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The Path Forward for a Public Plan:

How the Expansion of Public Health Insurance in the U.S. Can Remedy Socioeconomic Disparities in Access to Care

I: Introduction

The American health insurance system is broken. Its patchwork of private and public coverage leaves many without affordable access to care. Even with the expansions made by the Affordable Care Act, 29 million (and rising) are still uninsured. Among the insured population, 42 million are underinsured, saddled with prohibitively high deductibles and copays. The impact of these high out-of-pocket costs are stark: under and uninsured populations are more likely to forgo care, less likely to fill prescriptions, and more frequently skip vital medical tests or treatments (Collins, Gunja, Doty 2017). Unsurprisingly, such low health care utilization has been shown to cause worse health outcomes and lower quality of life (Chen et al. 2011). The less wealthy are thus less able to access high-quality health care, which contributes to and compounds upon existing health disparities between income levels, as individuals with lower socioeconomic status demonstrate worse health on average than those with higher incomes (Braveman et al. 2010). Furthermore, given the disproportionate distribution of racial minorities, migrants, and disabled individuals among the low income population, the negative health effects of the financial barriers to care are most keenly felt by marginalized groups. Health care is a

human right, and its inaccessibility based on wealth makes insurance reform an issue of health justice.

The injustice borne of our broken health insurance system has spurred the rise of Medicare expansion proposals among progressives. In fact, supporting Medicare expansion has essentially become table stakes for the Democratic presidential candidates; nearly every candidate has endorsed some form of public health insurance expansion. However, the exact form such an expansion will take varies widely, ranging from modest expansions in Medicare to a complete single-payer transformation. As such, these proposals vary in their predicted impact on health disparities. By exploring the structural differences in the proposed public health insurance reforms and drawing connections between those proposals and health insurance systems abroad, this paper will evaluate which plan would best accomplish the universal health care coverage that is needed to address the socioeconomic disparities in access to care, while still navigating the political barriers to such reform.

II: Public Option for All (or for Some)

The prospect of a public option for health insurance is not new. In 2009, the first iterations of the Affordable Care Act passed the House of Representatives and the Senate Health, Education, Labor, and Pensions Committee with a robust public option to be offered on state exchanges. The argument was (and still is) as follows: a public plan with fees based on Medicare would be more affordable than private plans, thus increasing competition and lowering premiums across the market (White 2018). However, contentious debate in the Senate saw eligibility for a public option narrow; one compromise saw the public option restructured as a Medicare buy-in limited to those fifty-five and older. But even this modest expansion lacked

substantial support in the Senate, and the public option was eventually eliminated entirely from the bill (Halpin and Harbage 2010). When the Affordable Care Act passed in 2010, it was without a public option to compete with private plans on the exchanges.

Nearly ten years later, the public option has returned to the fold as a path forward for health insurance reform; between the 115th Congress and 116th Congress, seven different bills have been introduced that would allow Americans to buy-in to a public plan. But once again, opinions diverge on exactly which Americans would be allowed to participate. Some bills, such as the Medicare at 50 Act, propose a Medicare buy-in option limited to U.S. citizens ages fifty to sixty-four. Other bills restrict eligibility in different ways; the Medicare-X Choice Act would at first confine access to the public option to people living in geographic areas with limited private competition, and the Choose Medicare Act would be open to all U.S. citizens, but workers could only leave their company's insurance if their employer allowed it. Unique among the public option proposals, the State Public Option Act would allow for a Medicaid buy-in option, but only in states that elect to expand the program. The least restrictive public option proposal, the Keeping Health Insurance Affordable Act, would see a public option available on the marketplace for all U.S. citizens (Kaiser Family Foundation 2019a).

Given their substantial differences in eligibility, these plans would also have differences in their impact on health care disparities. While plans restricted to certain age groups or locations could certainly improve insurance costs for those populations, individuals outside those categories may not see any improvements. Furthermore, a public option sold on the exchanges would only directly benefit those who actually utilize the exchanges to find insurance. For the 150 million Americans who receive health insurance through their employer, it is unclear what effect a public option would have on their cost of care (Gaffney 2017a). This limitation is

particularly worrying considering that 28 percent of U.S. adults who receive employee-sponsored health insurance are currently underinsured – a limitation that could be worsened if switching to the public option was dependent on employer permission (Collins, Bupal, and Doty 2019). Furthermore, a Medicaid buy-in plan would likely experience the same problems as the ACA Medicaid expansion, with improvements in health care access generally isolated to expansion states (Hayes et al. 2017). Even a robust public option is exactly that – an option. Thus, it is unlikely to achieve universal coverage. In fact, the Congressional Budget Office has predicted that a public option would produce no significant reduction in the number of uninsured (Congressional Budget Office 2013).

However, it is inaccurate to say a public option would do nothing to address socioeconomic barriers to care. All of the proposed plans would allow for the government to negotiate and regulate prescription drug prices, significantly bringing down prices (Blumenthal, Seervari, Bishop 2018). Additionally, for whomever the public option would be available for, enrollees would likely enjoy substantially reduced costs. And if the public option were universally available, it is possible the competitive rates offered by a public plan would yield lower prices across the market or even begin a natural transition to an entirely public health insurance system; in fact, many Democratic candidates in support of a public option see it as a "stepping stone" to single-payer (Hacker 2016; Luhby 2019). But it is also possible that a public option – which would be entirely funded by premiums in many proposals – would suffer from a high-risk pool, thus increasing premiums in the public option and subsidizing the profits of insurance companies (Gaffney 2017b). For those who see health insurance companies as the root of socioeconomic disparities in access to care, the public option does not go far enough.

III: Medicare for All

A more revolutionary approach to health care reform, the Medicare for All platform proposes the consolidation of the financing and administration of the health insurance system under a single, federally-operated plan. Covering all U.S. residents, the program would eliminate premiums and nearly all copays. Instead, the program would be funded by a progressive income tax which would more heavily draw from very wealthy individuals. Despite its moniker, Medicare for All would actually make substantial changes to Medicare, eliminating the separation of services into Parts and expanding benefits to cover vision, dental, prescription drugs, and all other medically necessary services. And to much controversy, Medicare for All would also largely eliminate all private health insurance, employee-provided health insurance, and even most of Medicaid. Instead, every U.S. resident would be fully covered by the single-payer system (Kaiser Family Foundation 2019a).

The universal coverage enacted by a Medicare for All platform would essentially remove the socioeconomic barriers to health care. It would eliminate the under and uninsured populations, as every U.S. resident would be automatically covered. Theoretically, residents would also no longer have to forgo care or avoid filling prescriptions due to cost, as every health service would be provided without copayment. Beyond theory, it is possible to judge the effects of universal coverage on health care disparities by looking abroad. In Canada, where primary care is provided with no cost-sharing, residents are two times less likely to forgo medical care when compared to the United States; in fact, Canadian patients with low socioeconomic status actually use health care services more frequently than their high-income counterparts (Osborn and Squires 2016; Alter et al. 2011). In the United Kingdom, where coverage extends to pharmaceutical drugs as well, only 7 percent of adults reported problems with access to care due

to costs. This figure is a sharp contrast to the United States' 33 percent of adults reporting cost-related barriers to health care access (Osborn and Squires 2016). In terms of health outcomes, the universal coverage achieved by Canada and the United Kingdom has been shown to reduce socioeconomic inequalities in low birth weight, preventable disease incidence, and life expectancy (Martinson and Reichman 2016; Willson 2009; Ranabhat et al. 2018).

The clear benefits of a national health insurance program have seen the Medicare for All platform grow in increasing popularity among progressives. Senator Sanders' Medicare for All bill has been cosponsored by fourteen senators, including four presidential candidates; the House bill currently has 107 Democrats backing the measure (Kliff 2019; Abelson and Sanger-Katz 2019). Medicare for All also appears publically popular, with 56 percent of Americans and 81 percent of Democrats in favor of a single-payer plan. However, these figures are surface level. Once respondents are told a single-payer program would raise taxes or eliminate private insurance, support drops to just 37 percent (Kaiser Family Foundation 2019b). Furthermore, the health care and insurance industry is strongly opposed to such reform, with twenty five health care and insurance organizations – including the American Medical Association and the Blue Cross Blue Shield Association – already forming a coalition to lobby against Medicare for All (Pear 2019). While a national health insurance system may be the strongest solution to health care disparities, it remains unclear if there is sufficient political will to overcome such powerful opposition.

IV: Striking a Balance

In response to opposition from the health care and insurance industries – as well as concerns over freedom of choice – some on the left are promoting platforms that would combine

essential elements of both a public option and a national health insurance program. Entitled Medicare for America, the bill proposes a Medicare buy-in available to any legal resident and preserves employee-sponsored coverage; however, all uninsured people and newborns would be automatically enrolled in Medicare. As such, the plan would achieve universal coverage – one of the main advantages of Medicare for All – while maintaining the private insurance industry. However, payment structure differs from a single-payer plan. While still partially financed by a tax increase, Medicare for America would also exact premiums on enrollees, although capped and graded on income. The competition spurred by such low prices – coupled with stricter federal regulations – would likely see costs decrease in the private sector (Luthra 2019).

But accepting a two-tier system has its drawbacks. In Germany, higher-income citizens are allowed to opt out of the public system and purchase private plans. This has caused wealthier citizens to enjoy preferential treatment and shorter waiting times, as providers compete to attract their higher-paying private insurance (Lungen et al. 2008). Furthermore, it has been shown that out-of-pocket expenditures in countries with universal health coverage can lead to increased risk for premature illness and death (Baggio et al. 2018). Whether or not these are acceptable health inequities is a decision progressives will have to contend with as they attempt to pass health care reform in the coming years.

V: Conclusion

The United States is at a profound political moment in the history of health. By establishing universal coverage through the expansion of public health insurance, we have the opportunity to overcome decades-long socioeconomic inequities in health care access. And while some may favor more modest, limited expansions of public insurance, plans that stop short of

universal coverage will be insufficient to address longstanding disparities. In the coming years of reform efforts, as policymakers balance political palpability and national health, we must not waver from our commitment to assure universal access to affordable health care.

It is important to note that even an ideal single-payer system will not overcome all socioeconomic health disparities, or even disparities in access to care. Rural communities struggle with provider shortages, and a lack of diversity within the provider population dissuades health care utilization among marginalized groups (Weinhold and Gurtner 2014; Kolata 2018). Furthermore, the poorer health experienced by individuals of lower socioeconomic status is also a consequence of their stress levels, nutrition, and housing. In fact, access to health care only accounts for 10 percent of the risk for premature death (Artiga and Hinton 2018). Nevertheless, health care reform is still an exciting opportunity to address health care disparities in a way that is clear, measurable, and timely. There are few health disparities that would not be at least somewhat improved by the implementation of universal affordable access to care. By harnessing the power of the political moment, we have the ability to transform our health care system and take a bold step towards a more equitable and just society.

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