CHAPTER 2

Public and Private Coverage in the United States

April M. Falconi, PhD, MPH, MA

LEARNING OBJECTIVES

- What are the different types of health insurance offered in the United States?
- Who is covered by the different types of health insurance?
- What are the strengths and weaknesses of private versus public coverage?

INTRODUCTION

In the United States, health insurance coverage is offered through an array of public and private sources (**Table 2-1**), although more people have private health insurance than government-provided coverage. In 2014, 66 percent of the civilian, non-institutionalized population had private health insurance and 37 percent had government-sponsored insurance at some point during the year; 10 percent were uninsured for the entire year. Note that the totals do not add up to 100 percent of the population because some people have more than one type of health insurance or they are covered by public and private coverage at different points in the year (Smith & Medalia, 2015).

Private health insurance coverage is most often provided through an individual's employer, although individuals sometimes purchase their own health coverage independently. Public sources of health insurance include Medicare, Medicaid, the Children's Health Insurance Program, TRICARE, and federal and state health plans (Claxton & Lundy, 2008).

Certain characteristics, such as age, income, and disability status, influence the type of coverage an individual is likely to have. Nearly all (99 percent) individuals aged 65 years or older, for example, reported having health insurance in 2014, because most are covered by Medicare. Children under age 19 also had relatively high rates of coverage (94 percent), because Medicaid and the Children's Health Insurance Program cover most children from low- and even moderate-income families. In contrast, only 86 percent of working-age adults aged 19 to 64 years had health insurance in 2014 (Smith & Medalia, 2015).

People in low-income households (i.e., household income less than $25,000 per year) are also more likely to have government coverage than people in higher-income households, because Medicaid covers many low-income families. Individuals in households earning less than $25,000 per year, for example, were 17 percent more likely to have government coverage than individuals in households earning between $25,000 and $49,999 (Smith & Medalia, 2015).

Lastly, adults with a disability are less likely to have private health insurance than adults without a disability, because public programs

TABLE 2-1 Distribution of Health Insurance in the United States, 2014

	% of Population
Private	
Employer/Group	55.4%
Individual/Non-Group	14.6%
Public	
Medicare	16.0%
Medicaid/SCHIP	19.5%
TRICARE	4.5%
Uninsured	10.4%

Note: Some individuals had multiple sources of insurance, so percentages add up to more than 100 percent.

Data from 2015 Current Population Survey. Available at http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf

such as Medicare and Medicaid assist people with qualifying disabilities. Among adults age 18 to 64, 41 percent of those with a disability had private health insurance, compared to 74 percent of adults with no disability (Smith & Medalia, 2015).

This chapter will explain the different types of health insurance coverage provided in the United States, comparing sources of private insurance to public insurance, and will conclude with a discussion of the strengths and weaknesses associated with each.

PRIVATE HEALTH INSURANCE

Private health insurance is an agreement that a state-licensed health insurer or a self-funded employee health benefit plan will take on financial risk for health care costs, administer benefits, and pay claims, or contract these functions to a third party, for individuals or groups of individuals, and their families. Smaller employers and individuals generally pay state-licensed insurers not only to administer benefits but also to take on financial risk; this arrangement is called a **fully insured plan.** On the other hand, larger, especially cross-state, employers generally take on risk in-house by collecting premiums and paying out benefits in-house; this arrangement is called a **self-funded (self-insured) plan**. Self-funded employers may purchase administrative services from a third-party insurer, but that insurer will not take on any financial risk.

Outside of employment, options for coverage include public insurance (for those who qualify) or fully insured coverage either directly from a state-licensed health insurer or through a state health insurance exchange, set up by the 2010 Affordable Care Act (ACA).

The **group market** sells insurance to employers, and the **individual market** sells insurance to individual subscribers and their families. More formally, the group market is the online or brick-and mortar place where individuals, insurers, and employers buy and sell policies or administrative services that cover two or more individuals who are not members of the same immediate family. The individual market is the place where individuals and insurers buy and sell policies that cover an individual subscriber and her immediate family.

Both individuals and employers may purchase fully insured plans primarily from one of three types of private health insurers:

- Commercial health insurers: These companies are generally for-profit and organized as stock or mutual insurance companies. An example of a commercial health insurer is Aetna.
- Blue Cross and Blue Shield (BCBS): BCBS plans are nonprofit organizations. States regulate these plans, generally requiring them to have more of a community focus than commercial insurers. For example, they may have stricter requirements on excluding coverage of pre-existing conditions and on experience rating in order to make plans affordable to the sick. In some states (e.g., Connecticut, New Hampshire, Ohio), BCBS plans have converted to for-profit organizations and are now subject only to the state requirements for commercial insurers, but in other states (e.g., Arkansas, parts of California, New Jersey), BCBS plans remain nonprofits and continue to be subject to these requirements.

- Health maintenance organizations (HMOs): HMOs integrate health insurance with the provision of health care. An example of an HMO is Kaiser Permanente, in which Kaiser Health Plan has an exclusive relationship with the Permanente Medical Group and also owns hospitals, imaging centers, and other health care facilities. Health care services obtained outside of Kaiser's network of doctors, hospitals, and facilities are generally not covered by insurance. Most commercial insurers offer HMO products, but these plans generally do not integrate care delivery in the same way as a "true" HMO, because the insurer does not own facilities or contract exclusively with physicians.

For several reasons, large employers are more likely to bypass these options for health insurance and instead self-insure. While individuals and smaller employers pay insurers to take on the risk of illness or injury, self-insured employers take on this risk themselves. In other words, they are responsible for setting a premium that will cover the medical costs of their employees. Larger employers have the capacity to take on this risk because it is spread over many individuals. Therefore, the medical costs of a large group are more predictable from year to year than for an individual or small group, so a more accurate premium can be set each year.

But even if large employers have the capacity to take on risk, why would they want to? First, employers can save money on health insurance premiums by managing their own benefits and paying claims in-house (and anything that cannot be managed efficiently in-house can be purchased from a third-party insurer). Second, under the Employee Retirement Income Security Act of 1974 (**ERISA**), self-insured plans are exempt from many of the state regulations for fully insured plans, an important exemption for employers operating in multiple states. Designed to protect the assets of employees enrolled in private retirement plans, ERISA also sets rules for other employee benefit plans, including health insurance. While ERISA preempts most state laws regarding employee benefits, it does not preempt state laws for health insurance. Under the "deemer clause" (ERISA Section 514), however, states may not "deem" self-funded plans health insurance in order to subject them to state regulation. The deemer clause thus protects multi-state employers from facing inconsistent obligations in different states, so that they may offer employees working in different states the same package of health benefits.

Employment-based coverage is the most common type of private coverage and the most common type of health insurance, but not everyone has access to this coverage. Recall that in 2014, 66 percent of the population had private coverage, 55 percent had employment-based coverage, and 15 percent purchased insurance directly from an insurer (Smith & Medalia, 2015). Those without access may include workers in part-time or seasonal jobs, unemployed people, spouses and dependents of a worker without family coverage, and workers in firms that are too small to offer health insurance. Firms with fewer than 10 workers are the least likely to offer coverage; therefore, workers without employer-sponsored health insurance are most likely to be employed in small firms. Low-wage workers are also far less likely than higher-wage workers to have access to job-based coverage (Hoffman & Paradise, 2008).

Employees with access to coverage through their employer may still choose to purchase insurance on the individual market. There are benefits and costs to employment-based versus individual insurance. Employer and employee premium contributions to the employee's health insurance plan are exempt from federal and state income taxes, as well as Social Security and Medicare payroll taxes. Because of the tax treatment of health insurance benefits through an employer, and because of risk spreading across many individuals, employment-based insurance may be more generous than a policy on the individual market. But employment-based insurance may be unaffordable for some employees, or employers may not offer a plan option that the employee wants, for example because the plan excludes a certain provider or has out-of-pocket costs that are too

high. Purchasing an employment-based plan also ties employees to their employers.

For just this reason, there are transitional options for those who lose access to employment-based insurance. Individuals might lose access when (1) they lose their jobs or move jobs; (2) they work fewer hours and lose eligibility for coverage; (3) a person reliant on a spouse's health coverage gets divorced or separated; (4) children age out of dependent coverage; or (5) a spouse who provides health insurance for a family dies or becomes eligible for Medicare. In these cases, workers or their [former] dependents may be eligible for the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal program applying to non-federal workplaces with 20 or more employees (some states have even more expansive policies). People eligible for the program may buy into their former plan for up to 18 or 36 months, depending on the reason for the loss of access. The employer, however, is not required to make any contribution to the premium, so plans purchased through COBRA may be very expensive. **Figure 2-1** illustrates the relationship among different types of private health insurance options in the United States.

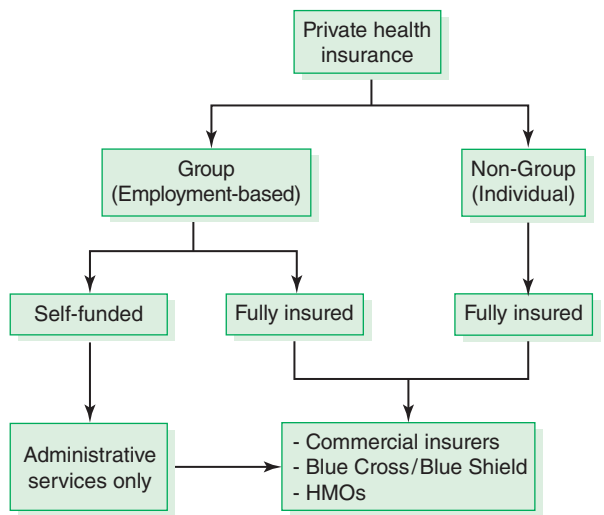
PUBLIC HEALTH INSURANCE

Public health insurance is an agreement that the government will take on financial risk for health care costs, administer benefits, and pay claims, or contract these functions to a third party, for individuals and their families. The government may also administer benefits for public health insurance plans, or it may contract administration to a private third party. Six government health care programs—Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), TRICARE, the Veterans Health Administration (VHA), and the Indian Health Service (IHS) serve approximately one-third of Americans (Corrigan, Eden, & Smith, 2003).

Medicare

Title XVIII (18) of the Social Security Act, commonly known as Medicare, is a federally administered program that provides health insurance for the nation's aged and disabled. Modeled on the BCBS plans of the 1960s, Medicare benefits are divided into four parts. Part A covers hospital care; Part B covers physician, imaging, and laboratory services; Part C, also known as Medicare

FIGURE 2-1 Private Health Insurance Options in the United States



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Advantage, is a set of managed care options (e.g., HMO, preferred provider organization [PPO]) that are privately offered as an alternative to traditional Medicare (Parts A and B); and Part D covers outpatient prescription drugs. Traditional Medicare does not cover long-term care or assisted living services. It also does not pay for dental or vision care, or hearing exams and hearing aids.

Individuals may also purchase supplemental insurance called **Medigap** to help pay for out-of-pocket costs (such as deductibles, coinsurance, and copayments) and benefits not covered by Medicare. Medigap policies are offered through private health insurers and are not public health insurance. Medicare does not subsidize premiums for Medigap purchases, but some employers offer Medigap policies (Cubanski et al., 2015).

In general, most seniors qualify for Medicare. People who are age 65 and older qualify for Medicare Parts A and B if they are U.S. citizens or permanent legal residents with at least 5 years of continuous residence. Adults under age 65 with permanent disabilities are also eligible once they have received Social Security Disability Income (SSDI) payments for 24 months. People with end-stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS) are eligible for Medicare as well, as soon as they begin receiving SSDI payments. These individuals are not required to wait 24 months. People may enroll in Part C if they are entitled to Part A and are enrolled in Part B. People are eligible for Part D if they are enrolled in Parts A or B (Cubanski et al., 2015), though some Part C plans also integrate prescription drug coverage.

Part A, or inpatient hospital insurance, also covers short stays in a skilled nursing facility, some home health care, and hospice care. Enrollment in Part A is automatic for anyone who qualifies for Social Security on the basis of age or disability; only a very small proportion of beneficiaries who do not receive Social Security income must pay a premium to enroll. Part A is financed primarily through a 2.9 percent payroll tax—1.45 percent from the employer, and 1.45 percent from the employee. Higher-earning individuals are taxed 3.8 percent—1.45 percent from the employer, and 2.35 percent from the employee. These payroll taxes fund the Hospital Insurance (HI) Trust Fund, which pays Part A benefits (and Part C hospital benefits) (National Health Policy Forum, 2016).

Part B, the supplemental medical insurance (SMI) program, covers physician and laboratory services, durable medical equipment such as canes and walkers, and outpatient care. Those eligible must pay a premium to enroll in Part B, although these premiums are heavily subsidized by general tax revenue. Premiums finance only a quarter of Part B, while the remainder is funded primarily through general revenues (Cubanski & Neuman, 2016). There is a financial penalty for failing to enroll in Part B immediately upon eligibility, as much as 10 percent per year, in order to reduce adverse selection.

Part C, also called Medicare Advantage, is an alternative to Parts A and B. Over 30 percent of Medicare beneficiaries are enrolled in Part C (Jacobson, Casillas, Damico, & Neuman, 2016). Part C plans may offer additional benefits not covered by traditional Medicare. Like Part B, Part C plans are also financed in part by premiums, but these premiums are subsidized by general revenues for physician and laboratory care, and by the HI Trust Fund for inpatient hospital care.

Finally, Part D is the outpatient prescription drug benefit (drugs administered in a physician's office are covered under Part B). Those enrolled in traditional Medicare (Parts A and B) may also enroll in a private, stand-alone prescription drug plan (PDP), while those electing Part C benefits may enroll in an integrated Medicare Advantage Prescription Drug plan (MA-PD). Like Part C, Part D plans are private, and thus financed in

part by premiums. General revenue covers just over three-quarters of the cost of Part D, while premiums and state funding cover the remainder (Cubanski & Neuman, 2016).

The federal government spent $539 billion (3 percent of Gross Domestic Product [GDP]) on Medicare in 2015 and provided health insurance coverage to approximately 55 million people: 46 million aged 65 years or older and 9 million people with permanent disabilities under age 65 (**Box 2-1**). When Medicare began on July 1, 1966, approximately 19 million people enrolled (Constantino & Angres, 2016; Cubanski et al., 2015). A majority of Medicare beneficiaries are female (55 percent), white (77 percent), and between the ages of 65 and 84 (71 percent). Most beneficiaries (74 percent) report being in "good" or "better" health, even though nearly half (45 percent) live with four or more chronic conditions, and one-third (34 percent) have one or more functional limitations in terms of activities of daily living (e.g., eating, bathing) that limit their ability function independently (Cubanski et al., 2015).

Most Medicare beneficiaries live on modest incomes. Nearly half of all Medicare beneficiaries (4 in 10) lived on an annual income of less than $20,000. Females, older beneficiaries (age 85 years or older), black and Hispanic beneficiaries, and non-elderly beneficiaries with disabilities are more likely to be low income. Most Medicare beneficiaries (59 percent) with incomes over $20,000 rely upon either employer-provided health benefits to supplement Medicare or Medigap health insurance to fill gaps in covered benefits (Rowland, 2015).

Medicaid and the [State] Children's Health Insurance Program

Passed at the same time as Medicare, Title XIX of the Social Security Amendment of 1965 is otherwise known as the Medicaid program. Medicaid was designed to provide access to health care services for low-income persons and other "categorically needy"

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BOX 2-1 Can Medicare Go Bankrupt?

Some policymakers claim that Medicare is running out of money and will eventually go bankrupt. To be clear, they are referring to the exhaustion of funds in the Part A Hospital Insurance (HI) Trust Fund, which pays for hospital benefits in traditional Medicare. While parts B, C, and D are funded mostly by premiums and general revenues, Part A is funded almost entirely by payroll taxes. The concern is that as the population ages, there will be too many Medicare beneficiaries and not enough workers contributing payroll taxes into the HI Trust Fund. In their 2016 annual report to Congress, the Medicare trustees projected that the HI Trust Fund would be depleted of assets by 2028.[1] But this situation is not bankruptcy, nor does it mean that hospital insurance for the elderly will cease to exist. Rather, it means that Medicare will cover most hospital benefits using income from sources other than HI Trust Fund assets, such as incoming payroll taxes. Ultimately, to ensure steady funding for hospital benefits, Congress must enact policy changes to slow cost growth and to raise revenue to strengthen the Trust Fund, for example by increasing the payroll tax.[2]

[1]Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds. (2016, June 22). *Annual report*. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/reportstrustfunds/

[2]Van de Water, P.N. (2016, July 18). *Medicare is not "bankrupt": Health reform has improved program's financing*. Retrieved from http://www.cbpp.org/research/health/medicare-is-not-bankrupt

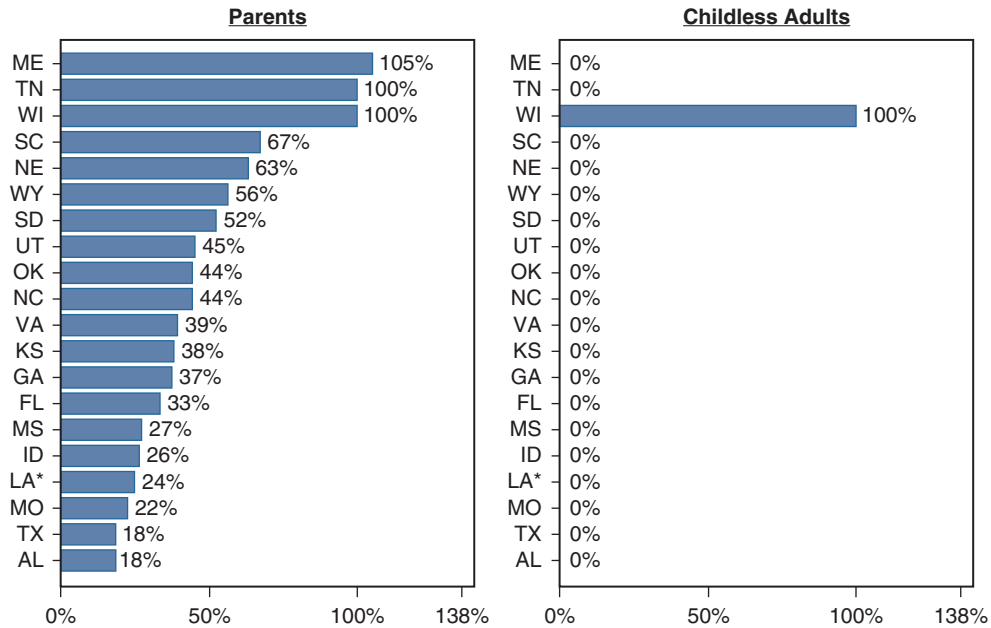
Data from: Boards of Trustees of the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds. 2016 Annual Report. Washington, D.C. June 22, 2016; Van de Water, Paul N. Medicare is not "Bankrupt." Center on Budget and Policy Priorities. July 18, 2016.

people—people who fall into some category of medical need based on illness or disability (Moore & Smith, 2005). Title XXI of the Social Security Act, known as the **State Children's Health Insurance Program (SCHIP)**, or just **CHIP**, provides federal funds for states to expand eligibility to low-income children who otherwise would not qualify for Medicaid (Longest, 2010). Together, Medicaid and SCHIP are the largest health insurance programs in the United States. At the beginning of 2016, they provided coverage for 72 million Americans, including 35 million children, in all 50 states (The Henry J. Kaiser Family Foundation [KFF], 2016b).

States administer Medicaid and SCHIP, but in order to receive joint funding from the federal government (50 to 83 percent of the cost of the program, depending on state per capita income), benefits and eligibility thresholds must be at least as generous as the federal baseline. To receive federal funding, states *must* cover children ages 6 and over, up to 100 percent FPL ($11,880 for an individual or $24,300 for a family of 4 in 2016); pregnant women and children under age 6 in households earning up to 133 percent of FPL; the elderly and those with disabilities who receive SSI benefits up to 75 percent FPL; very-low-income working parents eligible for welfare benefits; and some low-income seniors and other categories of disabled workers (KFF, 2011).

States may receive additional federal Medicaid funding to cover individuals above these thresholds. In particular, under the ACA, states have the option to expand Medicaid to all nonelderly individuals up to 138 percent FPL, and the federal government will cover nearly all of the costs of additional recipients. Even in states that have not expanded Medicaid, most have more generous eligibility requirements than the federal minimum for at least some groups, especially children. But across these non-expansion states, income and asset requirements vary considerably (**Figure 2-2**) (Gornick, Greenberg, Eggers, & Dobson, 1985; Morrisey, 2013).

FIGURE 2-2 Variability in Eligibility Requirements Among States That Have Not Expanded Medicaid, January 2016



NOTE: Eligibility levels are based on 2016 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2016, the FPL was $20,160 for a family of three and $11,880 for an individual. Thresholds include the standard five percentage point of the federal poverty Level (FPL) disregard.
*Louisiana has adopted the Medicaid expansion, but it has not yet been implemented.

Reproduced from Kaiser Family Foundation; http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/

Similar to Medicare, Medicaid is called an "entitlement" program because anyone who meets eligibility requirements may enroll in Medicaid coverage. Individuals qualify for Medicaid only if they meet certain federal and state requirements pertaining to residency, immigration, and U.S. citizenship (Centers for Medicare and Medicaid Services [CMS], 2015b). Childless adults, or those over age 21 who are not disabled, pregnant, or elderly, are generally not eligible for Medicaid in the 19 states that have not adopted the health reform expansion, regardless of their poverty level, as of February 2016 (Center on Budget Policy and Priorities [CBPP], 2015; KFF, 2016a).

Although states have some flexibility in designing benefits for Medicaid recipients, every state Medicaid program must offer certain basic services to receive federal funding. These services include:

- Hospital inpatient and outpatient care
- Lab and X-ray services
- Physician services
- Skilled nursing facility care for individuals aged 21 years and older
- Home health care for persons eligible for skilled nursing services
- Rural health clinic services
- Pregnancy-related services, including prenatal care and 60 days of postpartum care
- Pediatric and family nurse practitioner services
- Vaccines for children
- Family planning services and supplies

States may also receive federal funding to provide additional services such as physical therapy, vision care, and dental care, if they choose to do so (Longest, 2010). Coverage of nursing facility care and home health care is noteworthy, given that Medicare provides limited coverage of these services, and private insurance options are significantly less affordable. Medicaid, therefore, is the primary payer for institutional and community-based long-term services and support (KFF, 2013).

Some states do not comply with federal minimums for benefits and eligibility but still receive federal matching funds; these states have an approved waiver under Section 1115 of the Social Security Act. Waivers may include provisions such as charging premiums, eliminating certain benefits to expand coverage, and mandating enrollment in managed care (Rudowitz & Musumeci, 2015).

Together, states and the federal government spent a combined $475 billion on Medicaid services in fiscal year (FY) 2014 (KFF, 2015). The federal government spent $350 billion (2 percent of GDP) (Constantino & Angres, 2016). States influence the total amount of spending on Medicaid because they have flexibility in determining who is eligible and what services they will cover, and because the federal government provides matching funds for the costs of services (CBPP, 2015). Most Medicaid spending (65 percent) is on acute care (e.g., physician services, inpatient and outpatient care, payments toward managed care plans). A significant portion (30 percent) of costs, however, is for long-term care services and supports. Administrative costs make up the remaining 5 percent of Medicaid spending (KFF, 2013).

Dual-eligible beneficiaries, low-income individuals who are enrolled in both Medicaid and Medicare, accounted for 38 percent of Medicaid spending, though they constitute just 15 percent of the Medicaid population. Most spending on dual-eligible beneficiaries is for long-term care services and supports. Children and non-elderly adults, including pregnant women, make up the majority of Medicaid enrollees (75 percent) but account for just one-third of Medicaid spending (KFF, 2013).

Tricare

Service members, their dependents, and retirees (and retirees' dependents) receive health insurance through TRICARE (formerly known as the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]). TRICARE was implemented in 1966 and provides health care benefits for all seven uniformed services—the Army, the Navy, the Marine Corps, the Air Force, the Coast Guard, the Commissioned Corps of the Public Health Service and the Commissioned Corps of the National Oceanic and Atmospheric

Administration, and the National Guard and Reserve (Committee on the Qualifications of Professionals Providing Mental Health Counseling Services Under TRICARE [TRI], 2010).

The "TRI" in TRICARE refers to its three main benefit options: an open-network option that covers most civilian providers (TRICARE Standard), a health maintenance organization option (TRICARE Prime), and a preferred provider option (TRICARE Extra). In 2002, a supplemental or "wrap-around" option much like Medigap was added for Medicare-eligible retirees (TRICARE for Life). Prior to TRICARE for Life, beneficiaries lost their TRICARE coverage when they reached age 65, and Medicare became their primary source of health coverage (TRI, 2010). TRICARE covers most medically necessary inpatient and outpatient care:

- Emergency and urgent care
- Medical and surgical procedures
- Home health care
- Hospice care
- Clinical preventive services
- Maternity care
- Pharmacy services
- Behavioral health care services

TRICARE generally does not cover services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of an illness, injury, or treatment of pregnancy or well-child care. Nursing homes, long-term care, custodial care, and assisted living facility care are not covered under any circumstances (Defense Health Agency [DHA], 2016).

TRICARE served 9.5 million beneficiaries worldwide in FY 2014 (DHA, 2014). Only about 20 percent of beneficiaries are active-duty members of the armed forces or activated members of the National Guard or Reserve. Another quarter (26 percent) are family members of active duty or activated personnel; the remainder are retirees and their family members (TRI, 2010).

Veterans Health Administration

The Veterans Health Administration (VHA) was established in 1946 as a division within the Veterans Administration (VA) to provide health coverage to U.S. veterans. The VHA is not an insurance plan, but rather a provider. VHA facilities provide comprehensive medical services, including inpatient and outpatient care, preventive care, mental health care, and health promotion and disease prevention services, among other services (United States Department of Veteran Affairs [VA], 2016b).

For medical conditions unrelated to military service, the VHA bills the veteran's insurer if he has private insurance, but not does not bill Medicare or Medicaid. For these non-service related conditions, some veterans are required to pay a copayment for services, though low-income veterans are generally exempt from cost-sharing. Service-related medical conditions are covered at no additional cost to the veteran or his insurer (VA, 2016a).

Generally, individuals who served in the active military service and were separated under any condition other than dishonorable qualify for health coverage through the VHA; veterans' families, however, are not eligible. Some current and former members of the Reserves or National Guard who were called to active duty and completed the full period may also qualify for coverage (VA, 2015). In 2014, the VHA provided care to more than 8.7 million veterans (VA, 2016c).

Indian Health Service

The Indian Health Service (IHS), an agency under the Department of Health and Human Services (HHS), provides health care services to over 2 million federally recognized American Indians and Alaskan Natives and their descendants (Department of Health and Human Services [HHS], 2015). Like the VHA, IHS is a provider, not an insurer. Unlike the VHA, however, IHS does not bill insurance for care; rather, the program pays IHS facilities and contracted providers directly. IHS users do not pay premiums, deductibles, or copayments for their care.

Due to limited funding, the IHS provides mostly primary care, including inpatient and outpatient care, ambulatory care, dental services, and pediatric care. Most IHS facilities are located on reservations; beneficiaries, therefore, typically live on or near federal reservations. Tribally

operated health care facilities in Alaska, however, are located throughout the state (Boccuti, Swoope, & Artiga, 2014).

Other Government-Sponsored Health Insurance Programs

Some states and localities have their own health insurance or health provision programs for low-income and uninsured individuals. These health plans are known by different names depending on the state and have different eligibility and enrollment procedures (Summer, 1998; United States Census Bureau [USCB], 2016). Some programs require out-of-pocket payments (e.g., monthly premiums or copayments) from beneficiaries, although the amounts are typically low (Summer, 1998).

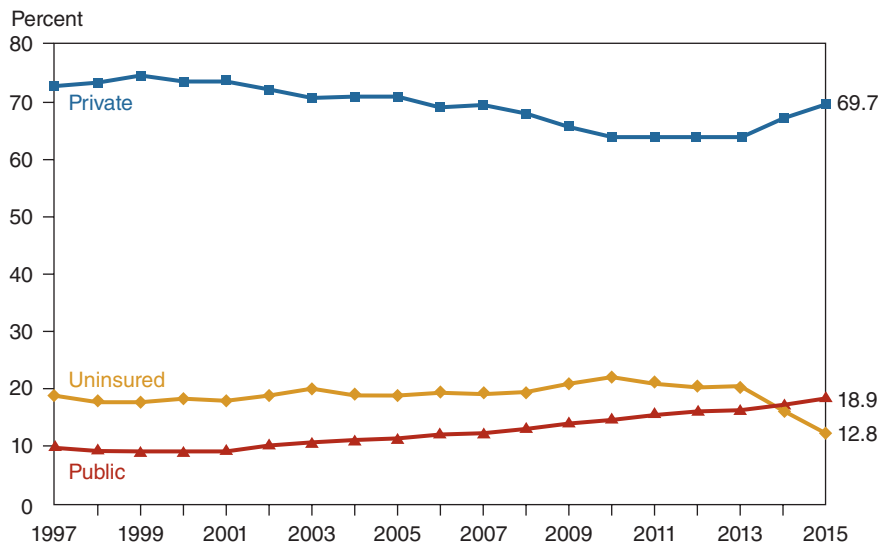
TRENDS IN HEALTH INSURANCE COVERAGE

For decades since the passage of Medicare and Medicaid, the uninsured rate at a given point in time remained relatively stable at around 15 percent of the population. After the ACA's major provisions went into effect in 2014, however, uninsurance began declining relatively rapidly; in 2015, 9 percent of the population was uninsured (**Figure 2-3**).

Beginning in the 1990s, enrollment in private health insurance among the non-elderly began to decline, more rapidly so just after the Great Recession (2007 to 2009) (Figure 2-3). Since the ACA and recovery from the recession, however, enrollment has risen again and is now at roughly 66 percent of the non-elderly population, compared to 71 percent in 1997 and 61 percent from 2010 to 2013. Meanwhile, enrollment in public insurance has steadily climbed from roughly 14 percent of the non-elderly population in 1997 to 25 percent in 2015. During this same time period, uninsurance among children declined dramatically, from 14 percent of children in 1997 to just 5 percent in 2015; most of this decrease was due to enrollment in public programs such as CHIP (Cohen, Makuc, Bernstein, Bilheimer, & Powell-Griner, 2009; Furman & Fiedler, 2014; Ward, Clarke, Nugent, & Schiller, 2016).

Most of the elderly have had coverage through Medicare since 1965. The share of beneficiaries enrolled in Part C plans has increased from 18 percent in 1999 to 31 percent in 2016 (Galewitz, 2011; Jacobson et al., 2016).

FIGURE 2-3 Trends in Insurance Enrollment for Adults Ages 18–64, 1997–2015



Reproduced from National Health Interview Survey, 1997-2015. https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf

COMPARING PRIVATE AND PUBLIC COVERAGE

While many have strong opinions on whether private insurance is better than public insurance, it is important to understand the strengths and weaknesses of the two types.

Compared to public insurers, which generally offer a single benefits package at a fixed price, private insurers offer a wider variety of plans at different prices and benefits levels. Because private insurance companies compete for contracts with employers and individuals, they have developed numerous innovative tools and products with the goal of improving health and lowering costs, including pay-for-performance, disease management programs, and consumer-directed health plans (CMS, 2015a). Private insurance thus allows employers and individuals to select plans that are more tailored to their needs and preferences. The elderly, for example, may not care as much about the availability of obstetricians and pediatric providers, while younger adults may wish to have a variety of choice in pre- and post-natal care. The elderly, in contrast, may care much more about the inclusion of particular hospitals in the insurer's network or the availability of disease management programs, while the young may wish to pay lower premiums in exchange for more restricted networks and higher deductibles.

Because most private insurance in the United States is tied to employment, however, a major drawback compared to public insurance is that people lose their coverage when they leave their job or when a spouse leaves a job. This system leaves individuals vulnerable to losing insurance when they may need the most assistance—such as when a spouse dies or becomes unable to work, when a marriage dissolves, or when an employee must leave to take care of a sick parent. Further, job-based coverage leaves out the self-employed and the unemployed. Moreover, not all jobs offer insurance with dependent coverage, so some spouses and children are uninsured even when there is a worker in the family. Employer-based coverage also interferes with job mobility, called "job lock," which can result in employees taking or remaining in a job that is inappropriately matched to their skills and interests in order to maintain health insurance coverage.

The tax advantage to employment-based insurance also favors higher earners and results in the loss of billions of dollars of revenue. For example, suppose that Phil earns $50,000 per year, while Sandra earns $150,000 per year, but that both are offered health insurance at a premium of $10,000 per year. Sandra's income is taxed at a much higher rate than Phil's, perhaps 20 percent on average compared to Phil's 10 percent. Because employment-based insurance premiums are not taxed, Sandra saves 20 percent × $150,000 on taxes = $30,000 by purchasing the plan with pre-tax dollars, while Phil saves only 10 percent × $50,000 = $5,000. Not only does this tax treatment favor the wealthy, but it results in a $35,000 loss in revenue for the government. Because so many Americans have tax-free employment-based insurance, the estimated total revenue loss to the federal government is $248 billion dollars (Congressional Budget Office, 2013).

Further, the tax advantage also results in over-insurance. Phil and Sandra are now sitting on $35,000 of tax savings. One option is that they could spend this money, but the expenditures would be taxed. Another option is that they could put away the money for retirement in a tax-advantaged account, but they would not be able to spend it for decades. Yet another option is that they could contribute the money, tax-free, to pay for the premiums on an upgraded health plan, for example, a PPO with no deductible instead of an HMO that requires them to visit a primary care physician before seeing a specialist. Employment-based insurance thus encourages plans with benefits that are more generous than if those plans were to be purchased with taxed earnings.

Although employers usually contribute some share of the premium, employees may pay for health insurance in the form of lower wages, (or slower growing wages).But for some groups, wages may not adjust to accommodate the cost of insurance. Workers at minimum wage, for

example, cannot by law accept wages that are below their current level. If the cost of health insurance is too high, then this group is at risk for unemployment. Likewise, sick and disabled employees and women of childbearing age cost more to insure, but employers cannot legally lower their wages to reflect this cost because of anti-discrimination statutes. Instead, employers may target these groups more subtly by hiring them less often and firing them more often (Summers, 1989).

Public insurance fills some of the gaps in the market for private insurance, providing coverage for some of the country's most vulnerable populations, including American Indians, the elderly, veterans, and the categorically needy (Iglehart, 1992). One of the biggest strengths of government-provided insurance is its size. With so many enrollees, the government has enormous influence over providers. In fact, Medicare does not negotiate with doctors and hospitals but rather sets administrative prices through the legislative process for Parts A and B. Providers must either accept the set prices or else lose a large volume of business.

With some exceptions (such as Medicare Parts C and D), however, the government does not offer those eligible for public insurance much choice in their plans, and universal benefits may not be universally appropriate. Individuals have different needs and preferences, and for some individuals, the government package of benefits may be inadequate, while for others, it may be too much (Summers, 1989).

One financing problem specific to Medicare is the high cost of health care coinciding with a declining ratio of workers to retirees. The aging baby boom population could potentially result in fewer contributors to the system while more beneficiaries simultaneously draw resources from it. Because Part A is financed through payroll taxes, insolvency of the HI Trust Fund is a threat if there are not enough workers to support the elderly (Moon & Davis, 1995).

Summary

Although most adults (and their dependents) receive coverage through private, employer-based insurance, many special populations receive care through government-sponsored programs, including the elderly through Medicare, the categorically needy through Medicaid or through state or local programs, military service members through TRICARE, veterans through the VHA, and American Indians and Alaskan natives through the IHS. Some characterize the U.S. health insurance system as fragmented due to the many ways through which individuals may obtain coverage, the variability in benefits offered through health plans, and the variability in costs to the consumer. This "system" of coverage, consequently, means that some individuals "fall through the cracks," if they do not meet eligibility requirements for any of the government-sponsored programs or are not covered through their employer. Some individuals may also find they have more care than they need while others cannot access sufficient care to cover their needs at an affordable price. The health insurance system in the United States continues to evolve and improve, however, to reduce inequities

and inefficiency through the passage of legislation, such as ERISA, Medicaid benefit expansions, and more recently, the Affordable Care Act.

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