if a family can afford to purchase coverage, high deductibles and cost-sharing raise the question of whether low-income recipients may forgo needed care out of concern for its costs, or whether the average American can determine what care is needed and what is

not. Moreover, the free-market approach leaves consumers essentially on their own when it comes to figuring out what coverage they need and where to purchase it. Finally, without regulation of the individual market, consumers may be unable to buy or retain coverage if they become sick, or may only be offered a plan that excludes the very care they most need.

Reproductive Health—Today and Tomorrow

One thing is certain: The 2008 elections will have a tremendous impact on the resurgent health care reform debate. Depending on the outcome, sexual and reproductive health advocates face very different scenarios.

In general, private insurance and Medicaid are strong in providing coverage of sexual and reproductive health services. In particular, the vast majority of Americans with employer- or government-sponsored insurance have coverage of prenatal, delivery and postpartum care, obstetric-gynecologic exams, a wide variety of contraceptive methods and services, and diagnostic tests and treatment for STIs and cervical cancer. This coverage is in many cases mandated by federal or state law. For example, the Pregnancy Discrimination Act of 1978—one of Congress’s few forays into insurance regulation—requires all but the smallest employers’ health plans to cover pregnancy-related care. In addition, 27 states have policies requiring private insurance coverage of prescription contraceptive drugs and devices, and federal law requires coverage of pregnancy-related care and family planning services under Medicaid.

Abortion and infertility treatment are exceptions to this otherwise broad coverage. Coverage of abortion appears to be common under employer-sponsored plans, although four states limit such coverage to cases of life endangerment. For Medicaid, the Hyde Amendment has for three decades banned the use of federal dollars for abortion, with few exceptions (currently, in cases of life endangerment, rape or incest). Seventeen states use their own funds to cover medically necessary abortions for Medicaid beneficiaries. Under both private and public insurance, coverage of infertility treatment is typically limited,

with many plans excluding the more advanced and expensive procedures. About one-quarter of the states require private plans to cover at least some forms of infertility treatment; the breadth and details of these mandates vary widely.

None of the public-private partnership proposals are designed to change this status quo in substantial ways and will instead pull more people into this current, generally strong coverage. The new purchasing arrangements they would establish, moreover, seem most likely to mirror this coverage. The FEHBP, touted as a model by many proponents of this approach, includes broad coverage of sexual and reproductive health care and has a requirement to cover the full spectrum of contraceptive methods.

Some public-private proposals do envision a new mandate or incentives for insurance plans (in the new purchasing pool or through employers as well) to cover preventive health services. The details of what would be included under this rubric are rarely specified in an initial proposal, although some would tie coverage to the recommendations of the U.S. Preventive Services Task Force or some other evidence-based criteria. Advocates and providers of sexual and reproductive health care would want to play close attention to a preventive care provision at every stage of the legislative, regulatory and oversight processes. In addition, the debate over expanding health insurance coverage may provide political or rhetorical opportunities for or challenges to restoring abortion coverage under Medicaid.

The free-market approach, in contrast, poses significant risks for the continued coverage of many sexual and reproductive health services. Of particular concern is the movement against benefit mandates. Undermining or overturning these laws could affect not only contraceptive coverage mandates, but state policies requiring coverage of newborn screening, pregnancy complications, cervical cancer and STI screening, infertility treatment, and breast cancer diagnosis and treatment. The potential drawbacks of the free-market approach in terms of affordability and quality of coverage may be just as damaging to the provision of sexual and reproductive health care. The

high cost of buying a comprehensive plan and the high deductibles and copayments common under the plans that are most affordable may lead some low-income Americans to forego routine gynecologic care, screening for reproductive cancers and STIs, and family planning services and supplies—essentially, a choice between their health and their wallets.

The diverging health care philosophies of Democratic and Republican leaders indicate that—barring a landslide victory by one party or the other in the 2008 elections—the political battle over health care reform may be protracted. Proponents of the two approaches differ over all of the big-picture issues: How should the system be shaped to ensure that coverage is made affordable and accessible? What role should the government play in making this happen? Will coverage be extended to everyone, or will some members of society, such as immigrants, continue to be excluded? How can society even afford to expand coverage, while containing the ever-rising cost of care in the context of a struggling economy?

These big-picture issues in all likelihood will dominate the health insurance reform debate for a considerable period of time. In contrast to the last major health care debate in the 1990s, it seems unlikely that Congress today would dwell on the fine details of a benchmark or required benefit package. Rather, the parochial interests of sexual and reproductive health advocates may be secondary decisions, to be made late in the process, in the course of drafting rules and regulations. Long before that stage, these advocates will need to work within a broader health care coalition to ensure that the initial questions are answered correctly and to secure their seat at the negotiating table. www.guttmacher.org

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