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State Initiatives in Health Care Reform

- Many states are actively considering health care reform; however, most proposals still face barriers. Reallocation of health care costs due to reform provides an incentive for employers who face higher costs to move out of the state. Individual states may not have a sufficient tax base to implement and sustain reform measures.

- State attempts to regulate employers who self-insure raise significant issues related to the Employee Retirement Income Security Act of 1974 (ERISA). To be effective, most state proposals would require Congress to waive ERISA preemption. Congressional consideration of waiver requests could result in revisiting the issue of ERISA preemption.

- A federal district court ruled May 27, 1992 that ERISA preempts a New Jersey hospital rate-setting law that would require self-insured health plans to pay surcharges to cover the costs of care provided to the poor. The ruling could have a dramatic impact on numerous state reform efforts.

- In 1991, there were 992 state mandates requiring that certain benefits be included in health insurance plans. These mandates have been criticized as making insurance unaffordable for small employers. Consequently, many states have passed basic benefits laws or bare bones laws that exempt enrollees from most mandates.

- Insurance reforms are attractive to states because they are consistent with the states' traditional role as regulator of insurance and rely on the private sector to expand coverage, thus appearing not to place large burdens on state budgets. Their effectiveness in expanding coverage is problematic, however, and their ultimate impact on state budgets is unclear.

- In the absence of national reform, individual states will continue to affect their local health care delivery system through regulation of health insurance and health providers. Employers and other purchasers of health care services who are active in more than one state are likely to find increasing diversity across local health care service markets.

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◆ Introduction

In the midst of a long and protracted national debate on health care reform, states' efforts to reform their individual health care systems have drawn increased attention. In the absence of a national consensus on health care reform, a number of analysts and policymakers are hoping that states' experimentation will demonstrate the effectiveness of a variety of approaches to expanding access to care and/or constraining the growth of health care costs. While states face many of the barriers that the federal government faces in reaching a consensus, their smaller size and greater homogeneity have led to a wide range of legislation. The political dynamics of state legislatures also affect state approaches to health care. Part-time legislators; well-organized provider groups; varying degrees of organization among employer, consumer, and patient advocacy groups; as well as the relative strengths of the local political parties all combine to make each state's approach to health care unique.

The ability of individual states to implement comprehensive health care reforms is constrained by a number of factors. States face significant limitations in their funding of health care services and are constrained by federal law. Many state reform proposals require waivers for the state to continue receiving federal funds through the Medicaid program. **A number of state health care proposals raise significant issues related to federal preemption under the Employee Retirement Income Security Act of 1974 (ERISA) for employers who self-insure. To be effective as models for a future federal health care system, most state proposals will require a waiver of the federal preemption under ERISA. A waiver can only be granted by a statutory change, i.e., an act of Congress, signed by the President. Congressional consideration of waiver requests could result in a reexamination of the whole issue of federal preemption.**

The health care delivery system is actually composed of interconnected local health care service markets, each with its own unique characteristics, each providing different incentives to employers, patients, and providers. Some analysts have argued that the diverse characteristics of the local health care delivery systems need to be taken into account in designing and implementing national health care reforms. **Most of the proposals for national health care reform, such as the play-or-pay proposals, small group reform, and managed competition proposals would give states a major role in organizing and regulating their local health care delivery systems.**

Age distribution, the proportion of the population in rural settings, and ethnic composition and health status of the population all affect the local health care delivery system. These factors largely determine a state's health care needs, influence the structure of the local health care delivery system, and affect the financial and physical barriers to access to health care services. These characteristics vary considerably by state. For example, 18 percent of Florida's population is over age 65, compared with 12.1 percent nationwide. Since the elderly are more frequent users of health care services, the percentage of a state's residents who are elderly is a strong determinant of the characteristics of a local health care delivery system.

Although the vast majority of Americans live in urban areas, many states have a high percentage of their population in rural areas, including Vermont (67.8 percent); West Virginia (63.9 percent); Maine (55.4 percent); and Mississippi (52.9 percent). Among the problems of health care delivery in rural areas is low population density, which requires providers to service large geographic areas. Urban areas, where population density is higher, face problems of higher costs due to the higher cost of living in cities.

The economic environment of states, as reflected in the per capita income of their residents also varies considerably. In 1989, per capita income ranged from $24,683 in Connecticut and $23,778 in New Jersey to $11,724 in Mississippi and $12,345 in West Virginia. These

differences are also reflected in the number of low-income individuals in each state. In 1989, 2.9 percent of Connecticut's population had incomes below the poverty line, while the comparable figures were 8.3 percent for New Jersey, 15.8 percent for West Virginia, and 22 percent for Mississippi. Lower-income individuals are most likely to receive health insurance coverage through a public program, if they have health insurance at all. Because this group is most likely to be without health insurance, they are the primary users of uncompensated care and emergency room care for basic services.

The incidence of diseases and their impact on a state's health care system can also vary radically across states. The treatment of acquired immunodeficiency syndrome (AIDS) is an example. According to the U.S. Department of Health and Human Services, the lifetime cost of treating an individual infected with the human immunodeficiency virus in 1990 was $75,000. The number of AIDS cases per 100,000 in 1990 was highest in the District of Columbia (110.26), New York (45.30), and Florida (33.30). The number of AIDS cases per 100,000 in 1990 was lowest in South Dakota (0.6), North Dakota (0.6), and Wyoming (0.8).

These and other differences in characteristics among states have led to very different approaches to regulating the health care system. These differences are reflected in the regulation of the financing of health care through state insurance laws and in regulation of the health care delivery system. Moreover, a state's approaches to providing health care to the indigent, both within the Medicaid program and elsewhere, have had important effects on the health care system that all patients and payers face.

This *Issue Brief* investigates some of the ways states affect their local health care delivery system, the health care reform proposals various states have considered or implemented, the constraints imposed by existing federal law and programs on states' efforts to reform their health care systems, and the potential effects of these reforms. One of the federal programs that has significantly affected local health care delivery markets, and thus the costs paid by all payers, is the Medicaid program.

◆ The Medicaid Program: State Experimentation at Work

State and local governments, together with philanthropic organizations, were the traditional source of health care for the poor until the mid-1960s. Most of this care was provided in state and community hospitals. Over the past few decades, many of the initiatives toward regulation of the states' health care systems have come from the federal government. The states' traditional role of providing health care for the elderly poor was taken over by Medicare in 1965, while the Medicaid program, a federal-state partnership for providing care to the poor, was also initiated in the same year.

States must meet several guidelines in order to receive federal funding under the Medicaid program, but within these guidelines they are free to set eligibility requirements, benefits, and reimbursement levels. In the absence of consensus on health care reform, the diversity among Medicaid programs makes them natural experiments in the delivery and financing of health care services. These variations can serve as useful comparisons for policymakers considering the implications of particular proposals.

Beneficiaries: Wide Eligibility Variation

From the outset, Medicaid program eligibility has been strictly limited to a specific portion of the poverty population—namely, women and children qualifying for cash welfare benefits and the elderly and disabled qualifying for cash welfare benefits. These strict criteria necessarily deny coverage to a large portion of the poverty population. Some recent legislative changes have altered the welfare-Medicaid link and broadened eligibility possibilities in states to include a greater portion of the poverty population.

There are two general categories of individuals who are eligible for Medicaid: the categorically needy and the medically needy. Under the categorically needy provision in Medicaid, eligibility is determined by whether or not individuals are in one of the categories approved for Medicaid coverage. Generally, to be eligible a person must meet welfare definitions of age, blindness, disability, or membership in a one-parent family with dependent children. Once persons are determined to fall into one of the required coverage groups, they must meet the specified income and resource criteria set by each state. A few states set more stringent eligibility requirements for recipients of Supplemental Security Income (SSI). As a result, state thresholds for Medicaid vary widely. As of January 1992, the percentage of poverty qualifying a family of three for Aid to Families with Dependent Children (AFDC) ranged from 15.5 percent ($1,788) in Alabama to 76.6 percent in Alaska ($11,076) (table 1). Regardless of state eligibility variations, states are required to cover mandatory categorically needy groups (AFDC recipients and SSI recipients who are aged, blind, or disabled; pregnant women with incomes below a certain threshold; and phased in coverage of children under age 7).

Table 1
Annualized Medicaid Eligibility Thresholds[a]—Aid to Families with Dependent Children (AFDC), Medically Needy, and Pregnant Women—as a Percentage of Poverty, January 1992

	AFDC Family of Three		Medically Needy Family of Three		Pregnant Women Family of Three	
	Threshold	Percentage of poverty ($11,570)	Threshold	Percentage of poverty ($11,570)	Threshold	Percentage of poverty ($11,570)
Alabama	$ 1,788	15.5%	b	b	$15,388	133.0%
Alaska[c]	11,076	76.6	b	b	19,232	133.0
Arizona	4,008	34.6	b	b	16,198	140.0
Arkansas	2,448	21.2	$ 3,300	28.5%	21,405	185.0
California	7,956	68.8	11,208	96.9	21,405	185.0
Colorado	5,052	43.7	b	b	15,388	133.0
Connecticut	6,972	60.3	9,276	80.2	21,405	185.0
Delaware	4,056	35.1	b	b	18,512	160.0
District of Columbia	4,908	42.4	6,540	56.5	21,405	185.0
Florida	3,636	31.4	3,636	31.4	17,355	150.0
Georgia	5,088	44.0	4,500	38.9	15,388	133.0
Hawaii[c]	7,992	60.0	7,992	60.0	24,624	185.0
Idaho	3,780	32.7	b	b	15,388	133.0
Illinois	4,404	38.1	5,904	51.0	15,388	133.0
Indiana	3,456	29.9	b	b	17,355	150.0
Iowa	5,112	44.2	6,792	58.7	21,405	185.0
Kansas	4,752	41.1	5,640	48.7	17,355	150.0
Kentucky	6,312	54.6	3,696	31.9	21,405	185.0
Louisiana	2,280	19.7	3,096	26.8	15,388	133.0
Maine	6,876	59.4	5,496	47.5	21,405	185.0
Maryland	4,524	39.1	5,304	45.8	21,405	185.0
Massachusetts	6,948	60.1	9,300	80.4	21,405	185.0
Michigan	7,044	60.9	6,804	58.8	21,405	185.0
Minnesota	6,384	55.2	8,508	73.5	21,405	185.0
Mississippi	4,416	38.2	b	b	21,405	185.0
Missouri	3,504	30.3	b	b	15,388	133.0
Montana	4,680	40.4	5,316	45.9	15,388	133.0
Nebraska	4,368	37.8	5,904	51.0	15,388	133.0

(continued)

Table 1 (continued)

	AFDC Family of Three		Medically Needy Family of Three		Pregnant Women Family of Three	
	Threshold	Percentage of poverty ($11,570)	Threshold	Percentage of poverty ($11,570)	Threshold	Percentage of poverty ($11,570)
Nevada	$4,176	36.1%	b	b	$15,388	133.0%
New Hampshire	6,192	53.5	$7,392	63.9%	15,388	133.0
New Jersey	5,088	44.0	6,792	58.7	21,405	185.0
New Mexico	3,888	33.6	b	b	21,405	185.0
New York	6,924	59.8	9,000	77.8	21,405	185.0
North Carolina	3,264	28.2	4,404	38.1	21,405	185.0
North Dakota	4,812	41.6	5,220	45.1	15,388	133.0
Ohio	4,008	34.6	b	b	15,388	133.0
Oklahoma	5,652	48.9	5,508	47.6	15,388	133.0
Oregon	5,520	47.7	7,356	63.6	15,388	133.0
Pennsylvania	5,052	43.7	5,604	48.4	15,388	133.0
Rhode Island	6,648	57.5	8,892	76.9	21,405	185.0
South Carolina	5,280	45.6	3,396	29.4	21,405	185.0
South Dakota	4,848	41.9	b	b	15,388	133.0
Tennessee	5,112	44.2	3,000	25.9	21,405	185.0
Texas	2,208	19.1	3,204	27.7	21,405	185.0
Utah	6,444	55.7	6,432	55.6	15,388	133.0
Vermont	8,076	69.8	10,800	93.3	21,405	185.0
Virginia	3,492	30.2	4,296	37.1	15,388	133.0
Washington	6,372	55.1	7,800	67.4	21,405	185.0
West Virginia	2,988	25.8	3,480	30.1	17,355	150.0
Wisconsin	6,216	53.7	8,268	71.5	17,934	155.0
Wyoming	4,320	37.3	b	b	15,388	133.0
Average State	$5,106	43.6%	$6,191	53.3%[d]	$18,521	158.9%

Source: National Governor's Association, January 1992.

[a]AFDC/medically needy thresholds current through January 1992. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the payment standard. In Colorado, Georgia, Kentucky, Maine, Michigan, Mississippi, Oklahoma, South Carolina, Tennessee, and Utah, the threshold is the state's need standard. In these 10 states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' payment standards are actually significantly lower than the eligibility threshold.

[b]Data not available.

[c]Poverty levels for Alaska and Hawaii differ from other states: Alaska—family of three = $14,460; Hawaii—family of three = $13,310.

[d]The percentage represents the average medically needy threshold as a percentage of poverty only for those states that have medically needy programs.

The second major eligibility category is the medically needy. States have the option of covering certain individuals whose income and or resources preclude them from gaining categorical eligibility. To become eligible under the medically needy category, persons must meet the nonfinancial standard for categorical eligibility and have income and resources that fall below the medically needy standard after deducting their incurred medical expenses. Medically needy income cannot exceed 133.3 percent of the maximum AFDC payment for the same sized family.

In fiscal year 1990, 23.8 million persons were Medicaid recipients—85 percent of the 28.2 million eligible persons (table 2). Most Medicaid recipients fall into one of three categories: children under age 21, permanently and totally disabled, or persons aged 65 or over. Children under age 21 comprise the single largest group

Table 2
Number and Percentage of Medicaid Enrollees Who Received Medicaid Services by State, Fiscal Year 1990

	Enrollees	Recipients of Medicaid Services	Percentage
	(thousands)		
Total	28,217.4	23,858.3	84.6%
State			
Alabama[a]	431.2	352.0	81.6
Alaska	49.8	39.1	78.4
Arkansas	289.9	264.3	91.2
California[a]	4,756.2	3,624.2	76.2
Colorado	239.9	190.6	79.5
Connecticut	249.6	249.6	100.0
Delaware[a]	54.2	41.0	75.6
District of Columbia	109.0	93.5	85.8
Florida	1,186.3	1,038.4	87.5
Georgia[a]	715.6	650.9	91.0
Hawaii[a]	93.4	85.0	91.0
Idaho	65.8	54.6	82.9
Illinois	1,394.1	1,067.5	76.6
Indiana[a]	378.8	347.9	91.8
Iowa[a]	272.3	239.6	88.0
Kansas[a]	232.9	194.4	83.5
Kentucky[a]	523.6	467.7	89.3
Louisiana	649.3	585.1	90.1
Maine[a]	156.3	133.0	85.1
Maryland	440.6	330.4	75.0
Massachusetts[b]	689.4	590.7	85.7
Michigan	1,173.4	1,048.0	89.3
Minnesota	401.8	380.3	94.6
Mississippi	496.0	432.9	87.3
Missouri[a]	530.5	448.2	84.5
Montana[a]	73.8	61.1	82.7%
Nebraska	132.1	119.2	90.2
Nevada[a]	63.2	47.0	74.4
New Hampshire[a]	51.8	44.8	86.6
New Jersey[a]	642.0	566.8	88.3
New Mexico	158.5	129.9	81.9
New York	2,614.3	2,329.5	89.1
North Carolina	635.5	563.3	88.6
North Dakota[a]	55.4	49.0	88.5
Ohio	1,337.4	1,220.8	91.3
Oklahoma	330.9	273.3	82.6
Oregon	262.3	227.2	86.6
Pennsylvania	1,303.5	1,177.2	90.3
Rhode Island[c]	138.4	117.0	84.5
South Carolina	354.2	317.1	89.5
South Dakota	60.0	49.3	82.1
Tennessee	693.8	613.3	88.4
Texas	1,758.9	1,442.1	82.0
Utah[a]	140.0	108.3	77.3
Vermont[a]	68.8	60.4	87.8
Virginia	440.6	379.5	86.1
Washington[a]	532.0	447.6	84.1
West Virginia	318.4	250.3	78.6
Wisconsin[a]	561.9	392.7	69.9
Wyoming[a]	36.1	28.9	80.1
Territory			
Puerto Rico[c]	1,513.6	d	d
Virgin Islands	11.8	11.1	93.5

Source: Unpublished data from the U.S. Department of Health and Human Services, Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Services, Division of Medicaid Statistics.
[a]Medicaid Statistics Information System states' recipient and expenditure data.
[b]Data for blind recipients are estimated.
[c]States' enrollee and recipient data are estimated.
[d]Not available.

of Medicaid recipients. Nationally, there were 11.2 million recipients in this category (table 3). By far, the largest concentration of Medicaid recipients was among children aged 5 and under (24.1 percent) (table 4).

Financing: Variations in Funding Sources

Medicaid is administered and funded by states with matching grants from general federal revenue. The ratio of federal to state funds, termed the federal medical assistance percentage (FMAP), is based upon a state's per capita income. Under current law, a state's FMAP can range from 50 percent to 83 percent. The remaining funds to administer a state's Medicaid program can come entirely from state budget funds or be partially financed by local government funds (up to 10 percent of total Medicaid costs).

States differ considerably in both their Medicaid spending and the share of their federal Medicaid

Table 3

Recipients of Medicaid Services by Categorical Eligibility, by State, District of Columbia, and U.S. Territories, Fiscal Year 1990

	Total Recipients	Aged 65 and over	Blind	Permanently and Totally Disabled	Dependent Children under 21	Adults in FDC[a]	Other Title XIX Recipients	Basis of Eligibility Unknown
	(thousands)							
Total	25,255.1	3,202.1	83.3	3,634.7	11,220.0	6,010.4	989.5	115.0
State								
Alabama	352.0	68.0	1.6	82.4	122.4	68.5	8.3	0.9
Alaska	39.1	2.7	0.1	3.9	22.4	10.2	0.0	0.0
Arkansas	264.3	44.9	1.3	51.3	84.0	43.3	39.4	0.0
California	3,624.2	438.3	23.7	529.2	1,560.3	998.3	25.6	48.8
Colorado	190.8	33.6	0.2	28.5	81.1	43.6	3.7	0.0
Connecticut	249.6	45.7	0.3	30.9	144.7	10.6	16.4	0.0
Delaware	41.0	4.3	0.2	8.3	28.0	2.7	1.0	0.5
District of Columbia	93.5	11.8	b	15.1	45.4	21.1	b	0.0
Florida	1,038.4	162.5	3.3	184.1	454.7	233.6	20.2	0.0
Georgia	650.9	83.4	2.8	123.8	270.7	149.1	2.6	18.4
Hawaii	85.0	11.9	b	8.5	40.8	20.3	0.0	3.5
Idaho	54.6	6.8	b	9.2	24.6	13.3	0.5	0.0
Illinois	1,067.5	87.9	1.2	168.8	544.7	249.4	15.5	0.0
Indiana	347.9	46.5	1.1	56.9	155.4	85.2	0.0	2.6
Iowa	239.6	35.0	0.7	32.7	96.0	59.2	14.8	1.1
Kansas	194.4	24.3	0.1	21.5	89.5	57.9	0.1	0.9
Kentucky	467.7	55.0	2.0	92.3	163.3	112.0	37.4	5.9
Louisiana	585.1	89.7	1.8	84.9	279.9	128.8	b	0.0
Maine	133.0	20.9	0.2	22.9	52.6	31.1	4.8	0.5
Maryland	330.4	43.3	0.3	51.8	156.9	71.2	6.9	0.0
Massachusetts	590.7	95.3	10.2	96.3	217.2	128.8	43.0	0.0
Michigan	1,048.0	84.5	2.1	139.4	527.7	294.3	0.0	0.0
Minnesota	380.3	52.9	0.6	30.9	180.0	99.2	16.9	0.0
Mississippi	432.9	62.7	2.8	76.3	208.2	81.7	1.2	0.0
Missouri	448.2	65.2	1.2	70.4	191.3	106.4	2.0	11.8
Montana	61.1	7.1	0.1	9.6	23.3	14.2	4.8	1.8
Nebraska	119.2	17.7	0.2	13.8	50.9	25.8	10.8	0.0
Nevada	47.0	7.8	0.4	7.2	19.7	10.3	1.4	0.2
New Hampshire	44.8	10.1	0.4	6.3	19.8	8.1	0.0	0.2
New Jersey	566.8	72.3	1.2	89.8	265.6	128.7	0.1	9.2
New Mexico	129.9	13.5	0.5	21.7	63.5	30.5	0.1	0.0
New York	2,329.5	336.1	3.9	342.6	1,021.7	455.3	159.9	0.0
North Carolina	563.3	103.6	1.2	72.1	243.7	142.9	b	0.0
North Dakota	49.0	10.0	b	6.2	18.6	10.7	3.0	0.4
Ohio	1,220.8	108.6	1.5	146.9	634.6	279.8	49.4	0.0
Oklahoma	273.3	52.7	0.6	34.9	121.4	59.4	4.3	0.0
Oregon	227.2	23.9	1.1	27.7	111.0	63.4	0.0	0.0
Pennsylvania	1,177.2	131.6	1.2	178.1	538.1	276.8	51.5	0.0
Rhode Island	117.0	21.5	0.3	23.4	46.1	24.7	0.9	0.0
South Carolina	317.1	50.8	1.8	67.8	131.8	65.0	b	0.0
South Dakota	49.3	8.8	0.1	8.1	21.5	10.7	0.0	0.0
Tennessee	613.3	85.3	3.7	124.1	271.0	120.3	9.1	0.0
Texas	1,442.1	234.1	3.6	145.7	722.3	336.3	0.0	0.0
Utah	108.3	8.0	0.1	11.1	49.4	33.7	4.7	1.3
Vermont	60.4	10.0	0.1	8.2	25.9	15.6	0.4	0.2

(continued)

Table 3 (continued)

	Total Recipients	Aged 65 and over	Blind	Permanently and Totally Disabled	Dependent Children under 21	Adults in FDC[a]	Other Title XIX Recipients	Basis of Eligibility Unknown
	(thousands)							
Virginia	379.5	67.5	1.1	60.6	154.0	86.3	0.0	0.0
Washington	447.6	45.8	0.4	59.1	200.8	125.6	14.1	2.1
West Virginia	250.3	28.2	0.3	37.1	105.0	77.8	1.8	0.0
Wisconsin	392.7	65.2	1.2	75.3	158.5	78.2	9.7	4.6
Wyoming	28.9	2.8	b	2.7	15.1	7.9	0.4	b
Territory								
Puerto Rico	1.3	0.0	0.7	55.7	431.2	390.1	402.1	0.0
Virgin Islands	11.1	1.0	b	0.8	6.0	2.8	0.6	0.0

Source: Unpublished data from the U.S. Department of Health and Human Services, Health Care Financing Administration, Medicaid Bureau, Office of Medicaid Statistics.
Note: Arizona has an independent Medicaid system, operating under a federal waiver.
[a]Adults in families with dependent children.
[b]Greater than zero but less than 50.

match. For example, Massachusetts spends $393 per capita on its Medicaid program with a 50 percent match from the federal government, California spends $252 per capita with a 50 percent match, while Alabama spends $143 per capita with a 73 percent match.

Services Covered: Not All States Are Equal

States are required to cover mandatory services, which include such services as inpatient hospital care, outpatient hospital care, and care offered by rural health clinics. The most frequently reimbursed service types were physicians' services and prescription drugs. Each were used by more than 17 million recipients. State Medicaid programs may also offer optional services. These services include a variety of categories, such as covered providers, outpatient services, covered therapy, medical devices, preventive care, and institutionalized care (table 5).

Reimbursement

The reimbursement methodologies for the various services covered by Medicaid also vary widely across the states. The Medicaid reimbursement methodology used by states must meet the following criteria regardless of the service being covered. First, providers must accept Medicaid reimbursement as payment-in-full. Second, Medicaid is the payer of last resort—private insurance and Medicare pay first. Third, the payment methods and procedures used must ensure that payments will be "consistent with efficiency, economy, and quality of care" (Congressional Research Service, 1988).

States have the option of choosing to reimburse nursing facilities using a retrospective system, a prospective system, or a combination. Under a retrospective system the provider's reimbursement is based on past costs. In a prospective system fees are determined in advance and may be related to past costs. Thus, a prospective system forces providers to conform to a set fee system rather than incurring costs in anticipation that fees will adjust in the future in response.

In 1989, 34 states reported that they used a prospective payment system; only three states reported using a retrospective payment system (table 6). Six states reported using a combination. Maine and New Hampshire reported using a retrospective payment system for skilled nursing facilities and a prospective payment system for intermediate care facilities (table 6).

Table 4
Medicaid Recipients as a Percentage of State Populations, by Age and Sex, Fiscal Year 1990

State	Total Recipients	Age						Sex	
		5 and under	6–14	15–20	21–44	45–64	65 and over	Male	Female
Total[a]	10.3%	24.1%	12.6%	11.0%	6.0%	3.7%	11.9%	6.7%	11.5%
Alabama[b]	8.6	18.3	9.0	8.9	5.2	4.1	19.4	5.9	11.0
Alaska	7.8	19.3	11.5	9.0	5.0	2.5	10.9	5.6	10.1
Arkansas	10.9	31.7	9.9	12.9	6.4	5.0	15.4	7.6	14.0
California	12.2	26.0	15.9	14.6	8.0	5.6	17.7	9.1	14.9
Colorado	5.7	12.3	7.6	7.2	3.4	2.3	9.8	4.0	7.3
Connecticut	7.6	22.1	19.9	12.6	1.8	0.9	10.1	5.6	9.5
Delaware	5.9	23.5	8.3	6.4	3.9	2.0	6.2	4.2	7.6
District of Columbia	16.4	39.5	24.3	26.5	9.5	8.6	19.6	12.2	20.2
Florida	7.9	24.0	10.4	10.7	4.9	2.9	8.7	5.6	10.0
Georgia	10.3	26.2	12.8	10.8	6.0	4.7	17.2	6.9	13.1
Hawaii	7.7	17.7	13.6	8.6	5.0	2.2	10.4	5.7	9.2
Idaho	5.2	14.0	4.7	6.0	3.9	1.9	6.9	3.6	6.7
Illinois	9.1	23.6	14.8	10.8	6.2	3.8	8.1	6.8	11.3
Indiana	6.4	16.5	9.5	6.6	4.2	2.7	8.2	4.5	8.0
Iowa	8.6	22.3	12.6	10.9	6.5	2.8	9.2	6.6	10.4
Kansas	7.7	17.3	9.8	10.2	5.9	2.9	8.4	6.1	9.3
Kentucky	12.9	34.2	17.9	14.3	8.8	6.3	15.4	9.8	15.5
Louisiana	14.5	44.0	20.4	14.7	8.8	5.1	19.5	10.6	17.9
Maine	10.8	22.0	15.6	10.7	7.5	4.9	17.2	8.0	13.4
Maryland	7.0	18.4	9.6	9.8	4.6	2.7	9.3	4.8	9.1
Massachusetts[c]	10.1	27.8	15.7	12.7	6.2	4.2	14.6	7.3	12.8
Michigan	11.4	31.5	16.3	15.1	8.6	3.8	10.0	8.5	14.2
Minnesota	8.7	23.0	11.3	12.2	5.8	2.6	12.1	6.8	10.5
Mississippi	16.2	40.4	18.4	16.2	8.6	7.5	27.2	11.2	21.0
Missouri	8.6	18.7	10.5	9.4	5.2	4.0	13.4	6.1	10.5
Montana	7.4	15.5	9.6	7.6	5.7	2.9	9.0	5.6	8.9
Nebraska	7.4	21.8	9.0	9.2	4.5	2.5	9.4	5.5	8.8
Nevada	3.9	9.8	5.1	3.6	2.4	1.5	6.4	2.7	5.0
New Hampshire	4.1	12.7	5.5	4.0	2.5	1.6	8.3	2.8	5.4
New Jersey	7.3	17.4	12.6	9.6	4.7	2.6	8.9	5.2	9.2
New Mexico	0.9	26.1	9.5	7.1	5.6	3.1	10.2	6.0	11.0
New York	12.9	32.8	20.1	14.9	8.1	5.5	15.9	9.6	16.0
North Carolina	8.8	25.2	11.5	11.4	5.4	3.6	13.1	5.9	11.5
North Dakota	7.7	20.1	9.0	7.6	5.3	2.8	12.9	5.7	9.5
Ohio	11.2	33.4	15.9	14.7	8.0	3.7	9.1	8.2	13.3
Oklahoma	8.8	20.5	12.1	11.7	5.6	3.3	13.1	6.1	11.4
Oregon	7.9	25.1	10.6	9.5	6.0	2.4	6.3	5.7	10.0
Pennsylvania	9.7	d	d	d	d	d	d	d	d
Rhode Island[e]	12.4	d	d	d	d	d	d	d	d
South Carolina	9.3	25.7	11.1	10.7	5.4	4.0	17.5	6.4	12.1
South Dakota	7.1	20.3	8.4	6.8	4.6	2.6	9.4	5.0	9.2
Tennessee	12.5	33.0	15.6	14.2	7.9	6.1	17.4	8.9	15.8
Texas	8.5	25.8	10.1	8.9	4.5	3.0	14.9	6.1	10.8
Utah	6.2	14.5	5.8	6.4	5.1	2.3	5.5	4.4	7.9
Vermont	10.7	25.0	15.9	11.1	7.6	4.5	14.6	8.4	12.8
Virginia	6.0	15.2	7.0	6.4	3.5	2.8	11.9	4.1	7.8
Washington	9.2	22.9	13.2	10.5	7.2	3.2	10.2	7.0	11.2
West Virginia	13.8	41.2	19.7	15.7	10.7	5.7	12.4	9.2	14.5

(continued)

Table 4 (continued)

State	Total Recipients	Age: 5 and under	6–14	15–20	21–44	45–64	65 and over	Sex: Male	Female
Wisconsin	8.2%	19.4%	9.6%	9.8%	6.1%	3.3%	10.7%	6.3%	9.8%
Wyoming	6.2	20.5	7.9	6.4	4.6	1.4	7.2	4.1	8.5

Source: Employee Benefit Research Institute tabulations of the March 1991 Current Population Survey and unpublished data from the U.S. Department of Health and Human Services, Health Care Financing Administration, Bureau of Data Management and Strategy, Office of Program Services, Division of Medicaid Statistics.
[a]Total excludes persons in Arizona because the state does not participate in the Medicaid program. It includes Puerto Rico and the Virgin Islands.
[b]Medicaid State Information System's states' recipient and expenditure data.
[c]Massachusetts' blind recipient and expenditure data are estimated.
[d]Data not available.
[e]State's data are estimated.

Nearly all states reported that in 1989 they were using a prospective reimbursement system for inpatient hospitalization of Medicaid beneficiaries (table 6). Only Delaware, West Virginia, and Wyoming reported calculating payment as a percentage of actual costs or charges (table 6).

New Jersey is one of four states (others are Maryland, Massachusetts, and New York) that have implemented all-payer hospital reimbursement systems.

States determine the prospective payment schedule for hospitals in different ways; two alternative models are (1) selective contracting, which is used by Medi-Cal, the Medicaid program in California, and (2) a per admission, all-payer system, which is used in 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 (UR) process that limits a hospital's ability to arbitrarily extend stays.

New Jersey is one of four states (others are Maryland, Massachusetts, and New York) that have implemented all-payer hospital reimbursement systems. The New Jersey all-payer system regulates hospital reimbursement rates and overall revenue, while reimbursing on a per admission basis. Allowances are made for uncompensated care provided in both inpatient and outpatient settings, and the costs of that care are distributed proportionately across payers through a surcharge on hospital bills. 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 the uninsured nationally (6.6 visits versus 3.2 visits, respectively) (Rosko, 1989).

The New Jersey surcharge has been challenged in court; a federal judge ruled that self-insured benefit plans are exempt under ERISA from paying more

Table 5

Medicaid Services by States, the District of Columbia, and U.S. Territories, October 1991

	Categorically Needy	Categorically and Medically Needy	Total
Mandatory[a]			
Optional			
Covered providers			
podiatrist	12	33	45
optometrist	14	36	50
chiropractor	8	19	27
other practitioner	13	32	45
private duty nursing	8	20	28
Christian Science nurses	1	2	3
Outpatient services			
clinic	15	40	55
dental	12	36	48
Covered therapy			
physical therapy	11	31	42
occupational therapy	8	26	34
speech, hearing, and language disorders	11	29	40
respiratory care	3	11	14
Medical devices			
dentures	8	31	39
prosthetic devices	14	38	52
eyeglasses	16	33	49
prescribed drugs	16	38	54
Preventive care			
diagnostic	5	21	26
screening	4	19	23
preventive	3	20	23
Institutionalized care			
aged 65 or over in IMDs[b]			
inpatient hospital	14	26	40
nursing facility	11	22	33
intermediate care facility for mentally retarded	21	28	49
inpatient psychiatric for under age 21	10	29	39
Christian Science sanitoriums	4	11	15
nursing facility for under age 21	20	30	50
hospice care	9	24	33
Miscellaneous			
emergency hospital	14	28	42
personal care	9	19	28
transportation	14	37	51
case management	10	33	43
rehabilitation	12	33	45

Source: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Intergovernmental Affairs, 1992.

[a]Mandatory services include inpatient hospital; outpatient hospital; rural health clinic; other laboratory and x-ray; nurse practitioner; nursing facility and home health for individuals aged 21 and over; early and periodic screening, diagnosis, and treatment for individuals under age 21; family planning and supplies; physician; and nurse-midwife.

[b]Institutions for mental diseases.

than the actual costs of hospital services. This ruling, which is being appealed, may have important implications for other state efforts to expand coverage. Issues surrounding ERISA preemption and its impact on state reform efforts is discussed later in this *Issue Brief*.

In 1989, 42 states used a fee schedule to reimburse physicians who treat Medicaid beneficiaries. Seven states reimbursed physicians based on the usual or customary fees charged for the same services in the past.

OBRA '81 allowed states to limit Medicaid recipients' freedom to choose a provider.

Arizona has combined a managed care and competitive bidding approach. When Arizona began its Arizona Health Care Cost Containment System (AHCCCS) in 1982, it was the first time the state had a program eligible to receive federal Medicaid funds. Prior to the enactment of AHCCCS, Arizona's 14 counties had the responsibility of providing medical care to the poor. Under AHCCCS, the state uses a bidding process to select providers who are paid a capitated amount. Each enrollee is assigned a physician who manages his or her care. Beneficiaries also face copayments, although the law states that no patient is denied services due to an inability to pay. AHCCCS 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. An assessment of AHCCCS found that there was no difference in access, utilization, or satisfaction with the program by beneficiaries between the AHCCCS and traditional Medicaid programs (McCall, Jay, and West, 1989).

OBRA '81 allowed states to limit Medicaid recipients' freedom to choose a provider. Forty-one states have received freedom-of-choice waivers under this law and have implemented some sort of managed care program. These programs, typically health maintenance organizations (HMOs), have had to overcome a number of obstacles. First, the Medicaid population is more transient with respect to the program than are privately insured patients. Second, the benefits typically offered by Medicaid, especially long-term or chronic care, are not typically offered by managed care plans. Finally, in states with managed care options there may be an adverse selection problem in which patients who are more severely ill elect not to enroll in the managed care plan. Because the amount prepaid plans are generally paid is a percentage (usually 95 percent) of the average cost of treating Medicaid patients in nonmanaged settings, adverse selection can result in higher overall charges to the Medicaid program. In the 27 states with mandatory enrollment in managed care, plans distributing severely ill patients across plans can equalize the burden, although it is a difficult administrative task.

The Medicaid Program and Cost Shifting

The Medicaid program impacts on the local health care services market in a number of ways. The program's eligibility requirements affect the number of individuals without health coverage. As those requirements are relaxed, the number of uninsured within a state falls, and the amount of uncompensated care provided by hospitals is reduced. As a result, the hospital charges for private patients may be lower because hospitals face a reduced need to pay for losses incurred by nonpaying patients. Conversely, to the extent that the local Medicaid program's reimbursement is inadequate in covering a hospital's costs, the hospital may continue to shift costs.

Research into the extent to which Medicaid reimbursement policies affect the costs of private patients has generally found that private payers' costs are increased by Medicaid underpayments. One researcher investigating the impact of a reduction of Medicaid reimbursement rates on hospital charges to private patients in

Table 6
Medicaid Provider Reimbursement Methods for Various Services

State	Reimburement Method				
			Inpatient Hospital		
	Nursing Facility Services	Physician Services	Prospective Rates	Diagnosis Weighted	Percentage of Costs or Charges
Alabama	prospective	fee schedule	per diem	a	a
Alaska	prospective	reasonable charges	per discharge	a	a
Arizona	prospective	negotiated rate	a	a	a
Arkansas	prospective	fee schedule	per diem	a	a
California	prospective	fee schedule	per discharge	a	b
Colorado	combination	fee schedule	per discharge	X	a
Connecticut	prospective	fee schedule	per discharge	a	a
Delaware	prospective	fee schedule	a	a	X
District of Columbia	prospective	fee schedule	per discharge	a	a
Florida	prospective	fee schedule	per diem	a	b
Georgia	prospective	fee schedule	per admission	a	a
Hawaii	c	reasonable charges	per diem	a	a
Idaho	combination	fee schedule	per diem	a	b
Illinois	prospective	fee schedule	per diem	a	a
Indiana	prospective	reasonable charges	per discharge	a	b
Iowa	prospective	fee schedule	per discharge	X	a
Kansas	c	fee schedule	per discharge	X	a
Kentucky	prospective	reasonable charges	per diem	a	b
Louisiana	prospective	fee schedule	per discharge	a	b
Maine	d	fee schedule	per discharge	a	a
Maryland	c	fee schedule	per service	a	a
Massachusetts	retrospective	fee schedule	per discharge	a	a
Michigan	prospective	fee schedule	per discharge	X	b
Minnesota	prospective	fee schedule	per admission	X	a
Mississippi	c	fee schedule	per diem	a	b
Missouri	prospective	fee schedule	per diem	a	a
Montana	prospective	fee schedule	per discharge	X	a
Nebraska	combination	fee schedule	per diem	a	a
Nevada	prospective	fee schedule	per discharge	a	a
New Hampshire	d	reasonable charges	per discharge	X	a
New Jersey	prospective	fee schedule	per discharge	X	a
New Mexico	prospective	fee schedule	per discharge	a	b
New York	prospective	fee schedule	per discharge	a	a
North Carolina	prospective	fee schedule	per diem	a	a
North Dakota	prospective	fee schedule	per discharge	X	a
Ohio	combination	fee schedule	per discharge	X	a
Oklahoma	prospective	fee schedule	per discharge	a	a
Oregon	combination	fee schedule	per discharge	X	a
Pennsylvania	retrospective	fee schedule	per discharge	X	a
Rhode Island	prospective	fee schedule	per diem	a	a
South Carolina	prospective	fee schedule	per discharge	X	a
South Dakota	prospective	fee schedule	per discharge	X	a
Tennessee	retrospective	reasonable charges	per diem	a	a
Texas	prospective	reasonable charges	per admission	X	a
Utah	prospective	fee schedule	per discharge	X	a
Vermont	prospective	fee schedule	per diem	a	a
Virginia	combination	fee schedule	per diem	a	b

(continued)

Table 6 (continued)

State	Reimburement Method				
			Inpatient Hospital		
	Nursing Facility Services	Physician Services	Prospective Rates	Diagnosis Weighted	Percentage of Costs or Charges
Washington	c	fee schedule	per discharge	X	a
West Virginia	c	fee schedule	a	a	X
Wisconsin	prospective	fee schedule	per discharge	a	a
Wyoming	prospective	reasonable charges	a	a	X

Source: National Governor's Association and the Physician Payment Review Commission.
[a]Not applicable.
[b]Payment equals the lesser of the prospective rate and the percentage of costs or charges.
[c]No survey response.
[d]Retrospective payment for skilled nursing facilities and prospective payment for intermediate care facilities.

Illinois found that, for every $1,000 in government revenues the hospital lost, private admission charges were raised $0.15. Given the average loss of $1.88 million for each hospital in Illinois, that translated into an increase of $282 per private admission (Dranove, 1988). The Employee Benefit Research Institute's (EBRI) study of hospital cost shifting in Houston, Texas found that about 4 percent of hospital charges could be attributed to cost-shifting from the Medicaid program (Custer, 1989). The degree of cost shifting is likely to vary considerably by state given the differences in states' reimbursement methodologies.

The Medicaid Program and State Health Care Reform

One common reform advocated for 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.

The Oregon Basic Health Services Act, passed in 1989, is intended to provide universal access to a basic level of health care for all Oregonians. This act would require that all employers in Oregon provide a basic benefits package to their permanent employees and dependents. The Medicaid program would be expanded to cover everyone under the poverty level. The basic benefits package that all residents would receive would be based on an explicit prioritized system of health care services worked out for the Oregon Medicaid program.

The basic strategy of the Oregon program is to extend coverage to the uninsured by prioritizing health care services and funding only those services that have the highest priority. They have thus made an explicit trade-off between benefits and coverage.

The Oregon program has generated a great deal of controversy, largely due to the health care prioritization component. An 11-member Health Services Commission (HSC), composed of five physicians, three consumer representatives, one public health nurse, and one social worker was established to define an adequate level of coverage. In a series of surveys, public hearings, community meetings, and interviews with health professionals, the HSC created 709 condition and treatment pairs and 17 categories of health care. The categories constitute the basic zones of priorities on the list. For example, acute fatal conditions (i.e, appendectomy, repair of deep open wound of the neck), where treatment allows full recovery, was determined to be the top priority category. Other examples of the

17 categories include preventive care for children (i.e., immunizations), preventive care for adults (mammograms, blood pressure screening), maternity care, and a category for services in which treatment causes minimal or no improvement in the quality of life (i.e., medical therapy for gallstones without cholecystitis, medical therapy for viral warts) (Garland, 1992). The 709 pairs were grouped and prioritized into the 17 categories based on measures of quality of life and clinical treatment outcomes. The members of HSC then made adjustments to the list, moving condition-treatment pairs up and down the list, some of the pairs (25 percent) as much as 100 lines or more, based on subjective criteria fashioned on values elicited from the public (Wiener, 1992).

Most health care reform proposals reallocate the costs of health care services in order to expand access to care.

The plan requires a demonstration waiver from the federal government because it calls for a benefit reduction for some Medicaid recipients. The Bush administration has stated its support for state experimentation but has voiced opposition to explicit rationing. At publication time no decision had been made on whether the state would be granted the waivers it needs.

Expanding the Medicaid program to reduce the number of uninsured in a state has the advantage of employing an existing financing and delivery system. Conversely, Medicaid is perceived to offer lower quality care than private plans or Medicare. One of the factors contributing to perceived and actual problems with the quality of care provided to Medicaid enrollees is the relatively low reimbursements to providers. Currently, physicians treating Medicaid patients are reimbursed, on average, 69 percent of the amount that Medicare reimburses them for the same services (Physician Payment Review Commission, 1991). If a Medicaid expansion were to increase physician and hospital reimbursement rates to the levels of other payers, costs to the federal and state governments would be much higher.

◆ ERISA and Other Barriers to State Reform Efforts

Many states are actively considering a variety of approaches to health care reform. These proposals vary according to the type of system used to provide health care coverage and for whom; how the system will be financed; the types of health care services provided; and how the system will be administered (table 7).[1] Even if individual states are able to reach consensus on an approach to implement, most proposals still face a number of barriers in attempting to expand access or reduce health care cost inflation.

Most health care reform proposals reallocate the costs of health care services in order to expand access to care. As a result of the reallocation, some groups would face higher costs in the form of increased labor costs, higher insurance costs, or higher taxes. Therefore, state health care reform provides an incentive for employers who face higher costs to move out of the state. While this is also true of national health care reform, there are language, cultural, and technical barriers that may limit movement out of the country but these barriers are much less of a factor in movement between states. Moreover, individual states may not have a sufficient tax base to implement and sustain comprehensive health care reform measures. **Finally, the interaction of state and federal law places important constraints on states' ability to regulate the health care delivery system. ERISA authority is of particular significance to state health care reform.**

[1]The proposals included in table 7 have been reported out of committee in their respective state legislatures or have been proposed by prominent state officials. Several states not listed in this table also are considering health care reform proposals.

Table 7
State Programs and Proposals on Health Care Access for the Uninsured

State/Bill Name	Status	Type/Number Covered	Financing	Services Provided[a]	Administration
California California Health Care in the 21st Century, 1992	S.B. 6 as amended would create a commission to study the proposal. Introduced March 17, 1992.	Universal All state residents	Cost: $34 billion annually Overall average of 6.75% payroll tax on employers. Overall average 1% tax on employees' wages. Tax on self-employed based on earnings.	Based on a comprehensive health maintenance organization package	Regional health insurance purchasing corporations
Florida Universal Health Access Plan of 1991[b]	Reported out of House Health Care and Appropriations Committees and placed on House calendar. Died on House calendar.	Single-payer All state residents	$18.2 billion from premiums $8.5 billion from federal Medicare $7.1 billion from federal Medicaid Premiums would equal $178 per person per month.	MH/SA, P, Pr, HC-In, HC-Out,	Florida Universal Health Access and Cost Containment Commission
Georgia Basic Health Plan	Passed Legislature. Draft model proposed by Insurance Commissioner April 1992. Final model was released July 1, 1992.	Model Health Insurance Policy. Uninsured residents and nonresidents under 250% of poverty who work in Georgia.		MN, HC-In, HC-Out, Pr	Managed Care
Hawaii[c] Prepaid Health Care Act 1974 (PHCA)	Enacted into law 1974.	Employer mandate All full-time employees	Employers pay at least one-half of the cost and employees pay no more than 1.5% of gross income. Premiums average: Individual — $94/mo. Family of four — $263/mo.	P, HC-In, HC-Out	Blue Shield and Kaiser Foundation Health Plan
State Health Insurance Program (SHIP) 1989	Enacted into law 1989.	50,000 Called the "Gap Group." People who fall into the gaps of PHCA, including unemployed workers, part-time workers, seasonal workers, and low-income self-employed and dependents.		P, Pr, HC-In	Blue Shield and Kaiser Foundation Health Plan
Idaho Idaho Universal Health Insurance Plan, H.B. 1352	Unanimously defeated on the floor of the Senate February 26, 1992.	Single-payer All state residents	Payroll tax on employers not in excess of 8%. Tax on employees' wages not in excess of 1.75%. Tax on self-employed income subject to taxable limit for Medicare health insurance not in excess of 9.5%. Federal Medicare and Medicaid funds.	MH/SA, P, Pr, HC-In, HC-Out, Rx	Board of Governors

(continued)

Table 7 (continued)

State/Bill Name	Status	Type/Number Covered	Financing	Services Provided[a]	Administration
Illinois Universal Health Care Act, H.B. 2774	Bill amended in committee and on the House floor. Tabled on the House floor May 22, 1992 according to House rule 37-G.	Single-payer All state residents	Tax on employers and self-employed, income tax on individuals, Medicare and Medicaid funds, and tax on alcohol and tobacco.[d]	MH/SA, P, Pr, HC-In, HC-Out, Rx, LTC	Universal Health Care Board
Kansas Kansas Health Care Reform Act, S.B. 553	Died in Senate Public Health and Welfare Committee.	Single-payer All state residents and nonresidents who work in Kansas	8% payroll tax on employers, 8% tax on adjusted gross income, Income tax surcharge[e] on individuals, tax on tobacco. Federal Medicare and Medicaid funds.	MH/SA, P, Pr, HC-In, HC-Out, Rx	Kansas Health Care Commission
Massachusetts Health Security Act, 1988[f]	Enacted into law 1989. The law was to take effect in 1992 but was postponed until 1994. Several bills have been introduced that call for the repeal of the Health Security Act.	Play-or-pay All state residents	12% payroll tax on the first $14,000 of wages		
Minnesota Health Right Act, 1992	Signed by the Governor April 23, 1992.	160,000 of the state's uninsured population	$254 million per year by 1997. State subsidies for individuals and families up to 185% of poverty. Subsidies paid for by 1% gross premium tax on HMOs, 2% tax on doctors' and hospitals' gross revenues, and 5 cents per pack cigarette tax.	MH/SA, P, Pr, HC-In, HC-Out, Rx	HMOs PPOs
Mississippi S.B. 2447	Died in Senate Public Health and Welfare and Appropriations Committees.	To cover the gap group of individuals who do not qualify for Medicaid and cannot afford health insurance	Legislative appropriations	P, Pr	Program would be part of the Division of Medicaid
Missouri H.B. 900 S.B. 441	H.B. 900 defeated in April 1992. S.B. 441 never reported out of committee.	Single-payer All residents and nonresidents who work in Missouri	Employers pay a payroll tax of either 7.5% (S.B. 441) or 9% (H.B. 900). Employees pay an income tax surcharge. Self-employed persons pay a tax (7.5%- S.B. 441; 9% H.B. 900) on income subject to taxable limit for Medicare health insurance tax. Federal Medicare and Medicaid funds.	MH/SA, P, Pr, HC-In, HC-Out, Rx	Board of Governors Missouri Health Care Trust Fund

(continued)

Table 7 (continued)

State/Bill Name	Status	Type/Number Covered	Financing	Services Provided[a]	Administration
New York UNY*Care 1990[f]	Proposal by the state health department May 10, 1990.	Play-or-pay All state residents	13% payroll tax on the first $14,000 of wages. Premiums: Individual — $1,400/year Family — $3,200/year		UNY*Care
Ohio Universal Health Insurance Act 1990 (H.B. 175)[b]	Pending in the select Committee on Health Care Reform.	Single-payer All state residents and residents of other states who work in Ohio.	9% payroll tax on employers 1.25% on employees, 10% on gross earnings of self-employed subject to taxable limit for Medicare health insurance tax, 10% excise tax on alcohol and tobacco. Federal Medicare and Medicaid funds.	MH/SA, P, Pr, HC-In, HC-Out, Rx	Ohio Universal Health Insurance Board of Governors
Oregon Basic Health Services Act 1989[g]	Passed by the legislature Waiting on a waiver from Health Care Financing Admin.	Medicaid reallocation and employer mandate. All state residents			Managed care plan, currently under development
Pennsylvania H.B. 20	Passed Dec. 11, 1991 in the House. Referred Dec. 26, 1991 to Senate Public Health and Welfare Committee. Reported out June 9, 1992 as amended. Received first consideration June 9, 1992. Referred back June 15, 1992 to Senate Appropriations Committee.	All uninsured children	Free services for children under 150 percent of poverty. Sliding scale subsidies for those between 250 and 150 percent of poverty. Deductible and copayments no more than 0.1 percent of family income. No out-of-pocket costs for children under 100 percent of poverty.	P, Pr, HC-In, HC-Out, Rx	Creates a separate agency of the Commonwealth government Children's Health Fund Authority
Utah Utah Universal Health Insurance Plan, H.B. 64	Passed out of House Rules and Human Services Committees. Referred back to Rules Committee, where it died.	Single-payer All state residents	9% payroll tax on employers, 1.25% tax on employees' salaries, 10% tax on self-employed income, subject to taxable limit for Medicare health insurance tax. 10% tax on tobacco products and liquors. Federal Medicare and Medicaid funds.	MH/SA, P, Pr, HC-In, HC-Out, Rx	A Board of Directors
Wisconsin S.B. 521	Died in Senate Health Care Access and Affordability Committee.	Single-payer All state residents	Payroll tax on employers that is at least equal to the aggregate amount employers contribute for health care costs and workers' compensation premiums (indexed). Graduated income tax on individuals not to exceed the amount currently spent on health care (indexed) Federal Medicare and Medicaid funds.	P, Pr, HC-In, HC-Out, Rx, LTC	Department of Health Planning and Finance

(continued)

Table 7 (continued)

Sources: All information derived from bill language except for the following states: Calfornia - John Garamendi, *California Health Care in the 21st Century: A Vision of Reform: Executive Summary*, John Garamendi, Insurance Commissioner, State of California, February 1992; Hawaii - The George Washington University, National Health Policy Forum, "Expanding Access to Health Care in the States: Experimenting with Mandates in Hawaii and Massachusetts," *Issue Brief* no. 555 (December 1990); Oregon - Oregon Health Services Commission, *Prioritization of Health Services: A Report to the Governor and Legislature* (Salem, OR: State of Oregon 1991).

[a]Following is a list of the services provided by the bills and their abbreviations as they appear in the table.
MH/SA - mental health and substance abuse.
P — primary care consisting of all physician and specialist visits, laboratory and x-ray costs, home health care, short-term nursing home care, and maternity care.
Pr — preventive care consisting of physical exams, childhood immunizations, and health screenings.
HC- In — in-patient hospital care
HC-Out — out-patient hospital care
Rx — prescription drugs
LTC — long-term care

[b]The Florida and Ohio bills expressly exclude nursing home care from the list of covered services.

[c]The Prepaid Health Care Act of 1974 requires employers to provide health care to their employees but does not include dependents. An attempt by the state to include dependents under the law was preempted by ERISA.

[d]The bill assigns a percentage of the universal health care budget to the various sources as follows: 31 percent from the federal government, 13 percent from the state, 3 percent from the alcohol and tobacco tax, 34 percent from employers, and 19 percent from income tax on individuals.

[e]The law graduates the income tax surcharge based on Kansas taxable income as follows: $5,000 and under—0 percent, $5,001–$9,999—1 percent, $10,000–$24,999—3 percent, $25,000–$39,999—4 percent, $40,000 –$74,999—5 percent, $75,000–$99,999—6 percent, $100,000 and over—7 percent. The law also provides for a surcharge of 2 percent on interest and dividends received exceeding $1,000.

[f]No specifics were given as to the type of services offered under the plan.

[g]An 11 member commission developed a prioritized list of 709 treatment outcomes emphasizing preventive care. Funding has been approved for 587 of the procedures by the state legislature. Employers will be required to offer the same basic prioritized-based health plan as the state Medicaid program.

ERISA establishes uniform standards that employee benefit plans must follow to obtain and maintain their tax-favored status. ERISA section 514(a) provides that ERISA generally supersedes or preempts all state law otherwise applicable to pension and welfare plans covered by ERISA, with the exception of state law regulating insurance, banking, and securities. The exception covering insurance in effect allows certain indirect state regulation of insured health plans. Recent court decisions have affirmed that ERISA exempts employers who self-insure their health insurance benefits from many such state laws. Many employers choose to self-insure because they are exempt from state mandated benefit laws, which specify certain types and levels of coverage the group policies must include. Moreover, self-insured plans have been able to invoke ERISA preemption protection to avoid paying taxes on insurance premiums or taxes that fund state pools to insure poor risks. As a result, ERISA preemption has limited states' ability to finance health care proposals.

As noted earlier, **a federal district court ruled May 27, 1992 that ERISA preempts a New Jersey hospital rate-setting law that would require self-insured health plans to pay surcharges to cover the costs of care provided to the poor.[2] The court held that ERISA preempts state law that allows hospitals to include in their charges costs they incur when they care for the uninsured, subsidize the Medicare program, and give discounts to other types of plans. Thus, self-insured plans are exempt from paying more than actual costs of hospital services.**

If the New Jersey ruling is upheld by an appeals court, it could have a dramatic impact on numerous state reform efforts. As a result, Congress has stepped up its interest in the issue of ERISA preemption. Sen.

[2]*United Wire, Metal, and Machine Health and Welfare Fund v. Morristown Memorial Hospital.*

Dave Durenberger (R-MN) warned that if the decision is upheld, all of the state provider tax programs could be struck down. Durenberger has announced his intention to introduce legislation that would allow states to apply for federal ERISA waivers to permit them to impose nondiscriminatory surcharges or state insurance taxes on self-insured plans as part of overall health care legislation.

Several states are considering single-payer models for their health care delivery systems.

Similarly, Sens. Patrick Leahy (D-VT) and David Pryor (D-AR) have expressed interest in legislation that would set guidelines for granting ERISA and Medicaid waivers to states. Leahy introduced legislation (S. 1972) in November 1991 that includes a provision allowing certain state health plans, which would have to be approved by the U.S. Department of Health and Human Services, to supersede ERISA with respect to provisions relating to state authority to include self-funded health insurance plans in a state health insurance reform effort. Leahy's bill is intended to allow states to be flexible in designing new health care financing and delivery systems. Leahy and Pryor are reportedly considering introducing legislation that would exempt businesses with locations in more than one state from state regulation provided that they offer a package of health benefits equivalent to $1,250 per year for single employees and $2,500 for families.

In the absence of congressional action, more employers may choose to self-insure as states move to enact laws establishing standards for group benefit plans. As a result, the scope and influence of these state reform efforts could be diminished. Thus, states must consider the potential impact of ERISA's broad preemptive rule when developing health care reform proposals. Many of the proposals currently being considered would require an ERISA waiver, which in turn would require an act of Congress. Increased activity in state health care reform could potentially force a profound change in the ERISA preemption rule.

State Reform Proposals

Health care reform proposals generally fall into three generic models: comprehensive reform, employer mandate or play-or-pay employer mandate, and small group insurance market reform. In a comprehensive reform model the health care delivery system within the state would be radically altered. For example, under one model the state government would be the sole administrator and purchaser of health care services in the state. The system would be financed through taxes, and providers would be paid directly by the government. Employer mandates and play-or-pay employer mandates would expand on the employment-based system by requiring that employers offer health insurance to their employees or pay a payroll tax. Small group insurance market reform measures would alter the regulation of the insurance market and thereby increase access to care. The increased access to care would be accomplished by removing barriers to higher risk individuals for purchasing insurance and by reducing the variability in premiums faced by small groups over time.

Government Single-Payer Reforms

Several states are considering single payer models for their health care delivery systems. One example of this type of legislation is Ohio's proposed Universal Health Insurance Plan Act. First introduced in 1989, this proposal has received a great deal of attention but has not been voted on by the full legislature. Under this act, all residents of the state and residents of other states who work in Ohio would be covered by the plan. The plan would be financed by a 9 percent payroll tax on employers, a 1.25 percent payroll tax on employees, a 10 percent tax on the gross earnings of self-employed persons, an excise tax on alcohol and tobacco, and federal Medicare and Medicaid funds. The

plan would cover an extensive list of services, including inpatient and outpatient hospital visits, physician services, prescription drugs, necessary dental care, vision services for children aged 18 and under, and mental health and substance abuse treatment. Private insurance companies would be permitted to sell insurance in Ohio only for those services not covered by the plan (Ohio State House of Representatives, 1991). **This proposal would need an ERISA waiver to be implemented, or employers who self-insure could remain outside the system and not be subject to the payroll tax.**

According to the bill's original sponsor, State Rep. Robert Hagan (D), funding for this plan would come from a redistribution of the dollars Ohio residents are currently spending on health care (Hagan, 1991). It would not increase overall costs. It is difficult to see how this goal could be accomplished without major changes in the health care delivery system.

State Insurance Commissioner John Garamendi has developed a proposal calling for universal health care for all Californians without waiting periods or preexisting condition clauses.

Ohio currently has about 1.1 million uninsured residents. Extending coverage to this group could cost as much as $1 billion in new spending. Cost control efforts that limit provider incomes could lead to a decrease in the supply of providers, especially physicians and other providers who are relatively mobile. Reductions in administrative costs are difficult to capture in a tax system and may not be adequate to pay for the increased services.

An alternative approach has been proposed for California. State Insurance Commissioner John Garamendi has developed a proposal calling for universal health care for all Californians without waiting periods or preexisting condition clauses. The proposal is being called "24-hour" because it would combine the health components of all private policies for health, auto, and workers' compensation.

Garamendi's proposal is based on the managed competition model developed by economist Alain Enthoven. It would divide the state into regions, each of which would be served by a regional health insurance purchasing corporation (HIPC). Residents would then be assigned to a HIPC, which would be responsible for purchasing health insurance for all of the residents of the region. The HIPCs would be managed by committees of employers and consumers appointed by elected officials. Specific details about the plan's benefit package are unclear. The proposal calls for a package based on a comprehensive HMO plan that would incorporate the state health insurance mandates where appropriate. The State Health Commission would define this package on an on-going basis depending on the amount of money raised by the tax in a given year.

Garamendi estimates that the proposal would cost the state $34 billion annually. Funding for the plan would come from a 6.75 percent payroll tax on employers and a 1 percent tax on employee wages. Garamendi argues that this would save California employers 1.25 percent on their current health care costs, which are currently about 8 percent of payroll. In addition, employers could save $1 billion on their workers' compensation costs, and auto insurance premiums would be reduced by 15 percent (Garamendi, 1992).

A California universal health care bill will certainly raise the issue of an ERISA preemption waiver because it involves a payroll tax on employers and employees, with the revenues earmarked to purchase health benefits. It would also require that health benefits be purchased from a HIPC.

The chances of a single-payer plan being enacted in any state this year are slim. Even if the political will for

reform is present, states face a number of barriers to implementing a single-payer program. To include companies that self-insure their health insurance benefits, a state will need a waiver from ERISA. In order to incorporate federal Medicare and Medicaid funds, the state will need waivers from the Department of Health and Human Services. In addition, most states have constrained budgets. According to the National Council of State Legislatures, 31 states, the District of Columbia, and Puerto Rico report that general revenue collections for FY 1992 are below budget levels (National Council of State Legislatures, 1992).

Employer Mandates

Under the employer mandate model, employers would be required to provide their employees with a state-developed basic health care benefit package. In addition, a fail-safe program would be created to assist those individuals who would not be able to obtain employer-sponsored coverage.

At present, Hawaii is the only state using the employer mandate model. The Prepaid Health Care Act of 1974 (PHCA) requires employers in the state to provide group health insurance coverage to all full-time employees (defined as those working 20 hours or more a week). PHCA exempts seasonal workers, part-time employees, and dependents. Employers are required to pay at least one-half of the cost of coverage and must limit employees' cost to 1.5 percent of gross salary. The basic benefit package of primary care services includes 120 days of hospitalization per year, surgery and anesthesia, medical services (in home, office and hospital), diagnostic laboratory services, x-ray services, and maternity services (George Washington University, 1990).

The actual increase in the number of Hawaiians with health insurance coverage resulting from the implementation of PHCA is difficult to determine. A 1978 study conducted by the Martin E. Segal Company found that 46,000 people who had not been covered by health insurance prior to PHCA gained coverage under PHCA. A separate study conducted by Hawaii Medical Services Association (Blue Shield of Hawaii) found that only 5,000 people who had been uninsured prior to PHCA gained coverage under the act. These figures represent only estimates of the program's impact because no detailed analyses of the new enrollees has been conducted.

Two additional factors affecting Hawaii's PHCA are a tradition of employer-sponsored health insurance and labor shortages. Before World War II, Hawaii's economy was dominated by pineapple and sugar cane plantations. The owners of these plantations considered the provision of health care as part of their obligation to their employees (Dukakis, 1992). That tradition has continued as Hawaii's economy has been transformed into one based on tourism and services. The labor shortage in Hawaii—mostly the result of geographic isolation—also impacts Hawaii's PHCA. Although employers are not required to offer health insurance coverage to dependents, many do in order to attract and retain skilled workers.

As stated above, PHCA requires employers to offer health insurance coverage only to their employees; dependents of employees do not have to be covered. In addition, employers are not required to offer health insurance coverage to part-time or seasonal workers. To cover this gap group, Hawaii's state legislature created the State Health Insurance Program (SHIP) in 1989. The program, funded by the state, offers a basic benefits package of mostly outpatient and preventive care services with some inpatient services, such as labor and delivery and short stay surgery. The legislature appropriated $14 million in the original legislation, and the program now costs the state approximately $10 million per year. Enrollees below the poverty line pay no premiums, and the rest pay a premium on a sliding scale based on income. As of June 1992, 17,233 individuals of the estimated 50,000 people in the gap group were enrolled in the program.

One of the main issues raised by the employer mandate model is who would bear the added costs of the

mandate. The Hawaiian example shows how the model works in a restricted labor market, but other states are not characterized by tight labor markets. EBRI simulated the change in employment that might result from an employer mandate. The simulation held wages and other components of total compensation constant and relied on two assumptions: the sensitivity of employer demand for workers to changes in the price of labor and the costs of the mandate (EBRI used three separate costs for the mandate per employee: $970, $1,450, and $2,430). EBRI estimated that between 200,000 and 1.2 million workers could become unemployed as a direct result of a national mandate that all employers provide health benefits to their employees. Individual state mandates may generate different results depending upon the characteristics of their own labor markets. For a further discussion of the coverage and costs of an employer mandate, see *EBRI Issue Brief* no. 125, "Health Care Reform: Tradeoffs and Implications" (Custer and Foley, 1992).

In 1976, state policymakers in Hawaii tried to expand the coverage of PHCA to include substance abuse treatment. This move was challenged by Standard Oil of California, which claimed that self-insured plans are exempt from state laws under ERISA and therefore did not have to comply. After a lengthy appeals process, the U.S. Supreme Court ruled in favor of Standard Oil in 1981, affirming that ERISA preempted PHCA. The state sought a remedy from Congress. In 1983, Congress granted and the President signed into law an exemption from ERISA for PHCA. However, the exemption was restricted to the law as originally passed, allowing no changes or additions to the law; consequently, coverage for substance abuse treatment could not be added.

The play-or-pay model requires employers to offer health insurance benefits to their employees or pay a payroll tax that would go toward funding a government-operated health insurance plan for individuals not covered by an employer-sponsored plan. Massachusetts has come closest to fully implementing this model. Under the Massachusetts Health Security Act of 1988, all employers in the state would be required to offer health insurance coverage to their employees or pay a 12 percent payroll tax on the first $14,000 of wages, totaling no more than $1,680 per employee annually. Proceeds of this tax would fund a state operated health insurance program for individuals not covered by an employer plan. The law did not define a minimum health insurance package that employers would be required to offer.

At the time of enactment, the law received strong support from both the legislative and executive branches of the Massachusetts state government, stemming largely from a strong economy and a low unemployment rate (3 percent in 1988). However, by 1990 the Massachusetts economy was in recession. The unemployment rate climbed to 9.7 percent in March 1991, causing legislators to reconsider the implications of the additional expenses that would be incurred by employers under the play-or-pay model. In addition, Governor Michael Dukakis, an early and strong supporter of the law, was succeeded by Republican Governor William Weld, who is not supportive of the law. The law was scheduled to take effect on January 1, 1992; however, in August 1991 the legislature voted to delay the effective date until January 1995. The ultimate fate of this program is unclear.

One issue raised by the play-or-pay model is how many employers would choose to offer health insurance benefits or pay the payroll tax. The proportion of employers that would actually drop their health benefits if a play-or-pay proposal were enacted depends on a number of factors. If the public plan were considered inferior to private plans, employers might continue to offer private health benefits in order to gain a competitive advantage in the labor market. Those employers whose costs are extraordinarily high may choose not to offer health benefits. To the degree that these higher costs are due to poorer health risks the public plan may suffer from adverse selection. That is, the public plan may insure the poorest health risks in the population. As a result, the costs of the public plan may be greater

Table 8
State Mandated Benefits Laws, August 1991

State	Total Number of Laws	Number of Laws by Type: Covered benefits	Covered providers	Extended coverage	Miscell-aneous[a]	State	Total Number of Laws	Number of Laws by Type: Covered benefits	Covered providers	Extended coverage	Miscell-aneous[a]
Alabama	9	1	7	1		Montana	25	5	12	6	2
Alaska	13	3	9	1		Nebraska	16	2	8	6	
Arizona	20	5	8	6	1	Nevada	27	10	10	6	1
Arkansas	26	9	10	7		New Hampshire	18	2	11	4	1
California	32	10	13	6	3	New Jersey	20	6	7	4	3
Colorado	20	8	8	4		New Mexico	23	5	12	5	1
Connecticut	37	14	12	7	4	New York	29	12	10	5	2
Delaware	9	1	5	3		North Carolina	16	5	7	4	
Florida	19	9	5	5		North Dakota	24	8	8	8	
Georgia	14	3	5	5	1	Ohio	17	3	8	5	1
Hawaii	14	8	3	3		Oklahoma	17	4	7	6	
Idaho	9	2	3	3	1	Oregon	22	8	6	5	3
Illinois	23	6	8	6	3	Pennsylvania	22	5	12	3	2
Indiana	13	2	8	3		Rhode Island	16	9	2	5	
Iowa	10	2	4	4		South Carolina	9	0	4	5	
Kansas	17	5	7	5		South Dakota	20	2	12	6	
Kentucky	17	8	4	4	1	Tennessee	20	6	8	5	1
Louisiana	24	8	10	5	1	Texas	27	7	11	6	3
Maine	20	7	9	4		Utah	20	4	9	7	
Maryland	35	12	13	6	4	Vermont	10	6	0	4	
Massachusetts	26	9	8	6	3	Virginia	25	6	11	6	2
Michigan	17	7	6	4		Washington	28	8	11	6	3
Minnesota	32	12	10	8	2	West Virginia	19	7	8	4	
Mississippi	13	2	8	2	1	Wisconsin	24	8	6	7	3
Missouri	18	6	6	5	1	Wyoming	11	1	5	5	
						Totals	992	298	394	246	54

Source: Greg Scandlon, *Health Benefits Letter, #15 Special Report* (August 29, 1991).
[a]Some states have passed a number of mandates that do not fit into the above categories. Examples of these laws include: hair pieces for Alopecea Areata in Minnesota, insulin infusion pumps in Wisconsin, and treatment for rape or sexual assault in Illinois.

than forecast, and additional revenues may be needed to pay for the benefits.

The Massachusetts program may reflect some of the difficulties states face in implementing a health care reform program that attempts to provide universal coverage. State budgets are often prohibited by state constitutions from running a deficit, and where they are not prohibited states face more constraints in borrowing money than the federal government. States also face a limited, and more mobile tax base than the federal government. As a result, they may be reluctant to individually finance universal coverage.

Small Group Reform

States may be more willing to use their traditional role as insurance regulators to change the health insurance market in order to increase access to health care. Most of these efforts are aimed at small employers. A majority of the working uninsured (65 percent) are self-employed or work for firms employing fewer than 100 workers (Foley, 1992). Some policymakers propose reforms that would change coverage mandates, health insurance rating and renewing, and the creation of risk pools for uninsurable individuals.

Table 9
State Basic Benefits Laws for Small Private Establishments, Eligibility and Benefits, September 1991

State	Group Size	Months Uninsured[a]	Inpatient	Office Visits	Maternity Care	Well Child Care	Effective Date of Legislation
Arizona	Fewer than 40	3 months	15 days/year	2 visits/year	Prenatal & obstetrical	Through age 6	Sept. 1991
Arkansas	No maximum	12 months	15 days/year	5 visits/year	Prenatal & obstetrical	Through age 6 (optional)	Feb. 1991
Colorado	Fewer than 26	None					July 1991
Florida[b]	Fewer than 25	None					Oct. 1991
Georgia[c]							d
Illinois	Fewer than 25	12 months				Newborns	Jan. 1991
Iowa	Fewer than 26	12 months	30 days/year	2 visits/year	Prenatal & obstetrical		July 1991
Kansas	Fewer than 26	24 months					July 1990
Kentucky	Fewer than 51	36 months	14 days/year	50% payment			July 1990
Maryland	2–25	12 months (individuals) 24 months (groups)	10 days/year	10 visits/year	Prenatal & obstetrical		July 1991
Missouri	Fewer than 51						Jan. 1991
Montana	Fewer than 21				Prenatal & obstetrical	Through age 2	July 1991
New Jersey	No maximum	12 months	21 days/year				Sept. 1991
Nevada[b]	Fewer than 26	6 months					Jan. 1992
New Mexico	Fewer than 20	6 months	25 days/year (includes home care)	7 visits/year	Prenatal & obstetrical	Through age 6	July 1991
North Carolina[c]	Fewer than 26						Jan. 1992
North Dakota	Fewer than 25	12 months					July 1991
Oklahoma[c]	No maximum	15 months					Spring 1990
Oregon[c]	Fewer than 26	None					Spring 1989
Rhode Island	Fewer than 26	3 months (individuals) 24 months (groups)	20 days/year	4 visits/year	Prenatal & obstetrical	First year and immunizations to age 8	Sept. 1990
Virginia	Fewer than 50	12 months	30 days/year	2 visits/year	Prenatal & obstetrical	Through age 6	July 1990 Sunset date July 1994
Washington	Fewer than 25	None					June 1990
West Virginia	No maximum	None	20 days/year	4 visits/year	Prenatal & obstetrical		June 1991

(continued)

Table 9 (continued)

Source: Scandlen Publishing, Inc., "Small Group Market Reform Laws Enacted in 16 States," *Health Benefits Letter* (August 8, 1991):1–3; and data compiled by Karen Milgate for Families USA Foundation, July 1991.
[a]Number of months that an employer must not have offered health insurance to any employees to be eligible for bare bones laws.
[b]The Florida and Nevada laws require that the state mandates be offered as an option.
[c]In Georgia, the law authorizes the insurance commissioner to deliver a model health insurance plan; in North Carolina, Oklahoma, and Oregon, the law calls for a committee or board to develop a basic health care plan.
[d]Not available.

Mandated and Basic Benefit Laws—**State insurance mandates, which require that certain benefits be included in either group or individual health insurance plans, became widespread in the early 1970s. In 1991, there were 992 state mandates** (table 8).

Many critics of state mandated benefits believe they raise the costs of health insurance to levels that are unaffordable for small employers. In response to this criticism, **many states have passed basic benefits laws or bare bones laws that typically exempt enrollees from most of the state mandated benefit laws. As of October 1991, 23 states had enacted basic benefits health insurance laws.** Most of these laws have eligibility requirements limiting firm size (generally to 25 or fewer employees) and restricting coverage to employers that have not offered health benefits for a specified period of time (usually one year).

Basic benefits laws vary widely by state (table 9). Georgia and Oklahoma have appointed commissions to develop a model insurance package. Florida, Missouri, and Washington waive all state mandates, while Arkansas, Maryland, New Mexico, Rhode Island, and others specify minimum standards for health insurance policies. Response to the laws has been as varied as the laws themselves.

In Illinois, the basic benefits law contains four provisions. First, firm size eligibility is limited to fewer than 25 employees. Second, all state mandated benefits are waived except for mammography screening, extended benefits to adopted children, and well-child care for newborns. Third, to be eligible firms cannot have offered health insurance for at least 12 months. Fourth, carriers marketing basic benefits policies in the state are required to submit a report on their basic benefits policy to the Insurance Commissioner's office annually. The basic benefits law became effective August 1, 1991.

Three carriers have been approved to write basic benefits policies in the state: Health Care Service Corporation (Blue Cross of Illinois), Travelers of Hartford, and Travelers of Illinois. To date, only Blue Cross of Illinois has marketed a basic benefits policy. As of January 31, 1992, six policies had been written in the state, covering 21 people.

According to Blue Cross of Illinois, the 12-month waiting period (minimum amount of time that a small employer had to be without health insurance) is the prime deterrent for program implementation. Small employers in Illinois initially had a positive reaction to the policies, but very few applicants were able to meet the waiting period requirement. Blue Cross intends to lobby for an amendment in the legislature that would reduce the waiting period requirement to six months.

The Washington basic benefits law waives all of the state mandated benefits and limits eligible firm size to fewer than 25 employees. After a slow start, the Insurance Commissioner's office reports that the plans are starting to show signs of fulfilling their legislative intent. Basic benefits policies first became available in June 1990. As of December 31, 1991, 7,211 employees and their dependents have health insurance coverage through a basic benefits policy; 2,447 of that group had no previous coverage.

The Arkansas law, passed September 1991, requires 15 days per year of inpatient services; 5 physician office

visits per year; and optional obstetrical, prenatal, and well-child care. Maximum benefit amounts are set at $100,000 annually and a lifetime maximum of $250,000. Annual deductibles were set at $200 per year for individuals and $500 per year for families. Most state mandated benefits are waived.

As of March 1992, two companies had applied to the state insurance commissioner's office to market basic benefits policies: Golden Rule Insurance and Arkansas Blue Cross/Blue Shield. The premiums for the benefits packages presented by the two companies were higher than the premium target set by the state legislature. In early April, the Commissioner's office held a hearing to look into the problem, and the two companies stated that the minimum requirements set by law made a basic benefits policy too expensive for small employers to provide coverage to low-income individuals and families (which are the target groups). On May 11, 1992 the Arkansas Insurance Department announced amendments to the basic benefits law. Among the changes were a reduction in the number of covered office visits from five to two and an increase in the annual deductible from $200 to $500 for individuals and from $500 to $1,000 for families.

The experiences of the states with basic benefits policies points up one of the problems with basic benefits approaches to expanding health insurance coverage. **While there is good evidence suggesting that state mandates increase the costs of providing coverage, it is not clear that the reduction in premiums resulting from offering less generous insurance is enough to induce many of the uninsured to purchase insurance.**

Allocation and Reinsurance Models—**Health care costs generally account for a larger portion of operating costs for small employers than for large ones. In addition, small employers often face significant rate increases or policy cancellation at renewal time. Insurers are unable to adequately pool the risks of small groups.** Pooling the risks would require that some of the good risk groups pay higher premiums. Competition in the small group market drives down the premiums for good risk groups but leads to highly volatile premiums if members of those groups incur large medical costs. Moreover, insurers face higher administrative costs for small groups.

At their December 1990 conference in Houston, the National Association of Insurance Commissioners (NAIC)[3] adopted two model acts for states to use in developing their own small group reform laws: an allocation model and a reinsurance model. Both were designed to stabilize the small business health insurance market, limit abusive rating practices, and guarantee the availability and renewability of coverage. The allocation model is designed to spread high risk groups among carriers in a state by assigning a high risk allotment to all the carriers who participate in the allocation program. The high risk allotment is a target number of high risk individuals assigned to a participant carrier in proportion to the carrier's small group market participation in the state. The target number can be adjusted to reflect the differences between average claims costs for the allocated individuals in the state with the average claims costs for the allocated individuals covered by the insurer. An employer who has been rejected for insurance twice in six months can apply to the allocation program. The program estimates the number of high risk individuals in the small employer group, and the employer is sent a listing of carriers whose high risk allocation has not been filled from whom the employer could purchase coverage (Scandlen, 1992).

The reinsurance model is based upon legislation that Connecticut enacted in 1990. Under Connecticut law, all insurers in the state are required to participate in the reinsurance pool. High risk individuals may be rein-

[3]The NAIC is a group comprising the chief insurance regulatory officials of the 50 states, the District of Columbia, and the four U.S. territories that promotes uniformity of legislation and regulation of insurance.

sured through the pool. The maximum premium an insurer can charge a high risk individual is 150 percent of the standard risk for individuals of the same age and sex. The costs of the pool are met by an assessment on each participant based on the participant's portion of the small group market in the state (Lewin/LCF, 1990). Currently, 15 states have passed laws to reform rating and renewal practices in the small group market (table 10).

Risk Pools—**An estimated 1 percent of the under age 65 population is considered uninsurable (Tippler, 1991). These are individuals who suffer from a chronic illness or have other characteristics that make it difficult or impossible for them to purchase health insurance. Since 1990, 25 states have created risk pools to help provide health insurance coverage to this group** (table 11).

Although risk pools vary considerably by state, there are several common characteristics among them. First, risk pools are generally administered by an association of carriers in the state. Second, the benefit package offered is usually quite comprehensive, generally specifying that a minimum package should include inpatient and outpatient hospital services, physician services, skilled nursing care, home health care, and prescription drugs. Third, risk pools generally offer a range of deductibles from a low of $150 to a high of $2,000, depending on the premium paid. Fourth, most risk pools have waiting periods (with options for a waiver in emergency situations) to protect the pool from the burden of enrolling individuals with immediate health care needs.

The funding of risk pools is controversial. In 1990, the pools paid out $77.6 million more than they collected

Table 10
State Rating and Renewal: Small Group Market Reforms, 1991

	CO	DE	FL	IA	KS	NE	NM	NC	ND	OR	RI	SC	SD	VT	WV
	Group Size														
	25 and fewer	25 and fewer	25 and fewer	25 and fewer	25 and fewer	25 and fewer	25 and fewer	3–25	25 and fewer	25 and fewer	a	25 and fewer	25 and fewer	Less than 49	25 and fewer
Limiting Premium Increases	x	x	x	x	x	x	x	x	x	x		x	x	x	x
Limiting Transfers between Rating Classes		x		x		x	x	x	x			x	x		x
Guaranteeing Policy Renewal	x	x	x	x		x	x	x	x	x		x	x		x
Guaranteeing Continuity	x			x	x			x		x	x			x	
Creating Reinsurance Mechanism				x				x		x				x	
Limiting Rate Differentials		x		x	x	x	x	x	x	x		x	x		x
Guaranteeing Availability														x	
Requiring Community Rating														x	
Limiting Medical Underwriting	x			x						x				x	
Expanding Jurisdiction of Insurance Commissioner	x							x						x	
Requiring Disclosure of Rating and Renewal Practices	x	x		x	x	x	x		x	x		x	x	x	x
Requiring Whole Group Coverage					x										

Source: George Washington University, Intergovernmental Health Policy Project, *State Health Notes* (Washington, DC: George Washington University, 1991).
[a]Data not available.

Table 11
State Risk Pools, Year End 1990

State	Year Opera-tional	Partici-pants	Premiums Collected ($ millions)	Claims Paid ($ millions)	Assessment to Members ($ millions)	Admins-trative Costs ($ millions)	Lifetime Benefit	Deductible Offered	Waiting Period
California	1991	8,901[a]	na	na	$0[b]	na	$500,000[c]	$500 - PPO $0 - HMO	90 days
Colorado[d]	1991	na	na	na	na	na	$500,000	$300; $750 $2,000	6 months
Connecticut[e]	1976	2,200[a]	$ 4.5	$10.4	$6.5	$0.6	$1,000,000	$500; $1,250 $2,000	12 months
Florida[e]	1983	5,934[a]	12.4	17.4	8.1	2.8	$500,000	$1,000; $1,500 $2,000	12 months
Georgia[f]	na	na	na	na	na	na	$500,000[c]	$500; $1,500	6 months
Illinois	1989	4,370	12.0	24.1	0[b]	1.7	$500,000	individual $500; $1,000 family $1,000; $1,500	6 months
Indiana	1982	3,080	8.4	17.0	7.3	0.7	No maximim	$500; $1,000 $1,500	180 days
Iowa	1987	1,971	4.6	5.1	2.1	0.4	$250,000	$500; $1,000 $1,500; $2,000	6 months
Louisiana[f]	na	na	na	na	na	na	$500,000[c]	$1,000; $2,000	6 months
Maine	1988	400	0.5	1.2	0.7	0.1	$500,000	$500	90 days
Minnesota[e]	1976	25,272	25.7	49.5	22.2	3.1	Regular Plan $500,000 Medicare Plan $100,000	$500; $1,000	6 months
Mississippi[f]	na	na	na	na	na	na	$250,000	To be determined	12 months
Missouri[d]	1991	na	na	na	na	na	$1,000,000	$500; $1,000	12 months
Montana	1987	304	0.6	0.6	0	0.03	$250,000	$1,000	12 months
Nebraska	1986	2,904	4.4	6.8	4.0	0.3	$500,000	$250; $500 $1,000	6 months
New Mexico	1988	1,303	2.9	4.2	2.5	0.2	No maximum	$500; $1,000	6 months
North Dakota	1982	1,656	2.6	4.3	1.7	0.2	$250,000	$500; $1,000	180 days
Oregon[e]	1990	1,211[a]	1.3	1.1	1.2	0.4	$500,000	$500	6 months
South Carolina	1990	1,072	1.6	1.8	0.09	b	$250,000	$500	6 months
Tennessee	1987	4,121	10.8	17.1	3.0	0.5	$500,000	$1,000	6 months
Texas[f]	na	na	na	na	na	na	$500,000	individual $250 family $500	6 months
Utah[d]	1991	na	na	na	na	na	$500,000[c]	$500; $1,000	6 months
Washington	1988	2,793	4.7	7.2	3.0	0.6	$500,000	$500; $1,000	6 months
Wisconsin	1981	9,287	10.6	17.6	11.0	1.5	$500,000	$1,000	6 months
Wyoming[e]	1991	94[a]	0.02	g	0.08	h	$250,000	Varies	6 months

(continued)

from the 78,873 risk pool enrollees. On average, plans collected $1,364 per enrollee and paid out $2,348 per enrollee. Premium shortfalls are the result of premium caps that vary by state. State law sets premium caps at a fixed percentage of standard individual premiums in the state (generally between 125 percent and 150 percent).

Table 11 (continued)

Source: Aaron K. Trippler, *Comprehensive Health Insurance for High Risk Individuals: A State by State Analysis* (Bloomington, MN: Communicating for Agriculture, 1991).
Note: na = data are not available.
[a]Data for California is through June, 1991; data for Connecticut and Florida is 1989; data for Oregon is for fiscal year 1990/1; data for Wyoming is through April 1991.
[b]California and Illinois are funded by state appropriations.
[c]The following states have an annual benefit: California - $50,000; Georgia, Louisiana, and Utah - $100,000.
[d]Colorado's pool became operational in April 1991, Missouri's pool became operational in November 1991, and Utah's pool became operational in August 1991, no data available on the pools' operations.
[e]Data for Connecticut and Florida are for 1989; data for Minnesota are for preliminary audit; data for Oregon are for fiscal year 1990/1991; data for Wyoming are through April 1991.
[f]The pool is not yet operational.
[g]Claims paid in Wyoming amount to $548.
[h]Administrative costs in Wyoming are $6,892.

States have several options to recoup losses paid by risk pools. California and Illinois pay the losses directly from state general revenues. Colorado imposes an income tax surcharge on all state residents, and Louisiana has passed a surcharge on hospital patient revenues. The most common form of funding the pools comes from assessing insurers in proportion to their share of the state health insurance market (Tippler, 1991).

Aside benefiting the uninsurable, states and employers may also benefit from risk pools. Although the populations served by the risk pools and Medicaid 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 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 a source of payment for the chronically ill reduces the need for them to shift the cost of treating this group to other payers.**

Risk pools increase insurance costs for those employers who do not self-insure. In those states that finance the deficit of the pools through an assessment on insurers, the insurers pass that cost on in the form of higher premiums. There are data to suggest that the presence of a risk pool in a state funded by an assessment on insurers reduces the number of employers offering health benefits (Gable and Jensen, 1989).

The impact of small group insurance market reforms on health insurance coverage depends upon the sensitivity of the demand for health insurance to changes in price for small employers and their employees. Researchers evaluating the Robert Wood Johnson Foundation (RWJF) projects for the medically uninsured, in which small employers were offered substantial subsidies to provide health insurance, found that small business employers' primary reason for not offering health insurance was the high cost of coverage—85 percent of employers not offering insurance cited high premiums as an important reason (McLaughlin, 1991). Previously uninsured small employers began to offer insurance to their employees during the enrollment phase of the demonstration projects. However, only 17 percent of previously uninsured employers enrolled in even the most successful project targeted at small employers (McLaughlin, 1991).

These results suggest that small group reform may not dramatically increase the number of individuals with health insurance. Moreover, individuals who do puchase coverage are likely to be those who believe that they will need health care services. As a result, the costs of providing insurance for individuals who are good risks may increase. The burdens placed on public

programs and risk pools may also increase. States may find that the costs of these programs are greater than first estimated.

Legislated Small Group Insurance Reforms—**On April 16, 1992, Minnesota enacted the Health Right Act with small employer insurance reforms. These reforms include guaranteeing the issue and renewal of health insurance plans to small employers (defined as those with 2–29 employees).** In addition, carriers will be required to offer two basic benefits plans that will be exempt from state mandates (except continuation of coverage and dependent care mandates) with maximum out-of-pocket costs of $3,000 per individual and $6,000 per family. General premium rates must not vary more than 25 percent on either side of the index rate by July 1, 1993. These variations can be based only on health status, claims experience, the employer's industry, and the length of time that the small employer has been covered. To spread the risk among the state's carriers, the law calls for the creation of a health coverage reinsurance association to share and transfer high risk groups among state carriers.

On April 16, 1992, Minnesota enacted the Health Right Act with small employer insurance reforms. These reforms include guaranteeing the issue and renewal of health insurance plans to small employers (defined as those with 2–29 employees).

The Health Right Act also contained a program for extending health insurance coverage to individuals through an expansion of the state's current children's health plan. Enrollment of parents and dependent siblings of children (under 185 percent of poverty and not eligible for Medicaid) currently enrolled in the children's health plan will begin October 1, 1992. Families may continue their enrollment if their incomes exceed 185 percent of poverty but do not exceed a maximum of 282 percent of poverty, paying the premiums on a sliding scale. Beginning July 1, 1994 the plan will be extended to all individuals and families with incomes above 185 percent of poverty who are not eligible for Medicaid and who meet the plan's income requirements; their premium payment will be based on a sliding scale. Services provided include those of the children's health plan with the addition of drug and alcohol dependency, inpatient hospital services, and emergency medical transportation.

The plan is funded by a 1 percent tax on premiums paid to HMOs and nonprofit health service corporations; 2 percent tax on revenues of hospitals, health care providers and wholesale drug distributors; and a 5 cent per pack cigarette tax (Minnesota House of Representatives, 1992). These costs will be passed on at least in part to all payers. There is some question as to whether this feature of the plan is affected by ERISA preemption.

Implementation of the law is projected to cost the state $254 million annually in subsidies by 1997 and estimated to cover 160,000 Minnesotans, a little under one-half of the estimated number of uninsured in the state. The actual costs of the plan and the number of people who would gain coverage will depend upon how sensitive the demand for health insurance is to changes in premiums.

The Bush administration has proposed a health reform plan in which individuals who live in families with incomes above the poverty level would be given a subsidy through the tax system for purchasing health insurance. In examining the likely impact of such a subsidy, EBRI found that, even assuming a very strong price sensitivity, which is unlikely for low-income families, fewer than 30 percent of those currently uninsured and eligible for the subsidy would be likely to become insured as a result of the plan.

That result is consistent with what has actually happened in Minnesota. The Health Right Act is an expansion of Minnesota's Children's Health Plan (CHP). Of the current 80,000 children eligible for CHP, 21,651 were enrolled in the program as of October 1991.

Washington state is debating legislation similar to Minnesota's Health Right Act. The bill calls for the creation of a basic health plan. The plan would be available to individuals and families with incomes at or below 300 percent of the federal poverty level. Small businesses could sign up for the plan as a group but would be required to have 75 percent or more of the employees with income of 300 percent or below the federal poverty level. Individuals who enroll in the plan as part of a small business group would not be eligible for state subsidies.

The legislation also calls for reforming the small group insurance market. Small group carriers would be required to offer a basic benefit package. All small group carriers operating in the state would be required to participate in the Washington Small Employer Health Benefits Coverage Program. This program is similar to NAIC's reallocation model in which all small group carriers in the state will be assigned a high risk allocation to evenly spread the risk of high risk individuals. Limits would be placed on rate increases, and small group carriers would be required to renew a policy except in cases of fraud, nonpayment of premiums, and misuses of services.

The legislation would also enact reforms in other areas of the state's health care system, including medical malpractice reform; practice parameters and risk management protocols; standardized health care insurance claim forms; set up of a data collection, storage and retrieval system; and incentives to providers to participate in the Medicaid program.

Small group reforms are attractive to states for a number of reasons. They are consistent with the states' traditional role as regulators of insurance. They rely on the private sector to expand coverage and therefore do not appear to place large burdens on state budgets. Finally, they reduce perceived inequities in the health insurance market in which large employers face lower costs than small employers. However, the effectiveness of these reforms in expanding coverage is problematic, and their ultimate impact on state budgets is unclear. Moreover, some of these efforts may face unforeseen barriers in ERISA.

◆ Medical Malpractice Reform

Another health care reform policy proposal aimed at controlling health care costs is medical malpractice reform. Proponents of this reform argue that large medical malpractice awards lead to higher medical malpractice insurance premiums and ultimately result in higher health care costs. To discourage this, states have sought to encourage out-of-court settlements by passing voluntary arbitration[4] statutes and limiting damage awards. To date, 15 states have adopted voluntary arbitration statutes.[5]

In 1975, the Indiana state legislature passed the most comprehensive state medical malpractice reform package to date. Under the original law, Indiana placed a cap of $500,000 on all awards. Indiana later raised the cap to $750,000 for claims occurring after January 1, 1990. Under the law, before a claim can proceed to trial

[4]Arbitration is a fault-based alternative to the use of the courts in resolving medical malpractice claims. It involves submitting a dispute between parties to persons, selected by law or agreement, for resolution. The use of arbitration may be voluntary or compulsory, and the arbitration decisions may be nonbinding or binding. Arbitration panels operate with less formality than courts, but the legal principles applicable to the courts govern the decisions in that liability is established only upon finding that the injury was due to the health care provider's negligence or fault (Government Accounting Office, 1990).

[5]The following states enacted voluntary arbitration statues in the mid-1970s, Alabama, Alaska, California, Georgia, Illinois, Louisiana, Michigan, Ohio, South Dakota, Vermont, Virginia. The following states passed such legislation in the mid-1980s, Colorado, Florida, New York, and Utah.

it must first be reviewed by a panel of three health professionals. If the claim passes the review, the claimant has two years from the time of the incident to take legal action. The defendant is liable for the first $100,000 of the settled claim. The balance is paid by a patient compensation fund, which derives its resources from a surcharge on physician and hospital malpractice premiums (currently 125 percent of the premium). The law also places a cap of 15 percent for lawyers fees for damages paid from the Patient Compensation Fund (PCF).

Currently, 24 other states have placed caps on malpractice claim awards. Twenty-one of these states have placed the caps only on "pain and suffering" awards.

Critics of the Indiana law believe injured parties are not properly compensated. However, **a study comparing the average awards for large claims ($100,000 or more) in Indiana with Ohio and Michigan—two neighboring states without tort reform—found that the average award amount was higher in Indiana. In Indiana, the average award for a large claim, in the period 1975–1988, was $404,832. For the same time period, the average award in Ohio was $303,220 and $290,022 in Michigan** (Gronfein and Kinney, 1991).

Currently, 24 other states have placed caps on malpractice claim awards. Twenty-one of these states have placed the caps only on "pain and suffering" awards. Nebraska, South Dakota and Virginia cap all malpractice awards at $1,000,000 (Robert Wood Johnson Foundation, 1991).

Maine developed a malpractice reform plan, the Medical Liability Demonstration Project, that does not use financial caps but rather sets practice parameters and risk management protocols in four medical specialties: anesthesiology, emergency medicine, obstetrics and gynecology, and radiology. The parameters give physicians immunity from litigation provided that they stay within the given set of parameters. Some medical malpractice insurers may fear that they will be held liable retrospectively if the law is found to be unconstitutional (U.S. General Accounting Office, 1992).

What is unclear in these efforts is what effect malpractice reform will ultimately have on the costs of health care services and therefore access to care. The magnitude of defensive medicine, in which physicians order unnecessary services simply to protect themselves in the event of a lawsuit, has never been adequately measured. It simply has not been established that malpractice reform would alter physician costs and treatments sufficiently to affect costs or access to care.

◆ State Insurance Regulation

Without enacting major health care reform, state regulation of health insurance remains an important determinant of the characteristics of the local health care services market. The growing popularity of managed care has been accompanied by increased state regulatory activity. A number of states have passed laws that are designed to regulate the activities of managed care organizations.

Eighteen states have enacted some form of an any willing provider mandate. Under such a mandate, the managed care network must accept or offer the opportunity of participation to any provider in the state who meets the criteria set by the network. In Montana and Wyoming, these mandates cover a broad base of providers in the state. In Arkansas and Idaho, any willing provider mandates apply to only specific providers such as pharmacies.

Other state laws prohibit gatekeepers, defined as the primary contact provider who determines whether to

refer a patient to other providers within the network. These mandates affect open managed care networks such as preferred provider organizations (PPOs) and point-of-services (POS) plans. Proponents of these laws contend that a gatekeeper role should not be included in an insurance product. In New Jersey, Pennsylvania, and Texas current statutes allow gatekeepers for HMOs but not PPOs.

Several states have passed many laws and proposed legislation to govern utilization review activities.

A third group of laws, referred to as limiting benefit differential mandates, restricts the amount of coinsurance or other fees that a network may charge for seeking care from a provider outside of the network. Twenty states limit the coinsurance differential to 20 percent, and three states—California, Nevada, and Texas—set a limit of 30 percent (Cooper and Green, 1991).

Closely related to managed care regulation is state regulation of utilization review (UR), a process of systematically reviewing care to determine its necessity and appropriateness. UR is used in all types of health care plans, from traditional indemnity plans to HMOs. UR's increased popularity has been accompanied by an increased effort by states to regulate it. UR was originally designed to determine the appropriateness of care. However, some providers claim that UR is being performed by reviewers unqualified to judge the necessity and appropriateness of care. **Some providers also contend that the criteria and protocols used by UR firms are designed more to save money than to promote high quality care (George Washington University, 1991). Several states have passed many laws and proposed legislation to govern UR activities.** The most common types of laws would require UR to be performed by professionals licensed in the state; physicians of the same specialty as the attending physician to review all denials for payment; UR organizations to maintain extended hours of operations; UR plans to have specific appeals processes; all UR personnel to be licensed health professionals; and disclosure of all clinical protocols and criteria used in UR (Cooper and Green, 1991).

A study done by the Wyatt Company for the Health Insurance Association of America, analyzed the costs of three managed care laws and three UR laws. In their analysis of the any willing provider mandate, Wyatt found that administrative costs would increase by 170 percent if the network was open to all providers.

In their analysis of the gatekeeper function of managed care plans, Wyatt found that in a PPO the savings associated with gatekeepers ranged from 4.2 percent to 13.5 percent of claims. The average savings was 6.83 percent. These savings would be lost if gatekeepers were prohibited.

Wyatt's analysis of limiting benefit differential mandates to 20 percent would reduce the incentives to patients to opt for in-network care by 6.1 percent. As a result, claims costs for a plan and its members would increase by 1.3 percent.

Wyatt's findings of the effects of laws requiring local offices and same specialty physician reviews on the total costs of UR services varied greatly by the amount of nonoperational overhead and the effect that increasing the number of sites had on that overhead. Making the assumption that 25 percent of total costs are nonoperational overhead and overhead costs do not vary, first year costs were estimated to increase by 32 percent and costs in the second and subsequent years were estimated to increase by 25.6 percent if UR firms were required to have local offices and same specialty physician review.

In their analysis of extending UR firms' hours of operation, Wyatt found that a typical UR firm is open 11 hours a day to service 4 time zones. If the firms were to operate 24 hours a day, seven days a week, Wyatt estimated their costs would increase by 44 percent to 47 percent.

A state's ability to implement universal health care coverage for its citizens may be constrained by federal law, the state's limited tax base, and the mobility of those who would bear the costs.

Most UR firms keep records by employer group. To convert to state specific recording, Wyatt estimates that the first year costs would be between $10,000 and $50,000 for a single state. Assuming no reporting changes are required, the cost per state for year two and thereafter would be between $3,000 and $5,000.

In 1990, the American Managed Care and Review Association (AMCRA) established the Utilization Review Accreditation Commission (URAC) to set up voluntary national standards for the UR industry. URAC has developed performance standards designed to set up consistent regulations by individuals with experience in the UR industry. The District of Columbia has adopted URAC standards for UR firms dealing with workers' compensation. In Connecticut, Indiana, and North Dakota statutes were passed allowing the state insurance commissioner to waive the state UR accreditation requirements if the UR firm could prove that it has national accreditation. Illinois, Iowa, Nebraska, and Tennessee are among a group of other states considering similar legislation.

State regulations of managed care plans and UR companies have an impact on self-insured plans as well as non-self-insured plans. Courts have recently held that ERISA preemption protects the self-insured plan from direct state regulation. State laws regulating managed care and UR indirectly influence self-insured plans. A self-insured plan that contracts with a managed care plan and/or a UR company will bear the increased costs that these laws place on those firms (Lutes and Snyder, 1991).

◆ Conclusion

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 arrangement and specialty mix of physicians, and the laws regulating the financing and delivery of medical services. These characteristics affect not only the political process leading to change but the effectiveness of private efforts to manage health care costs.

A state's ability to implement universal health care coverage for its citizens may be constrained by federal law, the state's limited tax base, and the mobility of those who would bear the costs. The success of various proposals and the ability to use them as a model for national reform may depend on the ability of states to receive an ERISA preemption waiver. Moreover, although a number of states have implemented, or seem close to implementing, significant reform measures, many states have not seriously considered these proposals. It seems likely that most states will not take major action on health care reform in the near future.

However the national debate on health care reform is resolved, the diversity across states is likely to influence the implementation of any national reform. In the absence of national reform, individual states will continue to affect their local health care delivery

system through regulation of health insurance and health providers. Employers and other purchasers of health care services who are active in more than one state are likely to find increasing diversity across local health care service markets.

This *Issue Brief* was written by Ken McDonnell, Michael Anzick, and William Custer of EBRI with assistance from the Institute's research and education staffs.

◆ References

Alpha Center. *Health Care for the Uninsured: State Initiatives.* Washington, DC: Alpha Center, 1991.

Bureau of National Affairs, Inc. "Oregon: Federal Officials Support Health Plan, But Say Waiver Request Will Face Scrutiny." *BNA Pension Reporter* (19 August 1991): 1515–1516.

Congressional Research Service. *Medicaid Source Book: Background Data and Analysis.* Washington, DC: U.S. Government Printing Office, 1988.

Cooper III, Paul P., and Kylanne Green. "The Impact of State Laws on Managed Care." *Health Affairs* (Winter 1991): 161–169.

Custer, William S. *Hospital Cost Shifting in Texas.* Special Report SR-1. Washington, DC: Employee Benefit Research Institute, 1989.

Custer, William S., and Jill Foley. "Health Care Reform: Tradeoffs and Implications." *EBRI Issue Brief* no. 125 (Employee Benefit Research Institute, April 1992).

Dranove, David. "Pricing by Non-profit Institutions: The Case of Hospital Cost-Shifting. "*Journal of Health Economics* (March 1988): 45–47.

Dukakis, Michael S., and Cyril Roseman. "Learning from the Aloha State." *The Journal of American Health Policy* (January-February 1992): 11–14.

Executive Office of the President. Office of Management and Budget. *Budget of the United States Government, Fiscal Year 1993.* Washington, DC: U.S. Government Printing Office, 1992.

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

Foley, Jill D. "Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey." *EBRI Issue Brief* no. 123 (Employee Benefit Research Institute, February 1992).

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

Gabel, Jon R., and Gail Jensen. "The Price of State Mandated Benefits." *Inquiry* (Winter 1989): 419–434.

Garamendi, John. *California Health Care in the 21st Century: A Vision for Reform, Executive Summary.* Sacremento, CA: Insurance Commissioner, State of California, February 1992.

Garland, Michael J. "Rationing in Public: Oregon's Priority-Setting Methodology." In *Rationing America's Medical Care: The Oregon Plan and Beyond.* Washington, DC: The Brookings Institution, 1992.

Geisel, Jerry. "States Rethinking Health Cover Laws: Massachusetts Plan Appears Doomed." *Business Insurance* (6 May 1991): 1, 79–80.

George Washington University. Intergovernmental Health Policy Project. "Small Group Market Reform: Insurers, States Seek Solutions to Small Market Insurance Crisis." *State Health Notes* (7 October 1991): 4–5.

————. National Health Policy Forum. "Expanding Access to Health Care in the States: Experimenting with Mandates in Hawaii and Massachusetts." *Issue Brief* no. 555 (December 1990).

Gronfein, William P., and Eleanor DeArman Kinney. "Controlling Large Malpractice Claims: The Unexpected Impact of Damage Caps." *Journal of Health Politics, Policy and Law* (Fall 1991): 441–464.

Hagan, Robert F. *New Release from State Representative*

Robert F. Hagan, D-53, Youngstown. 18 February, 1991.
Jensen, Gail, and Michael Morrisey. "Group Health Insurance: A Hedonic Price Approach." *Review of Economics and Statistics* (February 1990): 38–44.
Kessler, Martha. "State Experiments with Expanding Health Care May Serve as a National Model: Massachusetts." *Bureau of National Affairs Pension Reporter* (December 2, 1991): 2188–2190.
John Kitzhaber, MD. *The Oregon Basic Health Services Act*. Salem, OR: Oregon State Senate, n.d.
Lewin/ICF. *Proposal to Expand Access to Health Care in Connecticut, Final Report*. Submitted to Connecticut Blue Ribbon Commission on State Health Insurance. Washington, DC: Lewin/ICF, 1990.
Lutes, Mark, and Lynn Shapiro Snyder. "Is Your Self-Funded Health Plan Safe from Anti-Managed Care State Legislative Proposals?" Paper presented at the Managed Care Conference, Washington, DC, 1991.
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): 63–67.
McLaughlin, Catherine G. *The Dilemma of Affordability: Private Health Insurance for Small Businesses*. Prepared for the American Enterprise Institute conference, American Health Policy: Critical Issues for Reform. October 3-4, 1991, Washington, DC.
Minnesota House of Representatives. *Bill Summary: H.B. 2800 Health Care Access (Health Right)*. St. Paul, MN, April 20, 1992.
National Council of State Legislatures. *State Legislative Report: NCSL State Budget Update: February 1992*. Denver, CO: National Council of State Legislatures, 1992.
Ohio State House of Representatives. *Summary of House Bill 175: The Ohio Universal Health Insurance Plan*. Columbus, OH, 1991.
Physician Payment Review Commission. *Physician Payment Review Commission: Annual Report 1992*. Washington, DC: Physician Payment Review Commission, 1992.
Robert Wood Johnson Foundation. *ABridge: A Special Edition on Medical Malpratice* (Spring, 1991).
Rosko, Michael D. "A Comparison of Hospital Performance under Partial-Payer Medicare PPS and State All-Payer Rate-Setting Systems." *Inquiry* (Spring 1989): 48–61.
Scandlen, Greg. "NAIC Adopts Guaranteed Issue Model for Small Groups." *Health Benefits Letter* (January 16, 1992): 1–3.
Trippler, Aaron K. *Comprehensive Health Insurance for High-Risk Individuals: A State by State Analysis*. Bloomington, MN: Communicating for Agriculture, 1991.
U. S. General Accounting Office. "Medical Malpratice: Alternatives to Litigation." Washington, DC: U.S. General Accounting Office, 1992.
————. *Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program*. Washington, DC: U.S. General Accounting Office, 1990.
Vermont Legislative Council. *Summary of Vermont's Health Care Reform Bill (H.733)*. Montpellier, VT, May 7, 1992.
Wiener, Joshua M. "Oregon's Plan for Health Care Rationing." *The Brookings Review* (Winter 1992): 26–31.
Wilkerson, Israel. "Indiana Law at Center of Malpractice Debate." *New York Times* (20 August 1990), p. A 13.