Contested Public Health Care Option Already Popular in Many States

by Senator Dede Feldman (D-Alb)

Over 45 years ago, I, along with hundreds of other earnest young high school debaters across the country, found myself tackling the same national question that the policy makers of the day were arguing: Should the United States adopt a national health care plan for seniors over 65 years of age?

The opponents of the plan, which we now know as Medicare, produced the same arguments against the program that we are hearing today against any public health care option. We young debaters neatly wrote down the "con" arguments that the AMA, the Hospital Association and the insurance companies supplied us with about how the plan would lead to socialism, spell the end of private insurance, shut down hospitals and drive doctors out of practice.

While the "con" side of the official, national debate question sometimes won in high school that year, the US Congress passed the Medicare program in 1965. None of the things that the opponents said would happen came to pass. In general, Medicare has been one of the most popular programs in the nation's history. And although the program is now addressing higher costs due to maturing baby boomers and, the growing, unrestrained price of pharmaceuticals and medical care, most admit that it has been successful at keeping down administrative costs and providing basic coverage to virtually all seniors.

Fast forward to New Mexico, 2009, where the cost of family premiums has more than doubled since 2000, now averaging over $13,000 per year. In spite of the best efforts of a strapped state government, employers--particularly small employers-- are dropping coverage for their employees, and the state remains second only to Texas in the percentage of residents with no coverage at all.

A vicious cycle has taken hold here, as it has

elsewhere, where, as the number of people without insurance increases, emergency rooms deliver care to them at the highest cost—which is then passed on to those of us with insurance. Estimates of how much this cycle jacks up the average New Mexico premium range from at least $1,000 to $2,3000 a year.

Much of my time, as a state legislator, is devoted to fielding calls from constituents who have insurance, but are grappling with gaps in their policies, fewer and fewer choices of services and providers and, especially, the fear that any illness, or any change in their job status, will mean loss of coverage, and, potentially-- bankruptcy.

That's why many legislators around the country, over the past ten years, have been working hard to develop and support innovative state programs that expand access, contain costs and provide more affordable choices. Many of the programs that states have created are public options that co-exist with the private market. They are the same type of option that is now being proposed nationally—and they are working.

In New Mexico, the State Coverage Insurance program (SCI) now covers almost 40,000 low-income working adults in a private/public partnership utilizing revenue from employers, employees, and the state and federal governments. HMOs run this public option under a contract with the state. Private doctors and others provide the care to thousands who were previously uninsured.

Pennsylvania's Adult Basic Care (ABC) Program provides comprehensive coverage to adults living below 200% of poverty (about $35,000 for a family of 3), with low monthly fees. Maryland's Healthy Insurance Partnership provides a premium subsidy to small businesses, which covers 50% of premium costs.

Maine's public option—DirigoChoice— has been in place since 2003 offering businesses and individuals policies through a private insurer, Pilgrim Health Care. Although not as many people have enrolled as hoped, the program has driven down administrative costs and captured some savings with a larger pool and fewer people relying on emergency

rooms. This has translated into "uncompensated care" costs no longer being added to everyone's health insurance bill.

Other public options, like Illinois' AllKids or Iowa's Children First initiatives make coverage affordable for children without access to private insurance.

Other states allow businesses and individuals access to existing insurance pools. New York allows employers to buy into the Medicaid program regardless of their employees' income. And Connecticut's legislature just passed a bill to allow businesses to pool with the more affordable state employee health plan.

All these state programs offer families a public health care choice, most often with the cooperation of the private insurance market. But as state budgets shrink, and the waiting lists for some of the programs grow, it is clear that they are not enough.

Without pre-empting state initiatives that may go further than federal reform, Congress should move forward with a strong pubic health care option to increase access and affordability. Only a public program—with as large a pool as possible-- can contain costs for the entire system by reducing administrative costs and using its bargaining power to negotiate better rates. Yes, such an option might force regular insurance companies to be more competitive, more attentive to reforms that Medicare and Medicaid are already making to improve the quality of health care while containing costs.   Is that such a bad thing?

I don't think so, and neither do thousands of others who benefit from these public options through lower costs and greater access.

The very suggestion of a public option has already forced concessions from hospitals, pharmaceutical corporations and insurance companies. The latest is a pledge to voluntarily reduce the growth of health care costs by $2 trillion over the next ten years.

These voluntary concessions are admirable, but they do not make for real health care reform. Only a bill with a strong public health care option, cost controls and reforms in the delivery system does that.

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