1

The State Role in Health Care Reform: Why Do We Care?

Health Care Reformers Turn to the States

It is by now well known that the United States is the only Western industrialized nation without national health insurance. Following the 1992 presidential elections, however, it seemed that this exceptionalism was about to end. Newly elected President Bill Clinton declared health care reform to be a (very) high domestic priority. Pollsters revealed citizen support for reform. Key interest groups (including health care providers, commercial insurance companies, and much of the business community) voiced support for reform as well. Even leading Republicans generally agreed that there was a "health care crisis" that needed to be addressed.

In the fall of 1993, the president unveiled his plan. The federal government would establish a health insurance benefit package that every American would receive. "Health plans" (mainly large health maintenance organizations) would compete to provide the benefit package. Employers would fund most of the cost, but employees would pay some too, and they would have a fiscal incentive to choose a low-cost plan. Newly formed "health alliances" (quasi-governmental agencies established and administered by state governments) would manage the competition, protecting consumers and employers alike. The newly competitive environment would

generate savings (and if it didn't, a national health board would ensure savings by imposing caps on the premiums charged by the plans). There would thus be health insurance (and health security) for all and a gradual reduction in the nation's trillion dollar health care bill.

Soon after the proposal was released, however, the momentum for reform disappeared. Interest groups that supported reform in the abstract opposed key elements of the president's plan, especially the requirement that employers provide insurance to their employees and the proposed caps on insurance premiums. Meanwhile, consumers worried that the emphasis on managed care would eliminate freedom of choice and undermine existing doctor-patient relationships. And the new bureaucracies envisioned by the plan (such as the so-called health alliances) fed Republican arguments that the plan was just another big-government proposal generated by big-spending liberal Democrats.

By the summer of 1994, Congress had rejected the Clinton plan, along with a host of alternative proposals. The 1994 midterm elections then produced a Republican Congress (the first since 1946), an apparent repudiation of Clinton's ambitious domestic agenda. Voters distrusted government's ability to solve the health care crisis (and were persuaded by the Republican's platform of lower taxes and less government).

In this changed political environment, the Clinton administration shifted tactics: the new goal is to encourage states to be the source of health policy innovation. This strategy consists primarily of providing a handful of states with greater discretion when implementing Medicaid, the federal-state health insurance program for the poor. States are encouraged to use this authority to expand the program to cover segments of the uninsured. Tennessee, for example, is implementing a program called TennCare, which offers a choice of managed care plans to nearly 1.5 million low-income persons, a third of whom were previously uninsured.[1] Oregon has a similar program.[2]

Other health care reformers, having acknowledged that na-

tional health insurance is off the political agenda, also focus now on the states. The goal is to support state programs for the uninsured. The hope is that innovative state programs will become models emulated elsewhere.

State programs for the uninsured can be divided into several categories. First are efforts to encourage or require employers to provide health insurance to their employees. Hawaii, for example, requires most employers to provide health insurance to their employees.[3] Oregon has a similar requirement, though it is not scheduled to go into effect until 1997. Other states, unwilling to impose employer mandates, provide tax credits (or similar subsidies) to small businesses that provide health insurance to low-income employees.

A second strategy is to use state dollars to pay for private insurance. Minnesota, for example, subsidizes private insurance for families with income below 275 percent of poverty and individuals with income below 100 percent of poverty.[4] This program, called MinnesotaCare, is funded by a special tax imposed on health care providers. Washington State has a similar program, called the Basic Health Plan, which provides subsidized insurance to persons with income below 200 percent of poverty.[5] Washington's program is financed primarily by so-called sin taxes (on alcohol and tobacco) and by a tax on hospitals and HMOs.

Third are initiatives which seek to lower the cost of private health insurance. These programs generally focus on small employers, the group with the largest number of uninsured workers. California, for example, has created a health insurance purchasing pool for small employers. The assumption is that if small employers pool their insurance business, their ability to negotiate lower rates increases. Other states permit insurers to offer "bare bones" health insurance policies (by waiving state laws that require every insurance policy to cover services such as drug treatment or mental health coverage). Still other states impose an actual cap on increases in insurance premiums.

Fourth, and finally, a number of states provide subsidies to

those health care providers who care for the uninsured. In 1987, for example, state and local governments spent over $18 billion to cover uncompensated care.[6] In addition, a few states impose a special tax (called a surcharge) on all hospital bills, then distribute the funds collected to hospitals that provide uncompensated care. New York has had such a program for over a decade.

To be sure, these various state programs, taken together, have hardly made a dent in the overall number of uninsured. (Indeed, the number of uninsured continues to rise.) Reformers hope, however, that the failure of national health reform will encourage more states to adopt programs for the uninsured. Perhaps Montana or Missouri will adopt their own employer mandate. Or maybe Alabama or Arkansas will implement a program like Washington's Basic Health Plan. This hope, that states will act as policy laboratories, and that other states will replicate programs that work, has led to an alliance between those who have argued for years that health reform should be led by the states and those who would prefer a national solution but believe it unlikely.

Liberal reformers are not alone, however, in pinning their hopes on the states. The new Republican leaders in Congress, joined by several of the nation's governors, also argue that states should be given increased authority to run health and welfare programs. For example, Republican legislation would turn Medicaid into a block grant, under which states would receive a fixed amount of federal Medicaid dollars, but would be able to spend those dollars with very few (if any) federal strings. One goal of the block grant approach is simply to reduce federal expenditures: federal spending would be capped and controlled. Supporters also suggest, however, that a block grant would enable state policymakers to innovate and contain costs in ways now impossible. This increased authority is the main draw for the nation's governors.

There is, as such, a second and even more unlikely alliance, this one between liberal reformers and conservative cost-cutters, both of whom look to the states as a source of innovation and leadership.[7]

Given the mood of the day, Congress is likely to increase state authority over health care policy and put off indefinitely further consideration of national health insurance. Even if Medicaid is not converted to a block grant, for example, state flexibility under the program will surely increase. Federal regulations governing the quality of health care provided by nursing homes may also be eliminated, replaced (if at all) by an assortment of state regulatory regimes. In time, even Medicare, the federally funded and administered program for the aged and disabled, may be replaced by a collection of state-based insurance initiatives.

The policy implications of this "devolution revolution" are unclear.[8] How will states respond to their increased authority (especially if it is accompanied by a reduction in federal dollars)? What are the strengths and the limits of states as policymakers? Who will win and who will lose?

One source of insight is the literature on state health reform activities. What states have done provides clues as to what states might do. Unfortunately, the literature is surprisingly thin. There are, to be sure, several organizations that do a good job of tracking and reporting state health care policy.[9] There are also a handful of articles and books on recent state health reform activity.[10] By and large, however, the more analytic work focuses on the half dozen states that have enacted comprehensive reform; there is hardly anything written about the other 45. Moreover, even the literature describing the reform leaders needs to be revised. The reform leaders are retreating fast. Washington State, for example, recently rescinded a state law that would have required employers to provide employees with health insurance beginning in 1999. Minnesota repealed its goal of universal coverage by 1997, substituting a goal of 96 percent coverage. Florida, Vermont, and Colorado also retreated from their flirtation with comprehensive reform.

The reduced commitment to reform is hardly surprising. State legislators in 1996 are generally less likely to enact insurance expansions than their state or federal counterparts were in 1994. The Republican revolution is firmly entrenched in many state-

houses. Washington State illustrates the point. In 1993, the state's Democratic-controlled legislature enacted a comprehensive health insurance program, one that was hailed by reformers around the country as a model to be emulated. The next year, the Republicans took over the statehouse, and by early 1995 they had repealed the most publicized piece of the reform initiative, the employer mandate.

The 1994 elections are not, however, the only reason that states are not likely to enact universal coverage programs. An obvious obstacle is money: finding new dollars for reform is difficult, especially since state policymakers are no more likely than their federal counterparts to seek tax increases. State innovation is also limited by fear of business exodus. States are in an ongoing interstate competition for business, and state officials worry that if they increase the burdens imposed on the private sector (perhaps by requiring employers to provide health insurance to their employees) then at least some employers will move their businesses elsewhere. A third obstacle is the fear of becoming a welfare magnet. State policymakers worry that if they enact universal insurance, and other states do not, then some uninsured persons might migrate in solely to receive the new benefits.

The changing medical marketplace also makes government action less likely. For example, many big businesses are now forming large health insurance purchasing alliances, thereby gaining discounts and savings that were previously unavailable, and thereby reducing even further their incentive to support programs for the uninsured.

Finally, for those few states who elude the interest-group, institutional, and ideological barriers, there are inter-governmental barriers as well, most notably the Employee Retirement Income and Security Act (known as ERISA), which prohibits states from requiring employers to provide health insurance to their employees. It also prohibits states from regulating or taxing those companies that self-insure.[11] Since nearly 70 percent of all employees work for companies that self-insure, ERISA is a powerful barrier to nearly