CHAPTER

8

State Roles in Health Care Policy: Past as Prologue?

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States have had primary responsibility for the development and implementation of health care policy, regulation, and program administration for most of this country's history. Yet, by virtue of financing and administering two of the largest programs in the entire federal government—Medicare and Medicaid—the federal government has a very large role in health policy as well. Given an increasingly complex health care system, neither level of government would seem to have the capacity to enact, implement, and enforce all the policies and programs needed to manage the health care system. Indeed, with large and growing proportions of the budgets of both federal and state governments (not to mention local governments) being consumed by health care costs, neither is prepared to bear the financing burdens alone.

If both are essential, then the more important question becomes how each level of government can best share their joint responsibilities for regulating, financing, and improving the efficiency of the nation's health care system. This chapter examines what roles the states have played in health policy and seeks to evaluate how well they have performed them. Such an assessment may help shed light on which roles states are best equipped to undertake as the nation begins to shift more responsibility to them.

Theoretically, the relationship of the federal government to states in the health arena could lie at any point along a continuum between a complete abdication of control to the states to a complete takeover of all responsibility by the federal government. Debates surrounding federalism in health policy over the past thirty to forty years have focused on where to place the fulcrum in this continuum. From the federal government's perspective, the question often has been framed as: Can the states be entrusted with broad powers and

flexibility? When must the federal government set national standards and rules to assure equity and efficiency in the health care system? From the states' perspective, the question is often expressed as: When will the federal government give us the flexibility we need to structure our own cost-effective health care systems?

These issues have been the subject of intense national debate in the recent past. The nation's 1993–94 debate on health care reform presented an opportunity to reexamine states' roles (Chisman et al., 1994). The Clinton proposal would have given states substantial responsibilities to administer and finance a national health care system, while making dramatic improvements in national uniformity in health care coverage levels and benefits. A year later, in 1995, Congress was again debating how much authority and control to give to states, through its consideration of proposals to place numerous federal health programs, including the Medicaid program, into block grants to the states. This would shift the balance of power toward much greater state control.

Such debates are critical ones for a country that claims to be committed to equality yet is deeply suspicious of a large federal presence in state or local affairs. But to carry on an informed debate, it is important to understand the strengths and weaknesses of the states' capacities and willingness to undertake various roles and responsibilities in health policy.

This chapter reviews the experience of the states in performing a broad range of roles in health policy, including financing or paying for health care; assuring the public's health; regulating health professionals, facilities, and insurance arrangements; and experimenting with approaches to comprehensive health care reform. For each of these roles, emphasis is placed on state governments' relationships with the federal government and on variations among states in how they approach these roles. It also describes changes in the way states have carried out these roles in the past ten to fifteen years and points out some of the challenges facing states in performing these roles in the future. It concludes by discussing trade-offs between significant state flexibility versus greater federal involvement in performing these critical roles in health policy.

FEDERALISM AND HEALTH POLICY

Debates about the appropriate responsibility of each level of government for various functions in the health care system have a long legacy. Since the nation's founding, there has been a constant struggle to find the right balance between a strong central government and state and local autonomy. From the late 1700s to the early 1900s, local governments were clearly dominant, with neither the states nor the federal government having much involvement at all. That began to change in the 1930s. First, the Social Security Act (1935) authorized federal grants to states for maternal and child health care, and for care to disabled individuals. Second, the Food and Drug Administration (FDA) within the federal government was created in 1938 to assure the safety and efficacy of food and pharmaceutical products crossing state lines, drawing its authority from the commerce clause of the Constitution giving Congress the power to regulate commerce among the states.

From the 1930s through the 1950s, states' involvement in health care was limited to basic public health functions, such as control of communicable diseases, direct delivery of certain services such as care for the chronically mentally ill, and administration of federal grants-in-aid. With the start of the health insurance industry in the 1940s and 1950s, states also began to regulate both Blue Cross and Blue Shield plans and commercial policies. Meanwhile, Washington's role in and spending on domestic programs grew in response to the Great Depression that reinforced a belief that national institutions were needed to "strengthen the economy and perform functions that states could not be expected to perform on their own" (Rivlin, 1992). In other words, state and local health and welfare systems were not regarded as capable of addressing national economic hardships.

The 1960s marked a period of escalating influence of the federal government over health care policy. Here, as in many other arenas, states were viewed as performing their assigned responsibilities poorly. Like other programs that grew out of the administrations of Kennedy and Johnson, Medicare and Medicaid were created, in large measure, to address shortcomings in

the states' abilities to serve the needs of the elderly, poor, urban residents, and minorities (Thompson, 1986).

The states' role in health care diminished considerably in the 1970s as Medicare and Medicaid grew well beyond most of their creators' predictions and as other federal programs, such as support for community health centers, expanded in scope. In 1965, state and local governments spent about the same amount ($5.2 billion) as the federal government on health and medical care. By 1980, the federal government was spending twice as much as state and local governments and two and a half times more in 1985 (U.S. Department of Health and Human Services, 1987). Continuing disparities among the states in the reach and effectiveness of various health and social service programs were quite apparent. For example, participants at a January 1980 conference on state and local government involvement in health care concluded that state governments were more vulnerable to political patronage and more inefficient than the federal government (Jain, 1981).

During the 1980s, President Reagan ushered in a new era characterized by an effort to return to the states greater control and discretion over the financing, delivery, and regulation of health care. In his first State of the Union Address in January 1982, the president promised cuts in taxes, cuts in federal spending, and a reduction in burdensome federal regulatory requirements by giving more decision-making authority to state and local governments (*Congressional Quarterly*, 1982). Block grants, which consolidate funds from many different categorical programs into one lump sum that is distributed to the states on a formula basis, became a key vehicle to achieve all three goals. While the Democratic-controlled Congress agreed to transfer some control to the states, it tried to cushion the blow by appropriating more money for block grants than the Reagan administration had requested. Nonetheless, federal grants to state and local governments (excluding payments for individuals) fell by 38 percent in inflation-adjusted dollars between 1980 and 1989 (U.S. Office of Manaagement and Budget, 1990).

Contrary to expectations, state governments responded by considerably expanding their own spending on health and social services. According to a U.S. General Accounting Office study (1995), state expenditures on health-related programs funded in part with federal block grant funds increased in 85 percent of the states studied. If the block grants represented a test of the states' political commitment to human service programs without federal mandates and with reduced federal funding, they "passed this test . . . to a greater degree than most observers anticipated," according to an analysis by the Urban Institute (Peterson, 1986).

Their ability to pass the test was possible because of an economic upswing that began in late 1982 and remained through the 1980s. That enabled more than half of the states to raise personal income or sales taxes from 1982 to 1986; state tax collections rose by 33 percent over this period. This infusion of funds allowed states not only to restore federal funds cut at the beginning of the decade, but to reduce taxes and even initiate new and innovative health programs toward the end of the decade.

At the start of the 1990s, the states' good fortunes came to an abrupt end. It began with regional economic recessions in New England in 1988, eventually hitting every region of the country by the end of 1992. State budgets took a beating. By 1992, most states were in their second and third years of "making painful spending cuts, raising taxes, imposing new fees and using all sorts of accounting gimmicks to squeeze their budgets into balance" (Lemov, 1992).

Despite these difficulties, states did not come to be viewed as "failing the test." This may be due to the fact that the federal government was in no position to make up for their deficiencies. But it may also be because of the creative ways in which they handled health care policy during the economic downturn. For example, even though more poor individuals were entitled by the federal government to Medicaid between 1986 and 1992, the states found the means to finance rapidly expanding Medicaid budgets. One of the more popular methods involved taxing hospitals and other health care providers and counting those revenues as state Medicaid funds that then qualified for federal matching dollars. This resulted in greater federal spending, with little or no increase in state outlays for Medicaid expansions. A few states also made the commitment to provide health

care coverage to all of their residents, even though the federal government failed to make a similar promise (Lipson, 1994). Ironically, if states faced any barrier to doing even more, they blamed the mandates and rigid rules imposed by the federal government.

By the mid-1990s, states faced the prospect of gaining even greater control and flexibility for the administration and financing of health and human service programs. In 1995, Congress considered seriously a proposal to turn the entire Medicaid program over to state governments by giving them a block grant with very few federal strings attached. But the increased flexibility would come with a price: strict annual spending growth caps would be placed on them.

How would states handle increased responsibility with fewer dollars? Would they, as in the early 1980s, respond by increasing state allocations to health programs and using other creative methods to stretch existing funds? Or would they be forced to cut eligibility, services, or provider payments to make ends meet?

To predict how states would respond to a transfer of responsibility from the federal government and how they would use the additional flexibility, it is useful to examine how well they have performed previous and long-standing roles. Similarly, to gauge how well states are prepared to meet emerging roles that arise from a changing health care system, it is instructive to examine how they have addressed health care problems that arose in the past decade.

STATES AS PAYERS OF HEALTH CARE SERVICES

All states bear a large responsibility for financing health services for the poor, primarily through the Medicaid program, for which financing is shared with the federal government. States also pay the costs of providing health coverage to state employees and retirees, and sometimes for other publicly employed workers, such as teachers, police, and the like. In addition, most states also help subsidize some of the costs of delivering health services to those without any coverage at all, public or private. Significant changes have occurred in state financing of health services over the past decade, the most notable being the tremendous rise in total spending. In response to the cost growth, states have undertaken a variety of measures to control the annual growth of such costs and to cover uninsured people in more cost-effective ways.

State Medicaid Programs

An estimated $125.2 billion was spent on the Medicaid program by both the federal and state governments in 1993, and served 32.1 million individuals (Kaiser Commission, 1995a). The Medicaid program is actually fifty-six programs (fifty states and six other jurisdictions) because each state is allowed to operate its own Medicaid program within relatively broad federal guidelines. These guidelines specify both required and allowed eligibility groups and health care benefits. Within these federal parameters, states have adopted more or less generous programs, depending on such factors as the state's economic capacity to finance Medicaid services, state or regional health care costs, the demographics of the state's population, influence of interest groups in the state political and budget processes, competing priorities with other state programs, and federal financial incentives or sanctions.

This flexibility has resulted in great variation in the Medicaid program from state to state. For example, in 1993, state expenditures per capita ranged from $1,275 in the District of Columbia and $1,104 in New York to $278 in Idaho and $276 in Utah (Kaiser Commission, 1995b).[1] Eligibility for Medicaid also has varied widely among the states. Federal Medicaid rules require that anyone eligible for cash welfare programs are also eligible for the program. But state Aid to Families with Dependent Children (AFDC) eligibility thresholds, for example, ranged from $1,440 in annual income for a family of three in Mississippi to $7,800 in Vermont as of February 1995 (National Governors Association, 1995). Less variation among state eligibility standards occurs in coverage of the aged and disabled because fed-

[1]These figures are per capita (covering all residents of each state), *not* per Medicaid beneficary. Per beneficiary spending averaged $3,895 across all states, ranging from $2,380 in Mississippi to $9,700 in New Hampshire.

eral rules govern eligibility for Supplemental Security Income (SSI), the cash assistance program for low-income people in those groups.

Federal guidelines also have permitted coverage of several other groups of people at a state's option. Beginning in 1984, Congress enacted a series of laws that gradually expanded coverage for more low-income people who did not qualify for cash welfare programs. The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) was the first in a series of laws to break the long-standing connection between eligibility for cash assistance (AFDC or SSI) and Medicaid. It permitted states to provide Medicaid coverage to all pregnant women and children up to age five in households with family incomes *above* the state's AFDC standard of need but below the federal poverty level. OBRA-86 also permitted states to cover the aged and disabled who made less than the federal poverty level but still had incomes above the SSI eligibility threshold.

Later, the Medicare Catastrophic Coverage Act of 1988 required all state Medicaid programs to pay for the Medicare premiums, deductibles, and co-payments for elderly and disabled Medicare beneficiaries who made less than 100 percent of the federal poverty level.[2] Then, OBRA-89 and -90 mandated that state Medicaid programs cover all pregnant women and children up to age six living in families with incomes below 133 percent of the poverty level. On a phased-in basis, all children below age nineteen living in poverty were required to be covered by Medicaid by the year 2002. States were still allowed to cover pregnant women and infants whose incomes were up to 185 percent of the poverty line and by July 1994, thirty-four states had set the level at some point above the 133 percent minimum.

In an attempt to reduce wide interstate variations, each state's "match rate," or the proportion of each state's Medicaid costs covered by the federal government has been determined on the basis of per capita personal income relative to the national average. As of 1995, those with less than the national average are entitled to greater federal funds; those with more than the national average get less. So, the federal matching rate varied from 80 percent in a state with the lowest per capita income (Mississippi) to 50 percent, which is the minimum match rate.[3]

Though the variable federal matching rate was intended to reallocate resources from the wealthier to the poorer states, this did not occur. According to a 1995 Kaiser Commission report,

> Medicaid spending per poor person is generally greater in higher income states than in lower income states. For example, Medicaid spending per person below 150% of the poverty line varied from $4,852 in New York and $4,007 in Connecticut [high-income states] to $958 in Idaho and $953 in Utah [low-income states]. Because of differences in program generosity, many higher income states have federal per capita contributions which are well above the national average, despite low federal matching rates. In contrast, many lower income states have federal per capita contributions which are well below the national average, despite much higher federal matching rates" (Kaiser Commission, 1995b).

Early studies of interstate spending variations attributed these differences to the tendency of lower-income states, particularly in the South, to spend very little on the poor, regardless of how much money the federal government offered to help them serve this group (Sundquist, 1969). Another study confirmed that differences in Medicaid coverage of the poor reflected variations in states' income standards used to determine welfare, and therefore Medicaid, eligibility as well as states' coverage of certain optional eligibility groups under the program (Holahan & Cohen, 1986).

By the mid-1990s, however, such explanations fell short. While state policies affecting welfare eligibility were influential in the 1970s and 1980s, the gradual delinking of Medicaid from welfare eligibility diminished the influence of state welfare policies on Medicaid spending variation. Increasingly, interstate spending differences have been better explained by a combination of factors: variations in the states' ability to pay, the

[2]While the Medicare Catastrophic Coverage Act was later repealed by Congress, the provisions pertaining to Medicaid eligibility expansions were retained.

[3]Major changes to the federal matching rate formula were the subject of considerable debate in the 104th Congress.

composition of Medicaid recipients in each state, cost of health care in the state, and provider payment policies, especially those concerning payments to disproportionate share hospitals (DSHs) that serve greater numbers of Medicaid and uninsured people.

The multiplicity of factors contributing to interstate spending variations highlight the shortcomings of the federal funding formula, which only accounts for differences in states' per capita income. Thus, many proposals for Medicaid reforms often suggest changes to the federal formula that would take into account each state's ability to pay, the cost of health care in each state, and differences in the number of poor, elderly, or disabled people (Kaiser Commission, 1995b). However, changes in the federal formula would produce winners and losers and "set off a battle royal among states about how to divide the dollars" (Fraley, 1995).

Why? Because a great deal of money is at stake. The expected federal–state tab of $170 billion in fiscal year 1996 is over three times what was spent just six years earlier in 1989 (Fraley, 1995). For the states, total state spending on Medicaid grew at rate much higher than nearly every other state spending category, except corrections, during this period of time. In 1993, 18.4 percent of state budgets on average was consumed by Medicaid expenditures, almost double the 10 percent figure in 1987 (National Association of State Budget Officers, 1994).

The growth in Medicaid spending in the past seven years was due in part to an increase in those eligible for Medicaid. Nationwide, approximately 32.1 million individuals were covered by Medicaid in 1993, compared to 23.2 million in 1987. Most of this growth reflects expanded coverage of pregnant women and young children, and increases in the number of blind and disabled beneficiaries. However, according to an analysis of the reasons for cost growth between 1988 and 1992, only 36 percent of the increase was attributable to greater enrollment (Coughlin et al., 1994). Health care inflation (the rise in medical care prices) played a major role in the rise in Medicaid spending, contributing another 26 percent of the cost growth. Increases in service utilization, which reflect greater amounts and intensity of care, as well as increased payments to providers in excess of the medical inflation rate contributed the last 33 percent of the cost growth during this period.

Generally speaking, states were able to absorb the increasing costs of the program at the beginning of the eligibility expansions in 1986 because state budgets were relatively healthy in the late 1980s. But as the economic recession of 1991–92 squeezed state revenues and caused Medicaid rolls to swell, states needed to employ a variety of techniques to reduce the annual rate of cost growth, or increase revenues to, the Medicaid program.

In some states, fiscal crises turned a casual search for alternative sources of Medicaid revenue into an economic imperative. Dozens of states decided to increase revenues to cover growing Medicaid costs, initially by requesting donations from, and later by imposing taxes on, hospitals and other providers. States then used these provider donations or taxes to generate additional federal matching funds and to pay hospitals higher rates than they would have otherwise received. States with high federal match rates found the strategy particularly attractive; by the end of 1991, nearly half the states had adopted either provider donation or tax schemes, or both.

Among thirty-two states with a provider tax or donation program in fiscal year 1992, the revenues represented on average 23.5 percent of states' nonfederal expenditures on Medicaid. In some states, however, the figure went much higher. Tennessee, for example, raised $1 billion, or nearly half of its total Medicaid budget, from provider fees and other revenues (Lipson, 1993).

By 1993, the cumulative effect of state Medicaid provider donations and taxes on the federal government was high. The provider taxes were cited as one of the major contributors to rapidly increasing Medicaid costs at the federal level. And because federal Medicaid reimbursements to states increased so dramatically between 1989 and 1993, the rise in federal payments served to transform the Medicaid program from its primary role in financing health care for the poor, elderly, and disabled into a major federal revenue sharing program for states (Miller, 1992). "Medicaid growth has reversed the decline in federal grants to state and local governments," wrote Miller. He based this conclusion on trends showing that federal grants to states dropped

from 17 percent of total federal spending in the late 1970s to 11 percent throughout the 1980s. Due to the rise in Medicaid payments alone, these figures increased to 13 percent in 1993 and were projected to reach 16 percent by 1993. As a proportion of all federal grants to state and local governments, Medicaid payments rose from 15 percent in 1980 to 35 percent in 1991, with a possible rise to 55 percent in 1997 (Miller, 1992).

In response to very high annual growth rates in total Medicaid spending, Congress enacted a law designed to prevent states from repaying the provider taxes back to the hospitals in the form of increased rates. The law banned donation programs, set ground rules for provider tax programs, and set aggregate national and state limits on payments made to disproportionate share hospitals (DSHs), or those that serve greater than average numbers of Medicaid and uninsured patients.

States' use of provider taxes to generate federal Medicaid funds represented yet another battleground in an ongoing contest between federal and state governments over how much the federal Treasury will dispense to states for their Medicaid programs. The Medicaid financing system has always given states tremendous incentives to devise ways to maximize federal funds. Despite Congress's limitations on the states' use of provider taxes to finance their share of Medicaid, the solution represented a temporary "fix," deferring a decision on the real issue underlying the controversy: How should the federal government and the states divide responsibility for raising the funds necessary to pay for health care provided to poor and low-income people? As the most recent round of federal government attempts to rein in these costs plays itself out over the next several years, this question will undoubtedly surface again.

In response to rising Medicaid costs, states did more than just try to maximize federal funds. In fact, nearly all states implemented a variety of cost-cutting measures. Between 1984 and 1992, the vast majority of states changed their hospital reimbursement methods from cost-based to prospective payment based on diagnosis-related groups (DRGs), consistent with the federal Medicare program. Nursing home reimbursement has also switched to prospective payment methods, using case-mix adjusters to vary rates based on the intensity of care needed by each patient. And with the growing costs of pharmaceutical drugs—total Medicaid spending grew by 116 percent between 1989 and 1993—states have tried to limit expenditures by using formularies and requiring the use of generics, performing drug utilization reviews, and limiting quantities permitted to be dispensed. Federal law also required that drug manufacturers pay rebates to state Medicaid agencies for single-source drugs, to approximate the discounts provided to HMOs and large group purchasers.

But by far, the states' most significant effort to contain costs was to increase enrollment of Medicaid beneficiaries into HMOs and other managed care arrangements. "Expanding the use of managed care to improve access and contain costs is a central goal of virtually all Medicaid programs today and is a feature of Medicaid in 43 states and the District of Columbia" (Rowland et al., 1995). There is a great deal of variety in the types of managed care plans utilized—from HMOs paid on a fully capitated basis to partially capitated plans to primary care "gatekeeper" programs that continue to pay physicians on a fee-for-service basis, but dispense an extra monthly fee to them to coordinate and manage the care received by patients.

A review of studies on the effects of Medicaid managed care programs confirmed cost savings of 10 percent to 15 percent below those of the regular fee-for-service system (Rowland et al., 1995). However, such savings were more common in programs that rely on prepaid capitated plans, rather than on physician gatekeeper models. The review left open the question of whether such savings are due to more efficient care (i.e., substituting outpatient physician visits for emergency room use) or discounts to providers' rates. It also suggested that while access to primary care appeared to increase under such plans, use of preventive services may stay the same or even decline, and health outcomes were not significantly better (Rowland et al., 1995).

From the states' perspective, managed care does no harm and at least assures a lower rate of increase and more predictability in annual costs compared to the fee-for-service system. This explains why, in 1994, 23 per-

cent of all Medicaid beneficiaries were enrolled in managed care arrangements, up from 14 percent in 1993 and just 3 percent in 1983. But these figures masked significant interstate variation. Arizona and Tennessee, for example, had enrolled virtually all Medicaid beneficiaries into managed care plans, through waivers from federal Medicaid rules that otherwise prevent mandatory enrollment into managed care. Oregon, Washington, Utah, and Massachusetts had over 40 percent of Medicaid beneficiaries in managed care plans. But some states had very little (i.e., less than 10 percent) or no managed care enrollment at all (Lewin-VHI, 1995).

With more and more of the privately insured population enrolled in managed care, states began to find it easier to interest HMOs and other managed care plans in serving the Medicaid population. In 1995, a third of all Medicaid recipients were projected to be enrolled in managed care arrangements of some type. However, states' ability to enroll all of their Medicaid population into managed care still depended on the willingness of the federal government to grant them permission to make managed care enrollment mandatory. And states continued to face big challenges in assuring that managed care plans would guarantee access and high quality, not to mention improved health outcomes, for groups that by definition—being poor, old, or disabled—have more serious health risks and problems than the rest of the population.

State Programs for the Uninsured

Although it is generally assumed that the Medicaid program provides health insurance protection for the nation's poor, it does not do so completely. The percentage of all poor people covered under Medicaid dropped from a high of 65 percent in 1976 to a low of about 40 percent in 1984, then rose to 58 percent in 1993 due to recent expansions that covered more low-income people ineligible for welfare. Medicaid's inability to cover all the poor is one reason that nearly one in six Americans under the age of sixty-five lacks health coverage. Approximately four of every five persons without health insurance are in poor and near-poor families in which one or both parents are working, but are not offered or cannot afford health insurance through their workplace.

Often, it falls to state governments, along with city and county governments, to help subsidize the costs of caring for those who lack health coverage. While many of these individuals are served by public health agencies or public hospitals that provide direct care to those without health insurance, many states also administer programs to provide coverage to such people.

State "indigent care" programs comprised one type of program. Often funded and administered jointly by the state and local governments, all but ten of the fifty states had medically indigent care programs in operation on a statewide basis in 1985. Even in states without such programs, most had nonuniform county-based programs in operation that may have covered some or all of the state's population (Desonia & King, 1985). Estimates of total state and county expenditures for health care services provided under these state indigent care programs ranged from $2.5 billion to over $15 billion annually (Butler, 1988, p. 39).

State indigent care programs are extremely diverse, and little data are available on the number of people covered or served. About twenty states have general assistance medical programs, which serve as a safety net for single adults or disabled people who have little or no income and are ineligible for federally supported welfare programs such as AFDC or SSI. Another twenty-five states have indigent care programs in addition to or instead of general assistance medical programs and are often operated in conjunction with county governments. Some states operate other small programs that cover very limited target populations or specialized services, such as pharmaceuticals for the elderly.

For many years, states met their obligation to assure care for the medically indigent by subsidizing providers—primarily hospitals—for the cost of delivering care to the uninsured. However, throughout the 1980s, it became increasingly apparent to policymakers that reimbursing hospitals for uncompensated care costs would not address access to primary care or other outpatient care that might prevent inappropriate use of

hospitals by the uninsured. And no matter how much states gave to hospitals—even through Medicaid disproportionate share hospital (DSH) funds, for example—the growing numbers of uninsured people continued to overwhelm public hospitals.

State policymakers, tired of trying to fill a seemingly unending well of uncompensated care costs out of state general revenue funds, searched throughout the 1980s and early 1990s for a more broad-based financing strategy to pay for care of the uninsured. State governments experimented with a variety of insurance premium subsidy programs that targeted low-income workers and small companies, which are less likely to provide coverage to employees.

Several states, such as Hawaii, Maine, Massachusetts, Michigan, Minnesota, and Washington, established pilot programs that offered state subsidies to low- and moderate-income families to help them afford health insurance premiums. These programs typically restricted eligibility to individuals with incomes under 200 percent of federal poverty guidelines, and did not have access to an employer-sponsored group insurance plan. They also structured premium subsidies and copayments according to a sliding fee scale based on income. In addition, several offered coverage primarily through managed care systems, such as HMOs, which would be less costly. Minnesota initially limited its program to children, but later expanded it to cover low-income families as well. A few of these programs were eliminated during the economic recession of the early 1990s (e.g., Maine and Massachusetts). But most of them were continued, or even expanded, when federal funds became available through Section 1115 waiver programs (see below).

The few states that made a commitment to assure health coverage to all or most of their residents in the early 1990s found that insurance premium subsidy programs were essential to make coverage affordable for low-income individuals (Lipson, 1994). But the cost to the states was high. By the mid-1990s, more and more states turned to the federal government to help pay for the subsidies to the uninsured.

Specifically, they asked for greater leeway to stretch existing Medicaid dollars to finance coverage for the uninsured. By the middle of 1995, nearly twenty states had applied for federal Medicaid waivers under Section 1115 of the Social Security Act that permits states to conduct special demonstration programs. For the most part, they were using the Section 1115 waivers to help pay for expanded coverage to low-income uninsured with dollars saved from enrolling all previous Medicaid enrollees into managed care plans, or by using disproportionate share hospital dollars to subsidize premiums for less costly care (Holahan et al., 1995). A few states, such as Tennessee and Florida, relied on new funds like premium contributions from low-income people to generate additional federal Medicaid match funds as well.

Meanwhile, many states supported other voluntary approaches to help make health insurance more affordable to employers, particularly small firms that had trouble gaining access to the private health insurance market. For example, Oregon and Massachusetts authorized tax credits for small businesses providing health care benefits for the first time. Many states enabled the formation of health insurance purchasing alliances and multiple employer trusts to encourage small businesses to buy health coverage as a large group at lower costs.

However, states came to realize very quickly that voluntary approaches would only solve part of the problem. Officials in several states believed that more drastic measures would be necessary to provide coverage to everyone, which was not only the equitable thing to do, but necessary to end cost shifting by providers and to gain greater control of health care costs. That brought several states to consider the possibility of mandating employers and individuals to purchase health insurance.

States have been generally reluctant to consider employer mandates, not just because businesses oppose it, but because of the economic implications: firms can leave the state if faced with higher costs. A few states, notably Massachusetts, Oregon, and Washington, overcame political objections by the business community in passing laws that would have eventually either required employers to provide coverage, or pay taxes if they did not. But none of these states was able to implement the mandates for two reasons. First, to enforce such laws,

states needed federal exemption from the Employee Retirement Income Security Act (ERISA), which prohibits states from mandating employer coverage. Hawaii remains the only state that has received an ERISA exemption, which allows it to mandate that employers cover certain workers' health insurance premiums. But Congress has been unwilling to grant any further exemptions. Second, support for the employer mandates deteriorated in these states after Congress failed to enact national health care reform in 1994 and more politically conservative leaders were elected to both Congress and state legislatures that same year.

Clearly, states have a major role to play as payers of health care. While their relationships with the federal government in sharing the financial burden often have been strained, neither seems to be able to do without the other. For the most part, states have gone much further than the federal government in trying different approaches to saving costs, especially by enrolling Medicaid beneficiaries, public employees, and low-income uninsured people into managed care plans. This experience should serve the federal government well if it decides to enroll greater numbers of Medicare beneficiaries into managed care.

However, significant variations remain in state Medicaid programs, which contribute to continuing inequities in their coverage of the low-income population. Furthermore, not all states have the same capability to administer increasingly complex programs; for example, contracting, negotiating with, and monitoring managed care plans require an entirely different set of skills than those needed to pay provider claims.

Moreover, huge differences continue to exist among the states in their commitment and ability to subsidize health care for uninsured residents. While almost every state tries to assure access to emergency care, only those states with better economies and tax bases are generally willing and able to provide access to basic health care for most or all of their poor citizens. Virtually every state perceives limits on its ability to provide comprehensive health benefits to every resident because of political and economic realities that make it hard to impose taxes to support such services. One clear message from the states' efforts to expand the reach of Medicaid and other programs for low-income people is that no state can do it without the financial help and legislative sanction of the federal government.

STATE ROLES IN ASSURING THE PUBLIC'S HEALTH

One of the oldest and most fundamental roles played by states in the health arena has been seeking to protect the public's health. Originally, this meant controlling the spread of communicable disease. The role has expanded exponentially over the past several decades to include protecting the environment, workplaces, housing, food, and water; preventing injuries and promoting healthy behaviors; responding to disasters and assisting communities in recovery efforts; assuring the quality, accessibility, and accountability of medical care, and providing basic health services when otherwise unavailable; monitoring population health status and changes in the health care system; and developing policies and plans that support individual and community health improvement. The Institute of Medicine (1988) condensed these various activities into three basic functions: assessment of health status and systems; policy development; and assurance of personal, educational, and environmental health services.

In some ways, states are more similar to each other in their approaches to these basic public health functions than the other roles they play in the health arena. However, their ability to perform all of their public health protection roles has been eroded by an increasing need to provide health services directly to those who cannot obtain them in the private sector. The biggest challenge facing state public health agencies today is how they can strengthen their capacity to protect and promote the public's health, while assuring that basic health services are still available to those who cannot pay.

Among the three levels of government—federal, state, and local—states have primary responsibility for public health functions. States have the constitutional authority to make laws that provide for public health and welfare. Even so, states must carry out certain public health protection responsibilities delegated to them by the federal government, such as monitoring and

assuring that they meet environmental quality standards. At the same time, states have great incentives to encourage or require local governments to share responsibility for implementing various public health programs. They must also decide how much each locality should receive of available federal and state public health funds, based on their needs and capabilities.

Personal health services funded or provided by states, often in cooperation with local government, range from public health nursing and communicable disease control, to family planning and prenatal care, to nutritional counseling and home health services. States have long been involved in the direct provision of health care, though their role is sometimes overshadowed by local governments, which are more likely to own and operate expensive public hospitals. Many states, however, continue to operate mental institutions.

Total state health agency expenditures (excluding Medicaid) rose from $2.5 billion in 1976, to $6.8 billion in 1985, to $8.3 billion in 1988. Of all these dollars, the majority—about 75 percent—are devoted to personal health services, with an emphasis on maternal and child health services. Personal health program expenditures on services provided outside institutional settings showed the largest increase over this period. As of 1988, federal grant and contract funds contributed 36 percent of total spending (down from 56 percent in 1985) while state funds contributed 55 percent; fees and other sources made up the remaining 5 percent. Interestingly, most of the federal funds given to states for health programs come from the U.S. Department of Agriculture's Special Supplemental Food Program for Women, Infants, and Children (WIC). Local Health Departments spent another $1.6 billion in 1985, rising to $4 billion in 1988 (Public Health Foundation, 1990).

As important as these services have been to communities, state and local governments could barely keep up with the need to provide care to those who could not afford it in the private sector. The demand for services from public health agencies rose gradually during the 1980s, as more and more people lacked health insurance and had few other alternatives in the private sector to obtain free or low-cost care. By 1988, it had become increasingly clear that "many state governments [were] unwilling to provide a large amount of funding necessary for providing health care to all indigent people as well as support public health departments" (Institute of Medicine, 1988)

That the public health functions were neglected or sorely wanting, in order to provide care to those without the ability to pay, became painfully clear with the emergence of new diseases, especially AIDS, and the resurgence of "old" diseases, including typhoid, measles, and tuberculosis. The latter in particular "is a warning to public policy makers of the danger of neglecting the public health agencies and programs" (Gittler, 1994).

This does not mean that states were completely negligent. In fact, when human immunodeficiency virus (HIV) first appeared in the early 1980s, states filled an important gap left by the federal government in responding to one of the major public health crises of our age. Nearly 80 percent of the states formed an AIDS task force, commission, or other advisory group to review state policies and recommend changes to the governor or the legislature, long before the federal government organized such a commission (see Robins & Backstrom, Chapter 20).

Virtually every state government, especially those hit hardest by the epidemic (New York, California, New Jersey, Florida, and Texas), contended with a myriad of issues that the federal government largely avoided during the first several years of the epidemic (Shilts, 1987). They had to decide how to establish screening programs and whether to allow or require tests for HIV among various groups of the population; how to establish surveillance of HIV infection that protected the public's health while maintaining individuals' right to privacy; what legal actions would be necessary to reduce discrimination against persons with AIDS or HIV infection; what types of financing options could be used to pay for services needed by AIDS patients; how to provide comprehensive, coordinated medical care and support services to AIDS patients; what types of public education programs were needed; and how much to support research on the causes and treatment of AIDS (Rowe & Ryan, 1987).

There are numerous examples of states taking the initiative to address the AIDS epidemic, with the ma-

jority of them doing so in ways that helped reduce the panic and fear associated with AIDS. For example, in almost every state legislature where it was proposed, mandatory premarital testing for HIV was defeated, recognizing that this was among the least effective methods available for detection and control. Many states took explicit action to extend antidiscrimination protection to people with AIDS or HIV infection. And nearly every state established public health education programs aimed at health professionals, persons displaying high-risk behaviors, the general public, or all three groups.

As the Institute of Medicine observed, however, "public health officials at the state and local level are very much aware of their responsibility to make sure that AIDS is combated effectively. But they are hamstrung by the speed with which the problem has developed and the political heat it has generated, as well as by the difficulty of marshaling enough resources to do what they feel is needed" (1988, p. 134).

It became clear that public health was receiving an ever smaller share of the total health care spending pie. Between 1981 and 1993, total U.S. spending on health care rose by over 200 percent, while funding for public health activities dropped 25 percent. If the solution to the crumbling public health infrastructure simply involved increased funding, it might be possible to address the problem. But it was not that simple.

The deterioration of public health agencies was due only in part to insufficient funding for core public health activities. Public health agencies also had more difficulty recruiting and retaining qualified health professionals, in part due to lower salaries than those offered by the private sector. More seriously, the Institute of Medicine concluded that the public health system "is a hodgepodge of fractionated interests and programs, organizational turmoil among new agencies, and well-intended but unbalanced appropriations—without coherent direction by well-qualified professionals" (1988, p. 139). A follow-up report in 1992 found little change. In other words, to deal adequately with AIDS, tuberculosis, and other serious public health problems would take more than increased funds. It would also require stronger leadership, a more skilled public health workforce, a comprehensive data collection system, and greater coordination between public and private sectors and among levels of government.

To their credit, state policymakers have started to explore ways to address this challenging agenda. In order to breathe new life into essential public health functions, states in the 1990s started the process of cutting back on their own involvement in providing direct services to individuals. But in some cases, they did so by shifting more responsibility back to city and county governments—in effect, dumping the problem on other public agencies.

Some states signaled a more fundamental change in their approach to the problem by providing greater incentives to the private sector to care for low-income people, as discussed previously. Such actions were spurred in great part by the belief that expanded insurance coverage—perhaps even universal coverage—was on the horizon as suggested by health care reform debates occurring in 1993 and 1994. Universal coverage would make it possible for states and local governments to completely withdraw from their role as providers of direct care to the indigent and operators of public hospitals since this care would be available in the private sector.

For example, states such as Washington and Minnesota, which were among those to make significant commitments to universal coverage, also made the improvement of public health an explicit goal of state health reform. To achieve this goal, they updated or redefined the core functions of their public health agencies and allocated some additional funds to strengthen the capacity of local health agencies in performing them (Washington State Department of Health, 1994; Minnesota Department of Health, 1995).

Few other states followed their lead, however. With the defeat of national health care reform proposals in 1994 and the slowing of state health care reform efforts in 1994 and 1995, the words "universal coverage" faded quickly from public dialogue and media attention. Even in the absence of universal coverage, however, some states continued to strengthen their public health systems and redefine their roles to deemphasize direct delivery. In states where private managed care companies

found it more attractive to serve Medicaid clients than they had in the past, local Health Departments saw a decline in the amount of direct care provided to Medicaid patients. And as public hospitals realized it was in their interest to integrate inpatient with outpatient services, some local Health Departments found anxious buyers for their clinics.

The challenge before state public health agencies for the rest of this decade and into the next century becomes one of seeking such partnerships with the private sector or with local governments. The goal is not merely to decrease their role in direct care, but rather to engage private-sector and local government partners in efforts that will improve overall health status. One of the potential benefits of the emerging dominance of managed care organizations in the private health care market is their greater incentive to invest in prevention and ability to deliver population-based services, at least to their enrolled population. Indeed, some managed care organizations are becoming much more involved in activities once relegated solely to public health (*Medicine and Health*, 1995). Whether states are able to harness such ability for the good of the community at large, however, will be a much bigger test.

STATES AS REGULATORS OF THE HEALTH INDUSTRY

States are vested with broad legal authority to regulate almost every facet of the health care system. They license and regulate health care facilities and health professionals; restrict the content, marketing, and price of health insurance (including professional liability or malpractice insurance); set and enforce environmental quality standards; and enact a variety of controls on health care costs.

During the 1980s and early 1990s, states pursued two very different paths in the regulatory arena. For some industries or sectors, many states decided to eliminate or significantly reduce regulations in favor of allowing private market forces to achieve public policy objectives, such as cost control. But for other health care entities, most states strengthened regulations and gave state agencies more power to set rules for private market behaviors. What were the motivations that drove these opposite trends, and what have been the results of states' actions so far?

Traditionally, states have focused much of their regulatory attention on health facility construction or expansion and equipment purchases. As a result of federal legislation passed in 1975 (the National Health Planning and Resources Development Act), states were mandated to establish state health planning and development agencies. Their purpose was to review and approve certificates-of-need (CONs) for new hospital and health facility construction, a condition required for Medicare reimbursement by the federal government.

When the Reagan administration reduced and later eliminated the health planning program in the mid-1980s, several states began to weaken or abolish their CON programs. In 1983, New Mexico and Idaho were the first two states to repeal their CON statutes. In the following two years, another four states allowed their CON programs to sunset.

Another traditional focus for state regulatory oversight of the health care industry was hospital costs. In 1981, nine states had mandatory hospital rate-setting programs and another eight asked hospitals to comply with voluntary budget reviews (Esposito et al., 1982). Among these states was New Jersey, which since 1976 had been involved in an experiment funded by the federal Health Care Financing Administration to develop a hospital prospective rate-setting system based on a patient's diagnosis. The case-mix system, using a set of diagnosis-related groups (DRGs), was adopted in 1980, and was used to set the rates paid by all payers, including Medicare, Medicaid, and all commercial and nonprofit insurance plans in the state. This prospective payment, DRG-based rate-setting system was later adopted by the federal government to replace the former cost-based reimbursement system used to pay hospitals in the Medicare program.

But toward the end of the 1980s and the early 1990s, states swung back in the other direction. By 1995, only one state (Maryland) controlled the rates that all public and private payers could pay hospitals. One other state, New York, still had hospital rate setting in place for all commercial insurers, Blue Cross and Blue Shield,

HMOs, and Medicaid. The rest eliminated their hospital rate-setting programs, or made hospital budget review completely voluntary, and in 1995 New York seriously considered a major overhaul of its prospective hospital reimbursement methodology.

What drove these deregulation trends? The usual explanation is that states wanted to allow economic forces of supply and demand to reassert themselves. The antiregulatory, procompetition forces convinced a majority of legislators that excess supply would lead suppliers to drop their prices, according to basic economic principles. By getting states out of the business of price setting, buyers would be free to bargain with health providers to get lower prices.

The actual behavior of state policymakers indicates that in their role as purchasers of health services, they still preferred to protect their own financial interests by setting their own terms and prices. For example, while more states joined the CON deregulation bandwagon—twelve states repealed their programs after the federal government ended national health planning—the program hardly faded away. Efforts to repeal CON programs failed in several states. Furthermore, even states that deregulated the CON process still required some state review of newly constructed facilities, particularly nursing homes.

State officials understood that to permit unfettered construction of new nursing homes would strain their Medicaid long-term care budgets, since that program covers about half of all nursing home bills. The more beds built, the more would be filled and the more elderly and disabled people would eventually deplete their resources and come to rely on Medicaid. When it came to their own economic interests, states recognized great value in limiting health facility construction.

In a similar fashion, while states may have eschewed setting hospital rates for private payers, they were anxious to do so for their Medicaid programs. Between 1985 and 1995, nearly every state switched from a cost-based reimbursement system to pay hospitals to a Medicare-like DRG system in which states set the rates in advance. Granted, hospitals were allowed to keep any excess revenues if they could provide care at a cost less than the DRG rate for a given condition. But states also set limits on the profits that hospitals could make from Medicaid payments, and in most states, that amount is little to none. This suggests that state policymakers were far more comfortable letting private purchasers and payers fend for themselves in the market, than they were in trusting market forces to work in their own favor.

Nor did states give the market every opportunity to work by getting out of the way of competitive forces or loosening regulatory restrictions on the industry. This is best exemplified by reforms in the small group health insurance market. In the early 1990s, state policymakers came to recognize that those least able to secure affordable health insurance in the private market were small companies, generally those with fewer than fifty or so employees. Such companies are more subject to medical underwriting, which involves an assessment of employees' health status and their risk of needing health care. Because insurers based their premium rates on the health care experience of the group, rather than on community-wide rates, employers with older workers and those with even one worker who had a disabled child faced much higher premium rates. Some could not get insurance at any price. Small firms also lacked the leverage to bargain for better rates that larger companies with many more "covered lives" could obtain.

To level the playing field for small firms, all but five states had adopted what were collectively known as "small group insurance reforms" by the end of 1994 (Chollet & Paul, 1994). These included some of the following: (1) requiring all insurers that sell to small groups to guarantee issue of coverage, regardless of the groups' health risks, claims experience, and so on; (2) setting limits on the criteria that insurers could use to adjust rates, often restricted to age, geographic location, and family size; (3) setting bands around which rates could not vary (e.g., within 25% of the average premium for each class of individual or group); (4) allowing benefit packages sold to small groups to exclude some services that would otherwise be required; and (5) limiting preexisting condition exclusion periods to a certain amount of time, generally no more than six months to a year, and waiving such exclusions for people that formerly had coverage within the prior few months (referred to as portability). At least a dozen

states also authorized the establishment of purchasing alliances for small groups to increase their ability to bargain for better rates as a larger group.

The combination of these restrictions on insurers and the number of states adopting them would suggest a veritable conversion to the regulatory gospel. Yet it is clear from the legislative history of these reforms that their primary purpose was not to regulate per se, but to increase the availability and affordability of health insurance for those who wanted it. The laws did not coerce small firms to buy coverage since the decision to purchase health insurance remained voluntary. And compared to other strategies that might increase coverage, such as direct subsidies, the insurance reforms were certainly less onerous to state budgets.

What effect have the insurance reforms had so far? While few studies have carefully examined their combined or separate effects, early experience of the small group insurance reforms suggests that they have very little net effect on how many people are insured (Morrisey & Jensen, 1994). However, community rating of the small group market appeared to have the greatest impact on the market, by forcing insurers to compete on the basis of their ability to manage costs, rather than through risk selection (Chollet & Paul, 1994). With respect to health insurance purchasing cooperatives for small business, the early experience is only a bit more positive. Those that have the ability to negotiate with carriers (not all do) appear to have a better chance of holding down the rise in health care premiums (U.S. General Accounting Office, 1994; Lipson & De Sa, 1995).

The fundamental puzzle remains: How does one reconcile the seeming contradiction between state actions that are promarket and procompetitive with those that are clearly regulatory? Many analysts characterize the past several years as a period in which the pendulum has swung back in favor of market-oriented approaches to health care cost control. Yet state actions indicate an equally, if not stronger, trend to reassert greater control over the health industry.

The explanation lies somewhere in state policymakers' genuine attempts to find the right balance between market forces and government regulation that will most effectively hold down health care cost increases while assuring consumers' (voters') rights are protected. It is often a difficult balancing point, but one for which some states continually search.

Minnesota may be the best example of a state that continues to refine its market-oriented approach to health care cost control and its government intervention in the market to afford equal access and coverage for its citizens. Over the past twelve to fifteen years, the state sometimes swung more in one direction or the other. But for the most part, it has also striven to find the right amount and type of government attempts to structure the health care market.

For example, the state repealed its CON program in 1984, in line with its preference for using market forces to improve the efficiency of health care services and reduce health care costs. However, in recognition of its position as having one of the highest rates of nursing home beds per capita of any state, Minnesota slapped an indefinite moratorium on nursing home construction—one that continues ten years later. While the state still has among the highest ratios of nursing home beds to population in the country, at least it has not become any worse. Minnesota was also among the leading states in fostering the development and growth of new health care plans—HMOs, PPOs, and other hybrid managed care plans. It did so both by restructuring the state employee benefits program to restrict workers' choices to managed care plans, and later, by codifying into law the types of organizations they would require all health care entities to become. Called integrated service networks, or ISNs, these were regarded by some as "next-generation HMOs," defined as publicly accountable, risk-bearing, integrated financing and delivery systems. At the same time, the state established several requirements for HMOs to assure that the plans would in fact be accountable to consumers. For example, HMOs must be non-for-profit (with minimum and maximum capital reserve limits), and they must collaborate with public health agencies to develop plans that will improve population health.

The health care regulatory changes in Minnesota over the past decade demonstrate the state's strong interest in promoting marketplace solutions with an equally strong willingness to step in to protect consumers. Its example sets a good one for other states

struggling to find such a balance. But their exact actions are not necessarily ones that should be duplicated in every state. Health care markets are still essentially local. That is, the unique combination of provider supply, insurer types and market shares, purchaser sophistication in bargaining, and the ability of providers to guarantee care for the uninsured varies tremendously from state to state and from community to community.

Thus, the goal for each state is to determine how much leeway and how much protection to afford the players in each sector to make competition work and to make it work fairly in their state or local markets. One of the more difficult issues facing states in this arena concerns the appropriate type of regulation, if any, for one of the newest forms of managed care entities: physician/hospital organizations (PHOs). These organizations are alliances between hospital(s) and a group of physicians that join together for purposes of negotiating contracts with purchasers to provide health care services. In many cases, PHOs contract directly with insurance companies and HMOs. But in some instances, they are seeking to directly contract with employers; in the process the PHOs take on a level of financial risk that presents insurance regulators with some concerns.

State insurance regulators have just begun to formulate the questions that must be asked, even before they decide how to regulate these new organizations, if at all (Blankenau, 1994). For example, should PHOs be regulated as insurance plans if they assume financial risk? Does the answer depend on the degree of financial risk assumed? Or, is the relevant issue with whom the PHO contracts and whether state regulators can oversee their financial status? As a sign of their concern with promoting competition and delivery innovations that contain costs, state officials' biggest concern is how to regulate the financial risk borne by PHOs without thwarting the development of integrated delivery systems that are better able to control health care costs (Bureau of National Affairs, 1994).

States have an even more challenging task in determining whether those providers who cannot compete, or those the market will not include, will still be given a seat at the table. For example, what will happen if insurers regard academic health centers, public hospitals, and community health centers as too expensive to include in their provider networks? Will independent physicians, who wish to remain independent from large insurer or provider systems, be assured the right of contracting with all groups? Or will health plans be reserved the right to pick and choose the most cost-efficient providers, even if that means leaving out some that are the major providers of care to people in certain communities? As managed care continues to enroll an ever greater proportion of the population, these are questions that states will confront more frequently in the years ahead.

STATES AS LEADERS IN COMPREHENSIVE HEALTH REFORM

In 1993 and 1994, the nation debated proposals that would have changed its health care system in dramatic and fundamental ways. President Clinton was elected to office in part because of a campaign platform that emphasized the need for "health care that could never be taken away." In the aftermath of the defeat of his proposed Health Security Act, many commentators believed that the focus of the debate would shift to the states.

Perhaps a more accurate description of the direction of that focus, however, would have been a *returning* to the states. As this review of states' involvement in health care issues has shown, states have always been active in financing and regulating the health care system, and in seeking to promote or protect public health. But what often got lost in the glare of the spotlight on the national health care reform debate of 1993 and 1994 was that states were already undertaking comprehensive reforms of their own.

As already noted, several states have made important strides in expanding coverage to low-income uninsured groups through subsidy programs, Medicaid expansions, and insurance reforms. Many states have implemented effective cost-containment programs, such as hospital rate setting and setting limits on insurance premium increases. In the area of delivery system reforms, several states have enacted laws that actively encourage health care providers to form integrated systems that can achieve greater efficiencies and provide more coordinated patient care.

Moreover, a handful of states have even put together reforms addressing the triad of problems plaguing the health system—high costs, uneven access, and uncertain quality—in an integrated, cohesive fashion. Two states in particular—Oregon and Minnesota—stand out for their bold efforts to bring more rationality and equity to their health care systems.

The Oregon Health Plan

Oregon began its health care reform odyssey in 1989 with the passage of the Oregon Health Plan, an innovative program that would provide coverage to all individuals with incomes below the poverty line but limit covered benefits to those that had been proven cost-effective. The state's explicit attempt to ration services gained it much notoriety. According to the plan, if state funds were insufficient to cover all services to all poor individuals, services that fell lower on the "priority list" would be cut, rather than individuals or provider payments. While taking a step toward more rational allocation of resources, the plan remained vulnerable to charges of discrimination since the priority list has been limited to the poor.

Oregon coupled this plan with a mandate for employers to cover all qualified workers, tax incentives to encourage employers to provide coverage before the mandate would take effect, and concerted efforts to enroll Medicaid beneficiaries into managed care plans. The state was unable to get a federal ERISA exemption to implement its employer mandate, due to congressional resistance to tampering with large employers' benefit plans that are protected by ERISA. But because it obtained federal approval of its Section 1115 waiver application, over 125,000 individuals have been enrolled in the Oregon Health Plan thus far.

MinnesotaCare and Other Initiatives

Minnesota is also notable for its comprehensive approach to reform as well as its attempts to build on the successes of the private market in holding down costs in the larger health care system (U.S. Congress, Office of Technology Assessment, 1994). It folded its Children's Health Plan into a larger subsidy program, called MinnesotaCare, which has covered over 85,000 people. Although the state's uninsured rate remained fairly constant between 1992 and 1994, state officials believe the rate would have been higher if the program had not offset losses in private employer-sponsored coverage. The uninsured rate may even start to decline in the future when the state begins to implement its Medicaid 1115 waiver that will bring in more federal dollars to help finance coverage to even more uninsured people.

On the cost-containment side, Minnesota has sought to encourage more rapid formation of integrated service networks, which are systems that can accept capitated payments to deliver a comprehensive array of services. Although a law adopted in 1993 allows the state to limit annual increases in premium rates to these networks, the state has not needed to do so as cost increases have remained below the state-determined level. While intended as a backup mechanism, the state legislature nonetheless decided in 1995 to repeal this provision due to antiregulatory sentiment in the legislature.

To improve access and promote public health, the state adopted a set of reforms designed to increase the numbers of primary care physicians graduating from the state medical school, encourage the formation of rural health networks to make care more accessible in underserved areas, and ensure that managed care plans and public health agencies work together on projects that will improve overall population health.

It is still too early to evaluate the combined effects of these strategies on overall costs, insurance coverage levels, quality of care, and health outcomes in Oregon and Minnesota compared to those in other states. But these states give credence to the notion that in contrast to the national level, state-level political processes can produce consensus on a strategy that makes more than incremental change. This is not to say that states in general are better than the federal government at overcoming "craven politics, bureaucratic domination, or capture by special interests" (Brown, 1994). Nor does this mean that any state's approach should serve as *the* model for the nation; the country is simply too diverse to expect one model to serve the needs of every state.

Instead, the value of such attempts at comprehensive reform lies in the practical and political lessons they can offer to other states and to the federal government, even

before the final results are known. For example, according to Governor Howard Dean of Vermont, the key lesson from Oregon is that the public will support limitations in coverage, as long as they "see a perceptible improvement in service alongside the financial constraints" (Neville, 1995). Minnesota showed that, at least for four years, provider taxes were regarded as politically acceptable sources of financing for covering the uninsured. Moreover, efforts by state employee benefit programs to structure premium contributions and negotiate with managed care plans could serve as useful models for the federal Medicare program. Many state employee health benefit plans aggressively negotiate with contracting health plans, limit the number of plans that can participate to encourage competition, and require strong cost management techniques for those plans that win the contracts (National Institute for Health Care Management, 1995).

In the end, the most important lesson that states can teach through their attempts at comprehensive reform is that they cannot solve the financing problem alone, although they may be the most appropriate level of government for dealing with local delivery system problems. As Lawrence Brown concluded, "financing, coverage and entitlement issues require central government rules that are clear and firm and that admit exceptions that are few, marginal and well-justified. Delivery system and, perhaps, cost containment mechanisms demand the reverse: a federal framework of 'rules' that are fairly broad and flexible and that permit localities to improvise arrangements—within national limits to be sure—that make sense for them" (Brown, 1994, p. 14).

STATE ROLES IN HEALTH CARE IN THE FUTURE

The end of the twentieth century presents a mixed picture for states. The economic recovery of 1994 and 1995 brightened prospects for state revenue projections. States' reserves—an important indicator of fiscal health—were at their highest levels in fifteen years. But state budgets may be in for a battering.

The 1994 election that gave Republicans control of both houses of Congress resulted in a set of proposals that are likely to reduce the federal flow of funds to states in all areas, but especially in health care services. Congressional bills under consideration in 1995 proposed to turn over even greater authority for health care programs to the states through transforming two entitlement programs—Medicaid and Aid to Families with Dependent Children (AFDC)—into block grants. These proposals represented a significant departure from previous policy by ending the entitlement nature of these programs. States would also receive less federal funding than they did before because the bills proposed to limit the annual growth in spending on these programs, regardless of the number of people in need. One study found that even if states successfully controlled costs in their Medicaid program through provider payment reductions, elimination of optional benefits, and greater use of managed care, some states would still have to reduce the number of eligible people to live within the caps proposed (4 percent growth rate annually, compared to 10 percent that is projected between 1996 and 2000; see Kaiser Commission on the Future of Medicaid, 1995c).

How might states respond to cuts in federal funding on this order of magnitude? The answer depends on several factors. The first is how much flexibility the federal government grants them. Another set of factors involves differences among the states themselves—their administrative and management capabilities, their capacity to absorb the cuts, and their willingness to raise additional funds for health and social services. Wide variations in the latter set of factors suggest that the effects of federal budget cuts will play out in the states in very different ways.

While the intent of block grants is to give states more freedom, it remains uncertain just how much control the federal government is willing to give up. The history of the 1981 block grants showed that "over time constraints were added which had the effect of 'recategorizing' them. These constraints often took the forms of set-asides, requiring a minimum portion of funds be used for a specific purpose, and cost ceilings, specifying the maximum portion of funds that could be used for other purposes" (U.S. General Accounting Office, 1995). If they have fewer resources with greater responsibilities and only a small increase in flexibility, states will face the worst of all possible scenarios. It

would make it almost impossible for them to carry out long-standing responsibilities for overseeing the health care system and take on some of the new roles that are evolving from changes in the private health marketplace or in response to new public health problems. For example, if Medicaid funding is cut and eligibility is tightened, more people will be without health insurance. In turn, this will make it necessary for state and local public Health Departments to increase their resources devoted to direct patient care at the expense of critical public health activities needed to protect the general population.

With greater flexibility, states may be able to shield current Medicaid eligibles from being cut. Some believe that with increased flexibility to shift funds between programs and blend funds from different sources, efficiencies could be produced that will stretch dollars farther than they went before (National Health Policy Forum, 1995). Others believe that decisions about which programs to cut, how much to cut, and how the cuts should be targeted are likely to depend more on political choices. They argue that in the case of Medicaid program cuts, nursing home lobbyists will always win the day over advocates for poor children (National Health Policy Forum, 1995).

In terms of state administrative capacity, it appears that states have improved markedly over the past twenty years. Based on the growing number of staff in state legislatures, organizational restructuring of the executive branches, improved fiscal management practices, and other factors, "states have actually strengthened both their structures and functions and their finances to the point where they are quite capable of assuming full partnership in the federal system. Indeed, by almost every measure, states have improved their ability to govern, provide services, and meet the current and anticipated future needs of their constituents" (U.S. Advisory Committee on Intergovernmental Relations, 1980). Another report on the subject five years later found state governments to be "more representative, more responsive, more activist and more professional in their operations than they ever have been" (U.S. Advisory Committee on Intergovernmental Relations, 1985).

Other analysts have taken a less sanguine view of the report, arguing that there is not necessarily a direct relationship between large legislative staffs and enhanced effectiveness in governing (Thompson, 1986). Ten years after those reports were written, there remain large discrepancies among the states with respect to number and skill of legislative, policy analysis, and program management capability. New York and California, for instance, have much greater management capacity and legislative support staff than North Dakota and Alaska. So, some states will be better equipped to manage their own health and welfare programs, should Congress give them the flexibility to do so. Still, the scope of the changes and extraordinary increase in the states' responsibilities proposed by Congress suggest that every state will face significant administrative and technical challenges in designing and managing their own programs.

Each state's response to the massive turnover of responsibilities from the federal government will also depend on their capacity to absorb reductions in federal funds. If spending growth caps do not account adequately for variations in each state's demographic profile, for example, states with greater proportions of higher-cost elderly and disabled residents will be more hard-pressed than those with higher proportions of lower-cost children. States with fast-growing populations of poor and low-income residents will fare worse than those with steady or declining numbers of people in poverty.

Finally, one of the most important determinants of how each state reacts to federal funding cuts will be their fiscal systems and willingness to modify their tax structures to make up for lost federal dollars. Almost half the states have a limitation on the growth of state spending or revenue, usually tied to the increase in personal income (Gold, 1990). These measures could cause serious problems since none of them make an allowance for relaxing the limits when the federal government imposes new responsibilities on states or cuts in funding.

In addition, because most states rely heavily on personal/corporate income taxes and sales taxes, a recession could cause serious fiscal problems in nearly all states since economic downturns reduce the amounts raised

from these sources. Without any guaranteed financial assistance from the federal government, a recession could cause large revenue shortfalls in those states affected. Because all states but one have constitutional requirements to balance their budgets, a revenue shortfall dictates that states either cut spending or increase taxes. Given taxpayer resistance to tax increases, the latter is not likely unless there is a perceived fiscal emergency. The size of the federal funding cuts and their impact on each state will determine whether and in what circumstances such emergencies are serious enough to warrant such an action.

Some states that eschew tax raises may instead take the opportunity to restructure their tax systems to bring in revenue that escapes current tax mechanisms. For example, during the recession of the early 1990s, a dozen states enacted changes in their income tax codes to make them more progressive; others broadened their sales tax base to capture growth in the service sector (Lemov, 1992). These strategies could be used by other states to compensate for federal funding cuts.

The outcome of this experiment in public policy and in federalism cannot be predicted with any certainty. As this chapter amply demonstrates, some states will rise to the challenges ahead while others will perform poorly. If the past can be regarded as prologue, states will continue to display wide variation in the manner they carry out both traditional health policy roles as well as new ones demanded by a changing health care system. It also indicates that if states bear even greater responsibility for Medicaid policy with fewer federal restrictions, the differences among states in both eligibility levels and range of services will likely grow even more extreme.

Conclusion

After fifteen years of experience with a shift in the locus of control to the states, it is important to ask whether the variation that inevitably results from a lack of federal standards leads to an unacceptable degree of inequity among citizens of different states. There will always be states that are slow to act in the face of crises, or unwilling to address glaring inequities in the health care system. These are the states that are often held up as reasons for greater national involvement in health care issues of the day. And it is not always the "slow" or "unwilling" states that highlight the need for federal involvement in health policy. Sometimes the most innovative states illustrate the need for federal action by demonstrating the obstacles that federal law puts in the way of state efforts to make progress and the need for Congress to remove those constraints.

Occasionally, state government representatives argue that they would be happy to let the federal government take over any number of health programs, as long as states would not have to be financially obligated to help pay for them. But if the federal government expects states to help pay the bills, they argue, then state flexibility is essential due to variations in state economies and tax policies.

For now, this is the argument that seems to have won the day. In the immediate future, states are likely to continue to play a critical role in health policymaking, because the federal government is trying to reduce its responsibilities and would like the states to maintain their existing financial contributions to health services and long-term care. As long as the states' portion of the health care expenditures remains as high as it is, they will continue to retain substantial power in any national debate on health care issues.

Regardless of how much of the bill they pay, states are not likely to give up any of their other roles—as protectors and promoters of the public health and as regulators of the health industry. With the pendulum of federalism still swinging away from strong federal government control, states are likely to be first in line for taking on any new roles that the public decides are appropriate for government.

For now, the consensus appears to be that states have proven their ability to manage complex programs, successfully maneuver their way in and out of regulatory relationships with the private sector, and develop innovative strategies to deal with health care problems more quickly than the federal government in ways that respond to the unique set of political and economic factors and conditions in each state. As one review of the states' assumption of new roles during the 1980s concluded, "At its best, a renewed federalism—in which

the states play a more active policy-making role than the national government—can produce innovative solutions to vexing problems, allowing states to test these remedies on a small scale, discarding what doesn't work and building on what does" (Hamilton, 1988).

Whether this remains the case, however, will hinge on how states meet the challenges of the next decade. If they do well in the eyes of the public, the scale of federalism that tilted in their favor in the 1980s and 1990s will continue on into the next century. Their failure is likely to see the pendulum swing back to a stronger federal role.

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