EBRI issue brief
EMPLOYEE BENEFIT RESEARCH INSTITUTE

JANUARY 1991 NUMBER 110

◆ ◆ ◆

Many states are making important changes in the delivery and financing of health care that affect access, quality, and costs.

◆ ◆ ◆

States and Their Role in the U.S. Health Care Delivery System

- Qualifying income limits for Medicaid eligibility in 1989 ranged from 28 percent to 106 percent of the federal poverty level.
- Of the estimated 1 percent of Americans under age 65 who are uninsurable, approximately 60,000 participate in state risk pools.
- One study found that if there were no state mandates (including continuation-of-coverage mandates), 16 percent of those small firms not now offering health insurance would begin to do so.
- Seven states recently passed legislation exempting small employers that do not offer health insurance from state mandates on coverage.
- It has been estimated that about 50,000 Hawaiians (about 5 percent of the state population) fall through the gap between Medicaid and mandated employer-sponsored health coverage and are left without insurance.
- Maine recently established a five-year demonstration project, to begin in 1992, in which advisory committees in designated medical specialty areas develop practice parameters. These parameters, or protocols, will be used as evidence in medical liability suits.
- Several states, including Iowa, Florida, and Pennsylvania, have developed programs that collect and disseminate detailed information about hospital costs. This information allows purchasers to compare hospital costs by diagnosis.
- The effects of certificate-of-need (CON) laws vary considerably among states: one study found that more stringent CON regulation actually increased hospital costs, while another found that, after controlling for patient and hospital characteristics, states with stringent CON programs had higher mortality rates among Medicare patients than states without such programs.

◆ Introduction

The organization and delivery of health care services is determined in large part by the local environment. The financing, costs, and quality of health care services, as well as access to health care, are affected by the demographics and attitudes of the local population, the number and ownership of hospitals in the immediate area, the practice arrangements and specialty mix of physicians, and the laws regulating the financing and delivery of medical services. These factors are interrelated; for example, local laws may both affect and be affected by the number and specialty mix of physicians in an area.

The health care delivery system is undergoing change at every level. While there have been a number of proposals for reforming the health care delivery system, the nation has yet to achieve a consensus on the proper direction of that reform. The debate on national health care reform is affected by the federal budget deficit, differences in health care delivery systems across regions, and conflicting goals among the proponents of reform. Moreover, differences in health care delivery among states make the development of uniform policies difficult.

Conversely, the states have been actively involved in providing and regulating health care since their founding. The states face many of the same barriers that the federal government faces in reaching a consensus, and states have even more severe constraints on their ability to raise funds. However, their smaller size and the greater homogeneity in their populations' characteristics and health care delivery systems present fewer barriers to action and have led to a wide range of legislation. The political dynamics of state legislatures also affect approaches to health care. Part-time legislators; well-organized provider groups; varying degrees of organization among employer, consumer, and patient advocate groups; and the relative strengths of the local political parties all combine to make each state's approach to health care unique.

This *Issue Brief* investigates some of the approaches to health care delivery that states have adopted. It is intended to provide an overview of these approaches and a brief examination of their effects, rather than an encyclopedic listing of all the various approaches; the variations and combinations of state laws and regulations affecting health care financing and delivery could easily fill several books. This *Issue Brief* examines only a few of the methods that states have adopted to improve access to health care, assure its quality, and manage health care costs.

◆ Historical Background

Until World War II, state and local governments, together with philanthropic organizations, were the traditional source of health care for the poor. Most of this care was provided in state and community hospitals. Taxpayers and philanthropists provided 90 percent of the capital for the construction of hospitals (Cohodes and Kinkead, 1984). State regulation of health care delivery systems has varied considerably across the country, with many of the regulatory initiatives coming from the federal government.

The Hospital Survey and Construction Act of 1946 (the Hill-Burton Act) increased the role of state governments in the planning and regulation of health care services. Under this act, the federal government provided states with grants to construct or modernize hospital facilities. To receive grants, the states were required to develop plans for their hospital beds, but in fact the contents of these plans were often rudimentary descriptions of existing facilities (Feldstein, 1988). The Hill-Burton Act stimulated extensive hospital construction: more than 700 hospitals encompassing 145,000 nongovernmental, nonprofit beds were built between 1946 and 1960 (Cohodes and Kinkead, 1984). The original act also stipulated that hospitals receiving grants furnish assurances to the state agencies that some of the care was being provided to individuals unable to pay for it, although until the early 1970s there were no criteria for the amount of free care hospitals were required to provide.

The Kerr-Mills Act of 1960 established a federal-state matching grant program for financing health care for the indigent. States were free to choose whether they wished to participate and to determine the eligibility criteria for recipients and the benefits they would receive, although the law stipulated that income be one of the criteria and that care had to be provided by the private sector. This program was replaced five years later by Medicaid.

◆ The Medicaid Program

In 1965, Congress enacted Title 18 and Title 19 of the Social Security Act, creating the Medicare and Medicaid programs, respectively.

The Medicare program affected states in two ways. First, it relieved many states of their traditional burden of providing health care for the elderly poor. Second, it gave providers, especially hospitals, a steady source of income that in turn allowed them to continue to expand the number of services they could provide.

◆ ◆ ◆

The Medicaid program largely supplanted state efforts to finance health care for the poor. However, because many states have not adjusted income eligibility requirements for inflation, there is a wide disparity among states in the number of people covered.

◆ ◆ ◆

The Medicaid program replaced the Kerr-Mills Act in providing federal matching grants to states for financing health care to the medically indigent. States must meet several federal guidelines in order to receive funding, but within those guidelines each state is free to set eligibility requirements, benefits, and reimbursement levels (Fein, 1986). Generally, those receiving assistance from the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs are eligible for Medicaid. Each state has the option of extending Medicaid benefits to other populations and to offer more benefits. As a result, each state's Medicaid program is separate and distinct. Recent changes in state programs have increased the variation in Medicaid programs. For example, qualifying income limits for Medicaid eligibility in 1989 ranged from 28 percent to 106 percent of the federal poverty level.

The Medicaid program largely supplanted state efforts to finance health care for the poor. However, because many states have not adjusted income eligibility requirements for inflation, there is a wide disparity among states in the number of people covered. Moreover, changes in the Medicaid program enacted in the Omnibus Budget Reconciliation Act of 1981 (OBRA '81) reduced the federal match of state expenditures, altered the eligibility requirements for AFDC, and gave states wider latitude in paying for care. One effect of these changes was to reduce the number of individuals eligible for Medicaid. Table 1 depicts the relationship between Medicaid income eligibility requirements as a percentage of the federal poverty level in each state, state and federal Medicaid expenditures in each state, and the number of uninsured in each state in 1988. Thirty percent of the nation's uninsured live in families with incomes below the federal poverty level. Thus, the inverse correlation between Medicaid income eligibility requirements and the percentage of a state's population that lacks health insurance is not surprising.

Hospital Reimbursement

OBRA '81 allowed states to change the method that hospitals use to reimburse providers. States moved rather rapidly to replace the cost-based, retrospective reimbursement system that most hospitals had traditionally employed with some type of prospectively determined reimbursement. Retrospective reimbursement paid some proportion of a hospital's incurred

Table 1
Uninsured Population under Age 65, 1988, Medicaid Eligibility Thresholds, and 1990[a] Medicaid Expenditures, by State

State	Nonelderly Population without Health Insurance		Medicaid Eligibility Thresholds for a Family of Three (percentage of poverty)		1990[a] Medicaid Expenditures		
	Number (thousands)	Percentage of population	AFDC	Medically needy	Total dollars (millions)	% total state expenditures	% from federal grant
Alabama	686	19.7%	14.1%	b	$578	7.7%	73%
Alaska	88	20.9	77.2	b	128	3.9	52
Arizona	646	21.6	35.0	b	773	12.6	58
Arkansas	477	22.3	24.3	32.8%	566	12.2	74
California	5,010	20.5	79.1	106.4	7,505	10.7	51
Colorado	421	15.5	50.2	b	545	10.9	50
Connecticut	288	10.3	63.7	84.7	971	10.5	50
Delaware	61	10.7	39.7	b	125	5.9	50
District of Columbia	98	19.5	46.9	57.9	397	8.2	59
Florida	2,265	22.2	34.2	45.7	2,402	10.4	57
Georgia	1,024	18.6	44.9	43.8	1,594	13.5	62
Hawaii	107	13.0	57.8	57.8	223	5.2	41
Idaho	151	17.4	36.3	b	153	8.5	70
Illinois	1,185	11.8	40.8	54.6	2,318	12.0	51
Indiana	607	12.7	34.4	b	1,444	15.8	62
Iowa	217	9.0	47.0	62.6	578	7.5	61
Kansas	222	10.9	47.8	57.3	402	8.2	50
Kentucky	559	18.1	26.0	34.8	934	11.7	73
Louisiana	989	25.7	22.7	30.8	1,312	14.4	72
Maine	116	11.3	75.4	70.5	396	14.1	68
Maryland	423	10.6	45.0	52.7	1,106	9.4	43
Massachusetts	497	9.7	69.1	92.4	2,367	13.3	45
Michigan	680	8.3	68.2	65.5	2,359	13.5	54
Minnesota	406	10.4	63.5	84.6	1,386	12.7	53
Mississippi	504	22.4	43.9	b	597	13.3	79
Missouri	600	13.3	34.0	b	929	11.4	58
Montana	120	17.4	42.8	48.7	176	10.9	71
Nebraska	167	12.6	43.4	58.7	308	10.5	63
Nevada	229	23.9	39.4	b	c	c	c
New Hampshire	123	12.8	59.2	68.1	198	11.9	50
New Jersey	693	10.5	50.6	67.5	2,087	12.4	49
New Mexico	358	28.1	31.5	b	285	8.2	73

(continued)

costs. By comparison, prospective payment determines the amount to be paid, on a per diem or per admission basis, in advance of the care's provision. By 1985, only eight states still had retrospective reimbursement for inpatient care. This change, combined with a reduction in the number of persons eligible for Medicaid, resulted in a 50 percent reduction in the average annual growth in Medicaid hospital expenditures (Johns and Adler, 1989).

States determine the prospective payment in different ways; two alternative models are (1) selective contracting, which is used by Medi-Cal, the Medicaid program in California, and (2) a diagnosis-related group (DRG) all-payer system,[1] which is used in

[1]Under this system, patients with similar diagnoses are categorized into a specific diagnosis-related group. The payer reimburses a fixed amount based on the cost history of the group.

Table 1 (continued)

State	Nonelderly Population without Health Insurance: Number (thousands)	Nonelderly Population without Health Insurance: Percentage of population	Medicaid Eligibility Thresholds for a Family of Three (percentage of poverty): AFDC	Medicaid Eligibility Thresholds for a Family of Three (percentage of poverty): Medically needy	1990[a] Medicaid Expenditures: Total dollars (millions)	1990[a] Medicaid Expenditures: % total state expenditures	1990[a] Medicaid Expenditures: % from federal grant
New York	1,908	12.5	64.3	84.6	8,300	17.7	57
North Carolina	810	14.8	31.7	42.7	1,365	11.4	67
North Dakota	60	10.8	46.0	51.9	210	14.1	66
Ohio	977	10.1	38.3	b	2,745	12.8	59
Oklahoma	635	23.6	56.2	51.7	748	12.8	69
Oregon	411	16.9	49.1	66.7	392	5.7	61
Pennsylvania	976	9.5	45.8	53.7	2,586	11.5	49
Rhode Island	71	8.2	61.7	82.5	412	18.5	55
South Carolina	441	15.3	48.1	b	791	9.9	73
South Dakota	97	16.0	43.7	b	163	13.4	72
Tennessee	664	15.4	43.5	27.8	1,440	19.3	69
Texas	4,012	26.9	21.9	31.8	3,175	14.0	61
Utah	202	13.3	59.9	59.8	263	8.9	75
Vermont	57	11.9	75.0	103.0	149	12.1	62
Virginia	705	14.0	34.7	42.7	857	7.2	50
Washington	500	12.2	58.7	71.5	1,178	9.9	54
West Virginia	259	15.9	29.7	34.6	421	11.5	75
Wisconsin	402	9.7	61.7	82.2	1,358	12.3	58
Wyoming	65	16.0	42.9	b	54	3.6	65
Total/Average	33,271	15.7	47.1	60.1	61,353	12.0	56

Sources: Jack Needleman, Judith Arnold, John Sheils, and Lawrence S. Lewin, *The Health Care Financing System and the Uninsured* (Washington, DC: Lewin/ICF, 1990); Deborah Chollet, *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988* (Washington, DC: Employee Benefit Research Institute, 1990); and Karen A. Farrell, *State Expenditure Report* (Washington, DC: National Association of State Budget Officers, 1990).
Note: While the Census's Current Population Survey is a nationally representative survey, it may not provide accurate estimates for smaller states.
[a]Estimated fiscal year 1990.
[b]Not available.
[c]Not applicable: state does not extend Medicaid coverage to medically needy.

New Jersey. In California, legislation enacted in 1982 established a state agency that accepted competitive bids from hospitals for a per diem reimbursement rate. Hospitals with bids that were unacceptably high were excluded from the Medi-Cal program. The California system allows hospital prices to be set through a market mechanism. While per diem reimbursement gives hospitals an incentive to extend a patient's length of stay, the Medi-Cal program has a long-standing utilization review process that limits a hospital's ability to arbitrarily extend stays. The New Jersey system reimburses on a per admission basis, adjusted for the admission's DRG. Hospital prices are set by a regulatory agency; there is no control over admissions. Both states reduced Medicaid hospital expenditure growth, although New Jersey's reduction in expenditures was in large measure due to the reduction in the number of persons eligible for Medicaid.

New Jersey is one of four states (including Maryland, Massachusetts, and New York) that have employed all-payer hospital reimbursement systems. The New Jersey all-payer system regulates hospital reimbursement rates and overall revenue. Allowances are made for uncompensated care provided in both inpatient and outpatient settings, and the costs of that care are

distributed proportionately across payers. As a result, the need and the ability to shift costs across payer types are reduced. **Access to care seems to be better in all-payer states; the uninsured in New Jersey average about twice as many physician visits per year as do the uninsured nationally (6.6 visits versus 3.2 visits, respectively)** (Rosko, 1989).

Managed Care

The California, New Jersey, and other state Medicaid programs have been criticized for failing to link primary care with hospital cost containment (Omenn, 1987). In an attempt to manage costs, the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) gave states the ability to limit Medicaid recipients' freedom of choice among providers. **A majority of state Medicaid programs have a managed care program of some type, generally health maintenance organizations (HMOs). These programs have had to overcome a number of obstacles.** The Medicaid population is more transient with respect to the program than are privately insured patients. The benefits typically offered by Medicaid, in particular long-term or chronic care, are not typically offered by managed care plans. Finally, in states where managed care is an option, adverse selection may occur if patients who are more severely ill elect not to enroll in the managed care plan. The amount that prepaid plans are generally paid is a percentage (usually 95 percent) of the average cost of treating Medicaid patients in nonmanaged settings. If the enrollees in these plans are lower-than-average users of health care services, adverse selection can result in higher overall charges to the Medicaid program. In states with mandatory enrollment (for example, Wisconsin), distributing severely ill patients across plans to equalize the burden is a difficult administrative task.

Arizona has a combined managed care and competitive bidding approach. When the Arizona Health Care Cost Containment System (AHCCS) began in 1982, it was the first program in the state that was eligible to receive federal Medicaid funds. Previously, Arizona's 14 counties had had the responsibility of providing medical care to the poor. Under AHCCS, the state uses a bidding process to select providers. The providers are paid a capitated amount. Each enrollee is assigned a gatekeeper who manages his or her care. Beneficiaries also make copayments, although the law states that no patient is to be denied services because of an inability to pay. AHCCS delivers only acute care: Arizona received a waiver that exempts it from having to provide long-term care, home health care, family planning, or mental health care under this program. **An assessment of AHCCS found that there was no difference between the AHCCS and traditional Medicaid programs in terms of access, utilization, or beneficiary satisfaction with the program** (McCall, Jay, and West, 1989).

◆ ◆ ◆

A majority of state Medicaid programs have a managed care program of some type, generally health maintenance organizations. These programs have had to overcome a number of obstacles.

◆ ◆ ◆

Medicaid Expansion

One common reform sponsored by state governments is the expansion of Medicaid. While Congress has been gradually expanding the coverages states are required to offer under Medicaid, focusing heavily on children and pregnant women, a number of states have further expanded benefits and eligibility. For example, Connecticut's Medicaid program was expanded to cover approximately 61,400 of the state's 272,000 uninsured residents. Eligibility requirements for Medicaid have been adjusted to emphasize health care coverage for pregnant women. In 1988, Indiana extended Medicaid coverage for pregnancy and postpartum health care charges. Pregnant women and children up to age 1 who have family incomes under 50 percent of the federal poverty level are eligible.

Rationing in Oregon

Other states have found it difficult to meet the health care needs of their poor and Medicaid-eligible populations. **Oregon has adopted a controversial program to restructure its Medicaid benefits according to a system of prioritization.** With only about one-half of the population living below the federal poverty level covered by Medicaid, the state hopes to be able to expand the number of individuals covered by prioritizing the health care services covered and denying payment for the lowest priority services as budget limits are approached. On May 2, 1990, a first draft of the prioritized list was made public. It contained 1,600 benefits that are prioritized according to the "quality of well-being index," a measure that ranks a patient's net health benefit from a health care treatment. The factors used to develop the list include measures of the treatment's cost effectiveness and the average number of years of life that a patient has remaining or that could be gained by the treatment. A number of questions about the process used to develop this list have been raised, and the state is currently attempting to revise it. The state needs to supply the federal government with a final list in order to receive a waiver, since it hopes to have coverages that differ from those mandated by the Medicaid program.

Despite federal mandates, each state has different coverage, benefits, eligibility requirements, and methods of financing and delivering care, making its Medicaid program unique. Because Medicaid programs offer health benefits to a limited population, states have attempted a number of other programs to expand health insurance coverage.

◆ Risk Pools for the Uninsurable

It has been estimated that about 1 percent of Americans under age 65 are uninsurable. These individuals have chronic illnesses or other characteristics that make it difficult or impossible for them to purchase health insurance. Twenty-four states have responded to this problem by establishing health insurance risk pools. Generally, these pools offer health insurance policies to those under age 65 who are unable to purchase health insurance because of a medical condition. The premiums are limited by law to a given percentage (generally 150 percent) over an individual "standard risk" premium. Since these pools were established to provide insurance to high-risk individuals, they run a deficit that is usually paid for through a pro rata assessment on insurers within the state.

Approximately 60,000 individuals participate in state risk pools, far below the number of people estimated to be eligible for these pools. Although data are lacking, it seems likely that many potentially eligible individuals are unable to afford the coverage offered by the pools. The chronically ill, as a group, are likely to have lower incomes than other groups. Most states' risk pools do not offer financial assistance to low-income applicants.

Aside from providing health insurance to individuals who might otherwise be uninsured, risk pools have some advantages and disadvantages for the state and for employers. **Although the populations served by the risk pools and the Medicaid program do not overlap, risk pools may reduce Medicaid expenditures because chronically ill individuals can purchase coverage without having to spend down their assets to become eligible for Medicaid. Risk pools may also decrease costs for employers by enabling them to place chronically ill employees in the pool and purchase health insurance for other employees at lower group rates.** Moreover, assuring providers of a source of payment for the chronically ill reduces the need for them to shift the cost of treating this group to other payers.

Conversely, risk pools increase insurance costs for those employers who do not self-insure. The costs that the deficit risk pools incur are borne by insurers and passed on in the form of higher premiums to those who purchase private insurance. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from these costs. Data suggest that the presence of a risk pool program in a state reduces

the number of employers offering health benefits (Gabel and Jensen, 1989). Risk pools have been slower than private plans to adopt cost management strategies, with the exception of relatively high deductibles. These deductibles further limit the number of individuals willing to participate in the pools.

◆ State-Mandated Health Insurance Benefits

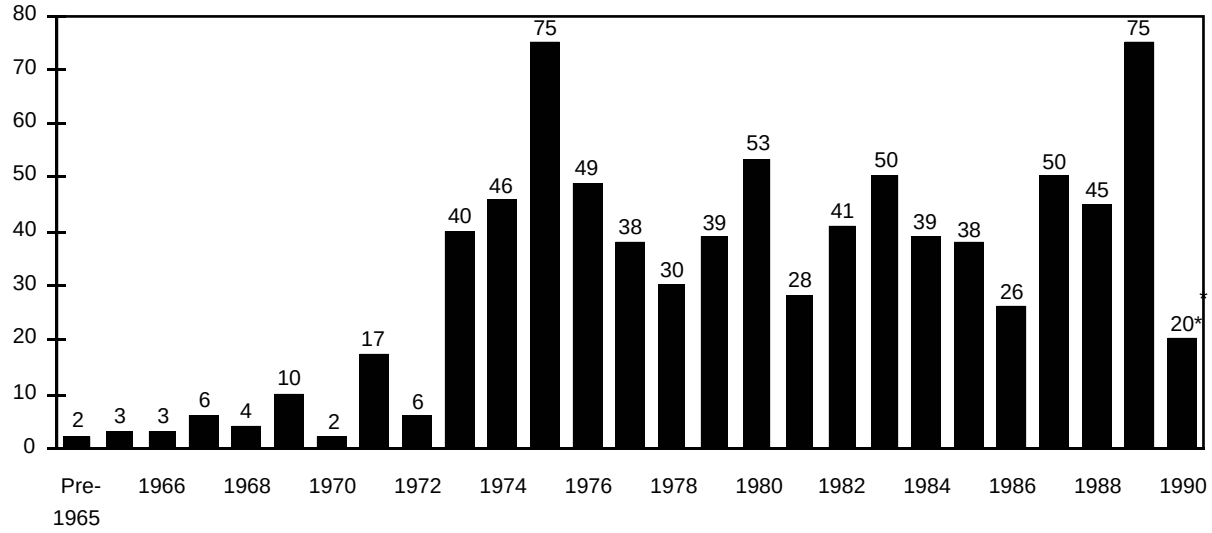
One method that states have used to attempt to expand coverages has been to mandate the benefits that must be included in all health insurance policies. One of the functions of state governments has traditionally been the regulation of insurance. Mandating the health care services that must be covered under an insurance plan was seen as a natural extension of this function. In the early 1970s, state insurance mandates, which require that certain benefits be included in either group or individual health insurance plans, became widespread (chart 1). With the exception of Hawaii, and Massachusetts in 1992, these mandates do not require that employers offer health insurance but only describe the benefits that must be offered by employers who do offer it.

State mandates have an important influence on an employer's decision to offer health insurance benefits and the way in which these benefits are financed. ERISA exempts from state insurance regulation those employers who elect to self-insure their health insurance benefits. Employers who self-insure pay the costs of their health benefits from a pool of their own money instead of paying premiums to insurers.

Mandated benefits can be grouped into four general categories: provider mandates, treatment mandates, special populations mandates, and coverage continuation mandates (Gabel and Jensen, 1989).

- Provider mandates require that an insurer reimburse different types of providers, such as psychologists, podiatrists, or chiropractors, in the same manner as

Chart 1
Number of State Health Insuance Mandates Enacted in Each Year



Source: EBRI tabulations of Blue Cross and Blue Shield Association data.
*Not complete year.

they reimburse physicians. This type of mandate clearly has the political support of the affected providers. It is also seen as a means of reducing health care costs by shifting care from more expensive physicians to less expensive providers in a way that enhances competition.

- Treatment mandates require coverage for certain procedures (such as in vitro fertilization) or diagnoses (such as mental health and substance abuse). These mandates are supported by the specific providers who would most benefit from having these treatments covered, and they are also supported by those who feel that society benefits from having these coverages. These treatments are generally among the most expensive to cover. Without the mandates, many employers and purchasers of individual policies would forgo this coverage.

- Special population mandates require coverage for groups that may not have coverage (newborns or adopted children) or that may be expressly denied coverage (the physically handicapped). As with treatment mandates, while some provider groups may benefit, the major support for these mandates comes from advocates of the affected populations.

- Coverage continuation mandates enable former employees and their dependents to receive coverage under a former employer's group health plan. Generally, they mandate that individuals who would otherwise have left an employer's group coverage due to a layoff, a change in marital status, or other event that may threaten coverage may elect to continue that coverage at their own expense. These mandates differ from the previous three in that they are direct attempts to reduce the number of people without health insurance generally and do not focus on specific populations. Twenty-seven states have continuation-of-coverage laws. Since the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the federal government requires employers with 20 or more workers to provide continuation rights. State laws may apply to smaller employers or for different periods of time, however, and may still affect employer plans.

The impact of state mandates on the availability, cost, and quality of health care varies by the type of mandate. There is little evidence concerning the effect of special population mandates on the health care delivery system, although for the most part the populations affected are small. Provider mandates have increased the range of treatment choices available to health care consumers. The available evidence on the effect of alternative mental health providers (psychologists and social workers) is mixed. One set of studies indicates that mandating the services of these providers results in increased competition, which lowers provider fees (Frank, 1982) without increasing utilization (Fairbank, 1989). Another study found that including psychologists' services in a benefit plan significantly increased the plan's premiums (Jensen and Morrisey, 1990). The difference in the quality of care provided by a social worker relative to a psychiatrist, or a chiropractor relative to an orthopedist, is at least partly subjective.

Treatment mandates often target diagnoses and procedures that add significant costs to group health plans. One study found that adding coverage for substance abuse treatment increases the monthly premium for group health insurance by about 9 percent, while inpatient psychiatric care increases the monthly premium for family coverage by about 13 percent (Gabel and Jensen, 1989). These costly mandates are often cited as reasons that small employers do not offer health insurance benefits and larger employers choose to self-insure. However, this study could not find a statistically significant relationship between mandates for the provision of psychologists' services, mental health benefits, and substance abuse treatments and the likelihood that small employers offer health benefits to their employees. Of this group of mandates, only psychologists' services were significantly related to medium-sized and large employers' decisions to self-insure.

However, small employers face higher costs than large employers when providing health benefits. They are also more likely to hire low-income workers, who may prefer cash compensation over noncash benefits. These employers are thus much less likely to offer health insurance than larger employers: in 1988, almost 50 percent of workers aged 18–64 without health insurance worked for employers with fewer than 25 employees (Chollet, 1990).

◆ ◆ ◆

The most important mandates in terms of an employer's decision to offer health insurance or to self-insure are the continuation-of-coverage mandates.

◆ ◆ ◆

Conversely, medium-sized and large employers, 42 percent of whom self-insure, are likely to offer many of these mandated treatments. The U.S. Department of Labor found that, in 1989, 98 percent of the employers that offered health insurance covered mental health treatments (U.S. Department of Labor, 1990). Ninety-five percent of the participants had coverage for inpatient detoxification for alcohol abuse, 78 percent had coverage for inpatient rehabilitation, and 84 percent had coverage for outpatient care for alcohol abuse. The percentages for drug abuse were 77 percent for inpatient coverage and 81 percent for outpatient care.

The most important mandates in terms of an employer's decision to offer health insurance or to self-insure are the continuation-of-coverage mandates. Although COBRA made this a national mandate, state programs may differ from the national law, especially with respect to firm size. Continuation-of-coverage mandates are intended to reduce the number of uninsured in a state. Employers have found that these laws increase their health insurance costs through adverse selection. The individuals who choose to continue coverage are more likely to utilize health care services than active employees and their dependents. These laws typically limit the premium that employers can charge. As a result, the addition of individuals who continue coverage increases the group's insurance risk and thus the group's premiums.

While the costs of treatments subject to state mandates may be considerable, their impact on the availability of coverage is unclear. It seems likely that for small employers these mandates simply represent an increase in costs that have already prevented them from offering health benefits to their employees. **One study found that if there were no state mandates (including continuation-of-coverage mandates), 16 percent of those small firms not now offering health insurance would begin to offer these benefits** and ". . . the largest gains would have occurred for firms most able to afford health insurance: mid-size firms, industries employing higher paid labor (transportation, utilities, manufacturing, and mining), corporations, and firms that were already providing life but not health insurance" (Gabel and Jensen, 1989).

Seven states recently passed legislation exempting small employers that do not offer health insurance from state mandates on coverage. These states exempt employers with fewer than 50 employees (Virginia, Missouri, and Kentucky) or fewer than 25 employees (Washington, Florida, Rhode Island, and Illinois) from most, but not all, of the state mandates. In Virginia, Blue Cross and Blue Shield has developed a policy that reduces the premium for individual coverage by about 40 percent and for family coverage by about 60 percent for small employers that are eligible for exemptions. It is too soon to determine how many small employers will begin to offer health insurance as a result of these programs.

◆ State-Mandated Employer Health Insurance Coverage

Two states have passed legislation requiring employers to offer health insurance benefits to their employees:

Hawaii and Massachusetts. The differences between the two programs are as fundamental as the differences between the two states. **The legislation creating the Hawaii program—enacted in 1974—specified a minimum set of benefits that each employer must provide.** These benefits were expanded in 1976. The costs of the health benefits are shared by employers and employees, with employers paying at least one-half and the employees' contribution capped at 1.5 percent of total wages. Because the law stipulated the set of benefits that employers were required to offer, it was challenged in court on the grounds that self-funded plans were exempt from the mandate under ERISA. **In 1981, the Supreme Court ruled that ERISA preempted state law in this case, but Congress enacted legislation that same year giving Hawaii an exemption from ERISA and restoring the law as originally enacted.** Thus, self-insured plans must provide the set of benefits described in the 1974 legislation but not the expanded coverages enacted in 1976.

It has been estimated that about 50,000 Hawaiians (about 5 percent of the state population) fall through the gap between Medicaid and employer-sponsored health coverage and are left without insurance. The state has begun a program to extend coverage to individuals with income under 300 percent of the federal poverty level who are not eligible for Medicaid.

The Massachusetts plan was enacted in 1988. To avoid ERISA preemption, the law stipulates that all employers with more than five employees must pay a tax of 12 percent on the first $14,000 of wages per employee (a maximum of $1,680) unless the employer provides health benefits that cost at least that amount. The bill also gives special provisions to small employers, allowing a phase-in period and a separate insurance pool. In addition, the bill establishes a buy-in to Medicaid for the disabled and pregnant women with incomes at or below 185 percent of the federal poverty income level. The tax on employers is scheduled to take effect in 1992. **There is some uncertainty about the future of this program, given the changes in the economic condition of the state, the state's budget deficit, and the downturn in the political fortunes of the program's major backers.**

◆ State Regulation of Health Care Delivery

States regulate the delivery and financing of health care in a variety of other ways. State boards license physicians and determine which other providers are permitted to provide care. States differ, for example, in the limitations placed on the practices of chiropractors, social workers, and podiatrists. They also differ in their limitation of the types of services offered in free-standing clinics and surgery centers. Several states limit the amount that physicians can charge Medicare recipients above the level at which Medicare reimburses. These regulations have important effects on the delivery of health care services, often in unintended ways.

Certificate-of-Need Laws

The introduction of Medicare and Medicaid, together with the expansion of private health insurance, created a surge of demand for health care services in the late 1960s and early 1970s. This increased demand in turn led both to an expansion in the supply of health care services and to increases in health care costs. An early diagnosis of the causes of health care cost inflation pointed to overinvestment in hospitals and other health care facilities. The Hill-Burton Act was intended to encourage states to plan for optimal use of health care facilities, but these planning activities were, in practice, very limited. In the mid-1960s, Congress passed legislation that established local and state voluntary planning agencies, but because these agencies were voluntary they had limited or no effect on the growth of health care facilities and costs.

Between 1964 and 1972, 22 states passed certificate-of-need (CON) laws that required health care facilities to gain approval from a state agency before undertaking any significant capital improvements. These laws varied considerably across states both in the types of facilities and investments covered and in their

effectiveness. Hospitals and nursing homes were generally covered, as well as other facilities such as medical laboratories. Investments covered included new plants and beds, new services, and new equipment to support existing services.

In the early 1970s, Congress enacted legislation to encourage states to develop CON programs by stipulating that federal funds (for example, from Medicare and Medicaid) could not be used to support "unnecessary capital expenditures" (Cohodes and Kinkead, 1984). The legislative history of CON laws before that time provides an important lesson in the dynamics of state political processes with respect to health care policy. Moreover, the effects of these laws on the delivery and costs of health care provides a similar lesson in the design and implementation of regulations. **While CON laws were ostensibly intended to reduce health care cost inflation by reducing unnecessary capital expenditures, they were often supported by the state hospital associations and other provider groups.** Whatever the motivation for these groups to support CON legislation, the laws had the effect of limiting competition in the health care services market. A study of the factors leading to the passage of CON laws in one state found that the growth rate of hospital expenditures per patient day was not related to the enactment of a CON law, but the degree of competition among hospitals was (Wendling and Werner, 1980).

The effects of CON laws vary considerably among states, depending on their programs' characteristics. In general, these laws have not been effective in restraining total costs or even hospital investments (Cohodes and Kinkead, 1984). **In some states, however, CON programs have effectively altered hospital investments**. The net effect on total health care costs within these states is unclear, but one study found that more stringent CON regulation actually increased hospital costs (Sherman, 1988). Another study found that, after controlling for patient and hospital characteristics, states with stringent CON programs had higher mortality rates among Medicare patients than states without such programs (Shortell and Hughes, 1988). **Since 1982, 11 states have repealed their CON laws.**

Malpractice Reforms

Several states limit malpractice awards in an effort to restrain health care costs. For example, Indiana limits both "economic" and "pain and suffering" claims to $500,000. The first $100,000 is paid by the defendant, while the remainder comes from the state's Department of Insurance Patient Compensation Fund. The fund is supported by a surcharge on medical malpractice premiums.

Maine recently established a five-year demonstration project, to begin in 1992, in which advisory committees in designated medical specialty areas (for example, anesthesiology, emergency medicine, or obstetrics) develop practice parameters or risk management protocols. These parameters or protocols will be used as evidence in medical liability suits. It is hoped that applying consistent standards to medical malpractice suits will both limit the number of claims and make them easier to defend.

Data Collection

States also determine what information about provider prices and costs is available to the purchasers of health care services. **Several states, including Iowa, Florida, and Pennsylvania, have developed programs that collect and disseminate detailed information about hospital costs.** This information allows purchasers to compare hospital costs by diagnosis. The effect of this information is unclear, although hospitals themselves have used the information to determine the source of the cost differentials.

Regulating Utilization Review

Many public and private health insurance plans include utilization review (UR) as a cost management technique. **UR includes a number of strategies for intervening in the decision to purchase health care.** These

may include preadmission certification, in which care is reviewed before it is given to determine its appropriateness; concurrent review, or case management, in which care is monitored as it is provided; and retrospective review, in which care is reviewed after it is given. These reviews are undertaken to determine whether the services provided are necessary and appropriate and therefore will be reimbursed. Most private health insurers provide some UR services, and there are a number of independent UR firms.

◆ ◆ ◆

One major issue in the development of these laws is the UR firms' criteria for determining the appropriateness of the services reviewed.

◆ ◆ ◆

A number of states have begun to regulate UR activities, using a variety of different approaches. Maryland passed the first law requiring that UR firms receive a certificate from the state in order to operate in 1985. A number of other states have since passed laws regulating UR. **Much of this legislation is similar to Virginia's legislation that is aimed at independent UR firms rather than at the review practices of established insurers, HMOs, and hospitals.** This legislation is designed to establish standards for these firms to prevent untrained individuals from making medical decisions and to limit any hardships on beneficiaries should a claim be denied. Provider groups are often supportive of this type of legislation.

One major issue in the development of these laws is the UR firms' criteria for determining the appropriateness of the services reviewed. UR firms do not want to make this information—which represents a significant investment—public and available to their competitors. Providers argue that without this information they face unwarranted intervention in the physician-patient relationship by third parties whose actions seem capricious. Although proposed in several states, legislation relating to this information has not yet been enacted.

◆ Conclusion

State approaches to the delivery and financing of health care services differ widely. These differences in health policy reflect the complex interaction of demographic, political, and economic forces within each state. The effect of these differences in health policy on the health of individuals is difficult to assess, but there are clear differences in access to health care, the costs of health care services, and the quality of care among states, at least as measured by the mortality rates of Medicare patients.

This *Issue Brief* has examined only a few of the ways in which states have affected health care delivery. The approaches examined raise several issues that must be considered in developing a national health care policy. The wide variety of state approaches makes it tempting to describe states as acting as policy laboratories, testing various strategies for reducing costs, increasing access, or improving the quality of care. Generalizing from any one state's experience, given that state's unique characteristics, may prove misleading, however.

States are taking the initiative in formulating health policy partly out of frustration with the progress of national health policy reform and partly because of the perception that regulating the financing and delivery of health care services is part of their natural function. A state's ability to initiate programs is limited, however, by its own financial constraints and by the limitations placed on it by federal law. Forty-nine states are required by their own laws to balance their budgets each year. The sources of revenue available to each state vary considerably, and federal law constrains states from exploiting these sources. For example, many states finance their risk pools through a surtax on health insurance premiums. Self-funded employer plans are exempt from that surtax under ERISA. As a result, the costs of risk pools are limited to those who purchase private insurance individually or through their em-

ployer. These individuals tend to work for smaller employers, who face higher costs for health insurance and are more likely to drop this coverage as an employee benefit as costs increase. Thus a state's attempt to finance health insurance for one group may lead to decreased coverage for another.

Local political dynamics and the limitations of state finances have often led to unintended results. Efforts to rationally plan the expansion of hospital beds and services through CON laws have not significantly reduced health care cost inflation; they have been used by provider groups to limit competition and may have adversely affected the quality of care. Efforts to expand health insurance coverage by mandating the coverages may have reduced the number of employers offering health insurance benefits and increased the number of employers who self-insure, decreasing states' ability to affect that portion of the health insurance market.

Conversely, these same local political dynamics have led states to adopt some of the approaches that have been advanced for national health care policy. These approaches range from selective contracting in California to price regulation for hospital services in New Jersey. They include the collection and dissemination of cost information in Iowa, Florida, and Pennsylvania; the construction of practice parameters in Maine; the development of an explicit rationing scheme in Oregon; and the mandating of employer-sponsored health benefits in Massachusetts. The success or failure of these approaches will be determined in large part by local characteristics, but careful examination of these states' experiences could yield important information on the appropriateness of the nation's health care policies.

This *Issue Brief* was written by William Custer of EBRI with assistance from the Institute's research and education divisions.

◆ Bibliography

Anderson, Maren D., and Peter D. Fox. "Lessons Learned From Medicaid Managed Care Approaches." *Health Affairs* (Spring 1987): 71–86.

Associated Press. "G.A.O. Says Medicaid Formula Hurts Needy States." *New York Times,* 9 December 1990, p. 35.

Blumstein, James F. "Providing Hospital Care to Indigent Patients: Hill-Burton as a Case Study." In Frank A. Sloan, James F. Blumstein, and James M. Perrin, eds., *Uncompensated Hospital Care.* Baltimore, MD: The Johns Hopkins University Press, 1986.

Bovbjerg, Randall R., and Christopher F. Koller. "State Health Insurance Pools: Current Performance, Future Prospects." *Inquiry* (Summer 1986): 111–121.

Chollet, Deborah. *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988.* Washington, DC: Employee Benefit Research Institute, 1990.

Christianson, Jon B., and Diane G. Hillman. *Health Care for the Indigent and Competitive Contracts: The Arizona Experience.* Ann Arbor, MI: Health Administration Press Perspectives, 1986.

Cohodes, Donald R., and Brian M. Kinkead. *Hospital Capital Formation in the 1980's.* Baltimore, MD: The Johns Hopkins University Press, 1984.

Fairbank, Alan. "Expanding Insurance Coverage to Alternative Types of Psychotherapists: Demand and Substitution Effects of Direct Reimbursement to Social Workers." *Inquiry* (Summer 1989): 170–181.

Fein, Rashi. *Medical Care, Medical Costs.* Cambridge, MA: Harvard University Press, 1986.

Feldstein, Paul J. *Health Care Economics*, 3rd ed. New York: John Wiley & Sons, Inc., 1988.

Frank, Richard G. "Freedom-of-Choice Laws: Empirical Evidence of Their Contribution to Competition in Mental Health Care Delivery." *Health Policy Quarterly* (Summer 1982): 79–97.

Freudenheim, Milt. "States Try to Cut Cost of Insurance for Medical Care." *New York Times,* 9 December 1990, p. A1.

Gabel, Jon R., and Gail A. Jensen. "The Price of State Mandated Benefits." *Inquiry* (Winter 1989): 419–431.

Jensen, Gail, and Michael Morrisey. "Group Health Insurance: A Hedonic Price Approach." *Review of Economics and Statistics* (March 1990).

Johns, Lucy, and Gerald S. Alder. "Evaluation of Recent Changes in Medicaid." *Health Affairs* (Spring 1989): 171–181.

Laudicina, Susan S. "State Health Risk Pools: Insuring the Uninsurable." *Health Affairs* (Fall 1988): 97–104.
McCall, Nelda, E. Deborah Jay, and Richard West. "Access and Satisfaction in the Arizona Health Care Cost Containment System." *Health Care Financing Review* (Fall 1989): 63–77.
Mennemeyer, Stephen T., and Lois Olinger. "Selective Contracting in California: Its Effect on Hospital Finances." *Inquiry* (Winter 1989): 442–457.
Oberg, Charles N., and Cynthia Longseth Polich. "Medicaid: Entering the Third Decade." *Health Affairs* (Fall 1988): 84–96.
Omenn, Gilbert S. "Lessons From a Fourteen-State Study of Medicaid." *Health Affairs* (Spring 1987): 118–128.
Rosko, Michael D. "A Comparision of Hospital Performance under Partial-Payer Medicare PPS and State All-Payer Rate-Setting Systems." *Inquiry* (Spring 1989): 48–61.
Rowland, Diane, and Barbara Lyons. "Mandatory HMO Care for Milwaukee's Poor." *Health Affairs* (Spring 1987): 87–100.
Scandlen, Greg. "States Enact Mandate Waiver Laws for Small Group Health Coverage." *Issue Review* (Blue Cross and Blue Shield Association, August 1990).
Sherman, Daniel. *The Effect of State Certificate-of-Need on Hospital Costs*. Staff report. U.S. Federal Trade Commission, Bureau of Economics, January 1988.
Shortell, Stephen M., and Edward F.X. Hughes. "The Effects of Regulation, Competition, and Ownership on Mortality Rates among Hospital Inpatients." *New England Journal of Medicine* (28 April 1988): 1100–1106.
U.S. Department of Labor. Bureau of Labor Statistics. *Employee Benefits in Medium and Large Firms, 1989*. Washington, DC: U.S. Government Printing Office, 1989.
Wendling, W., and J. Werner. "Nonprofit Firms and the Economic Theory of Regulation." *Quarterly Review of Economics and Business* (Fall 1980): 6–18.