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Great Expectations: The Limits Of State Health Care Reform

by Michael S. Sparer

With the defeat of the various national health insurance proposals in 1993-1994, liberal reformers look increasingly to the states as the source of health policy innovation. After all, several states are now implementing major reform initiatives. Minnesota, for example, provides state-subsidized insurance to families with incomes below 275 percent of poverty and to individuals with incomes below 100 percent of poverty. Tennessee provides a choice of state-subsidized managed care plans to nearly 1.5 million low-income persons, one-third of whom were previously uninsured. Hawaii requires most employers to provide health insurance to their workers. Reformers hope that these states will be models emulated elsewhere.

At the same time, many in the new Republican majority in Congress, joined by several governors, argue that states should be given increased authority to run health and welfare programs. Republican legislation, for example, would turn Medicaid, the federal/state health insurance program for the poor, into a block grant. One goal of this legislation is to reduce federal spending. Supporters also suggest that a block grant, with few federal strings, would enable state policymakers to innovate and contain costs in ways that are now impossible. This increased authority is the main draw for the nation's governors.

There is thus an unlikely alliance between liberal reformers and conservative cost cutters: Both look to the states as a source of innovation and leadership. The likelihood, however, is that no state will respond to the new era with either comprehensive insurance expansions or innovative cost containment measures. Instead, most states will tinker with incremental initiatives. Nearly all will cut Medicaid eligibility and encourage (or require) the remaining beneficiaries to enroll in managed care. Many will enact small-group insurance reforms. Some will subsidize private health insurance for a small minority of the uninsured, primarily women and children. Others will experiment with purchasing pools for state employees.

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Still others will reorganize programs and bureaucracies in an effort to increase efficiency. A few will do as little as possible. The variation and inequities inherent in the current system will continue and worsen.

Disappointing the Liberals

State-based reforms are a poor substitute for the national health insurance program that liberals have long fought for. It is highly unlikely, for example, that any state will enact universal coverage anytime soon. It is more likely that states that are health reform leaders will reduce their commitments to reform. This is happening already. Washington State 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 insurance by 1997, substituting a goal of 96 percent coverage. Colorado gave up on its comprehensive insurance proposal (ColoradoCare) and adopted instead small-group insurance reforms (which, although helpful to some, will not make a dent in the problem of the uninsured).

Obstacles. The first and most obvious problem is money: Finding new dollars for reform, at either the state or the federal level, is difficult indeed. For example, state policymakers are no more likely than their federal counterparts to seek tax increases, and financing significant reform without new taxes is hard to imagine. To be sure, moving Medicaid clients into managed care may save some dollars, and a few states (including Oregon and Tennessee) claim that the savings are sufficient to finance expansions of public insurance. Nevertheless, the savings generated by Medicaid managed care are not likely to be large (for reasons discussed below), and the incentive to use those savings to reduce budget deficits is quite strong.

State innovation also is limited by the fear of a business exodus and of becoming a welfare magnet. States are in an ongoing interstate competition for business, and state officials worry that if they alone adopt comprehensive reform, then some employers will migrate out while some uninsured persons migrate in.

A third obstacle is a series of federal laws that explicitly limit state reform activities. The Employee Retirement Income Security Act (ERISA), for example, prohibits states from requiring employers to provide health insurance to their employees. It also prohibits states from regulating or taxing companies that self-insure. Since nearly 70 percent of all employees work for companies that self-insure, ERISA is a powerful barrier to nearly every state reform initiative. Moreover, despite the rhetoric about the need for state experimentation, Congress seems unwilling to exempt states from the restrictions of ERISA: Business and labor, which both benefit from the law,
lobby vigorously against any waiver applications. Even Hawaii, which in 1983 received the nation’s only ERISA exemption, has been regularly rebuffed in its effort to amend its waiver.  

Finally, state legislators in 1995-1996 are even less likely to overcome the interest-group, institutional, and ideological opposition to universal health insurance than their federal counterparts were in 1994. Not only has the Republican revolution taken hold in many statehouses, but the changing medical marketplace makes government action less likely as well. 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.

State reform advocates might respond to this gloomy presentation with three arguments. First, some states delayed reform activity because of an expectation of federal action. With federal expansions now unlikely, state reforms become more likely. Second, Congress could change those federal laws that hamstring the states. ERISA waivers, while unlikely, are possible. Third, state-initiated expansions, although difficult, are still far more likely than substantive federal activity and should be encouraged.

It is impossible to predict, of course, how much flexibility Congress eventually will give the states. It also is too early to evaluate the success (or failure) of the fledgling reform activities now under way in a handful of states. Perhaps there will be unexpected successes. There are, however, other drawbacks to a state-dominated health care system: the inappropriate interstate variation and the intergovernmental tension that inevitably accompany such systems. Medicaid provides a good example.

Medicaid’s fate. Medicaid has, to be sure, benefited millions of people. The thirty-two million Medicaid beneficiaries have a health insurance card that entitles them to a relatively wide array of services. In some states the Medicaid benefit package compares favorably with those of typical private policies. Although Medicaid clients often have difficulty finding doctors who will treat them, poor persons with Medicaid coverage still see physicians more often than do poor persons without Medicaid coverage.

At the same time, however, Medicaid also has disappointed those who expected (or hoped) that the program would provide poor people with health care equal to that of the nonpoor. Nearly half of the nation’s poor citizens are not even eligible for coverage. Equally troubling, most Medicaid beneficiaries have long encountered a health care system that is disinclined to care for poor people, even if a poor person has a Medicaid card. As a result, millions of Medicaid enrollees have neither their own physician nor ready access to a private physician’s practice. For these clients, particularly those in urban areas, medical care is received most often in the emergency
rooms of large public hospitals.

Medicaid’s failings stem from a range of factors, including low physician reimbursement rates, unfriendly administrative bureaucracies, and an undeserved reputation as a health care program only for welfare recipients. Each of these problems is exacerbated by a complicated (and convoluted) administrative structure, under which state officials have significant discretion in deciding who in their state receives coverage, what medical benefits are provided, and how much health care providers are paid.

Why has the delegation of authority proved to be troublesome? One explanation is that it has produced inappropriate and inequitable variation in state Medicaid programs, even between programs in states with similar socioeconomic conditions and a similar commitment to social welfare; and ongoing intergovernmental tension, as federal, state, and even local officials each try to shift costs and responsibilities to the others.6

Consider, for example, the interstate variation in the nation’s Medicaid program. In California a family of three with monthly income below $934 can receive coverage, while a similar family in Alabama needs income below $149 to qualify. Similarly, a three-person family in Vermont needs income below $900 to qualify, while their neighbors in Maine can have no more than $458. Other border states have similar variation.7 In Pennsylvania a hospital that treats a Medicaid client receives in reimbursement approximately 79 percent of the cost of care. In New Jersey, however, a similarly situated hospital receives from Medicaid 105 percent of the cost of care.8 In twenty-eight states Medicaid pays for chiropractic services; six states cover hospice care. In no two states, however, do clients receive the same medical benefit package.

Most telling, however, overall Medicaid expenditures vary dramatically, even between states that seem similarly situated. In 1993, for example, California’s program spent $13.5 billion on about 5.2 million beneficiaries (or $2,801 per beneficiary), while New York’s program spent $20 billion on only 2.4 million eligibles (or $7,286 per eligible). Otherwise put, New York’s program spent $6.5 billion more on 2.8 million fewer clients. That same year New Hampshire spent $5,264 per beneficiary, compared with $3,171 in Vermont, and Arkansas spent $3,038, compared with $2,372 in Mississippi.9

Dis appointing The Conservatives

Conservatives offer two arguments in favor of returning policy-making authority to the states. First, most conservatives are ideologically opposed to a large centralized government. These critics look with dismay at the growth of the federal agenda since the New Deal and propose to dismantle
(or at least reduce) the federal role. Second, conservatives also believe that state officials are better equipped to develop practical solutions to difficult problems than are their counterparts in Washington. For that reason, several governors argue that states could do a good job of controlling Medicaid costs if only the program were turned into a block grant. The governors even suggest that states would accept a reduced federal contribution in exchange for the increased flexibility.

There are many in Congress, of course, who are attracted to block grants primarily as a way to reduce the federal budget deficit. Federal spending under block grants is capped and controlled, which is not the case with the entitlement programs they would replace (such as Medicaid and Aid to Families with Dependent Children, or AFDC). To the extent that conservatives also expect states to truly control health care costs, however, they will be as disappointed as their liberal counterparts.

For the past few years, for example, state officials have argued that encouraging (or requiring) Medicaid beneficiaries to enroll in managed care would significantly reduce Medicaid costs. The argument is illustrated by the following hypothetical example. In 1994 state X spent $100 on an average Medicaid client. In 1995 the state pays participating health plans $95 to provide enrollees with a comprehensive set of medical benefits. State officials claim $5 in savings. Officials also hope that health plans effectively manage beneficiary care, thereby reducing total health costs and thereby enabling the state to pay even less money next year.

Managed care as cost containment only works, however, if the Medicaid program would have spent more on the beneficiary in the old fee-for-service world than they are paying the health plan. If a health maintenance organization (HMO) enrolls a low-cost, low-risk client, who would have cost the state only $80 in a fee-for-service world, then the state has actually lost $15. This problem is accentuated by plans that market to low-cost clients but then negotiate high-cost reimbursement from states that are eager to encourage plan participation.

The problem of adverse selection is reduced (but hardly eliminated) if managed care becomes mandatory (as it is in more and more states). The problem would be further reduced if the technology of risk adjustment were further advanced. But cost containment in Medicaid managed care is limited by other factors as well. First, well-run managed care plans spend time and money trying to alter beneficiaries’ patterns of health care use. They hire new staff (from social workers to interpreters), provide additional services (from transportation services to special prenatal care programs), and then seek additional reimbursement from the state for these start-up costs. The payoff, however, which is a reduction in high-cost emergency room and inpatient utilization, often takes years to achieve. Second, states
incur start-up costs as they reorganize Medicaid bureaucracies and retrain workers: The administrative tasks involved in regulating managed care systems (from reviewing marketing materials to setting capitation rates to overseeing quality of care) differ greatly from fee-for-service administration.

Third, the managed care initiatives to date usually enroll only mothers and their young children. This is the least costly Medicaid population, however, comprising approximately 70 percent of Medicaid beneficiaries but spending only 30 percent of Medicaid dollars. To be sure, some states are experimenting with managed care for the aged, disabled, and other clients with special needs (such as the mentally ill, substance abusers, or the chronically ill). Moreover, some managed care programs for the aged population work particularly well. Nonetheless, states’ efforts to implement managed care for the aged, disabled, and special-needs populations are sporadic at best, and it will take time to develop and implement good programs on a large scale. Fourth, managed care cost containment will vary by state. Significant savings are more likely in states with high fee-for-service Medicaid expenditure patterns. In New York, for example, managed care organizations often produce significant profits even when paid only 80-85 percent of the average fee-for-service rates. Savings are less likely, however, in states such as California and Minnesota, which already have relatively low fee-for-service Medicaid programs. In short, managed care may (or may not) be a good policy idea, but it is not a wonder pill that will magically save billions of Medicaid dollars.

State officials might counter this pessimism by noting that making Medicaid into a block grant would enable them to cut Medicaid eligibility (in ways not permitted by current federal law) and cut provider reimbursement as well. After all, the Medicaid rolls have expanded largely because Congress required the states to expand coverage for pregnant women and young children. Similarly, federal law today makes it difficult for states to cut payments to hospitals and nursing homes. These are fair points. Indeed, given the reduced federal Medicaid contribution, states will have little choice but to cut eligibility, benefits, and reimbursement. But Medicaid costs will be reduced not because states develop a new and innovative cost containment approach, but instead because of political will (in this case, the federal government’s determination to slash its Medicaid spending).

The bottom line is that the federal government, and not the states, is imposing the Medicaid cost containment about to ensue (just as the private market is now imposing some restraint in the private sector). Despite all of the rhetoric to the contrary, national health care policy is again about to be imposed on the states, and the states will be forced to react. States could, of course, develop their own version of political will and implement a far-reaching cost containment initiative. One idea is to pool
the purchasing power of all publicly funded health insurance (including Medicaid, public employees’ coverage, workers’ compensation, and, with federal permission, Medicare). Another approach is to change Medicaid coverage for nursing home care to encourage greater use of private long-term care insurance.14 States also could impose a statewide health care global budget. However, no state is likely to impose these or similar ideas. Even Minnesota, which seemed to be moving toward a global budget, is retreating. In the end, health care cost containment (like health care insurance expansion) is too tough an issue for the states to handle alone.

Providing A Context: The Evolution Of Health Care Federalism

For more than 200 years policymakers and policy analysts have struggled to determine an appropriate division of labor between the states and the federal government. During the Revolutionary War, for example, the movement to strengthen the national government met vigorous resistance. Why fight the British if victory would simply transfer power to another distant monarch? Instead, in 1781 the colonies enacted the Articles of Confederation, a “firm league of friendship” among the thirteen colonies. There would be no president, a weak Congress (with members chosen by state legislatures), and a limited national agenda.

Even after the war ended, in 1783, the American settlers initially were uninterested in a strengthened national government. It took several years (1787) before the Constitutional Convention was held in Philadelphia. And while some of the Founding Fathers (notably Alexander Hamilton) hoped to create a powerful national government, the debate was generally between those (like James Madison) who wanted a large national government with minimal policy-making authority and those (the antifederalists) who wanted a small national government with minimal policy-making authority.

This bias against federal action dominated the first 150 years of American politics. The bias was particularly strong in the social welfare context, where the tradition of the English Poor Laws remained strong. Social welfare programs were a local responsibility, and assistance was to be provided only to the “deserving poor.”15 For Franklin Roosevelt, however, politics as usual was a prescription for disaster: A decentralized and limited government could not effectively respond to an economic depression. Roosevelt envisioned, instead, a strong federal government, fueled by a powerful Executive Branch, in which economic and social welfare programs would be insulated from the localistic political process. Roosevelt knew, however, that Congress was unwilling to establish a nationally administered social welfare system. The main obstacle was several southern Demo-
crats, who because of their long seniority chaired key congressional committees. The southerners worried that a national welfare system would undermine the southern sharecropper economy and provide too many benefits to former black slaves. Roosevelt agreed to compromise, and the result was the bifurcated welfare system (that still exists today). The federal government finances and administers the popular “social insurance” programs (like Social Security), while the states administer, set policy for, and help finance the politically unpopular “welfare” programs (like AFDC).

The New Deal model of welfare federalism was challenged during the mid-1960s. Lyndon Johnson was influenced, of course, by the civil rights movement, which encouraged federal officials to bypass state leaders whenever possible. Liberals in the 1960s also argued that many state officials were simply unprepared to tackle hard policy issues (most state legislators, for example, worked part time, without adequate staff or support, and were under obligation to the party bosses that put them in office). At the same time, academics documented the inherent state bias against redistributive programs: Not only do such programs benefit the poor—a politically unpopular minority—but they also undermine a state’s position in the interstate competition for business. Finally, there was a new cadre of social scientists who argued that poverty is caused primarily by social conditions (not by individual sloth) and that welfare programs should seek both to change those social conditions and to reduce the feelings of powerlessness and alienation that such conditions generated.

In this changed political environment, the Great Society federalism called for federal funds to be disbursed directly to community-based groups (rather than through state or local politicians). Interestingly, however, the model was applied more consistently in education, jobs, and welfare than it was in health care. Federal funds were used, for example, to fund local Head Start programs, job training programs, and day care programs. But while the community health center program followed the Great Society model, the major health care initiatives of the day, Medicare and Medicaid, did not. These were classic New Deal-style programs: The federal government finances and administers Medicare, while the states administer, set policy for, and help to finance Medicaid.

The variation in health care federalism was related to variation in the goals of the newly enacted health care programs. The community health center program was an effort to alter the nation’s health care delivery system. The goal was to create community-run primary care clinics in indigent communities. Medicare and Medicaid, in contrast, were efforts to provide the aged and the poor with access to the existing mainstream health care system. These were medical insurance programs, not efforts to change the health care delivery system.
By the early 1970s, however, it was clear that Medicaid beneficiaries had not obtained access to the mainstream medical system. It was also clear that the welfare federalism of the Great Society was to be short-lived. State and local officials complained that they were wrongly cut out of the policy loop. Academic researchers uncovered mismanagement and occasional fraud. Richard Nixon and his Republican advisers rejected the Great Society explanation for poverty. Nixon called for a “new federalism,” under which power would return to state and local officials. While several Great Society programs continued to flourish (and remain with us today), the Great Society model of federalism was generally abandoned.

American federalism since the 1970s has emphasized states’ rights. The political debate generally has assumed that federal officials have too much policy-making authority and states, too little. Presidents from Nixon to Reagan to Clinton have proposed devolving power back to the states. Public support for states’ rights remains strong.

In this context, the 1993 debate over health care reform generally assumed that federal reforms, if any, would delegate key decision-making authority to the states. The assumption was rooted in several factors. First, states are so deeply entrenched in every facet of health care policy and administration that the federal government is reluctant to absorb all of these functions. For example, states have significant discretion in shaping Medicaid policy: States determine, within broad federal guidelines, who in their state receives Medicaid coverage, what benefits beneficiaries can receive, and how much providers of care will be reimbursed. States also regulate much of the nation’s private health insurance industry, regulate the quality of care delivered by many medical providers, and, together with local governments, pay more than 14 percent of the nation’s health care bill. Each state also operates its own workers’ compensation system, medical malpractice system, medical education and licensure system, and, with local governments, public health system.

Second, state officials themselves have significant political influence, especially with a former governor in the White House, and while they lobby for increased funding to offset the fiscal burden of rising Medicaid costs, they also are anxious to retain their authority to set policy, regulate quality, and administer programs. A third factor is America’s political culture, which contains an aversion to centralized government authority, a belief that decision making in lower levels of government is more democratic, and the view that public policy should, wherever possible, reflect disparate local needs and conditions. New York City and rural Idaho (or even rural upstate New York) do not (and should not) have identical health care delivery systems, and national decisionmakers are (arguably) too removed to develop responsive and responsible programs.
Fourth, there is as well a widely held policy assumption that state and local autonomy encourages policy innovation; allows state and local officials to test, evaluate, and implement those ideas that “work”; and enables federal officials to correct (or abandon) policy initiatives before devising national blueprints. Fifth, state officials clearly have become better prepared to meet the difficult policy challenge of health care reform. Many state legislators are now full-time policymakers, most legislatures have professional staffs, and nearly all state agencies have attracted capable and committed bureaucrats. At the same time, state officials clearly have an incentive to innovate: By the early 1990s states were spending an average of 17.1 percent of their total expenditures on Medicaid (and in some states the percentage was much higher).  

For all of these reasons, in 1993 there were relatively few voices calling for a nationally financed and administered reform package. Consider, for example, President Clinton’s proposal for health alliances to “manage” the competition between rival managed care plans. It was state officials who would decide how many regional health alliances each state would have, the jurisdictional boundaries of each alliance, and whether the alliances would be state agencies or nonprofit organizations.

At the same time, those moderates and conservatives who opposed Clinton’s plan envisioned also a large state administrative role. Sen. Jim Cooper’s (D-TN) managed competition plan had state-established health plan purchasing cooperatives. Incremental reforms proposed by conservative Republicans generally supported strengthening states’ ability to regulate private insurance. Even “single-payer” proposals required states to be the single payer of all health care bills. Perhaps the only legislator who fought hard for a more nationalized approach was Rep. Fortney H. (Pete) Stark (D-CA). Stark’s idea was to expand Medicare to cover the uninsured.

**Needed: A Federal Framework For A National Problem**

Given the growing consensus that states should have additional authority in the health policy arena, Congress could decide to remove or reduce the federal barriers to state-based reform. Medicaid might become a block grant. ERISA waivers might suddenly be granted. The entire health care crisis could be delegated to those laboratories of democracy, the states.

Removing federal barriers could enable some states to proceed with innovative insurance reforms. Other states, such as Maryland, might experiment with regulatory cost containment approaches. Still others, such as California and New Jersey, might pursue market-driven policies. For the reasons discussed earlier, however, most states will neither enact comprehensive insurance expansions nor engage in serious cost containment ef-
forts. Indeed, any cost containment that occurs will happen either because federal officials have simply pulled dollars out of the system or because the market itself is becoming more efficient, but not because state officials are implementing new and innovative ideas.

The better reform approach lies not in providing states with expanded discretion, but in fashioning a partnership that both respects the diversity among the states and provides a federal reform framework. Without such a framework, the nation will neither contain health care costs, nor ensure universal coverage, nor eliminate inappropriate interstate variation. To be sure, the Republican 104th Congress is not about to enact such a framework, and even President Clinton has abandoned the effort. Eventually, the crisis will emerge again on the national agenda, and the pressure on Congress to act will return. Until that time, there is little likelihood that the states will satisfy either their liberal or their conservative supporters.

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NOTES

1. The differences between the two groups are also clear. Liberals, for example, generally oppose both the movement toward block grants and the effort to dramatically cut federal health and welfare spending.
3. It is easy to overestimate the importance of the ERISA barrier. Even if congress granted ERISA waivers to states that have applied, surprisingly little reform activity might ensue. For example, officials in Washington State lobbied vigorously for months for an ERISA exemption to permit an employer mandate. While Congress never granted the waiver, the state legislature recently made the point moot by repealing the mandate.
4. In 1974 Hawaii enacted a requirement that employers provide workers with health insurance. Shortly thereafter the federal courts held that Hawaii's mandate violated ERISA. In 1983, after a difficult legislative battle, Congress granted the state an ERISA waiver, largely because the mandate was enacted before ERISA itself was passed. Since then, Congress has not only rejected waiver applications from numerous mainland states, it has also rejected Hawaii's application to alter the terms of its waiver.

12. The On Lok Program in San Francisco, for example, provides medical care and social services to many aged, indigent, and frail residents of San Francisco’s Chinatown, in exchange for a capitated payment from both Medicaid and Medicare. Congress recently permitted On Lok to be replicated in several other cities around the country (as part of the Program of All-Inclusive Care for the Elderly, or PACE), to test the generalizability of the model.

13. The states will be forced to cope with the fallout from the upcoming cutbacks. For example, Medicaid eligibility cutbacks will simply increase the number of uninsured persons, a population state and local governments are ultimately responsible for.

14. New York is already experimenting with public/private long-term care partnerships, under which consumers who buy three years’ worth of private long-term care insurance can receive Medicaid coverage for nursing home care beyond the three-year insurance period, regardless of their assets. While a wealthy person in the program could receive Medicaid benefits during the fourth year of a nursing home stay, Medicaid officials expect to save money overall since few residents live in nursing homes that long.

15. The main exception was the Civil War pension program, which provided federally administered benefits to Union veterans.


18. Interestingly, policy outcomes have not reflected the rhetoric consistently. During the Nixon era, for example, the federal agenda greatly expanded. Not only did the federal government for the first time enact environmental and consumer protection laws, but Nixon himself proposed both national health insurance and welfare reform. Similarly, while Reagan persuaded Congress to significantly cut federal aid to the states, the Reagan Congress also was responsible for the expanded federal regulation of Medicaid.

19. The federal government during the 1980s reduced state authority over Medicaid, requiring states to liberalize their eligibility policies, and limiting state efforts to reduce provider reimbursement. However, Medicaid remains a state-dominated program.


22. Clinton’s reform proposal also required states to assure that all people, especially poor people, had adequate access to a choice of health plans. States (and regional alliances) were permitted to offer health plans financial incentives to expand into medically underserved communities. States also had to certify that participating health plans met minimum quality-of-care standards, were fiscally stable, and had the capacity to provide the entire benefit package. States had to develop and implement a new home care program for the disabled. States had to develop plans to integrate so-called special populations, such as the mentally ill and substance abusers, into the alliance system. States even had to continue operating Medicaid programs, even though Medicaid clients would be shifted into the new alliance system. The residual Medicaid program would provide clients with those benefits, including nursing home care and personal care, not contained in the basic benefit package.