The Strengths & Shortcomings of Government-Administered Health Insurance Programs

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As healthcare reform conversations continue on Capitol Hill, the tone and energy associated with them have escalated. While most agree the current system is flawed, there are widely differing opinions on how reform should be accomplished.

Given the current conversations, it's important to consider what we already know about what does and doesn't work in the current healthcare system, particularly in the parts where government is already deeply involved. Many may not realize that almost one in three people in the U.S. already has their healthcare paid for or provided by the government. Specifically, 42.6 million people (14.1 percent of the population) are covered by Medicaid; 43.0 million people are covered by Medicare (14.3 percent); and 11.6 million people (3.8 percent) are covered by military and veteran care.[1]

Taking a look at the strengths and shortcomings of each of these public programs is instructive as we as a nation consider what the future role of government should be in the U.S. healthcare system. It can also help us understand the implications of a public health insurance option as part of the reform package.

Medicare

Enacted in 1965, the Medicare program is most commonly associated with people age 65 and older. It is also available under certain circumstances to persons younger than 65 who have disabilities or end-stage renal disease. The funding responsibility for Medicare falls on the federal government.

Changed the Economics of Retirement

Medicare enables elderly and certain disabled Americans, many of whom have fixed incomes, to receive medical care and use their money to pay for other necessities such as food, rent or mortgage payments, and utilities. For many elderly individuals, Medicare has changed the economics of retirement, allowing those close to the poverty line to stay above it.

Popular with Beneficiaries

Survey results from the 2008 Consumer Assessment of Healthcare Providers and Systems demonstrate that Medicare beneficiaries rate the program highly. When asked to provide their overall rating of their health insurance plan, 59 percent of Medicare beneficiaries rated their health plan as a 9 or 10 (on a 10-point scale) compared to 50 percent of adult Medicaid beneficiaries and just 36 percent of adult commercial plan participants.[2]

Complete Portability

Another benefit of the program is its portability. With the exception of some of the Medicare managed care products, Medicare beneficiaries can expect to live wherever they wish and know that their benefits will stay with them.

Cost Effectiveness

Relative to commercial insurance, it costs considerably less to provide coverage through Medicare. This is due in large part to the tremendous difference in administrative costs. Administrative costs for government programs hover around 5 percent, but can range from 12 to 30 percent for commercial insurance.

Cost Shifting

Although administrative expenses for Medicare are low, the program also typically underpays healthcare providers for their services. This results in cost shifting, causing providers to look to commercial insurance to cover the gap, adding to the cost of private insurance coverage.

Sustainability of Program Questioned

One of the biggest drawbacks of the Medicare program relates to its financing, which is partially through payroll taxes. There is a concern that as the baby boom generation retires the program will no longer be sustainable because those drawing benefits will out number those funding the program.

Medicaid

The Medicaid program was established in 1965 to provide health insurance to low-income and medically vulnerable people. States administer the program under broad federal guidelines specifying minimum coverage standards. Unlike Medicare, which is funded entirely at the federal level, Medicaid funding is shared by the federal and state governments.

Crucial Safety Net

Medicaid's greatest achievement is its ability to extend a crucial healthcare safety net to those who would likely have no source of – and no means to pay for – healthcare coverage. Medicaid helps ensure disadvantaged children have access to healthcare services, addressing problems before they escalate and become more costly. Medicaid also provides care for low-income pregnant women, assuring greater access to prenatal care and better birth outcomes. These are just a few of the groups that are covered under states' Medicaid programs – groups of individuals that would almost certainly be classified as uninsured absent the Medicaid program.[3]

Adaptability Allows States to Tailor Benefits

Aside from increasing access to care for some of the most vulnerable members of society, Medicaid also has the advantage of being highly adaptable. It allows states to tailor the benefits provided to meet the needs of the local population and respond to new health problems that might emerge. States have used open-ended federal matching funds to underpin state mental health programs, develop community-based models for long-term care, and expand access to family planning services, to name a few.[4]

Lack of Portability

The same model that allows for flexibility in designing pro-

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grams also has a drawback, which is the accompanying lack of portability. Because eligibility, benefits and reimbursement structures differ among states, it is not possible for a person covered by Medicaid to relocate to another state and maintain coverage.

Growing Costs a Concern

Over time, Medicaid eligibility has steadily expanded.[5] As states have broadened their Medicaid umbrellas to cover additional groups, enrollment and, subsequently, healthcare costs have grown. Significant efforts have been made to contain Medicaid's costs, including the implementation of managed care, however healthcare costs continue to rise in the public and private sectors alike.

Parts of Safety Net at Risk During Economic Downturns

Add the effects of a sluggish economy to the program's growing costs and one of Medicaid's key weaknesses is exposed. Historically, states have expanded their Medicaid programs during good economic times and reined them in during bad economic times.[6] Unfortunately, this means that parts of the Medicaid safety net can disappear when people are most in need of health coverage because they have either lost their job or suffered some other hardship.

Military and Veteran Healthcare

In addition to Medicare and Medicaid, there are also a few other public programs that may not be as well known.

TRICARE, formerly known as CHAMPUS (the Civilian Health and Military Program of the Uniformed Services), is the military healthcare program for active duty and retired members of the uniformed services, their families, and survivors. Based out of the Department of Defense, TRICARE is regionally managed and combines direct care in military hospitals and clinics with networks of civilian healthcare providers.

The Department of Veterans Affairs (VA) provides medical assistance to veterans of the Armed Forces. Outpatient and inpatient care, including preventive and primary care, are provided to enrolled veterans within the VA healthcare system. The type of benefit that is provided is based primarily on the veteran's level of disability and income. In addition, the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) is a medical program through which the Department of Veterans Affairs helps pay the cost of medical services for eligible veterans' dependents and survivors of veterans.

Comprehensive System of Electronic Health Records

The Department of Veterans Affairs has been praised for its successful implementation of a comprehensive system of electronic health records. While only 1.5 percent of U.S. hospitals have comprehensive electronic medical records, this percentage increases to 2.9 percent when VA hospitals are included.[7] The Department of Veterans Affairs' system of electronic health records – which began being implemented in the mid-1990s – has been particularly effective at improving the quality of care provided to military personnel and veterans because they tend to be highly mobile.[8] The Department of Veterans Affairs has also been working to make sure its electronic health systems or capabilities are interoperable with those of the Department of Defense.

Access Problems

On the minus side, a 2003 report found that more than 25 percent of veterans enrolled in the VA healthcare system live over 60 minutes from a VA hospital. Wait times, particularly for veterans who need to be admitted to a hospital or for those seeking outpatient consultations with specialists, have also been found to be excessive. The average wait time for an initial outpatient appointment is over one year in Florida.[9] Similarly, military personnel enrolled in TRICARE have reported wait times that lag civilian benchmarks.[10]

Conclusion

Government healthcare plans and providers grapple with many of the same issues that their private market counterparts do. Cost, access and quality – the three elements that must be considered in any healthcare program or system – exist in a balance. Compromise is unavoidable, and any existing health system or proposal for reform must weigh these three elements and make choices to create a workable approach.

As negotiations continue on Capitol Hill, the significant impact that the Medicare, Medicaid, and military and veterans programs have had on people over time can't be ignored. Beyond the mere existence of health coverage and care, government-run programs do some things better than their private market counterparts. Yet the tradeoffs that have been made in order to keep these programs operating also can't be ignored. This snapshot just skims the surface of the pros and cons of government-run healthcare plans and programs, but serves as an important reminder about the lessons that can be drawn from programs already in existence as we move forward with healthcare reform conversations.

Endnotes

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