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UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

HEALTH CARE REFORM AT THE SUBNATIONAL LEVEL: AN ANALYSIS OF THE DIFFUSION OF HEALTH POLICY INNOVATIONS AMONG AMERICAN STATES

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

By

LARRY EUGENE CARTER
Norman, Oklahoma
1997

HEALTH CARE REFORM AT THE SUBNATIONAL LEVEL:
AN ANALYSIS OF THE DIFFUSION OF HEALTH
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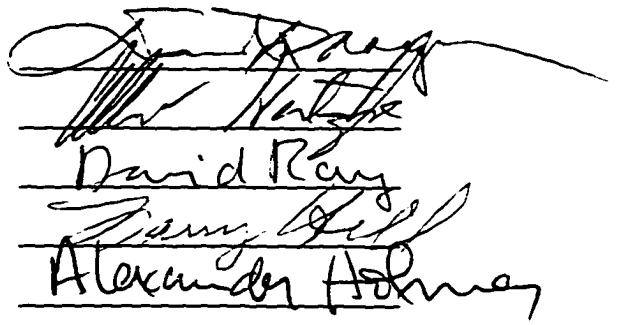
A Dissertation APPROVED FOR THE
DEPARTMENT OF POLITICAL SCIENCE

BY



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Abstract

Although the federal government has so far failed to pass any significant health care reform legislation, states continue to enact such legislation at a fairly steady pace. Spiraling increases in costs, a jump in the number of Americans without health insurance and an ongoing problem with access combined to make health care reform a high priority issue in the 1992 elections. But disagreement at the federal level over policy needed to correct these inadequacies left states to seek reform solutions of their own. The states have responded with a variety of initiatives which run the gamut from simple health insurance reforms to systemic approaches. Some states have passed a series of reforms while others have done very little.

This dissertation uses the framework of Walker's (1969) seminal study on the diffusion of policy reforms to identify independent variables which help explain why some states are more likely than others to be innovative in the health care arena. The quantitative analysis of state actions uses an index of eight key health reform areas as the dependent variable. The central conclusion is that health care diffusion occurs most quickly in states which have historically been innovators in other policy areas. The findings also suggest that diffusion of health care policy seems to be invigorated by the lessening of federal

preemptions. The dissertation also includes case studies of Oregon, Hawaii, and Oklahoma. The findings here emphasized the importance of history, political culture and political leadership in shaping health care innovation. The research concludes with an assessment of the movement toward managed care among the states, arguing that while such an approach may bring cost savings, it will do little to improve access to health care services.

CHAPTER 1

PUBLIC POLICY, FEDERALISM, AND DIFFUSION

Introduction

For many Americans, 1991's surprise victory by Harris Wofford (who campaigned for national health care) over Richard Thornburgh in a special Pennsylvania senate race signaled the return, if not the beginning, of health care reform as a viable campaign issue in the United States. Not only had the number of Americans without health insurance increased dramatically over the last decade, escalating costs threatened to price many of the working class already insured out of the market as well (See Table 1.1). Democratic presidential candidate Bill Clinton adopted health care reform as a key element of his campaign platform. Incumbent President George Bush never seemed to fully appreciate the salience of the health issue, offering only partial solutions to the problem. On the other hand, Clinton's campaign staff seized the issue promising sweeping reforms to the current system while emphasizing the right of all Americans to enjoy access to the health system at a reasonable cost. Presidential candidate Clinton carefully avoided being explicit as to how such a plan would be implemented or financed.

After narrowly winning the election, President

TABLE 1.1

Percentage of Non-elderly Uninsured, 1992

State	%	State	%
Alabama	20.1	Montana	12.3
Alaska	19.3	Nebraska	11.3
Arizona	18.5	Nevada	26.6
Arkansas	23.5	New Hampshire	14.8
California	22.2	New Jersey	15.3
Colorado	14.6	New Mexico	22.5
Connecticut	9.6	New York	16.1
Delaware	25.5	North Carolina	16.4
Florida	24.2	North Dakota	10.5
Georgia	22.4	Ohio	13.0
Hawaii	8.1	Oklahoma	25.8
Idaho	19.0	Oregon	15.5
Illinois	15.3	Pennsylvania	10.7
Indiana	12.6	Rhode Island	11.1
Iowa	11.7	South Carolina	20.8
Kansas	12.6	South Dakota	18.5
Kentucky	17.1	Tennessee	16.0
Louisiana	25.7	Texas	25.7
Maine	13.1	Utah	13.0
Maryland	14.0	Vermont	11.1
Mass.	12.4	Virginia	17.4
Michigan	11.9	Washington	12.4
Minnesota	10.0	West Virginia	18.5
Mississippi	22.7	Wisconsin	10.5
Missouri	16.6	Wyoming	13.5

Source: Public Policy Institute (1994 29)

Clinton announced he was putting his wife, Hillary Clinton, in charge of the reform effort. Ms. Clinton responded by putting together a huge task force with representatives from all sectors of the health care industry. Doctors, other health care providers, pharmacists, child advocate representatives, hospital administrators, insurance companies--seemingly every group with an interest in health care reform was invited to participate either on the panel or to testify in one of the many scheduled hearings. It soon became clear, however, that though there was a consensus for changing the current system, there was little or no agreement over the direction a replacement program should take. Predictably, the proposal that emerged from the Clinton study was extremely complex and enjoyed little support among key interest groups or congressional leaders. After an initial publicity surge when a summary of the proposal was released in paperback form, the Clinton health plan was pronounced DOA in Congress, never having reached the floor of either house for a formal vote.

For many members of the public, these two events, the Wofford Senate race and the collapse of the Clinton initiative, represent the beginning and the end of American health care reform. While these two events do represent bookends for the most recent reform efforts at the federal level, state governments had already initiated several reform programs long before the Pennsylvania Senate race.

State legislatures, fearing more cuts in Medicaid by the Republican Congress, have continued to introduce innovative proposals many of which involve federal waivers reluctantly agreed to by the Clinton administration.

Efforts by the Republican majority in Congress to reform the welfare system while attempting to balance the budget have turned many states into reform activists. The Republican promise to move toward block grants in the financing of social programs will undoubtedly mean less federal dollars for joint federal/state health care programs such as Medicaid. Already facing fiscal problems with the health care delivery system, states have begun to seek their own innovative measures to address these expected shortfalls. It is obvious to many state policymakers that these programs will no longer be open-ended. States will have to learn to spend only the amount allotted to them through the block grant procedures. Those states which postponed health reform in hopes that federal action was imminent now realize that major changes to the current system will have to originate at the state level.[1]

The purpose of this dissertation is to examine the response by American states to the growing demand for health care reform. It seeks to answer the basic question of which states are leading the way in responding to this need and

[1] For a counter argument that federal action is essential for any major health care reform, see Seward and Todd (1995).

why. In the context of this research, the word "reform" covers a broad range of ideas, proposals, and policy instruments. It essentially conveys the notion that among both political leaders and the public, a consensus prevails that the system is defective in various ways. In this sense, reform will refer to all attempts to modify the system, from sweeping calls for a Canadian-style single payer play to much more conservative proposals for individual medical account.

In this chapter, a review of policy literature is presented which mainly serves to emphasize the difficulty in analyzing health care reform efforts. The strengths and weaknesses of a number of policy theories are examined. The conclusion reached is that diffusion theory seems to be the most useful approach to identifying variables which help explain why some states are more likely than others to be innovative in the health care arena.

State Initiatives

Health policy innovation at the state level is not a recent phenomenon. Though rising costs within the health care system are perceived as a relatively recent occurrence, in fact states have struggled to hold down the cost of Medicaid ever since the program was created by Congress in 1965. Major reform legislation at the state level can be traced to 1974 when Hawaii passed the Hawaiian Prepaid Health Care Act. It requires employers to supply basic

health insurance for employees working more than 19 hours a week (State of Hawaii 1988). The state legislature at the time was encouraged to consider and pass this major reform by the belief that President Richard Nixon was preparing to introduce similar legislation at the national level and that Congress was inclined to pass such legislation. Shortly after passage in Hawaii, however, lobbyists from the business community and the American Medical Association (AMA) led a charge on Congress which effectively ended consideration of major federal reform. Later that year Congress passed the Employee Retirement Income Security Act (ERISA) which effectively preempted states from requiring employers to provide health insurance.[2]

Other states have been reluctant to attempt to duplicate the Hawaiian experience although it has proven to be relatively successful in holding down costs and making preventive health care more readily available to the vast majority of citizens. Hawaii's unique geography and culture have caused policymakers in other states to fret over the political repercussions of imposing employer mandated health coverage. Business owners in Hawaii find it very difficult (if not impossible) to simply pack up and move to another state. One California official praised the results of the

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[2] Hawaii was granted a very limited waiver to the original act which allowed the state to continue the program passed by the state legislature. Recently other states have been granted limited waivers to ERISA, but the act still precludes states from enacting most forms of universal care.

Hawaiian system but was quick to point out that he doubted such a plan could be adopted in other states without a "captive economic population" (PBS's "MacNeil Lehrer" 1991). California voters seemed to confirm the reality of such fears when they defeated a health reform proposition which would have imposed employer mandated coverage for most employees in the state.

Universal Care Efforts

It would seem the momentum for major reform, especially measures that propose universal coverage, has been lost at both the state and federal levels. In addition to Hawaii, five other states (Florida, Massachusetts, Minnesota, Oregon and Washington) had enacted principal legislation laying the foundation for universal health coverage. But budget constraints along with conservative gains in state legislatures stalled or halted all of these programs. The Oregon case is perhaps most symbolic of the recent change in the political climate. The Oregon program evolved after 1988 when a fiscal crisis forced state legislators to consider the idea of rationing as a mechanism for holding down spiraling costs in health care (Klevitz et al. 1991). The Oregon Health Services Commission (OHSC) was established to prioritize health treatments. The OHSC was also instructed to establish a formula which would grant access to the approximately 420,000 Oregonians without health insurance coverage. Medicaid coverage would also be

increased, but the number of services provided to recipients would be somewhat diminished by the rationing components of the plan (OHSC 1991).

One of the more controversial aspects of the Oregon plan was the provision for an employer mandate requiring companies not currently providing health insurance for full-time employees (over 17.7 hours) to "pay or play" by July of 1995 (Fryburg 1992). Either they must provide basic health insurance coverage or contribute to a pool which will provide coverage. Since the proposal was originally passed, Republicans have gained control of the state legislature. Not only has the employer mandate portion of the program been put on hold, there is an active effort to repeal all sections requiring mandatory participation. Washington's state legislature recently repealed the employer mandate provision of its 1993 legislation, but for a different reason. The state found that its reform measure had serious conflicts with ERISA, the previously mentioned 1974 federal law which prohibits states from regulating self-insured employer health plans (New York Times News Service 1995).

Conservative Reform Efforts

The most recent efforts toward health reform by the states reflect the current conservative dominance of health care reform provisions. Several states, including Tennessee, Connecticut, Hawaii, New Jersey, Oregon and Rhode Island, have attempted to "privatize" public health care

systems by pushing Medicaid recipients into Health Maintenance Organizations (HMOs). This is the type of program selected by the Oklahoma legislature and the subject of a case study in Chapter 4 of this paper. Oklahoma ranks toward the middle in health care innovations (Carter and LaPlant 1995). Previous Oklahoma reforms borrowed heavily from programs in other states as the state attempted to halt the growth of public health spending programs generally viewed to be inefficient. Other reforms had been considered but failed to generate much support. A plan for medical savings accounts proposed by then Governor David Walters went nowhere, and a Walters supported health care provider tax was defeated at the polls in 1992 (OHCA 1995).

The Oklahoma experience is typical of many states and offers an interesting political perspective as well. Like elected officials in other states, Oklahoma politicians seem to have the conflicting goals of holding down state health care costs without making wholesale cuts in Medicaid rolls. And though the Oklahoma legislature is still controlled by a Democratic majority in both houses, the conservative movement that led to Republican gains in Congress and other state legislatures is certainly no stranger to Oklahoma. In reality, many Oklahoma Democrats have more in common with the ideology of House Speaker Newt Gingrich than they did with former speaker Tom Foley. This conservatism is also reflected in the current make-up of the state's

congressional delegation. As of 1996, both senators are Republicans and all six congressmen are Republicans as well. This represents an almost complete reversal of the party representation just ten years ago. Republicans have made serious inroads at the state level as well. Even Governor Frank Keating, elected in 1994, is a Republican. Oklahoma's decision to move toward privatization at an incremental pace is certainly compatible with Republican initiated health reform efforts in other states.

Even before the current Republican gains, health reform efforts in other states have tended to be much more modest and limited in scope than the Hawaii or Oregon programs. For the most part, state legislatures have concerned themselves chiefly with modifications of regulations of health insurance companies operating within the state. These types of reforms usually are popular with the public and carry little political risk. Insurance companies of all types have traditionally been regulated at the state level and health insurance is no exception. As a result, there have always been variations in coverage requirements, pre-existing conditions and portability among the states. Even at this somewhat lower level of health reform, some states are much more innovative than others when it came to solving policy problems and resolving economic dilemmas.

Walker's Diffusion Study

These differences among the states in their approaches to policy problems were at the center of a major study by Jack L. Walker (1969) who conducted research on the diffusion of policy innovations among American states over a 200 year period. Walker examined twelve separate policy areas (including health) in an attempt to identify states which acted most quickly on innovations. Walker defined innovation as a "program or policy which is new to the states adopting it, no matter how old the program my be or how many states may have adopted it" (Walker 1969, 881). His duffusion research focuses on the relative speed of which states adopt a range of new policies. Virginia Gray (1973) also studied the diffusion of innovations among states, but chose to concentrate on specific policy areas rather than attempting to conduct a cross subject analysis. A synthesis of Walker and Gray's work is the foundation for the ranking of states as health care innovators in Chapter 3 as well as the source of the methodology used to determine the salience of various independent variables.

Public Policy Research

Diffusion research is a logical extension of the study of American public policy, though neither have reached a stage where there is complete agreement over methodology. Even with the introduction of systems theory (Easton 1965), group theories (Truman 1949 and Dahl 1967), elitism (Mills

1956 and Milliband 1969) and corporatism (Schmitter and Lehmbruch 1979), there is still no favored approach. The field consists of a "babel of tongues...spoken by tribes of experts" (Bobrow and Dryzek 1987), a condition that seems likely to persist for some time to come. Indeed, Harold Laswell's (1936) observation from nearly a half-century ago that politics is "who gets what, when and how?" is an apt description of public policy today as well.

The various theories listed above are helpful (if often contradictory) methods of approaching the policy process--each boasting its own limited validity. All forms (or frames) of policy analysis face three universal problems. First are the unintended consequences that often surprise legislators and policy wonks alike. A glaring example of unintended consequences in the health policy field is ERISA. Originally passed by Congress primarily to protect employee retirement funds from unscrupulous corporations, the act instead has been used by companies to avoid compliance with state-mandated health insurance coverage. By self-insuring, companies cannot be compelled to meet state minimum coverage of any kind.

Second, there are few minor disagreements among policy proponents. Differences usually represent disagreement so basic that refinement of competing theories is nearly impossible. Third, even policy studies conducted with the benefit of hindsight often offer equally compelling (but

conflicting) evidence of success by the competing policy methods. A classic case study of this phenomenon was Graham Allison's (1971) examination of the Cuban missile crisis in which he used three models (rational actor, organizational process and bureaucratic process) to explain a single event. Each model did indeed explain certain actions taken during the crisis very well. Combined the three models provided substantial information; individually, however, the models were only marginally successful.[3]

Problems With Fragmentation

American public policy also faces the continuous problem of fragmentation due to the federal nature of the American system. This fragmentation carries over into policy studies associated with policymaking institutions. Some of the more noteworthy examples of research concerning policy decisions by institutional and non-institutional actors include studies of Congress (Fiorina 1989; Mayhew 1974; Fenno 1966; Wildavsky 1964), the presidency (Light 1984: Cronin 1980; Neustadt 1960; Barber 1977; Wildavsky 1966; Schlesinger 1973), the judiciary (Baum 1990; Glazer 1975; Horowitz 1977), the media (Tyanger and Kinder 1987; Graber 1988; Key 1961; Linsky 1986; Bennett 1980) and the bureaucracy (Weber 1946; Meier 1985; Wilson 1975; Rourke 1984; Lindblom 1965). For the most part, this research is

[3] This section is primarily based on research originally presented by Bobrow and Dryzek (1987).

more concerned with the actor's role in the policy process than the policy itself. As a group, these studies have undoubtedly contributed to the aggregate knowledge of the public policy process, but basic, expandable frameworks to lift the study of public policy to the next level have failed to materialize.

Policy Stages Model

One area where there is some consensus among political scientists is on the existence of segmented stages of policy development. Generally the process is listed in the following stages:

1. agenda setting
2. formulation
3. adoption
4. implementation
5. evaluation

These stages (Jones 1970; Peters 1986) have managed to divide the policy process into distinct units of analysis, but offer no assumptions which encompass all five stages. The result is a continued lack of causal theory and a "weakened theoretical coherence" across stages (Sabitier 1991, 145). There is also sharp disagreement over the importance of each stage, the impact of individual stages and even who is responsible for each step. This has led to yet another group of policy studies which focus primarily on the separate stages of the policy process.

There are diverse theories on how each stage works. In the area of agenda setting, Cobb and Elder (1985) identify no less than nine triggering devices which can launch an issue onto the national agenda. Kingdon's (1984) approach to agenda setting is based on the concept of policy streams in which policy entrepreneurs carefully guide packages of issues to the top of the agenda in a similar manner.[1]

Policy formulation and adoption are the subjects of a classic study by Lindblom (1959) in "The Science of Muddling Through." In this article, Lindblom compares two methods of formulation, successive limited comparisons and the rational comprehensive method. Noting the large number of externalities involved in the policy selection process and the constant conflict of values, the author concludes that muddling through may qualify as a selection methodology in spite of its obvious shortcomings. Lindblom also identifies incrementalism as a viable policy method which tends to favor short-term implementation over long-term goals.

The implementation process is examined thoroughly in a 1973 book by Pressman and Wildavsky. Again a case study serves as the centerpiece of the work (the EDA project in Oakland) as the authors stress the inter-relationships among

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[1] Interestingly, the first case study in Chapter 1 of Kingdon's book centers on the activities of policy entrepreneurs during the Nixon administration and their efforts to promote Health Maintenance Organizations (HMOs). This effort fell short at the national level, but did influence Hawaii to pass the landmark state health reform in 1974.

bureaucracies even in the implementation of a rather obscure federal poverty program. A study of the policy and politics of hazardous waste (Lester and Bowman 1983; Davis and Lester 1988) offers some hope that studies in specific policy areas may offer theoretical devices which can be applied across policy lines. The authors' observation that the three dominant characteristics of states' hazardous waste policy appear to be the severity of the problem, the complexity of the political process and the uncertainty of an effective policy response could reasonably be applied to health care policy as well.

Another study by Sabatier and Mazmaian (1980) seeks to create a conceptual framework featuring a flow diagram which captures the main variables involved in the implementation process. Since the bureaucracy is the institution most likely to implement policy, studies have tended to focus on agencies and related policy fields. Public administration scholars have also shown interest in implementation as part of their research into management objectives.

Evaluation Studies

Perhaps more than any of the other policy stages, evaluation has triggered the most controversy among social scientists. The field experienced exponential growth in the 1970s as scholars hoped to use the scientific method to identify and promote the utilization of "good" public policy. But evaluation research has proven to be somewhat

less than scientific.

> Not only is evaluation a political act, but it also serves functions other than the assessment of worth. Thus evaluation may be a means for conflict management, a tactic used to reduce conflict by narrowing its scope. An evaluation may be an indication that the policy is subject to negotiation and modification once the research findings become available (Nachmias 1980, 116)

Cronbach (1982) goes so far as to say evaluation is an art, not a science. However, even critics of evaluation do not deny the need for a systematic approach to evaluation of social programs. In fact, large scale evaluations have been taking place since the 1950s, but the creation of Lyndon Johnson's Great Society was the big push that led to a large amount of federal dollars being made available for evaluation research (Rossi and Freeman 1993).

These studies only served to magnify the lack of structure in the evaluation process. In a 1969 speech, President Richard Nixon cited an evaluation of the Head Start programs as proof that large scale social programs were doomed to failure. A study by the Westinghouse Learning Corporation at Ohio State University had determined that the fledgling Head Start program would be "extremely weak" in the long-term. Academics responded by pointing out incidents of bias in the Westinghouse evaluation and the selective citations of Nixon. In social science journals scholars pointed out the need for independent evaluators, free of political ties (Williams and Evans 1972).

While it is obvious the problem of ideological bias has

not been overcome, efforts continue to establish value-neutral methods of evaluation. More recent efforts have centered on empirical tests (Shadish et al. 1991) and utility tests based on research quality along with prior knowledge and expectations (Weiss and Bacuvalas 1980). But the combative world of 1990s politics has only managed to make the issue more cloudy. Think tanks with strong ideological agendas such as the conservative Heritage Foundation have made policy decisions (and evaluation) even more problematic by issuing studies which claim to be nonpartisan, but in fact are designed to support conservative views. Some liberal groups are also guilty of such actions. In any case, the media spin specialists employed by both political parties have become experts at selecting the portions of research which best serve their respective political means, regardless of whether or not it reflects the true conclusions of the study.

Policy Typology

Among the more promising directions taken by academics have been efforts to categorize policy efforts by typology or issue networks. One of the most widely cited attempts at typology has been Lowi's (1964) assertion that all governmental policies fit in one of three categories; distributive, regulatory or redistributive. Lowi's findings were based on earlier works by Schattschneider (1935), Truman (1949) and Mills (1956). Murray Edelman (1964)

examined related arenas of power with special emphasis on regulatory efforts. Regulation has also been the subject of more recent studies by Meier (1985), Wilson (1980) and Weingast and Moran (1983).

Federalism and the Policy Process

Health care policy reflects the lack of policy uniformity between and among state and federal governments. Only recently has the American public begun to realize that the nation has no national health policy. The clamor for some sort of national leadership in the health policy arena is reminiscent of the "crisis" over lack of federal doctrine for energy policy in the 1970s. Though President Carter did manage to push through Congress the creation of the Department of Energy, much of the innovation in energy policy took place at the state level. A study of energy policy innovation (Freeman 1995) confirms that state energy policy was largely the result of cue-taking among state legislatures from energy legislation passed by other states. The study does not pursue the hypothesis that the states may have acted as a result a lack of a coherent policy by the federal government, but the parallels between the "energy crisis" and the "health crisis" certainly should be considered for future study.

Which arena should take the lead in reform is merely a continuation of a debate which has challenged American political science since the emergence of the discipline. In

spite of progress in federalism theory, a widely accepted paradigm has yet to emerge. American federalism theory can usually be traced back to the Federalist Papers. James Madison (1961) explained in "Federalist 51" that power in a federal system is first divided between the states and federal government and again divided by the three branches of the national government. This divided power combined with a checks and balance system was purposely incorporated to fragment power and guard against abuse of power from faction both inside and outside of government. Madison and the other founding fathers were so successful in their quest to dilute power that critics have long questioned whether federalist governments are equipped to deal with complicated social problems of modern society (Dicey 1959; Lasky 1939).

President Dwight Eisenhower, who had campaigned on a platform critical of the expanding role of federal government, requested in 1953 that Congress create a special commission to attempt to define the roles of central and state governments in domestic policy. With Republican majorities in both houses of Congress, Eisenhower was fairly certain he could push through the committee's expected recommendations. The problem for Eisenhower was that the Committee on Intergovernmental Relations concluded that the federal government could reasonably be active in nearly all arenas, and therefore it did not attempt to classify responsibilities among governments. A later study initiated

by Eisenhower in his second term basically reached the same conclusions (Anton 1989, 215). The hope among some politicians and scholars of federalism that an unassailable list of separate functions for state and central governments could be devised was seemingly laid to rest permanently.

But scholars who study federalism have continued their search for theory to divide policy responsibility using a parallel tack. Instead of randomly assigning certain policy areas to either state or central government, they have instead attempted to create a policy taxonomy which categorizes policies (defense, health, etc.) according to which level of government can implement them in the most economically efficient or politically expedient manner.[5] Determining the role of national and state governments in developing and administering social programs, especially in an area as broad as health care, has again proven to be difficult and the results are inconclusive. Policy areas tend to have unique characteristics which preclude narrow classification.

Peterson, Rabe and Wong (1986) explain away this problem by arguing that federal policy programs tend to follow cyclical patterns. They see the 1940s and 1950s as decades dominated by developmental programs; programs in which state and local governments carried out policy because there was little or no conflict over goals between state and

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[5]These two objectives are not necessarily mutually exclusive.

federal governments. In the case of redistributive policies, which dominated the 1960s, 1970s and early 1980s, the federal government financed programs and asked states to administer them, often under strict federal guidelines. As the government entered into areas in which government at any level had never previously been involved, intergovernmental conflicts began to materialize. The authors conclude that many of this country's current policy problems are the result of a failure to distinguish between developmental and redistributive programs. They recommend that the federal government largely abandon developmental programs, but support federal involvement in programs where significant spillovers are present. The authors also concluded that the federal government is the most efficient institution for collecting revenue and for controlling redistributive policy.

Another basic tenet of federalism theory has been that a strong central government is the institution best equipped to make substantial changes in policy. A strong federal government with more complete central control is better able to implement large scale policy change than a federalist government with power disbursed among several layers (Dicey 1959; Laski 1939). It is this basic niche of federalism theory which Gwendolyn Gray (1991) used as a focal point for her case study of health care policy development in Australia and Canada, two countries with active federal

systems. Gray grouped Madisonian federalists and anti-federalists alike into the orthodox school. This group "disagrees over the value of federalism, but are in substantial agreement that the system constrains the scope of government activity" (p.11). Gray also introduced a counter-theory or a "revisionist view of federalism" which sees federalism as a key to policy expansion.

Revisionist Theory

Though centered mainly on Canadian studies by Pierre Trudeau (1986) and Alan Cairns (1977; 1979), Gray often cites American theorist in her argument as well. The revisionist (or expansionist) model is straightforward enough, the central theme being that more governments mean more bureaucracies. Many scholars have concluded that bureaucratic institutions have a "proclivity to expand continuously " (Downs 1964; Miskansen 1971; Wildavsky 1974; Heclo 1974). This belief is tacitly supported by the fact that recent studies show public spending has increased most quickly within the subnational levels of government. This is also true in the United Stats where the number of subnational governments has continued to increase despite annual calls for cuts and consolidation.

These competing theories are part of Gray's search for a universal theory of federalism. The fact that Gray chose a developing policy area (health) to study federalist institutions in a comparative climate is also significant.

Recent articles have encouraged scholars to try to "weave together" federalism and policy theory (Krane 1993) while others have urged more rigorous studies of federalism in a comparative context (Elazar 1993).

American Federalism

While studies concerned with comparative federalism are still relatively rare, political scientists (and economists) in the United States have continued their attempt to develop an explanatory theory relative to the American federal system. Until recently, these studies have taken a historical approach, focusing on the practices that occurred during distinct periods of American history. For example, the period from the ratification until approximately 1935 is generally referred to as the period of dual federalism.[6] Dual federalism is also consistent with what was later dubbed "layer cake" federalism (Staton 1993, 129). The emphasis of these two models is on constitutional functions defined by the enumerated powers of the document itself as well as supporting decisions by the Supreme Court (e.g., Lochner v New York 1905). During this period, the court consistently upheld the dual federalism doctrine which assumes the enumerated powers of the national government are limited by the reserved powers of the state (Beth 1971, 51).

The formation of the New Deal radically changed the relationship among governments mainly through an increased

[6] The term "dual federalism" was first used by Corwin (1937).

scope of activity at all levels. The conflict between federal and state governments which had been the heart of dual federalism was replaced by the comity of cooperative federalism. Revisionists such as Morton Grodzins (1966) and Daniel J. Elazar (1962) claim that the conflict of dual federalism has been overstated and that cooperative federalism though identified as a product of government in the twentieth century had always been present. Grodzins insists there never was a layer cake federalism in which government responsibilities were neatly divided. He sees the relationship more resembling a marble cake where responsibilities are less clear and there is significant overlap in many areas.

Recent American federalism theory has moved away from these analogies toward approaches that emphasize fiscal and competitive relationships between and among governmental jurisdictions. Fiscal federalism represents an attempt to divide responsibilities among governments based on their ability to efficiently deliver goods and services (Oates 1972). Proponents of fiscal federalism argue that a federal system allows citizens to obtain the advantages of both centralization (economies of scale in the production of certain public goods) and decentralization (which offers variety in the provision of local public goods in accordance with preferences of different groups of citizens). The optimal number and size of governments ultimately depends on

a trade-off between benefit and cost characteristics. For example, whether a particular state should establish four or forty crime-control districts would depend on such factors as the variation in citizens' crime-control needs and preferences (which would tend to support greater decentralization) and economies of scale in providing crime control (which would seem to support an opposing argument for greater centralization) (Kenyon and Kincaid 1991, 9).

Competitive Federalism

Both economists and political scientists have begun to explore the concept of competitive federalism. Some would argue that this approach represents a return to the competition present in dual federalism, but it also stresses competition among states. For these scholars, competitive federalism is seen as a reaction to the failure of cooperative federalism to maintain the dynamics prescribed in the constitution. Instead they conclude that federal, state and local governments have been guilty of collusion resulting in a failure of government at all levels to be responsive to constituents. This idea of competition is at the center of Thomas R. Dye's (1990) call to apply public choice theory to American federalism. For Dye, federalism should serve as an arena for competition among all levels of government, "not just between the federal government and states, but also among the nations eighty-three thousand governments" (p.4).

Public Choice and Federalism

Supporters of competitive federalism (or public choice) most often cite a 1956 article by Charles M. Tiebout as the pioneering work in this area. Using economic theory, Tiebout sought to find a model for efficient allocation of public resources. He concluded that people are consumers of public goods while elected city officials are entrepreneurs who supply bundles of local public goods using tax dollars. Consumers who are unhappy with the price or selection of these goods can "vote with their feet" and move to another community where the goods supplied and the costs are closer to the customer's vision of equilibrium. This ongoing process also encourages communities to attract the optimal number of consumers in order to drive down the costs of goods (Breton 1991, 40). Tiebout's theory was the starting point for economists seeking a positive theory of government decision making and for political scientists wanting a theory similar to market behavior. The early reluctance of political science to embrace economic-based theory can partially be explained by timing. The early 1960s represented a high water mark for the behavioral revolution in political science which opposed the concept of individual rationality out of hand (Enelow and Morton 1993, 85).

In spite of this early resistance, public choice has firmly established itself within the political science and economic communities and is now touted as a rational basis

for policy decision models. As far as health care reform is concerned, public choice implicitly rejects a federal single-payer system and even copycat programs among states. Wildavsky (1990 41,44) explains it in this manner:

> Uniformity is antithetical to federalism. There might be some centralization in a federal system and there might be decentralization, but there must be noncentralization. Federalism is institutionalized competition...

Under public choice parameters, health reform would best be accomplished among subnational governments. As pointed out previously, since states already make many regulatory decisions with regard to health care, they would seem to be the most likely vehicle for reform. Under Tiebout's model of pure competition (and perfect information) citizen-consumers' mobility would measure the efficiency of such reforms by moving into states where they feel reform has been successful and out of states where they feel priorities are not in sync with their own vision of governmental health care responsibility.

A new federalism in which the states' roles in various policy areas is expanded by the devolution of power from the central government seems likely to become a reality if the conservative mood of Congress is approved in future elections. Diffusion is a central part of this new distribution of power. Successful experiments in health care policy by leader states will most certainly be adopted by followers. These policies will be adopted not because

they are mandated by the central government, but because they represent effective policymaking. These assumptions are predicated on the assumption that Congress will not pass any sort of national health care legislation and will be open to granting waivers to the many federal regulations concerning health care policy already in place.

Federalism and Diffusion

This brings us back to the question of how the evolving nature of American federalism may affect the diffusion of health care innovations. At issue is the shifting balance between the national government and the states. At this point in the nation's history, the pendulum favors state initiatives. At no time since the New Deal have the states been presented with more opportunities for pursuing diverse policy options. Thus a less centralized or less coercive federal system provides an ideal setting for diffusion within numerous policy arenas. In fact, whether states want more responsibility for certain policies or not, the current mood in Washington suggests that the states will end up with substantially greater control over a number of domestic programs. What will states do? Some critics worry about a "race to the bottom" as states may cut back on redistributive programs for fear of putting themselves at a competitive disadvantage. Yet, many Republican governors relish the opportunity to show what the states can accomplish. One thing seems clear, however. Some states

will undoubtedly rise to the challenge; they will lead the way. Others may falter or at least struggle to keep up. No doubt, though, states will learn from each other. What has already begun in the area of state health policy will continue and perhaps accelerate. States will innovate, adapt, and respond in diverse ways to the new challenges in health care presented by a more competitive federal system. Such a climate presents an ideal opportunity to explore further the process of how policies emerge and spread within a noncentralized system of government.

Diffusion Theory

Diffusion theory examines the process by which innovations, ideas or policies are spread among members of a social system (Rogers 1983). Early diffusion research was used by Agriculture Extension Services (AES) to discover ways to improve the spread of agricultural innovations among producers in an effort to improve farm production. A classic example of this type of study was an effort by the AES to trace the diffusion of hybrid corn among farmers in two Iowa farming communities. Information on the hybrid corn was made available through journals, the mass media, sales representatives and AES employees. Early adopters were farmers who were influenced by these methods to use hybrid corn for the first time (Valente 1993). Interpersonal communication then became a factor as early adopters persuaded other farmers to adopt the hybrid corn for

themselves (Royan and Gross 1950).

When the pattern of adoption is put into graph form, the general diffusion model forms an S-shaped curve. The curve reflects the three distinct stages of adoption. First, there is the take off point which represents early adopters. Second, there is a leveling off period when about half of the farmers have adopted the hybrid corn. Finally, the curve begins to flatten as the number of potential adopters shrinks accordingly. The importance of this and similar studies is to illustrate the process by which people learn about and decide to adopt innovations that may lead to widespread acceptance of new ideas or technology. The implications of such work later became obvious to sociologists and political scientists who applied diffusion studies to public policy innovations.

The journal articles of most sociologists studying diffusion theory are based on the work of Everett Rogers whose 1962 book Diffusion of Innovations is still most often cited by sociologists and political scientists alike.[7] But sociologists have most often pursued diffusion research which centered on the spread of innovation and ideas among organizations and clients; studies which parallel the hybrid corn study. On the other hand, political science articles have tended to be geographically-centered while examining policy diffusion among American states (Savage 1985).

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[7] A more complete and updated version appears as Rogers (1983).

Walker's (1969) landmark article on diffusion is prefaced as an attempt to construct a theory as to why some states adopt innovations more readily than others. The work represents a massive undertaking in the collection of data. Walker analyzed 88 different programs adopted by at least 20 states between 1870 and 1965.[9] Six to eight pieces of legislation were considered in 12 separate policy areas including welfare, health, education, conservation, planning, administrative organization, highways, civil rights, corrections and police, labor, taxes and professional regulation. In every instance, the author was concerned with the introduction of an innovation (legislative service, regulation, etc.) which had not existed before. Allowances were made for variations in enabling legislation, funding and even outcomes. As Walker himself noted, for this study "all adoptions (in the same area) are equal" (p.882).

Composite Innovation Scores

Using these data, Walker devised a composite innovation score for each state and ranked them according to their overall speed of adoption. He also provided rankings over three distinct time periods and provided aggregate data for

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[9]Hawaii and Alaska were both excluded from the study since neither became a state until 1959. Walker found records on legislative action taken while both still were still territories to be incomplete. However, both states are included in current research, the vast majority of health reforms having been adopted since 1960.

five regional composites. Among the conclusions reached by Walker is that competition and emulation play a key role in the spread of innovations among states and that certain programs adopted by a large number of states may come to be viewed as a legitimate state responsibility (p.890).

Walker also correlated innovation scores with measures of social development, economic development, party competition, malapportionment, office turnover and legislative professionalism. His findings again supported previous studies which showed that larger, wealthier, more industrialized states were more likely to quickly adopt innovative measures than smaller, poorer and less developed states (p.884). States with competitive party systems, apportionment which reflected an urban shift of the population, frequent turnover of office holders and a high degree of legislative professionalism were also seen as more likely to be progressive adopters.

Walker noted that these changes most often took place over a 25-30 year "political generation" (pp.895-896). For the most part, current health care reform efforts have been compacted into a 10 year period. While efforts to study health care reform might seem to be premature, in fact the quick passage of similar statutory provisions by state legislatures also supports Walker's claim that modern communications and networking among state policymakers would eventually expedite the diffusion process. This would

certainly seem to be the case with health policy innovations (This point will be examined in detail in Chapter 3).

Also germane to this study is Walker's observation that policy diffusion reflects regional or geographic emulation. He also notes that the adoption process can be visualized as a "succession of spreading inkblots on a map" (p.1187). He explains that state legislators and other state policymakers can more easily "analogize" to states nearby (e.g., Oklahoma and Texas) than states far away (e.g., Oklahoma and Oregon). He concluded this is due to geographic and demographic similarities (Mooney and Lee 1995). This theory also offers a plausible explanation as to why the Hawaiian health reform model has failed to be adopted by other states even after 20 years of measured success.

Competing Innovation Theories

Gray's (1973) work examined diffusion from a somewhat different perspective. Gray's study included analysis of only 12 issues and concluded that "innovativeness" is issue specific. More importantly, Gray questioned the usefulness of Walker's methodology in relying on aggregate data across time and a large number of unrelated policy areas. Still, Gray's findings supported the basic conclusions of Walker's work and certainly did not offer much evidence to debunk Walker's innovative ranking system.[9]

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[9]Gray's 1973 article in the *American Political Science Review* was followed by a comment from Walker which itself was followed by a rejoinder from Gray. As noted, disagreement among the two centered mainly on

Gray also supported the theory that innovations among states followed an "S" curve pattern with three distinct stages; take off, rapid development and declining growth (Benjamin 1985). Here again Gray provides support for the hypothesis that federalism influences diffusion of innovations. The "S" curve of which Gray writes is simply a cumulative plot of the familiar normal curve that offers "evidence of an absence of constraints and a randomness of interaction within the systems of study" (Chaffee 1975, 145). Diffusion of health care reforms over time is presumably not random, arrested or reversed, so there must be a constraint of some type. This paper contends that federalism is one of these constraints and attempts to identify others.

This is the tack taken in many previous studies. The authors assume that states with a shared problem will seek independent solutions, so there is a need to identify commonalities among states adopting reforms (Puro et al. 1985, 87). Eyestone (1977) identified two possible patterns of diffusion, emulation of virtue and policy necessity. Emulation of virtue theorized that states adopted some reforms simply because they were good government or good policy. In the policy necessity pattern the needs of interest groups were met whether or not the reforms

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research strategies more so than research results. See APSR Volume 67 December 1973, Number 4, pages 1186-1193 for the pieces in their entirety.

benefited the public as a whole. It should be apparent that Eyestone's patterns may not be as distinguishable as he hoped. Does the wave of current health care reforms fall under the emulation of virtue or policy necessity? An argument can certainly be made for both. This question will also be considered in later chapters.

Identifying Adopter Characteristics

Savage (1985) showed that 45 geographic-based diffusion studies were published in the 16 years after the Walker piece first appeared. The vast majority have dealt with diffusion of a single policy issue among states. The common thread among most of these studies has been the attempt by researchers to identify adopter characteristics. Among the most common characteristics of states studied have been population size, education level, urbanization, party competition, legislative professionalism and industrialization. The one characteristic which seemed to be most significant (especially in Walker's study) was affluence (Sigelman and Smith 1980). The most common finding in diffusion research was that there is a strong positive correlation between a states's wealth and innovative policies. But more recent studies have found the results to be mixed depending upon the policy area examined (Carter and LaPlant 1995; Fairbanks and Regens 1979; and Rosenbaum 1983).

Single Policy Issue Studies

More recently, diffusion studies have continued to focus on single policy issues. However, the latest trend is to ignore the time of adoption, a central theme of Walker's work. Scholars still search for reasons why some states are more innovative than others, they are just not concerned with who acted first. For example, an article on decriminalization of drugs by states (Thies and Register 1993) carefully noted that each legislature had altered state drug policies by 1990. But the study offered little insight as to why some states passed these statutes quicker than others. More appropriate for this study is a recent paper which examines health care reforms among states (Barrilleaux et al. 1994). Rather than ranking states according to the speed with which they passed health care reforms, the authors instead ranked states according to the number of health reforms passed.[10] This dissertation does offer a helpful model which divides health care reforms into distributive and allocative groups with a focus on the influence of executive capacity and ideology in the passage of such legislation.

Political science studies have managed to identify several factors which seem to somewhat explain health care

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[10]Barrilleaux et al. (1994) do not cite Walker or Gray as a reference and, in fact, do not even use the term diffusion. However, except for ranking states on quantity (or volume) of policies adopted instead of speed of passage, the paper certainly meets the criteria of a classic diffusion study.

innovation among states. The variables include cultural differences, contiguous relationships, slack resources, state administrative capability, legislative professionalism and political conditions. The latter includes the public's demand for change. That politicians have responded at the state level is reflected in the extraordinary efforts undertaken by many governors and state legislators to provide constituents with solutions to health costs and access problems (Gray 1994, 218).

State Innovations Continue

In 1993 alone, 1,850 health care reform proposals were introduced in state legislatures (Gray 1994, 217). By January of 1994, every state had passed at least minor reform legislation, and all states had established some sort of commission to investigate more substantial changes in the health care delivery system. While the number of different proposals and methods is impressive, the outcomes have been uneven to say the least. Massachusetts passed a pay-or-play program in 1988 then failed to implement it due to fiscal problems. Also the fact that all but three states have instituted some type of small business health insurance reforms may be somewhat misleading. Each state has dealt differently with community rating of premiums, guaranteed issue and high risks pools and usually modified the original action to meet local demands. For example, Texas restructured its program of health alliances for small

businesses after participation failed to meet expectations. The original plan drew heavily on programs already in place in Florida and California.

External Forces in Diffusion

A growing trend in diffusion theory has been to conduct case studies of legislation and attempt to identify external forces that may have played a roll in the passage or modification of a legislation. One external effect that has been considered both in older studies (Gray 1973) and more recent works (Brown 1993) is the influence or threat of preemption by the federal government. In health care, some authors believe that the threat of a national health care plan, especially a single-payer plan such as the Canadian model, has inspired states to push ahead with reforms of their own. However, some states have actually delayed action on reform until the federal government acts. The use of the Canadian model as a scare tactic represents a complete misunderstanding of the role that diffusion of innovations among states (or provinces in this case) played in the development of the single-payer system (see the discussion in Chapter 2).

Research Design and Data Collection

This research will trace efforts by states to reform health care. In most cases, this type of study requires the use of secondary data from at least two sources which track legislative action at the state level. That is primarily

the case in the chapter where Walker's model for state innovation rankings is recreated with an emphasis on health care reform. The data were checked against at least one other source, and the rankings are the result of original applications of methodology.

Primary sources play a key role in the case studies of state health care efforts. In addition to interviews with legislators, legislative staff and participating bureaucrats, transcripts of conference proceedings, agency summaries, copies of legislation and newspaper accounts were also used. When interviews were conducted every effort was made to contact parties representing several sides of the health issue (in most instances, there are more than two sides to a health related issue). In chapters where interviews are used, I have noted where limited sources were available.

Outline of Dissertation

A brief history of health care is necessary to establish the foundations of the mixed delivery model in place today in the United States. While Chapter 1 is more concerned with diffusion, federalism and public policy in general, Chapter 2 traces the development of the health care network since World War I. One of the more striking results of this study is the realization of how the number of players in health care has expanded over the last 80 years. The American Medical Association (AMA) was one of the

original players in the health policy arena. Though the association has a diminished role in the present policy network, at one point the group literally dictated state and federal action. This chapter also briefly touches on growth of a parallel health system in neighboring Canada with special emphasis on the role of provinces in creating the current single-payer system.

In Chapter 3, an attempt is made to create an updated version of Walker's innovation ranking design. In this case, recent data are used, but the basic methodology and use of multiple regression to identify salient independent variables are preserved. Comparing the innovation rankings of Walker and the rankings created some 25 years later proves to be a key part of this research. The central questions of this investigation are addressed in this chapter. Why are some states more innovative than others? Have some states recently become more innovative? What caused these states' innovation quotients to rise or fall?

The questions raised in Chapter 3 also play a central part in the next two chapters where three state reform efforts are examined in detail. In Chapter 4, two states which have attempted major reforms (Hawaii and Oregon) are examined. These states offer unique snapshots of health reform efforts which have attained varying degrees of success. The most complete case study is included in Chapter 5 where the efforts of Oklahoma are examined.

Primary sources are key to this chapter in spite of the fact that reform efforts have been contained in a somewhat compressed time frame. The case studies of these three states help to identify other variables that may explain why some states are more likely than others to attempt more sweeping innovations

In Chapter 6, the findings of this analysis are reviewed and an attempt is made to summarize the findings of this thesis. Along with discussion about the innovative tendencies of states, conclusions are also offered regarding the past and future roles of federal and state governments in a reformed health care system. Finally, I suggest possible avenues for future research which could contribute to the health care policy process at the state and federal level.

CHAPTER TWO

THE EMERGENCE OF MODERN HEALTH SYSTEMS

Introduction

America's current health care network is a hybrid system which combines private and public insurance and treatment. In many instances health care is treated as a commodity whose price is controlled by market forces. For the majority of American workers, increases in the costs of health care are reflected in increases in health insurance premiums. For other Americans, health care is a right. Elderly Americans (Medicare) and poor children (Medicaid) are two groups in which meeting certain qualifications entitles one to free or subsidized health treatment. In life threatening situations, hospitals and doctors are obliged by law to render medical aid regardless of the patient's ability to pay. This hodgepodge of sometimes conflicting systems is reflective of the history of health care in the United States.

This chapter will trace the history of health care in the United States from just around the beginning of the twentieth century to the present. A brief examination of the German and British health care systems is also included due to the strong influences both countries had on American policy choices. Finally, Canada and its single-payer system will also be reviewed. The Canadian system is especially important because of its proximity to the United States and

the many cultural similarities shared by the two countries. In all cases, a special emphasis is placed on the role of state and local governments in the administration and financing of health care. Contrary to popular perception, local control of health care systems is a near universal trait. While national governments often set minimal standards of care, lower levels of government also address important policy decisions.

The German Experience

In Europe, the appearance of national health plans coincided with the advent of the industrial revolution. Among the earliest efforts was creation of the German health system in 1883 under the leadership of Chancellor Otto Von Bismarck. The German system is salient to the American health care experience for several reasons. Bismarck's creation would serve as a prototype for many of the European programs as well as the United States.[11] And the German government also faced many of the same problems which American politicians would face over the next century.

Contrary to conventional wisdom, the German plan was not created from scratch, nor was it a socialized system. German craftsmen had long pooled their resources to form sickness funds which paid members cash benefits when they

[11] Other countries which created health insurance systems similar to the German plan included Austria (1888), Hungary (1891), Luxembourg (1901), Norway (1909) and Switzerland (1911) (Brand 1965, 211).

were injured or otherwise too sick to work. By the end of the 16th century, these groups were well established and were even utilized by miners. As medicine progressed, these payments were transferred to physicians thus becoming a form of health insurance. The payments were often based on members' income as well as their contributions to the fund (Stone 1980).

As the migration of workers to cities began to increase at the onset of the industrial revolution, living conditions (and thus the health of workers) began to noticeably deteriorate. The German government began to grow concerned about the effects of poor health on economic production as well as military strength. Studies showed that a large number of recruits from the cities were often unfit for service.

Citizens who were not members of sickness funds had previously relied on church-sponsored health charities for medicine and financial aid, but church-sponsored groups were soon overwhelmed by the sheer numbers of city dwellers. Still, the Roman Catholic Church opposed state intervention on philosophical grounds. Church doctrine held that individuals were responsible to themselves and God. State welfare would interfere with this relationship. Privately, Roman Catholic leaders also felt a state health program would undercut their political clout. In spite of this opposition, in 1876 the German Parliament established

minimal contributions for sickness funds and began regulation management. However, the Parliament stopped short of creating mandatory contributions by employers or membership for workers (Knox 1993).

Bismark's National Proposal

Bismarck wanted the national government to have a much larger role in the health insurance system. His original proposal called for doing away with sickness funds and replacing them with a federally controlled system featuring universal coverage, compulsory membership, contributions from employees and employers and accident as well as health insurance coverage. This plan ran into strong opposition from guilds, agricultural interests and local governments. The legislation that emerged was a compromise plan that not only allowed sickness funds to continue, but also established a system which combined federal oversight with private funding and local administration. The program was also far from universal. Less than 8 percent of the German population was covered under the original act, and it would take almost a century for incremental inclusion to expand the system to its current size (see Table 2.1).

Opposition of Doctors

Noticeably absent from coverage under the Health Insurance Act of 1883 were residents of small towns and rural populations. Also problematic was that the act completely ignored physicians. Though doctors' groups

TABLE 2.1 Categorical Expansion of Statutory Insurance in Germany

1883	Blue Collar Workers
1901	Transport and commercial (office workers)
1911	Agricultural and forestry workers, domestic servants
1914	Civil Service employees
1918	Unemployed people
1927	Seamen
1930	Dependents of fund members
1941	Pensioners
1966	farm workers and salesmen
1972	Self-employed agricultural workers and dependents
1975	Students and disabled workers

Source: Stone (1980, 78)

initially were not threatened by public health funds, they quickly began to organize opposition for three reasons:

1. a large growth in sickness fund enrollment
2. a substantial increase in the number of physicians
3. the practice by funds of contracting with doctors for salaries, thus limiting access of workers to private physicians.

D.A. Stone (1980, 50) summarized the problem in the following manner:

> In effect, social insurance created two patient pools where there had formerly been one. The creation of two separate markets for health services had a strong influence on the development of medical politics. Physicians were in the ironic position of trying to restrict the size of the public sector (and thus preserve the private sector) and to increase their access to it at the same time.

By 1911, the German government addressed the demands of the physicians by establishing licensing, allowing free choice of doctors by patients and limiting sickness fund membership to blue collar workers (Knox 1993, 31-32). Free choice of physicians is a problem that has reappeared in recent years as American states attempt to deal with HMOs which seek to hold down costs by requiring members to visit only doctors who are salaried or under contract to the insurance fund.

National Health Insurance in Britain

Great Britain's move toward national insurance was heavily influenced by the German model as well. David Lloyd George, Chancellor of the Exchequer in the Liberal Party cabinet, had visited Germany in 1908 and become familiar

with the system. When he began making plans to introduce his own version of health insurance, he dispatched several bureaucrats to Berlin for a more detailed study (Hollingsworth 1986, 21). For Lloyd George, health insurance was only part of a series of social reforms he envisioned. While the German program covered only sickness and disability, the British program Lloyd George envisioned would also include unemployment benefits (Reden 1985, 23).

Friendly Societies

Prior to passage of the National Insurance Act of 1911, the British had relied on voluntary insurance plans which were administered at the local level by friendly societies and trade unions. Friendly societies were one of the most important players in British politics and medical care. They served much the same role as the German sickness funds. When the U.S. later tried to emulate German and British efforts, the lack of similar groups contributed to the failure of political leaders to secure any substantial support for government-assisted health plans. Friendly societies were certainly one of the features that most distinguished British delivery of medical care from early American efforts at reform.

For a small fee, members of the friendly societies were guaranteed care from a doctor when they were sick. Doctors worked under contract and were paid a set fee for every person on their list. Though these workingmen organizations

provided no care for family members, by the end of the nineteenth century one half of all adult males in Great Britain were covered by one of the societies. Eventually the friendly societies became a victim of their own success. The societies relied on actuarial tables drawn up when most men died before middle age. When mortality rates began to improve due to better health care, the friendly societies began to experience financial difficulties and reluctantly turned to the government for help.

British View Toward Poverty and Health

The move toward national health insurance symbolized a deep seated change in how Britons viewed poverty. In the 1800's, poverty was seen as a disgrace. The Poor Law of 1834 was not passed to help the poor, but rather to protect society from the poor (Eder 1982, 3). By the early 20th century, Briton began to view poverty and health problems as the fault of society, not the poor themselves. Though Lloyd George's stated goal was to protect the wages of workers who became sick (Fox 1986, 5), historians tend to agree humanitarian and political considerations far outweighed economic concerns as primary motives for national health insurance (Searle 1971, 236).

Three major interest groups played prominent roles in creating the national plan; friendly societies, insurance companies and doctors. Because of the size of their membership, the friendly societies exuded the most

influence, but insurance companies also had political clout. With 30 million death benefit policies, the insurance companies did not want the government to provide a competing death benefit package. The insurance industry employed over 100,000 people and managed to have death benefits stricken from the final bill (Hollingsworth 1986, 12-20).

National Health Insurance

The National Insurance Bill covered mostly those with steady jobs and relied on compulsory contributions from both employees and employers. Coverage included doctors' care, drugs, treatment for tuberculosis, maternity costs and a sickness benefit. The Labor opposition was not especially strong, but the British Medical Association (BMA) was a vocal opponent. Unable to prevent passage of the bill by Parliament, the BMA chose to try to change the program during implementation. After gathering over 26,000 signatures from fellow physicians pledging not to sign up with national health, the group then presented its own demands to Lloyd George. Among these demands was choice of doctor by patient and administration of the plan by local health committees.

The most limiting demand was the BMA's insistence that the plan exclude any worker making over two pounds per week. Lloyd George was hesitant to negotiate, but did give into the BMA on the issue of local health committees. The committees were set up at the county level with one-third of

the members being appointed by the country, one-third approved by the friendly societies and the other third made up of workers who contributed to the plan (Brand 1965, 216). The doctors' plan to dominate the committees at the local level was blunted by this make-up, and in the end the only one of their demands to which the government acquiesced was free choice by both doctors and patients.

National Health Insurance would eventually cover over one-third of the population, but it was not the socialist program that many American critics would later claim. The NHI was decentralized and private in character. General practitioners did not work for the government, and some doctors chose not to participate at all. Unlike the various American schemes, the medical delivery system was, for the most part, egalitarian (Hollingsworth 1986, 21).

After World War II Britain again made significant changes in its health delivery program. Public health was perceived as fragmented with local boards and competing societies creating a patchwork of uneven service areas (Peden 1985, 114). The British government hoped that a consolidated national health service would reduce overall demand for medical care by improving the nations overall health (Keidan 1983, 173).[12] Parliament responded by creating the National Health Service (NHS) in 1946. By 1948

[12] Interestingly, a constant criticism of the current NHS system is that it is now too large and centralized to manage.

the NHS had assumed control of most volunteer hospitals. Private beds were allowed in NHS hospitals in an effort to attract private specialists, but for all practical purposes the creation of the NHS represented the end of local control of health services (Reden 1985, 155).

The American Experience

Until the beginning of the twentieth century, as far as the federal and state governments in America were concerned, health care was a non-issue. Doctors and their patients enjoyed a simple fee-for-service relationship. In rural America this meant bartering for services as often as not. Health care for the indigent was left up to local governments and private charities or churches.

In 1915 the American Association for Labor Legislation (AALL) began a push for mandatory health insurance paid for by workers. The AALL was established in 1906, its primary mission to lobby for laws at the state and federal level beneficial to American industrial workers. The group was controlled by academics though the membership included business leaders as well as workers. A central theme of the AALL's dogma was The Wisconsin Idea. Political scientist Richard Ely and economist John Commons, both faculty members at the University of Wisconsin, were part of a group of AALL members who believed there should be close collaboration between government and university in addressing social ills. The proximity of the university and the capitol in Madison

had provided a perfect proving ground for such collusion, and Governor Bob La Follette was an enthusiastic participant.

The group enjoyed some success in pressuring most states to pass some form of workmen's compensation. Its next big push was for compulsory health insurance. Proposals for broad forms of social insurance had been included in the platform of Teddy Roosevelt's Bullmoose Party in 1912, but had not been adopted by the major parties (Burrow 1963, 135). In 1916 the AALL introduced a plan for compulsory medical and sickness insurance. The program would have covered the poor using existing insurance carriers with costs paid for by employers, employees and states (Anderson 1968, 62-65). But the entry of the United States into World War I in 1917 short circuited passage at the state or federal level permanently deflating the reform movement of that era (Davis 1986, 438).

The AMA's Position Shift

In 1916, the American Medical Association (AMA) released the results of a study it had conducted of the newly implemented British system. The study noted that universal coverage in Britain had "unquestionably improved the conditions of the working class" (Stevens and Stevens 1974, 123). But physicians began to have second thoughts about federal control, fearing a loss of fiscal autonomy through standardized fees. After the war ended, the AMA

reversed its position and came out against any type of public health insurance, a position they have retained through the present (Lockhart 1988).

This shift in position by the AMA can be partly attributed to a takeover of the organization by the practitioner wing from the academic wing. The more conservative practitioners were able to pass the following resolution through the AMA House of Delegates in 1920:

> Resolved, that the American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for medical service to be rendered to contributors or their dependents, provided, controlled or regulated by any state or the Federal government (Burrow 1963, 150).

The AMA publicly equated compulsory insurance with socialism. This argument proved to be extremely effective in the 1920s and a modified version is still used today. The president of the AMA told a television audience in 1991 that centrally controlled health care was a major contributor to the collapse of communist governments in Eastern Europe and the Soviet Union (ABC's "Nightline" 1991). The doctor implied that expansion of public health care in the United States could lead to a collapse of the American economy as well. He also implied that a single-payer system similar to the Canadian model would also be catastrophic for American medicine. Historically, AMA opposition to any form of universal care has helped defeat proposals at the national and state level, but the lack of

cohesive support for such programs has also prevented government-administered health care on a large scale.

Hoover Committee on the Costs of Medical Care

A major problem for supporters of health care reform in the early part of the twentieth century was that while education had become recognized as a public concern, health care "emphatically had not" (Wector 1948, 273). The beginning of the Depression certainly magnified the problems in the American health care system, but studies, not legislation, seemed to be the only solution the federal government could offer. In 1932, President Herbert Hoover's Committee on the Costs of Medical Care (CCMC) released the results of a study which confirmed the health delivery system had serious deficiencies. The report stated that of the $30 per capita spending on medical care in the United States, $23 came from private citizens with the remaining $7 coming from government and charity.

The CCMC also found a correlation between income and health care spending. For the half of the American population that earned between $1,200 and $2,000 per year, the per capita spending on medical care dropped to $13 per capita. For the poorest Americans making less than $1,000 per year, the per capita spending was only $9. Poorer Americans were reluctant to spend money on health care when other staples were needed. More troubling was the discovery that physicians, seeing their own earnings decrease since

1929, were less and less likely to take on charity cases (Wecter 1948).

Social Security Act of 1935

Ironically, it was the near collapse of the American economy in the 1930s that paved the way for expansion of governments' role in health care. President Franklin Roosevelt saw an opportunity to greatly alter domestic policy. Compulsory health insurance was one of several areas to be considered by the Committee of Economic Security (CES).[13] Taking over a year to reach accord on suggestions, the CES proposed a series of programs including what became the basis for the Social Security Act (Marmor 1994). Fearing AMA opposition to compulsory health insurance would submarine the entire domestic agenda, Secretary of Labor Frances Perkins who chaired the committee recommended that action on health insurance be postponed. President Roosevelt agreed. The Social Security Act which passed did however usher in an era of federal/state programs. Federal grants went to states for categorical assistance which included health care for a few specific groups. Unemployment programs also were also symbolic of new federal and state cooperation (Biles 1991, 110).

Following enactment of the Social Security Act, Dr. Abraham Epstein, founder of the American Association for

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[13] Other policy areas studied by the CES included welfare, unemployment, child health and poverty among elderly Americans.

Social Security (AASS), began to develop a model bill for states to address what he saw as the primary weakness of social security--the lack of health insurance. Financed by a 6 percent tax on wages (with contributions by employers and the state government as well), the proposal would have paid most medical, hospital and dental costs. The bill was introduced in several states including California, Massachusetts, New York and Wisconsin.

In 1935, the California legislature established a committee to study the establishment of a health insurance plan similar to the AASS model. Employers with health care plans in place could opt out. The program would be financed with compulsory contributions of 1.5 percent from employers and 3.5 percent from workers. But when a final version of the bill was finally voted on by the California assembly in 1939, it was soundly defeated. Dr. Epstein's death in 1942 and the onset of World War II signaled the end for the AASS and its health car reform efforts.

In 1939 Senator Robert F. Wagner of New York introduced a bill which would have financed the construction of new hospitals, subsidized state health programs for the poor, provided cash sickness benefits and awarded federal funds to states which created comprehensive health programs (Sigerist 1960, 189-91). The bill eventually died in committee, again due mainly to the efforts of the AMA. But Wagner later combined forces with two other members of Congress to

introduce a plan for a national health insurance plan completely controlled by the federal government.

The Wagner-Murray-Dingell Bill

Financed by compulsory payroll taxes, the Wagner-Murray-Dingell plan was the first piece of major health care legislation to almost completely ignore the role of states. This bill also failed to make it out of committee, but was reintroduced on almost an annual basis from 1943 until 1949 (Anderson, 112). However, in 1950 President Harry Truman endorsed a version of the bill that would have covered medical, dental, hospital and nursing services for all Americans. Truman's plan also would have been financed by a payroll tax and coverage would have been extended to all contributors and their dependents. Poor Americans would have had their premiums subsidized by the government. The plan would be administered by a federal agency and, unlike the British system, would have allowed free choice for patients and doctors. Even with Truman's vigorous support, the plan was defeated mainly through the efforts of the AMA (Brown 1984).

In 1950 amendments to the Social Security Act authorized matching grants to states for direct payments to providers of medical care for medical treatment of persons on public assistance. This represented a major expansion for state discretion in the health care arena. Previously federal matching funds could be used by states only as part

of an average payment for monthly family medical care (Ginsburg 1988, 181).

Health Insurance After World War II

The current system of health coverage originated during World War II. A shortage of manpower combined with wage controls forced employers to offer health care benefits as an incentive to attract workers. Unions adopted the practice of seeking employer-based coverage, and the effort continued even after the war was over. Health insurance coverage became viewed as a job benefit in the same manner as paid vacations and sick leave.

From the start, the system has primarily been concerned with providing affordable health insurance for those able to pay as well as providing minimal care for all Americans, regardless of their economic status (Arnould et al. 1993, 5-6). This fee-for-service system featured free choice of provider and payment by a remote third party which almost guaranteed lack of bargaining power by insurers. Hospitals and physicians joined together to create Blue Cross and Blue Shield chiefly to facilitate payments to providers. In return for expediting payments and providing a large volume of patients, health care providers granted Blue Cross and Blue Shield substantial discounts (Weller 1984). It was a popular system that spread rapidly:

> ...it was cheap, it was tax deductible to the employer and tax free to the employee, employment groups could buy coverage at much less than the cost of individual coverage and employer-paid health

> benefits were a great source of bargaining prizes for unions. In the minds of many employees, fee-for-service coverage fully paid by the employer became normal, an entitlement (Enthoven 1993, 26).

Postwar Growth

In spite of the huge increase in the number of Americans covered by health insurance, the postwar growth in the private sector was somewhat uneven. The elderly were among several groups that continued to be underinsured. Retired workers were often forced to give up health insurance at a time when medical requirements increased and their financial resources decreased. Often they were forced to turn to their children for financial assistance. Truman's advisors abandoned their quest for universal insurance, but saw a chance for incremental expansion of federal insurance to carefully selected target groups. The elderly were the perfect group. Congress would find it very difficult to deny expanded coverage to the retired while at the same time relieving financial responsibility for their children.

Health reformers placated the AMA by excluding physician services from their Medicare proposal choosing instead to offer hospital insurance for those over 65. Social security funding further legitimized health insurance for the aged. The American tradition had always been that people should "pay their own way." All recipients of Medicare had previously contributed to Social Security thus

making the plan strongly resemble private insurance. In fact, social security recipients were referred to as "claimants", a term that at least suggested that benefits were owed by the government to the elderly.

In spite of these popular provisions, it was 1958 before congressional hearings were conducted to study hospital insurance for the aged. Just like health reform efforts in the past, the Medicare bill died in committee, but the issue of health insurance reform did not die with it (Greenfield 1966, 26).

Kerr's Compromise Bill. In 1960 Senator Robert Kerr (D-OK) and Congressman Wilbur Mills (D-AK) introduced legislation which represented the conservative response to Medicare. Though he opposed compulsory health insurance, Kerr acknowledged that the federal government had a role in guaranteeing health services for the elderly and the poor. In the congressional session prior to the Kennedy-Nixon presidential contest of 1960, Congress was under great pressure to pass some form of health legislation. Increasing medical costs had made health care an important issue for both candidates. The Republican administration attempted to help Nixon by introducing a bill which combined federal and state subsidies to finance coverage of indigent persons over age 65 through private health insurance companies. Liberal Democrats supported a compulsory system for people over 65 financed with Social Security taxes.

Neither bill made it out of the Ways and Means Committee.

As early as 1959, Senator Kerr had sent members of his staff to Oklahoma to meet with members of the Oklahoma State Medical Association. Oklahoma doctors made it clear that they shared the AMA's long-time position on "socialized" medicine and would oppose any federal program which financed health care. Kerr then invited a group of Oklahoma doctors to Washington in an attempt to show them that some form of health reform was imminent and the prudent move would be to participate in constructing a compromise program. After two days of conferences and visits among members of Congress, the physicians reluctantly agreed to support Kerr's efforts.

Joining forces with Mills, Kerr created a bill which rejected the Social Security approach. Unlike Medicare, the Kerr-Mills proposal allowed states to set standards of need and to determine the amount of benefits. Only the elderly with severe financial problems were eligible, and states were obligated to supply 20 to 50 percent of the funding. Kerr summarized the program in the following manner:

> The Kerr-Mills program provides greater benefits to those over 65 who need benefits. The benefits include doctors, surgeons, hospitalization, nurses and nursing care, medicines and drugs, dentists and dental benefits--even false teeth. Each state can provide what is needed within the state. The social security approach for aged care would provide mainly hospital and nursing home payments (Nation's Business 1963, 24).

In spite of federal incentives, many state government chose not provide full benefits allowed under the Kerr-Mills

plan, mainly due to the huge costs. In fact, only four states provided all the care allowed with the vast majority of states providing only a minimal amount of benefits and imposing strict eligibility requirements (Greenfield 1966, 28). If Kerr-Mills was disappointing as a health program, it was certainly a political success. By leaving control in state hands, Kerr-Mills eventually gained the support of the AMA. Privately, doctors hoped the Kerr-Mills plan would diffuse proposals by newly elected President John F. Kennedy and the expected push for passage of federally controlled Medicare.

But even with the support of President Kennedy, Medicare still failed to pass Congress. The Kennedy measure provided 90 days of hospital care and 120 days of nursing home care financed by a one-half percent increase in the Social Security tax. The bill did have the distinction of making it to the senate floor in 1962. It was defeated by a 52-48 margin when 21 Democrats (mostly southerners) sided with the Republican minority (Reeves 1993, 327). After Kennedy's assassination, Lyndon Johnson, a master politician took up the fight, but he too faced strong opposition from within his own party.

Johnson vs. Goldwater. The presidential election of 1964 offered American voters a clear choice for the role of the federal government in health care for the elderly. While Johnson proposed expansion of Social Security through

Medicare, Barry Goldwater promised if he were elected he would abolish the entire Social Security program (Johnson 1971, 103). Johnson's resounding victory in the 1964 presidential election seemed to give him the mandate he needed to pursue passage of a federal health program.

As chairman of the Ways and Means Committee, Wilbur Mills lack of support for Medicare inevitably led to most bills dying there. After the election of 1964, Chairman Mills realized there was a chance a health bill would go through Congress with or without his support. Mills decided in March of 1965 that he would personally introduce a new health reform bill in the House. President Lyndon Johnson's expert on Medicare, Wilbur Cohen, informed the president of Mill's intentions but warned that the program was likely to be a compromise of several bills (Johnson 1971, 212).

And there were any number of proposals for Mills to choose from. Since 1961, Senator Jacob Javits had been promoting a state-run program for persons over 65 whose income did not exceed $3,000 ($4,500 for couples). Financed by the national government, federal directives also would set eligibility requirements. The AMA's Eldercare program was also a federal-state program with subsidized private insurance for the elderly for hospitalization, physician visits and prescriptions. The Republican's Bettercare program (also known as the Byrnes bill) was very similar in coverage to Eldercare, but relied on federal rather than

state administration. In addition, there were bills calling for tax credits and medical savings accounts. To further complicate matters, most of these bills were sponsored by members of the Ways and Means Committee who were determined to influence the Medicare bill that would emerge (Congressional Quarterly Service 1965).

Under Mill's guidance, the final bill was a compromise which boasted elements from three other proposals. From Johnson's proposal, hospital insurance for the elderly financed through the Social Security system was included. From the Republican (Byrnes) bill came a voluntary program which would allow persons over 65 to purchase subsidized insurance for physicians' visits. Officially these two program were known as Part A and Part B of Title XVII of the Social Security Amendments of 1965 (Social Security Amendments of 1965 Sec 1902).

When the bill reached the Senate, a final effort was made by Sen. Russell Long to change the program from supplying limited benefits for the aged to one that focused on giving unrestricted benefits to the poor. President Johnson intervened through the Senate Finance Committee to head off any wholesale changes. The final bill called for an expansion of the Social Security system to include hospitalization, nursing home care, home nursing services and outpatient services basically to all Americans over the age of 65. As a special gesture to Harry Truman's previous

efforts, Johnson flew to Independence, Missouri to sign the bill into law and gave the former president the first Medicare card (Pearman and Starr 1988).

The Medicare Program

The Medicare program that passed consisted of two separate plans; Hospital Insurance (HI) or Part A and Supplementary Medical Insurance (SMI) or Part B. The HI portion of Medicare could be categorized as social insurance. It is financed through a compulsory tax on workers and employers. Administered by the federal government, benefits are not means tested and eligibility requirements are mainly tied to age. However, SMI is a government subsidized insurance plan that utilizes private insurance companies. The program is voluntary, administered by the federal government and is financed through equal contributions from participants and the federal government (Myers 1970, 88).

Both parts included deductibles and copayments similar to those in private insurance programs. This was part of a deliberate effort by Congress to insure Medicare was not perceived as socialized medicine. Ultimately, legislators hoped that both programs would be absorbed by private insurers. And within five years, Blue Cross and Blue Shield had indeed taken over much of the administration of Medicare (Stevens and Stevens 1974, 50-52).

The strong opposition of the AMA to Medicare may have

backfired. Not only did Congress pass an expanded Medicare program, Medicaid also emerged at the same time (Marmor 1970). Both passed in July 1965 and both programs were activated on July 1 of 1966. Members of the Association of American Physicians and Surgeons urged its members to boycott implementation, but the AMA left the decision on whether to boycott up to individual physicians. After a series of negotiations over reimbursement procedures, the AMA reluctantly called for all doctors to participate in Medicare (Pearman and Starr 1988, 10).

Costs Underestimated. From the beginning, however, it was obvious that estimates for the costs of Medicare were far short of reality. Within six weeks, President Johnson called for an investigation into rising medical costs. It seems that some doctors had agreed to take Medicare patients, but were charging two to three times the normal rates for patients over 65. Hospital bills also skyrocketed (Pearman and Starr 1988).

Congress began to correct the shortfall almost immediately by increasing the cap on the amount of income subject to Social Security taxes. But no effort was made toward more stringent eligibility requirements. In 1972, Congress even expanded Medicare coverage to disabled persons and those with end-stage renal disease (ESRD) (Moon 1993).

Medicaid. Compared to Medicare, Medicaid was "ill planned" and certainly less publicized, though both were

part of the same legislation. By offering states federal matching funds and expanding the definition of medical indigence, Medicaid had the potential to reach more people than Medicare from the very beginning. Though formally Title XIX of the Social Security Act, Medicaid was in reality an extension of the Kerr-Mills plan (Stevens and Stevens 1974, 51).

Some politicians viewed passage of Medicare and Medicaid as a chance to compare health insurance plans. Medicare had a compulsory plan (Part A) as well as a voluntary program (Part B) funded and administered by the federal government. On the other hand, Medicaid was another of a long line of programs which combined federal grant-in-aid programs with state administration.

Under Medicaid, each state was encouraged to provide medical assistance to the elderly not covered by Medicare as well as the disabled and families with dependent children who lacked the income "to meet the costs of necessary medical services" (Public Law 89-97). Though the legislation set minimal levels of service provision, states were given broad discretionary powers to determine eligibility requirements. Another important element of the funding for Medicaid was that it was left open-ended; the more a state chose to spend, the more federal dollars would be available. And the federal government was committed to provide 50 to 80 percent of the funding with the amount

based on a formula that funneled the higher percentage to states with the lowest per capita income (Stevens and Stevens 1974, 58-59).

While the costs of Medicare and Medicaid continued to grow much faster than the costs of living index, it also became clear to many politicians that these programs were not supplying adequate medical care to all that were supposedly included. In his memoirs Lyndon Johnson noted that:

> We had begun at long last to recognize that good medical care is a right, not just a privilege. During my administration forty national health measures were presented to the Congress and passed by the Congress-more than in all the preceding 175 years of the Republic's history (1971, 220).

But the president also noted that even after this expansion the United States was still fifteenth in infant mortality. Senator Edward Kennedy also called attention to the fact that other countries seemed to have better quality health care while spending less money. As a remedy to the "crisis" in American health care, in 1972 Senator Kennedy called for single-payer system in which the federal government paid literally all costs for health care for all Americans.

Kennedy Health Plan

Financed by a payroll tax, the Kennedy plan was based on the premise that the current system of private insurers was centered on profits. Insurance companies kept down costs by excluding those people with serious illnesses and/or pre-existing conditions. Kennedy's plan would

control costs through global budgets and would allow patients and doctors free choice in selecting health care (Kennedy 1972).

Though his proposal for universal coverage eventually failed, Kennedy's belief that the American health care system was headed into a crisis turned out to be somewhat prophetic. Health care expenditures as a percentage of the GDP in the United States had begun to soar. Other countries such as Canada and Britain also experienced increases but at much lower rates. In fact, America's total health expenditures for the period from 1970 to 1990 increased at an annual rate of 11.6 percent while the GDP increased at an annual rate of only 8.7 percent. These increases occurred even though hospital admissions and physician visits either fell or remained the same over the same period (Jencks and Schieber 1991, 1). Clearly the increases were the result of higher prices rather than increased utilization resulting from expansion of Medicare and Medicaid.

Medicare increased at an even higher rate prompting Congress to take several incremental approaches to control physician fees and hospital costs. Two of the more ambitious adoptions were Diagnostic Related Group (DRG) billing and the Prospective Payment System (PPS). Both programs resulted in some temporary savings for the federal government without passing on increases to the beneficiaries. However, lower payment outlays by the huge

government programs began to result in increased cost shifting by health care providers to private insurance companies. When insurance rates increased, more persons were unable to afford premiums. The states, which provide funds for indigent care as well as a portion of Medicaid funding, slowly began to feel increased financial pressures of their own (GAO 1992).

Background of Current System

It would seem that the somewhat limited goals of the current system were reached through a combination of private and public coverage which seemed adequate at least into the 1970s. Specifically the goals have been met through "three pillars"; private insurance providing coverage for 68 percent of Americans, public social insurance with 19 percent of coverage and charity care providing health care for the remaining 13 percent (Aaron and Schwartz 1984). The latter has been achieved mainly through subsidies and costs shifting, charging insured patients higher fees to offset the costs of uncompensated care. But health care costs have entered a pattern of sharp increases, rising much faster than inflation. As a result, health insurance premiums have also increased, putting health care out of reach for many low income workers. This development also inflated the number of patients receiving uncompensated care. Budget shortfalls have forced every level of government to scramble for more money to keep public health insurance programs at

minimal standards of service. But reduction in payment for services has become a favorite cost control ploy for Congress. While this provides short term fiscal relief, it often prompts more physicians and other health care providers to refuse to treat Medicaid and Medicare patients.

Insurance companies pass on cost increases to the public making health insurance affordable to fewer people. The end result is a self perpetuating cycle of rising costs. The Congressional Budget Office (CBO 1992) has projected that if health care spending continues to rise at the current rate, total expenditures for health care will reach $1.3 trillion by the year 2000.

These figures are put in better perspective when viewed in terms of per capita spending and percentage of the country's Gross Domestic Product (GDP). The United States spends more on health care per capita and a larger percentage of its GDP than any other member of the Organization for Economic Cooperation and Development (OECD), and the gap has begun to widen in recent years (CBO 1993). But these huge expenditures do not necessarily mean the United States has the healthiest population. Health status indices such as infant mortality rate and life expectancy are better in several industrialized countries which spend considerably less on health care. For example, Canadian life expectancy is over 1.6 years greater than Americans' while infant mortality rates are 25 percent lower

in Canada than in the United States (WHO 1989).[14]

Many blame problems in American health care on the inability of some Americans to receive basic health services. The problem of access is one which the federal government has previously attempted to address through Medicaid, Medicare and various other programs. These health agencies currently consume just over 25 percent of the federal budget (Goddeeris 1991).

Critics are quick to point to the less than impressive record of social programs created at the federal level in the 1960s and 1970s. Academics have joined politicians in questioning the federal government's ability to successfully manage such programs (see Pressman and Wildavsky 1973). Even a casual evaluation reveals that after spending billions of dollars on programs aimed at reducing social ills, the government's War on Poverty accomplished much less than many hoped and expected. Federal efforts to provide medical care to needy groups (e.g., the elderly and the poor) have created a second tier health network which suffers from delivery and fiscal problems. Some scholars claim these programs provide benefits mainly to those who provide the services, rather than those eligible to receive

[14] Naylor (1990) concludes that American infant mortality rates are skewed by extraordinarily high rates in inner cities. He points out that the rate for blacks in Los Angeles in 1989 was 20.8 per 1000 live births compared to 7.4 per 1000 live births for whites. A counter argument would be that these aggregate figures genuinely reflect the American society as a whole and serve to underscore the access problems for the underclass.

them (Lowi 1984).

A recent study from the Harvard Department of Social Medicine (Richard and Fein 1995) argues that the current crisis in American health care results from a lack of recognition of changing demands. The paper claims that the health policies enacted following World War II, though disjointed and uncentered, nevertheless were successful in overcoming shortages. Policies of that era were faced with a "deficit model" where the main goal was to increase the number of physicians, nurses, clinics and hospital beds. This was accomplished by increasing the number of medical schools and subsidizing the building of hospitals. Both states and the federal government were active in this movement. The large volume of health policy legislation passed in 1965-66 by Congress (including Medicare and Medicaid) fueled the growth of a for-profit health system which saw investors enter health care. The end result has been a system of reimbursement with little or no cost containment mechanisms.

Development Of The Canadian System

Contrary to popular belief, development of the Canadian health system was not a unilateral effort forced on lower governments by an all powerful central entity. To the contrary, all ten Canadian provinces had their own health care institutions in place before the current model evolved. The Canadian constitution specifically cedes primary

jurisdiction of health care to provincial governments (Guest 1980, 89). The two territorial governments and federal government are responsible for providing health care for native populations, immigrants, federal employees and military personnel. The interaction of these 13 governments is what makes the system function (Crichton et al. 1992, 3).

Each province is reimbursed around 40 percent of its budgeted expenditures on health care by the national government (Marmor et al 1990). Five provinces finance their portion of these costs through health insurance premiums, four use general revenues and one province uses a combination of both. The federal share of the program comes mainly from a 2 percent surcharge on income (Meslick and Storch 1980).

Health care costs and strategies in the United States and Canada roughly mirrored each other until the single-payer Canadian system was fully implemented in 1972. Since that time Canada has consistently had lower cost increases than the U.S. and is currently spending a smaller percentage of its gross domestic product than the United States.

The national government of Canada requires that the provinces meet four basic requirements:

1. Universal protection.
2. Comprehensiveness--must cover all medical care.
3. Accessible--no extra charges.
4. Publicly administered.

Each province has some unique aspects in its program, but the basic method of payment is essentially the same. Physicians are reimbursed by uniform fees paid by the provincial ministry of health. All provinces allow freedom of choice for both patient and physician. Doctors also retain the option to choose the appropriate care without direction from the government. Hospitals are not directly reimbursed for services, relying instead on global budgets which cover all expenses (Evans 1988).

Canadian Physician Fees

Physicians' fees are negotiated annually by provincial governments. If the submitted fees exceed the insurance budget, the government offers less money the next year. Two provinces have tied together global budgets of hospitals with physicians' fees. When the limit is reached, physician fees are immediately reduced, a practice very unpopular with Canadian doctors (Marmor and Mashaw 1990). Still, after early dissatisfaction with the program, recent studies suggest that Canadian doctors have adapted to the system and that salaries have not been adversely affected (U.S. GAO 1991).

Historically, health care in Canada reflects a variety of emphases among the provinces. Saskatchewan, the last province to join the current system, was the first to pass legislation authorizing municipalities to levy taxes for the purpose of hiring physicians and building hospitals. Ten

years later, in 1934, Newfoundland established a publicly funded hospital and medical care plan. Other provinces followed the American practice of using private insurance companies for medical coverage. Between 1935 and 1945 Alberta, British Columbia and Quebec all voted down public insurance plans. Hospitalization insurance was the first of a series of programs in which federal and provincial governments cooperated to finance health care.

Throughout the 1950's, provinces set up universal coverage of hospital services. By January 1961, all provinces had plans which covered costs of hospitalization except physician fees (Melicke and Storch 1980). The Medical Care Act which went into effect in 1968 offered the provinces federal money to begin a full coverage program. Provinces were guaranteed that at least 50 percent of the start up costs would be paid by the federal government, while poorer provinces could receive up to 80 percent federal funding.

Canadian Federalism

By design, the Canadian federalist system does boast a somewhat stronger central government than the American system largely as a result of the American Civil War. Canadian founders wanted to prevent provinces from having as much power as American states. In their view, one of the main causes of the secession and the resulting war was the autonomy of the American state governments. This is one of

the many differences that critics point to when an effort is made to present a comparative diffusion analysis of the United States and Canada. While differences do exist in the way the government is selected, the division and autonomous power of federalism is present in Canada just as it is in the American model.

Another argument against comparison is the seeming lack of diversity among Canada's relatively small population (27 million versus 248 million in the United States). The most common argument is that a Canadian style health system could never be developed or implemented in the United States because diversity in the United States will prove to be too large an obstacle. However, there are distinct differences among the Canadian provinces, the most obvious of which is the dominance of French-Canadian culture and language in Quebec. Unlike some of the Western provinces, Quebec's early hospital care system was run and supported by Catholic charities (Taylor 1979).

The largest differences, however, are observed between the cultures of the people. Most prominent of these disparities is what Naylor (1993, 27) refers to as American "ideological antipathy" toward government intervention in general and federal government intervention in particular. Polls continue to show that Americans continue to have more faith in state government than the federal government (Economist 1990). This coincides with Leichter's (1992)

observation that states have recently supplanted the federal government as the institution of initiative and activism.[15] American faith in state and local levels of government compares favorably with Canadian belief in provincial and local government. As in the Canadian experience, health system reform in the United States would seem to have a much greater chance of gaining consensual approval if it is initiated at the state or local level. Other American policy areas, such as education, are nearly completely controlled by lower levels of government.

Even the differences in coverage among Canadian provinces reflect a diversity in political and cultural beliefs among the country's peoples. Though national standards for minimal coverage are in place, provinces have substantial discretion in many coverage and fiscal areas. Some provinces have elected not to include dental care in the health plan, and there are significant differences in the handling and dispersement of prescription drugs. Even the method of payment for physicians varies somewhat with some provinces favoring fee-for-service arrangements with others more likely to employ salaries as compensation (Crichton 1990, 79).

One problem with which American states can identify is the increased financial pressure put on the provinces by the

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[15] For more on the emerging role of states see Clarke (1981), Osborn (1990), Bowman and Kearney (1986).

central government since the passage of the single-payer system. A recent study found that the costs of health care to the provinces now accounts for one-third to one-half of their budgets. Clearly cost containment is being left up to the provinces.

Recent Changes U.S.in Health Care Policy

In 1974, two important events occurred which would have important implications on U.S. health care reforms for the future. First, Hawaii passed the Prepaid Health Care Act (PHCA) which requires all employers to offer employees health insurance mainly through HMOs (Lewin 1993). The Hawaii state legislature passed the plan fully expecting Congress to pass some sort of employer mandate system. Employer mandates at the national level never materialized, but the Employee Retirement Income Security Act (ERISA) was enacted. The federal regulation exempted companies who self-insured from state-imposed mandated benefits, premium taxes or insurance regulations.

In 1977, Hawaii expanded insurance coverage to include substance abuse treatment. Chevron filed suit in federal court claiming that ERISA should preempt the entire PHCA. After receiving an unfavorable court ruling, the state of Hawaii sought relief through Congress by asking for an exemption to ERISA. In 1982, Congress granted an exemption, but within very narrow parameters. The exemption applies only to the 1974 version of the law. No other changes can

be made without congressional approval, and other states are effectively barred from regulating employers who choose to use self-insured health programs (Laenheim 1993, 25).

Negative Consensus For Change

The current drive toward reform reflects a growing discontent among various groups in the United States over the direction that health care is heading. There seems to be what Paul Starr (1993) calls a "negative consensus" on health care reform. There is nearly unanimous agreement that something is wrong with the current system, but no agreement over a remedy. This has led to an economic paradox. The stronger the motives driving governments to seek reform, the stronger the political reasons for resisting such action. Physicians, hospitals, insurance companies and other providers make a good living from health care and are reluctant to allow even minor changes to the system. In Hobbesian fashion, each interest group continues to maximize its own benefits at the cost of others (Brown 1994, 198). Combined with a burgeoning group of Americans who are reluctant to have the federal government involved in an area which represents such a large portion of the economy, lack of a consensual reform system could stall or even block health care reform at both the state and federal levels.

In spite of these obstacles, President Bill Clinton introduced a major health reform plan which would have

involved government at all levels, but would ultimately have been under control of the federal government. In addition to President Clinton's plan, five other major health care reform proposals were introduced in Congress, none of which enjoyed broad enough support to pass intact (Kaiser Family Foundation 1993). The four bills which emerged from committee in both the House and Senate in the summer of 1994 only seemed to amplify the disagreement over the form and substance of a reform package (Reifenberg 1994). Perhaps most troublesome for all of the plans is finding funding alternatives in the face of fiscal pressures at the federal level. A majority of American states, feeling budget pressures of their own, are considering health care reform at the state level. However, Congress and the executive branch are still influential players in these reforms since many of these changes would require federal waivers of current regulations. Like the plans under consideration in Congress, the aim of these programs is not only to expand coverage to a growing number of uninsured, but also to curtail escalating medical costs that have continued to out pace inflation over the last 20 years.

Requirements For Change

A radical change in American health care policy will require centralization of agencies which regulate health care providers (most likely at the state level) and possibly produce huge shifts in the redistribution of funds. To

achieve these formidable goals, states are considering a myriad of approaches. The plans (which are in various stages of adoption) run the gamut from single-payer options (Montana and Vermont) to community health purchasing alliances (Florida) to even rationing (Oregon). Hawaii, which is the only state with a mandated employer coverage plan in place, is currently attempting to extend coverage to workers' dependents and the unemployed through pool coverage (Dodson and Mueller 1993). Minnesota, Colorado and Washington also have hybrid plans that have been at least partially implemented by their respective state legislatures.

A report by the National Commission on the State and Local Public Service (1993) pointed out that not only will subnational governments play an important part in any reform, they already are major policymakers in the health care arena. The report goes on to list six traditional duties performed at lower levels:

1. Licensing of physicians and other healthcare providers
2. Certification of health facilities
3. Regulation of health insurance companies
4. Training doctors and other health personnel
5. Setting and/or reviewing hospital rates
6. Delivering public health services

The main point of the report is that the federal government

would be wise to pass a reform bill that leaves states plenty of room to maneuver and limits federal preemption. Any federal government attempt to solve the health care problem by shifting more costs to states and cities will not be accepted. The question of exactly which institution should run a revised health care network in the United States still has not been answered.

State Activism

State governments began to seriously consider health reforms in the late 1980s. The two chronic problems of costs and access were the targets of most reforms, but federal regulations still prevented universal solutions. By far, the bulk of reform activity has been aimed at limiting the erosion of employer-based private health insurance. This represents a somewhat pragmatic approach since the states have traditionally regulated insurance companies which do business within their respective borders. But federal regulation in the form of ERISA has proven to be problematic in this area as well.

While waivers of Medicare and Medicaid requirements are fairly routinely granted to states, there is no statuary provision for exemptions from ERISA. Under ERISA, states are allowed to regulate contracts with insurance companies and control the financial condition of health insurance carriers. Thus state governments are able to control health plans which are purchased from private insurers. But states

are preempted from requiring employer mandates for health insurance and may not tax employer benefits plans. More importantly, states have virtually no authority over employers who provide coverage through self-insured plans. This eliminates broad-based reforms which rely on surcharges to hospital bills in order to finance coverage for the uninsured (State Initiatives 1993). Even the recent minor modifications of ERISA passed by Congress were fiercely contested by lobbyists for business who fear any change in the regulations would allow states to subject companies to a host of mandated health benefits (New York Times 1995).

Other state reform efforts include programs which incorporate managed care with public programs, medical vouchers and health savings accounts. Still, states have been the most prolific in reforms of the private insurance markets, which brings us back to the focus of this study. Since federal regulations virtually prohibit system-wide reform, states have been forced to seek innovative (but still incremental) solutions to the problems of costs and access. Even at this level, some states have been much more aggressive in their passage of reforms than others. In the next chapter, this study will attempt to provide an explanation as to why some states are innovators and some are laggards in the search for solutions to the problems of health care.

Conclusions

It becomes fairly obvious after even a cursory review of the history of American health care that many of the problems which bedeviled Franklin Roosevelt's attempt to create a national health care plan are still present today. The same interest groups which opposed national health insurance as part of the Social Security Act of 1935, also opposed President Clinton's plan for a federally controlled system of universal coverage. Even the debate over the role of government in the health care system has remained the same. The basic question of whether health care should be a right or commodity has yet to be answered. So, the current system treats health care as both.

The role of state governments has expanded in recent years due mainly to the unintended consequences of federal action. Cost shifting in the last 20 years has been at least partially driven by congressional efforts to reduce the costs of Medicare and Medicaid. These costs are passed on to private insurers who in turn pass on the increases to consumers in the form of higher premiums. When the costs increase to a certain point, small businesses and individuals are unable to afford health insurance. When these uninsured require treatment for illness, their uncompensated care often is absorbed by the states and other public health providers. The current spate of layoffs by large corporations and the shift in the American economy

from manufacturing to low-benefit service jobs have only served to make the problem worse.

When scholars attempt to describe this country's health policy, often as not they avoid a direct simple response and allude instead to a mixed system of fee-for-service, HMOs and government health plans. This does describe the crazy-quilt system in place, but it avoids the question of national policy. However, the answer is very simple. The United States has no national health policy. As long as this condition continues, any reforms carried out at the state level take on even greater significance.

CHAPTER THREE

DIFFUSION OF HEALTH CARE POLICY INNOVATIONS AMONG STATES

Although major health reform at the national level may have lost momentum, the problems that moved reforms to the top of the agenda still remain. In lieu of action by the federal government, the states have pushed forward with a series of health care reforms designed to address the twin problems of costs control and access. The breadth of the current state reform efforts can be seen in a recent report by the Intergovernmental Health Policy Project (1995. Guaranteed issue, guaranteed renewal, community rating, portability, rate setting restrictions and high-risks pools are but a few of the areas that have been targeted for reform. Even universal coverage has been addressed by seven states,[16] though admittedly on a limited scale.

This resurgence of states as policy innovators has occurred in spite of several inhibiting factors. Barrilleaux et al. (1994) note that the lack of an established national health policy leaves states with little guidance in advancing reform. Also, state governments have been criticized in the past as being regressive, lacking the professionalism and/or political will to enforce creative policy innovations in the area of health (Clarke 1981).

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[16] The seven states that have adopted the goal of universal coverage are Florida, Hawaii, Massachusetts, Minnesota, Oregon, Vermont, and Washington.

Despite these concerns, states have become laboratories for innovation in the health policy area.

The research in this chapter has two objectives. First, it offers a ranking of the American states based upon the timing of their adoption of major health care policy reforms. The purpose is to determine which states are pioneers in the adoption of health care policy reforms, which states are followers and which states are laggards. The second aspect of this research offers an analysis of the causes of health care policy innovations. The role of the problem environment, political factors and regional influences are analyzed to predict the timing of innovations in the dynamic area of health care policy.

Diffusion Theory

The propensity for a state to adopt a new policy idea has often been studied under the rubric of policy diffusion. Diffusion of innovations among states was the main focus of Walker's (1969) landmark article which attempted to construct a theory as to why some states adopted innovations more readily than others. Walker analyzed 88 different programs adopted by at least twenty states between 1870 and 1965. Six to eight pieces of legislation were considered in 12 separate policy areas including health. In each instance, the author was concerned with introduction of an innovation (legislative service, regulation, etc.) which had never existed before.

Using these data, Walker devised a composite innovation score for each state and ranked them according to their overall speed of adoption. He also provided rankings over three distinct time periods and provided aggregate data for five regional composites. Walker correlated innovation scores with measures of social development, party competition, malapportionment, office turnover, and legislative professionalism. His findings supported previous studies which offered evidence that larger, wealthier, more industrialized states are more likely to quickly adopt innovative measures than smaller, poorer and less developed states (p.884). States with competitive party systems, apportionment which reflected an urban shift of the population, frequent turnover of office holders and a high degree of legislative professionalism were also seen as more likely to be progressive adopters (see Table 3.1).

This analysis begins along the lines of Walker's (1969) classic study. The states are ranked based upon the timing of their innovations. This study investigates regionalism in the diffusion process, the role of the problem environment, and the political factors which help explain the timing of innovation. Following Gray's dictum (1973) that innovation is issue specific our analysis focuses on the specific policy areas of health care reform.

Data and Analysis

This study uses the common definition of an innovation

TABLE 3.1 Walker's Composite Innovation Scores For The American States

New York	.656	Nebraska	.426
Massachusetts	.629	Kansas	.426
California	.604	Kentucky	.425
New Jersey	.585	Vermont	.414
Michigan	.578	Iowa	.413
Connecticut	.568	Alabama	.406
Pennsylvania	.560	Florida	.397
Oregon	.544	Arkansas	.394
Colorado	.538	Idaho	.394
Wisconsin	.532	Tennessee	.389
Ohio	.528	West Virginia	.386
Minnesota	.525	Arizona	.384
Illinois	.521	Georgia	.381
Washington	.510	Montana	.378
Rhode Island	.503	Missouri	.377
Maryland	.482	Delaware	.376
New Hampshire	.482	New Mexico	.375
Indiana	.464	Oklahoma	.368
Louisiana	.459	South Dakota	.363
Maine	.455	Texas	.362
Virginia	.451	South Carolina	.347
Utah	.447	Wyoming	.346
North Dakota	.444	Nevada	.323
North Carolina	.430	Mississippi	.298

Source: Walker (1969)

"as a program or policy which is new to the states adopting it, no matter how old the program may be or how many states may have adopted it" (Walker 1969, 881). In the area of health care policy, innovation is often narrowly associated with providing universal insurance coverage. Barrilleaux et al. (1994, 5) correctly surmised that

> ...having adopted a formal goal of providing universal coverage captures only a small amount of the activity in the states. Focusing on but a small number of states provides a skewed view of the politics of state health care reform.

This chapter examines state innovation in eight major health care areas: small business reforms, high risk insurance pools, pre-existing conditions, certificate of need, health commissions, guaranteed renewal, portability and guaranteed issue.

For this study small business reforms are any effort by states to make health insurance coverage more accessible and/or affordable to small firms. These companies are usually defined as those employing between three and twenty-five persons. But some states include companies with up to 100 employees in this category. High risk insurance pools are formed by states to insure persons unable to obtain health insurance coverage through private insures. This group is made up primarily of people in need of extensive health services. Pre-existing conditions legislation passed by states prohibits or limits insurers from denying coverage to a company or individual because of previous insurance

claims or health problems. Certificate of need requires health facilities (hospitals, clinics, etc.) to receive approval from the state for major capital improvements and expansion of facilities.

Health commissions are generally seen as the first step in health care reform, these groups study problems relating to health care costs and access. Ultimately, most commissions issue a report suggesting possible solutions. Guaranteed renewal legislation prohibits or limits insurers ability to deny coverage to a company or individual currently receiving coverage. Portability provides an individual with the right to retain health insurance coverage when between jobs, or in some cases, changing jobs. This is usually accomplished by converting group coverage to individual coverage. Guaranteed issue requires that all members of a population must be issued coverage with minimal exceptions.[17]

These eight reforms were selected for three main reasons. Initially, it was necessary to establish a minimum threshold for the number of states adopting an innovation. It does not make sense to speak of policy diffusion for the adoption of a program by only a handful of states. This study has followed Canon and Baum's (1981, 976) rule of

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[17] Sources for the adoption dates are the Intergovernmental Health Policy Project (1995; 1994a; 1994b; 1994c; 1993), United States General Accounting Office (1992), Public Policy Institute (1994) and the National Governors Association (1994).

thumb that

> ...to be included, an innovation had to be adopted in a minimum of 18 states and could not be explicitly rejected, following the first adoption, in as many states as had adopted it.

The eight health care reforms examined here have all been adopted by at least 38 states. Second, previous scholarship has identified these eight reforms as areas of significant reform activity (Intergovernmental Health Policy Project 1995; 1994a; 1994b; 1993; Barrilleaux et al. 1994). Finally, several of the reforms in this study are under consideration by the federal government as well. In his 1996 State of the Union Address, President Clinton called for Congress to pass the Kassebaum-Kennedy health reform package. The centerpiece of this bipartisan effort is federal adoption of portability regulations and prohibition of insurance companies from denying enrollment to persons due to pre-existing conditions (Apple 1996). In fact, the vast majority of the reforms examined in this study have been considered by Congress. It could be argued that today's health care innovations by the states may be the federal programs of tomorrow.

Innovation Scores

An innovation score following the design of Canon and Baum (1981) was initially created using a composite score for each state based on timing of its adoption of the eight health care reforms. The first adopter of a reform received a score of 1.00 and the non-adopters received scores of .00.

The last adopter of a reform received a score of slightly above .00.[18] For each of the eight health care reforms, each state was given a score corresponding to the proportion of the "adoption period" that remained when that state adopted the reform.[19] These data were calculated through early 1995. Following Walker's (1969) design, implementation, funding or effectiveness of these eight health care reform are not considered.

The innovation scores for each state shown in Table 3.2 are simply the mean of the individual scores it received for each health care innovation. Tennessee has the highest composite innovation score (.526) in terms of being an early adopter of health care reform. Tennessee was the first adopter of small business reforms and pre-existing conditions reform, both in 1955. It is important to note that Tennessee remains a leading innovator in the 1990s with its bold "TennCare" plan for the restructuring of Medicaid (see Health Care Reform: 50 State Profiles (1994), section on Tennessee). Connecticut, Pennsylvania, Florida and Oregon round out the top five. In his study of 47 public

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[18] Walker (1969) gave the last adopter the same score as non-adopters rather than a slightly "better score." Canon and Baum (1981) offer a theoretically more compelling approach by treating last adopters as slightly better than non-adopters.

[19] Take the case of certificate of need. Maryland was the first adopter in 1962 and received a score of 1.00. Indiana was the last adopter in 1990. For a state such as Connecticut (adopted in 1973), the score is calculated as:

$$\frac{1990-1973}{1990-1962} = \frac{17}{28} = .607$$

Table 3.2 STATE INNOVATION SCORES FOR EIGHT HEALTH CARE POLICY INNOVATIONS

	State	Score
1.	Tennessee	.526
2.	Connecticut	.469
3.	Pennsylvania	.394
4.	Florida	.388
5.	Oregon	.375
6.	Minnesota	.353
7.	Montana	.341
8.5	Maine	.335
8.5	Massachusetts	.335
10.	Wisconsin	.325
11.	Missouri	.318
12.	Alaska	.316
13.	Iowa	.310
14.	New York	.309
15.	Washington	.308
16.	Indiana	.300
17.	South Carolina	.295
18.	Delaware	.292
19.	Colorado	.290
20.5	Mississippi	.289
20.5	Vermont	.289
22.	North Dakota	.287
23.	Rhode Island	.284
24.	New Jersey	.277
25.	North Carolina	.274
26.	Michigan	.243
27.	Maryland	.240
28.	Oklahoma	.236
29.	California	.231
30.5	Ohio	.224
30.5	Texas	.224
32	Virginia	.219
33.	Illinois	.216
34.	New Mexico	.210
35.	Kansas	.207
36.	Nebraska	.189
37.	Idaho	.185
38.5	Georgia	.176
38.5	Wyoming	.176
40	Louisiana	.160
41	West Virginia	.159
42.	Kentucky	.156
43.	New Hampshire	.141
44.	Arkansas	.139
45.	Alabama	.121
46.	Nevada	.117
47.	Arizona	.115
48	South Dakota	.113
49.	Hawaii	.105
50.	Utah	.087

Source: Carter and LaPlant (1995)

policies, Lutz (1987, 396) reports that Connecticut, Pennsylvania and Oregon are pioneer states. This study clearly confirms that these states are also innovators in the area of health care policy.

In a recent survey of state policymakers and administrators, Chi and Grady (1991, 395) report that Wisconsin, Indiana, Colorado, New York, Pennsylvania, and Florida are considered innovators in the health policy area. All six of those states rank in the top nineteen in Table 3.2. Chi and Grady (1991) also reported that Massachusetts, which ranks in the top ten states in Table 3.2, is viewed as one of the most innovative states in the health policy area. Grupp and Richards (1975), in their mail questionnaire of of appointed, upper level administrators in ten American states, discovered that California received the most citations as the state with the best agency in numerous policy areas. California also received numerous citations in the health policy area. Surprisingly, California falls in the middle of the pack with a rank of 29 in Table 3.2. While California may be highly respected by administrative elites, it ends to lag behind many other states in the timing of health care reforms. Although Lutz (1987, 392) reports that California is the most obvious regional leader in his study, states such as Oregon and Washington have been leaders in the West when it comes to health policy reform. Finally, it comes as no surprise that states such as

Arkansas, Alabama, and Louisiana are in the bottom ten states in Table 3.2.

A note is in order on the low ranking of Hawaii in Table 3.2. Much of the discussion surrounding reform has tended to focus on attempts by states to achieve universal coverage. While these efforts are important (See Chapter 4 for an extended look at the Hawaii plan), a focus on universal coverage tends to overlook other important innovative steps taken by the states. Barrilleaux et al. (1994, 5) point out that the seven states which have adopted universal coverage as a goal all have "unique policy and political history." Hawaii's experience has received the most attention in recent years, and its location and history certainly make it unique among American states. While the Hawaiian system of expanded HMO coverage has certainly been successful in increasing health insurance coverage through employer mandates, no similar plan has been adopted by any other state.

Second Stage of Analysis

The second stage of this analysis explores the role of the problem environment, population density, political factors and regional influences as major forces behind the early adoption of health care reform. Initially, the influence of the problem environment on health care innovations are considered. Nice (1994, 33) asserts that

> ...a crisis, a deteriorating situation, or a vague perception that current performance is not satisfactory

> can spur decision makers into searching for new approaches, assessing their merits, and adopting those innovations that offer some prospect for improving the situation.

The role of the problem environment is examined with three main indicators: aged population (percentage 65 and over), per capita Medicaid spending and state/health hospital spending as a percentage of general expenditures (See Table 3.3). Aged population is included since the elderly can place significant demands on health care delivery systems. A graying population can place pressure on decision makers to initiate health care reform. Per capita Medicaid spending and state health/hospital spending as a percentage of general expenditures reflect budgetary pressures for health care reform. States with high levels of health spending on the poor and large budgetary commitments to health care may search for new approaches to ameliorate a perceived health care crisis.

This portion of the study also examines the relationship between population density and the early adoption of health care reforms. Population density is utilized to test Walker's (1969, 884) thesis that states with large populations and great cosmopolitan centers have a concentration of creative resources, are more sympathetic to change, and thus are the first to adopt new programs. Nice (1994, 26) observes that

> ...centers of advanced learning and research, as well as organizations large enough to permit specialization, tend to be concentrated in urban and metropolitan

settings. Rural states may have a more difficult time amassing the skill resources needed for innovation.

In considering the influence of political factors, legislative professionalism, liberal ideology and the influence of health providers have been selected for analysis. Walker (1969, 885) argues that "the states which provide the most extensive staff and research facilities in their legislatures ought to pioneer in the adoption of new programs." Jones (1994) notes that as legislatures become more professional, they are better prepared to handle the increasingly complex policy issues confronting the states. Furthermore, several studies emphasize the critical role of ideology in health policy making (Starr 1982; Skocpol 1993). Barrilleaux et al. (1994, 1) assert that "ideology is the most persistent force underlying state health reform efforts." In his extensive study of policy innovation, Nice (1994, 28) describes two key reasons that liberalism encourages policy innovation. A liberal opinion climate is likely to bring more issues to the attention of policymakers and liberals tend to have more faith in analysis so they are subsequently more open to experiment and change. This study utilizes Klingman and Lammers (1984) "general policy liberalism" factor scores for each state which are derived from an analysis of both expenditures and regulatory policy measures.

Finally, Barrilleaux et al. (1994) argue that the

influence of health providers on health policy making should not be ignored. They believe that a strong provider presence can effect the ultimate passage of health care reforms. Barrilleaux and Miller (1988, 1092) note that given health care providers' control of expertise and information, they exert a powerful influence on health care markets. "Health providers" is operationalized as the number of health and hospital employees per 10,00 population (FTE employment of state and local governments).

The final type of independent variable attempts to capture the influence of region. A factor analysis by Walker (1969) discovered regional groupings of the states based upon the timing of policy innovations. Berry and Berry (1990, 400) argue that policy adoptions in a nearby state can make it easier for politicians to justify its adoption of a similar policy. Dummy variables represent the Northeast, West and South. The North Central region serves as the reference category.

Dependent Variables

The dependent variables for this analysis are the innovation scores for each state in the eight health care policy reform areas as well as the total innovation scores reported in Table 3.2. Again following the work of Walker (1969) and Canon and Baum (1981), the independent variables are operationalized for the median years of adoption of the

health policy reforms.[20] This approach introduces some measurement error. For states that are early adopters of a reform, the independent variables are operationlized several years after the date of the adoption. For states that are late adopters of a reform, the independent variables are operationalized several years before the date of adoption. Although we recognize that scholars such as Berry and Berry (1990) have recommended event history analysis to overcome this type of measurement error, this approach is consistent with the methodology employed by Walker (1969), Canon and Baum (1981), and Nice (1994).

Results of Regression Analysis

The results of O.L.S. regression are reported in Table

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[20] The median year of adoption for certificate of need was 1973. Population density, health and hospital employment per 10,000 population (state/local FTE), aged population, per capital Medicaid spending, and state health/hospital spending as a percentage of general expenditures are operationalized for the early 1970s in the certificate of need equation. Grumm's (1971) legislative professionalism index is utilized in the certificate of need equation. Grumm's index is based upon data compiled from the mid-to-late 1960s. Pre-existing conditions, high risk insurance pools, guaranteed renewal, and guaranteed issue all have median years of adoption in the late 1980s or early 1990s. In those equations, population density, health and hospital employment per 10,000 population (state/local FTE), aged population, per capita Medicaid spending, and state health/hospital spending as a percentage of general expenditures are operationalized for 1990. Legislative professionalism is based upon 1986-1988 data. Kling man and Lammer's (1984) "general policy liberalism" measures, which is used in all the equations, is derived from expenditures and regulatory policy measures from the 1960s and 1970s. In the total innovation equation, the independent variables are also operationalized for 1990.

3.3.[21] Small business reforms, portability and health commission do not appear in Table 3.3. The model was simply unable to account for much of the explained variance in those reform areas. However, Table 3.3 does provide some interesting results. There is some evidence that the problem environment is related to the early adoption of health care reform. Aged population has a statistically significant effect on the total innovation score for a state. States with large concentrations of the elderly are likely to be early adopters of guaranteed renewal reform. The relationship between per capita Medicaid spending and health care reform is inconsistent across equations. States with high levels of per capita Medicaid spending are more likely to be early adopters of certificate of need reforms. States that devote a substantial proportion of their budget to health and hospital spending do not appear to be early adopters of health care reform. Population density generally has a negative influence on the early adoption of health care reforms, but the negative coefficients never reach statistical significance. Densely populated states are likely to be early adopters of certificate of need reforms.

The political measures provide some expected and

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[21] A note on multicollinearity is in order. Of the independent variables that appear in Table 3.3, the Auxiliary R2's (calculated by regressing each independent variable on the remaining independent variables) are all below .70.

TABLE 3.3 PREDICTING HEALTH CARE POLICY INNOVATIONS

Independent Variables	Total Innovation	Prex Cond.	High Risk	Guaran. Renewal	Guaran. Issue	Cert. of Need
% Age 65/Over	.41**	.13	.15	.33*	.17	-.05
P.C. Medicaid $	-.09	-.14	.17	-.31	-.06	.46**
Hlth/Hosp Spend. % State Budget	-.05	.02	.02	.01	-.13	-.07
Pop. Density	-.03	-.05	-.04	-.32	.09	.51**
Hlth/Hosp Emply.	.23	.34*	.23	.06	.26	-.20
Legsl. Prof.	.02	.42**	-.49**	.12	-.11	-.08
Gen. Policy Lib.	.48**	-.31	.59**	.11	.72***	-.18
Northeast	.19	.22	-.43*	.51**	.11	-.10
South	.20	.02	-.26	-.06	.21	.37*
West	.04	-.04	-.21	-.08	.12	.03
R^2	.31	.29	.31	.27	.37	.36
Adjusted R^2	.15	.10	.12	.10	.20	.19

Each cell entry is the standardized regression coefficient.

N=47 (Arizona missing data on Medicaid. Alaska and Hawaii missing data on general policy liberalism.)

* p<.10
** p<.05
*** p<.01

unexpected results. Previous research has hypothesized that states with professional legislatures are more likely to adopt innovative public policy reforms. Legislative professionalism not only has a negative influence on innovation in three of the five reform areas, it attains statistical significance for high risk insurance pools. It should be noted, however, that high risk pools are perhaps the simplest (if not the most successful) of reforms. Little if any state funds are needed, and in some cases the entire program has been handed over to the private sector. In the case of pre-existing conditions reform, the regression coefficient for legislative professionalism is in the hypothesized direction and it reaches statistical significance.

The expected results from the political variables involve the role of ideology. "General policy liberalism" in a state has a positive and statistically significant impact on the total innovation score for a state. States with an established record of policy liberalism are pioneers in the adoption of high-risk insurance pools and guaranteed issue. The influence of health care providers, measured as the number of hospital and health employees per 10,000 population, appears to have a generally positive impact on the adoption of health policy reforms. Rather than retard the adoption of reforms, health care providers appear to facilitate the early adoption of pre-existing conditions

reform.

There is some evidence of regional influences in the diffusion of health care policy reforms. While none of the regional influences in the diffusion of health care policy reforms are consistent across all the equations, certain regions are pioneers or laggards in specific policy domains. The Northeast has pioneered guaranteed renewal reform and Southern states have been leaders in the adoption of certificate of need reform. Furthermore, northeastern states have been noticeable laggards in the adoption of high risk insurance pools.

Conclusions

This analysis of health care policy innovations focused on eight major reform areas and explored the rankings of states in terms of overall health policy innovation. While Tennessee may not be the first state to come to mind for innovative activity in health care, it certainly demands careful attention. The high rankings of Connecticut, Pennsylvania and Oregon correspond with previous research (Lutz 1987) that these states are innovators. Many of the states that appear in the top 19 rankings have often been listed as innovative states in surveys of administrative elites. It was rather surprising to see California in the bottom half of the states since previous research had labeled the state as an aggressive innovator. While that may hold true in many policy areas, it does not ring true

for the health care policy reforms examined here.

The second aspect of this research attempted to uncover the major factors that influence the timing of health care policy adoptions. Walker's (1969) contention that states with large concentrations of people are likely to have the creative resources that lead to the early adoption of new programs is only confirmed for certificate of need reform. Nice's (1994) study of state policy innovation highlights the prominence of the problem environment in explaining innovation decisions. In this analysis of health care reform, however, the problem appears to play a limited role. The graying of a state's population spurs guaranteed renewal reforms, and it has a strong relationship with the level of total innovation for a state. Budgetary pressures in a state, measured as per capita Medicaid spending and the percentage of general expenditures devoted to health and hospital spending, do not appear to serve as a catalyst for the early adoption of health care reforms.

In the analysis of political factors, there appears to be no consistent relationship between legislative professionalism and health care innovation. Legislative professionalism had a strong and positive correlation with pre-existing conditions reform. Surprisingly, we discovered that less professionalized legislatures are early innovators in the area of high risk insurance pools, perhaps because their state health programs are in the worst fiscal shape.

Although legislative professionalism has an inconsistent influence across equations, health care providers have a consistently positive impact on the early adoption of health care reforms. This relationship could be illuminated through case studies that analyze the linkages between health providers and policymakers.

A growing body of literature (Marmor 1970; Starr 1982; Skocpol 1993: Marmor 1994; Barrilleaux et al. 1994) considers ideology to be a driving force behind health care innovations or the lack thereof. This research confirms the significance of ideology in the timing of health care innovations. A record of policy liberalism in a state is strongly correlated with the early adoption of major health care reforms. The impact of policy liberalism is conspicuous in the areas of high risk insurance pools and guaranteed issue.

The literature on policy diffusion has often explored the dynamics of regional influences. This study's results do not provide strong evidence for a consistent regional pattern of diffusion in health care policy innovations. With the expanded channels of communication between state governments, the explosion of national conferences and associations at all levels of government, and the proliferation of interest groups, geographic location may be a variable that is of diminishing significance (Lutz 1987, 396-397). Furthermore, the explosive growth in

communications technology such as the Internet may render geographic boundaries obsolete. Regionalism should not be rejected altogether, however. Northeastern states are aggressive leaders in the areas of guaranteed renewal and noticeable laggards in the area of high risk insurance pools. Southern states are pioneers in certificate of need reform. Berry and Berry (1990) emphasize the utility of nearby states in helping to justify unpopular policies to the electorate. Health care reforms can often be a "hard sell" to the public and the examples of neighboring states might be very useful for winning public acceptance of reform.

Scholars of federalism speak of the states fondly as "laboratories of experimentation." The following two chapters seek to go beyond this aggregate analysis by exploring other external forces which may have contributed to health care reform activities. These case studies show that in addition to the two factors identified in this chapter, geography, culture and elite sponsorship are also factors that influence health care innovation.

CHAPTER FOUR

HAWAII AND OREGON: TWO ATTEMPTS AT UNIVERSAL COVERAGE

Hawaii and Oregon were two of the first states to enact universal access laws. The two plans are very different and indicative of the variety of external factors which often drive such reforms. This chapter examines these two systems through the use of case studies in an attempt to identify political, cultural and financial forces which led to passage of large-scale reforms. The unique characteristics of the states and their reforms are important because the diffusion process seems to be stymied in cases of universal reform. While we have seen the growth of incremental reforms (such as those identified in Chapter Three), thus far, no state has adopted a universal plan already in place in another state.

Hawaii. First In Reform

When Bill Clinton was campaigning for president in 1992, he often cited Hawaii as an example of a successful health reform program. Though the state's Prepaid Health Care Act (PHCA) had been implemented in 1974, few policymakers (or scholars) seemed to be familiar with the system at that time. After the election, President Clinton seemingly cooled toward the Aloha State's program and instead opted to support a federally controlled program which never enjoyed much support in Congress.

In contrast to Clinton's plan, the PHCA is a relatively

simple operation which strongly reflects the influences of pre-statehood plantation culture. Employers are mandated to provided coverage for employees working at least 20 hours a week. Required benefits include hospital and surgical coverage (See Figure 4.1). Federal employees, state employees and persons already receiving public assistance are exempted from the program (State of Hawaii 1988). The plan does not replace any union contracted benefits or company offered plans which boast superior benefits. The Hawaii plan is targeted at small businesses with fifty or less employees. This is especially important in Hawaii since small businesses make up more than 90 percent of the state's individual employers.

To make the insurance affordable for small employers and low-wage earners, premium supplementation is available from the state and caps are put on the amount employers or employees must contribute. Employees contribute 1.5 percent of their gross wages or half of the premium costs, whichever is less (New York Times July 23, 1991). The employers' payment is limited to 5 percent of income before taxes. A supplemental fund is used to pay premiums for employees whose employers have gone out of business or somehow failed to supply coverage. According to Dr. John Lewin, former Director of the Hawaiian State Department of Health, the supplemental fund "has seen very little use and remains flush with money" (Lewin 1991).

FIGURE 4.1 Required Health Care Benefits In Prepaid Health Care Act Of 1974

HOSPITAL BENEFITS
- -At least 120 days of in-patient care per calendar year.
- -General nursing services
- -Drugs, dressings, oxygen, antibiotics and blood
  blood transfusions
- -Surgery

OUT-PATIENTS SERVICES
- -Out-patient surgery
- -After care
- -Home visits

SUBSTANCE ABUSE BENEFITS
- -Out-patient and in-patient treatment for drug and alcohol abuse treatment (including care from psychiatrist and/or psychologist)

OTHER
- -Maternity benefits
- -Lab services, x-ray films and radio-therapeutic services
- -Free choice of physician by employee

Source: The Prepaid Health Care Act of 1974, State of Hawaii.

Two insurers, Hawaii Medical Service Association (HMSA, the Blue Cross/Blue Shield program) and Kaiser Permanente, dominate the health insurance program in Hawaii. The two firms compete for business by pooling small business community risk pools. This eliminates the need for insurance companies to rate small companies on an individual basis. Rates for the pool are comparable to premiums paid by larger employers on the islands. For the insurers, this represents substantial savings in administration and makes it possible to negotiate reduced payments to health providers (Ching 1991). The community rating system is not mandated by the PHCA, but has evolved as the system matured. Coverage of dependents is not required by the act either, but the vast majority of companies offer such coverage for employees. As a result, health insurance can be offered to small business at competitive rates that are among the lowest in the nation (State of Hawaii 1991) (See Table 4.1.).

Before the passage of the PHCA. Hawaii's uninsured rate was about 17 percent, a figure in line with the rest of the nation in 1971. By 1989 the state claimed to have dropped the uninsured rate to about 5 percent (Department of Labor and Industrial Relations 1992). In 1991, a second program, the State Health Insurance Program (SHIP) was introduced in an attempt to expand coverage even more. SHIP offers low-cost insurance to persons with incomes below 300 percent of

TABLE 4.1 Comparative Data Of Health Insurance Premium Rares For Small Business Per Month, 1990

	Single	Family
Hawaii	$94	$263
Iowa	$139	$313
Georgia	$140	$340
Arizona	$140	$335
California	$141	$503
Illinois	$150	$415
New York	$154	$360
Massachusetts	$217	$508
Delaware	$240	$516
Kansas	$282	$564

SOURCE: Department of Labor and Industrial Relations. State of Hawaii. 1992.

the poverty level. Premiums are subsidized on a sliding scale and heavy emphasis is again placed on preventive medicine (Millbank Memorial Fund 1993).

A primary goal of SHIP is to affect utilization patterns, specifically the tendency for the uninsured to use emergency room services for primary care. Providers see SHIP as a means to steer these people toward primary care facilities and reduce the bad debt pools. Enrollees seem to like the program with a significant majority opting for SHIP over Medicaid when both are available (Neubauer 1993).

Health QUEST

The state's health system was modified again in 1994 when Governor John Waihee signed into law Hawaii Health QUEST. Health Quest covers individuals previously covered by SHIP, AFDC and General Assistance (GA). A single purchasing pool was created which guarantees its members access to primary care from one of five medical networks. The state obtained a waiver from HCFA and included all services required by Medicaid. Comparable to many private health plans, coverage includes annual physical exams, dental coverage, ESDST services for children, drugs and vision. (National Governors' Association 1994).

Under Medicaid and SHIP, the government was the payer for health care services. Under QUEST, federal dollars for Medicaid are combined with state dollars to purchase managed care coverage from five plans offered through HMSA, Kaiser,

Queen's Hawaii Care, Straub Care, Quantaum and Aloha Care. People whose household income in 300 percent or less of the federal poverty level are eligible if they meet asset restrictions. Coverage is free for those who meet the requirements, but the program is open to others willing to pay full premiums (about $280 a month for a single mother with two children).

QUEST has been a victim of its own success from the very beginning. In 1995, enrollment immediately soared to 170,000, about 40 percent above projected numbers, and the state found itself unable to finance the plan at that level. State officials were forced to tighten eligibility requirements and have cut off enrollment completely until the number of participants drops to 125,000. A supplementary program, QUEST-Net, has been created to help those making too much money to qualify for QUEST, but too little to pay full premium costs. For $61.80 per person per month, a limited benefits policy is available. As an incentive for enrollment, children whose parents opt for this program receive the full benefits of the QUEST package (Miller 1996).

As a result of these combined efforts, Hawaii has continuously boasted of insurance coverage in the 95 percent range in the 1990s, while other states have remained at the 70-80 percent range. In spite of this success, the Hawaiian system has yet to be adopted by another state. Critics

claim the fact that the state is isolated in the Pacific greatly reduces the economic impact of employer mandates. Small businesses unhappy with being forced to supply health insurance would likely find it impractical to relocate to another state. This might not necessarily be the case in mainland states where businesses are much more mobile. The same geographic characteristics also prevent (or at least hinder) wholesale immigration of persons seeking to take advantage of the state's health plans.

While both of these arguments have some merit, a more satisfying explanation can be found in the examining the state's unique culture and history. The fact that Hawaii enacted major health care reform a full 20 years before most states even considered minor legislation can be traced directly to the islands' evolution from a kingdom to the fiftieth American state.

History of Hawaiian Health Care

Even in the earliest days of the kingdom of Hawaii, the central government supplied at least rudimentary health care to all members of society. Hawaiian kings appointed "kahunas" who supplied medicinal herbs for their patients as well as imposing quarantines when needed. Much of their power was derived from the use of taboos which were used to control almost all aspects of everyday life. When King Kamehameha I died in 1819, the taboo system collapsed. Though white physicians and western medicine arrived a year

later, kahunas continued to practice a limited form of medicine well into the twentieth century. More importantly, the idea that medicine should be available to all members of society was an original part of Hawaiian culture.

The first non-Hawaiian physicians arrived with Captain Cook in 1778. But the sailors on the ships also introduced sexually transmitted diseases (such as syphilis), smallpox and bubonic plague. As a result, the native Hawaiian population declined from about 400,000 to just over 135,000 in a period of 50 years. This period also marked the establishment of huge plantations which needed a large, stable labor force to function. This demand coupled with a declining native population led to large-scale importation of laborers (Friedman 1992). To attract workers, the plantation owners supplied housing, a company store and free medical care.

In 1837, Ladd and Company, which owned a large sugar cane operation on Koloa, contracted with a doctor to provide all medical services for a fixed annual fee. This paternalistic system was in the owners self-interest because it helped to guarantee a secure work force. During this time Japanese, Chinese and Filipinos were brought in under contract to work the fields. In most cases, they were guaranteed medical care as part of their service contract, though they were not paid during periods when they were too sick to work. These immigrants brought their own health

care customs with them. The Japanese government went so far as to insist that the growers hire Japanese doctors to treat Japanese workers and sent over inspectors to insure adequate care (Donne 1973, 30).

Plantations and HMOs. As the plantation systems grew, they eventually evolved into the modern equivalent of HMOs. A worker received free health care as long as he went to the plantation physician. There were also caps on earnings. For example in 1920, only workers earning less than $100 per month were eligible for completely free health care. Plantation physicians supplemented their income by contracting with the state to supply health care to locals who did not work on the plantation. There were some problems with access, however. On the outer islands, the level of health care was irregular to say the least. And perhaps most important, the primary goal of the company doctors was to keep workers on the job.

The next substantial change in Hawaiian health care can be attributed directly to the arrival of the International Longshoremens' and Warehouses Union (ILWW) in 1935. The union expanded rapidly in both plantations and on the docks. A major strike in 1946 centered on "the conversion of perquisites (such as health care) into cash" (Dows 1968, 363). When the strike ended, the plantation system of paternalistic medicine had been replaced by the Plantation Medical Plan (PMP) which was, in effect, a self-insurance

system. Physicians who had been paid salaries by the plantation owners now worked under union contracts or dealt in fee-for-service care. But utilization became a problem, and costs for the new system soared. By 1950, the majority of union employees had switched to an indemnity plan offered by Prudential Insurance.

Hawaiian Health Insurers. In the 1930s, the Hawaii Medical Service Association (HMSA), the islands affiliate of Blue Cross/Blue Shield, and the Kaiser Foundation Health Plan were established as non-profits. Both expanded slowly until the beginning of World War II when the federal government instituted a series of wage and price freezes. Although still a territory, Hawaii was covered by these mandates. As a result, Hawaiian employers joined mainlanders in offering expanded health insurance coverage as a means to circumvent the wage freeze and attract workers.

While the competition between Kaiser and HMSA over the years certainly has helped keep health care costs low, other commercial insurance carriers are strangely absent. HMSA with its strong local contacts has become the dominant local provider currently providing coverage to over half of Hawaii's population. Kaiser enrollees make up roughly 18 percent of the population. Large mainland-based companies such as Mutual of Omaha, Prudential and Aetna are almost invisible in the Aloha state. Insurance executives note that neither HMSA or Kaiser pay commissions which serve as

incentives for sales and both companies are also exempt from a 4 percent tax applied to all other commercial carriers (Friedman 1992).

The Prepaid Health Care Act of 1974

As early as 1947 the Hawaiian legislature had considered bills requiring employers to provide health insurance for workers. In 1968, the legislature funded a study on prepaid health insurance. Steven A. Risenfield, a law professor at the University of California, was chosen to write the report. He had previously acted as consultant for other states including Hawaii. Risenfield's report, submitted in 1971, recommended that Medicaid be left intact and proposed employer mandated health insurance coverage that met the following guidelines:

1. Every employee in private employment shall be protected by a prepaid plan providing for hospital, surgical, and medical benefits.

2. The level of benefits should conform with the prevailing community standards.

3. Unless a collective bargaining agreement or self-initiated employer's policy provides for an allocation of the costs more beneficial to the employee, the costs shall be shared equally by the employer and the employee.

4. The prescribed coverage may be provided with any of the existing prepayment plan operators, regardless of whether they provide services, such as Kaiser or other medical group plans or reimbursement, either on a nonprofit principle, such as HMSA or similar organizations, or on the profit principle, as the commercial carriers.

5. The scheme does not intend to interfere with the collective bargaining process or interfere with

the services provided pursuant to such collective agreements, as in the sugar industry.

6. The free choice of physician by the employee shall be protected.

7. In order to avoid an oppressive burden on low-wage earners and their employers, the mandatory scheme should be coupled with a plan for premium supplementation from general revenues (Risenfield 1971, 48-49).

In addition, Risenfield suggested that persons exempted from unemployment insurance, federal employees and persons working less than 20 hours a week be excluded. Interestingly, the report suggested that the plan be controlled by the Department of Labor and Industrial Relations rather than the Department of Health. A model bill included in the report would eventually become the basis for the Prepaid Health Care Act.

Opponents to Reform Act. Small business associations, the Chamber of Commerce, the Hawaiian Employers Council and plantation owners strongly opposed the act, but sponsoring legislators picked up the support of the ILWU. The union went on record in support of the bill even it would take away a key bargaining chip in labor negotiations. Other unions on the island gave only tacit support, but on June 12, 1974, five years after the Risenfield study, the PHCA passed both houses of the Hawaiian legislature (Friedman 1992).

An interesting provision of the final bill was a clause which stated the Hawaiian law would automatically be

repealed when federal health legislation was passed (State of Hawaii, PHCA 1974). But health care legislation at the federal level failed to materialize. Instead, the U.S. Congress passed the Employee Retirement Income Security Act (ERISA) shortly after the PHCA took effect. As noted earlier, one of the provisions of ERISA was that it prohibited states from requiring companies to set minimal health coverage. Interestingly, passage of ERISA did not result in immediate challenges to the Hawaiian health plan by companies doing business in the islands, but when the state legislature sought to amend the original bill by including substance abuse treatment in 1976, Standard Oil took the state to court. A federal appellate court ruled that the PHCA did violate ERISA. The case ended in 1981 when the U.S. Supreme Court upheld that decision.

The only avenue of relief left for the state was to seek a congressional exemption (Lewin 1992). Even after filing the lawsuit, Standard Oil had never sought an injunction to prevent implementation of the PHCA. In fact, the program was implemented and accepted by Hawaiian employers. The state's congressional delegation originally argued that an exemption was deserved because the intent of ERISA was to install federal oversight of pension laws rather than health insurance regulations. To the surprise of the Hawaiian congressmen, several members of the Senate privately said ERISA was, in fact, intended to give the

federal government control of both areas.

After several failed attempts at obtaining a waiver, Hawaiian representatives finally managed to attach a very limited exemption to a large finance bill. Instead of celebrating, the state's delegation was forced to watch quietly as the bill passed both houses of Congress and was signed into law by President Ronald Reagan in January of 1983. Passage of the waiver locked the state into the provisions of the original 1974 act. The waiver is so restrictive that changes to the states original system have been very difficult to achieve. Still, Hawaii is the only state to have been granted a waiver broad enough to allow employer mandates (Friedman 1992).

Recent Efforts At Reform

Although the original goal of the Hawaiian program was universal coverage, recent budget shortages have forced the state to shift its focus to cost control. The 1996 state legislature faced tough fiscal choices with the state QUEST program. The federal/state Medicaid program is especially hard pressed for funds. QUEST has begun to require asset tests for recipients, essentially limiting the number of residents eligible for health insurance coverage. High utilization of Medicaid's fee-for-service insurance has pushed the costs of claims to over $20 million per month. The state has capped payments at $12 million per month in order to continue payments for the balance of the fiscal

year. As a result, health care providers are owed millions of dollars in late payments and have begun to pass on the cost to other sectors of the insurance market (Dendle 1996).

Governor Benjamin J. Cayetano's 1996 State of the State address called the current financial problems "the worst fiscal crisis in our state's history" (Cayetano 1996, 1). The governor proposed substantial across the board cuts in the coming budget. His only mention of health care was his hope that the state can attract big name providers and become the health care center of the Pacific rim. Representatives from the Mayo Clinic were recently invited to the islands to discuss opening a clinic in Hawaii. The ultimate goal is a health care mecca which would attract patients from all over the Pacific rim (Cayetano 1996).

The state found itself in court again in 1993 when the Department of Labor and Industrial Relations announced a proposal to remove pre-existing conditions limitations from employer health care plans. In the past, the state had allowed such limitations if they were offset by the presence of other substantial benefits (Cho 1995). Foodland Super Markets filed suit against the DLIT claiming ERISA did not allow states to take such action. United States District Court Judge Samuel P. King agreed with the food store chain ruling the DLIR had taken "unreasonable action" not exempted by Hawaii's ERISA pre-emption (U.S. Case 95-00537).

Republican proposals which would cut federal dollars

for Medicare and Medicaid reimbursements also have the state legislature nervous. State Senator Suzanne Chu Oakland expressed fear to her colleagues that proposed cuts could lead to rationing of health services in Hawaii (Oakland 1995). These financial problems have occurred seemingly in spite of the fact that Hawaii has one of the highest participation rates by insured residents in managed care programs. Nearly 40 percent of the state's insured are enrolled in such programs and many of the proposals at the federal and state level hinge on increased participation in HMO-type programs (Churchill 1995). Hawaii's experience would seem to indicate that the fiscal benefits of managed care may have diminished returns over time. At the very least, the state's problems reflect the difficulties of trying to administer federal and state programs with different perspectives on minimal care.[22]

Rationing: The Oregon Approach

While Hawaii's state legislature sought to establish a system of universal coverage with cost savings seemingly an unintended (but welcome) feature, from the onset of discussion Oregon's goal has been to control the cost of health care while methodically expanding coverage to a larger part of the population. The Oregon plan would

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[22] It should also be noted that John Lewin, former Director of Hawaii's Department of Health, and perhaps the program's most visible promoter, has moved to California where he represents a physicians group. Some department employees believe that much of the activism in the state's health community departed with Lewin.

eventually supply universal coverage, but there would be a limit on the procedures the state health plan will pay for. Faced with the escalating cost of medical technology, Oregon has prioritized 2,000 medical procedures and, using actuarial tables, decided how many items on the list the state can afford during a given fiscal year. A citizens' commission held statewide hearings, ordered a telephone survey and generally listened to what the voters in Oregon told them. As a result, Oregon has created a program that is unique to American government.

The idea of containing health care costs by rationing services can be traced back to a state budget crisis in 1988. The Oregon legislature decided it would no longer pay for most organ transplants as part of Medicaid. Instead, the money would be used to fund maternity care for about 1,500 women. As a direct result of this decision, a seven year old boy was denied funding for a bone marrow transplant which would cost around $100,000. The family of the boy began a campaign to raise the money through public appeals even though the boy's own doctors pointed out he was not in remission and the chances of a successful operation were very low. The boy died before the operation was performed still $30,000 short of the goal (Klevitz et al. 1991).

The case generated large amounts of publicity and criticism, but the Oregon legislature defended its decision and seemed to enjoy support from most Oregon voters. At the

next meeting of the state legislature, rather than address only the question of transplant funding, it was decided to attempt fundamental reform of the entire Oregon health care system. A leader in this movement was State Senator John Kitzhaber, who is also a physician[23](Conviser 1995).

In a article for the Stanford Law & Policy Review (Kitzhaber and Gibson 1991), Kitzhaber defended the state's decision to ration health care referring to it as a constructive alternative to a failing system. He argues that the states, unlike the federal government, are usually required to have a balanced budget. When economic downturns occur, state governments are forced to make cuts in social services such as health care. The common method of making these cuts is to lower the income eligibility standard for Medicaid. While Oregon was forced to lower eligibility to 58 percent of the Federal Policy Level (FPL) in the 1980s, the average for all states during the same period was under 50 percent. Alabama dropped the level to 14 percent of the FPL making Medicaid unavailable to the vast majority of the poor (Kitzhaber and Gibson 1991).

Costs Cutting Devices

Other devices states used to cut costs include underpayment for services, closing of health clinics and deferment of treatment by public hospitals. For example, physicians in New York routinely refused Medicaid patients

[23] Kitzhaber now serves as governor of Oregon.

when the state dropped the maximum payment for an office call to $11. Kitzhaber and Gibson complain that while all of these actions represent implicit rationing, the media has consistently ignored the practices. On the other hand, Oregon's decision to use the word "rationing" has lead to an emotional debate which "not only sidesteps the real issues, but draws attention away from the merits of the Oregon proposal and fails to address the indefensible character of the status quo."

Kitzhaber and Gibson also criticize the federal government for its lack of a cohesive health policy. Federal programs target specific groups of the public such as children while federal regulations preempt states from addressing the inequities among programs. The system seems to offer coverage to everyone except for Americans under 65 who make too much money to qualify for federal aid, but not enough to afford private insurance. The author sees some irony here in the fact that these uninsured Americans (many of whom are employed) are subsidizing health care for citizens who can often afford to pay for their own medical treatments (Kitzhaber and Gibson 1991).

It seems Oregon has been on the defensive about the rationing approach since the program was first made public. An early report by the Oregon Health Services Commission (OHSC) noted that state's plan addressed "realities" which other programs overlooked including:

-The reality of fiscal limits.

-The reality that health care does not necessarily yield health and that other social needs often have a greater impact on health; therefore health care allocations must be balanced against other social needs budgets.

-The reality that medical services are not of equal value and effectiveness; therefore savings from less effective and inappropriate care can be directed to those social needs which have a greater impact on health.

-The reality that policy-makers currently ration health care to the poor in an arbitrary way and are not held accountable.

-The reality that we need an explicit and integrated health policy to rationally and fairly allocate resources (OHSC 1991, 2).

This excerpt clearly states the goals of the Oregon programs and suggests that other states are rationing health care already; the public is just not aware of it.

Rather than a single act, the Oregon health care reform package consists of six separate bills. Senate Bill 27 passed in 1989, expanding Medicaid coverage to all Oregon families below the FPL and establishing the basic benefits package. Senate Bill 1077 (1991) created the Oregon Health Services Commission with a mandate to prioritize health services. Senate Bill 935 is the employer mandate bill which would require employers to "pay or play." Employees working more than 17.5 hours per week and their dependents must be offered health insurance coverage. A high risk pool for those unable to obtain conventional coverage was created by Senate Bill 534 in 1989. Small business reforms were

addressed by Senate Bill 1076 (1991) which also ordered the OHSC to include mental health and chemical dependency treatments on the priority lists. Finally, Senate Bill 1077 (1991) created the Oregon Health Resources Commission (OHRC) to study the impact of capitol expenditures on medical technology (OHPA 1996).

Make-up of the OHSC

Combined, the acts formed a demonstration project that could be carried out only if the federal Health Care Financing Administration (HCFA) would grant the waivers necessary to implement the program. The OHSC consisted of 11 members appointed by the governor and confirmed by the state senate. Five of the members have to be physicians with various areas of medical expertise. One of the physicians must be an osteopath, one member must be a social worker, one a public health nurse and the other four "health consumers" or members of the public. Members serves four year terms and receive no compensation for their service except for travel expenses. The crucial assignment for the commission was to prioritize health services (OHSC 1991). The commission's ranking of health services would serve as a guide for cost control measures.

Senate Bill 27 created a formula which would increase access to medical services to the 420,000 Oregonians not covered by private or public health insurance. A gap group of approximately 30,000 would be excluded in the initial

expansion of coverage, but other programs would be available to them at a later time. This gap group consisted mostly of uninsured part-time workers with incomes above the federal poverty level. Medicaid coverage would be extended to a larger group of people, but care would be rationed according to a priority system determined by the commission. Services deemed to be the most beneficial would be given high priority while those given the lowest priority would be dropped. If funding were limited in the future, services toward the bottom of the prioritized list could also be dropped (Fryburg 1972).

Senate Bill 935 also established the Insurance Pool Governing Board which would have the power to require those companies not currently providing health insurance for full-time employees (defined as those working over 17 hours per week) to "pay or play" by July 1, 1995. Tax credits for small businesses and limits on the amount employees could be required to contribute were included to lessen the impact of premiums. Senate Bill 534 established a high risk pool for residents who were unable to obtain insurance from private carriers or who had been dropped by an insurer as a poor risk. Premiums would be determined by the number of participants in the pool. A contract with a private insurer and a private health care delivery system would be sought by the board, but again, cost control was a primary priority. The board could only sustain losses up to 1 percent of the

total dollar amount of the premiums paid.

Methodology

The commission had been given three basic goals by the state legislature:

1. A comprehensive list of health services would be required which was detailed enough that benefit packages could be expanded and contracted with changing economic conditions.

2. Both public and private providers had to be involved.

3. The rankings of the list must accurately reflect the comparative benefits of health services (OHSC 1991).

Initially, the OHSC reviewed health systems in Canada, Great Britain, Japan, Sweden and West Germany. All of these countries have universal health care and are compelled by limited resources to practice various sorts of cost control. The findings of the commission indicated that all of the countries studied prioritized health care in an indirect method using informal limitations. All types of services and benefits are available to all citizens, but only after waiting in lines or enduring a lengthy appointment process. None of the systems offered the ranked order which would supply the flexibility the legislature was seeking.

Cost containment and expanded health care service programs in Washington, California, New York and Hawaii were also considered, but again, limitation seemed to be the dominant means of cost control. The commission decided it would be necessary to develop a ration plan from scratch. The first step was to establish five subcommittees that

would supply input data needed to combine quantitative measures of treatment effectiveness with fiscal costs and social values (See Figure 5-1). The MHCD subcommittee would set quantitative values form mental health procedures which would then be added to the list of standard health procedures. The Social Values Subcommittee (SVC) was ordered to survey public opinion to determine community values and health values. Community values were measured by means of community meetings held at locations all over the state. Determining health values was the first step in forming cost-benefit ratios and net-benefit ratios.

Telephone Survey

A telephone survey was also conducted. The survey represented a modification of Dr. Robert M. Kaplan's Quality of Well Being Scale (QWB) which allows quantified measurement of health states and symptoms. Basically respondents were asked to rate on a scale of 0 to 100 the quality of life that could be expected with various degrees of illness. A formula devised by the OHSC was then used to standardize the responses and rank them. The questionnaire required 72 responses for completion. The refusal rate for the survey was identical to the completion rate of 23.3 percent while 53.4 percent of telephone numbers available had either been disconnected or were otherwise invalid (OHSC 1991).

Outcomes Subcommittee. The Health Outcomes Subcommittee was

charged with collecting data that measured the effectiveness of treatment prescribed for a specific diagnosis. Using the International Classification of Disease, 9th Edition (ICD-9) as a guide, the subcommittee polled professional organizations to establish successful standard treatments for a long list of medical conditions. The age of the patient was a major consideration as well as the comparative results for treatment and non-treatment. Preventive treatments did not fit neatly into this data resulting in another category called "interventions." A separate committee, the Ancillary Services Subcommittee, was given the task of ranking interventions in a system that could be later incorporated into the master rating list.

All of the collected data was eventually given to the commission for the final ranking decisions (See Figure 4.2). First, each diagnosis was given a relative weight of 0 to 100 by the members of the commission. This weight considered value to society, value to the individual and value to a basic health care package. Value to society was based largely on reports collected at statewide community meetings and public hearing. Value to the individual measured the probabilities of death, return to former state of health and quality of life after treatment. The net-benefits of treatment versus non-treatment were also considered. Value to a basic health care package hinged on what the commission chose to call a "reasonableness test."

FIGURE 5.1 OREGON COST-BENEFIT RATIO FORMULA

$$B_n = \frac{c}{Y * \left[\sum_{i=1}^{5} (P_{i1} * QWB_{i1}) - \sum_{i=1}^{5} (P_{i2} * QWB_{i2}) \right]}$$

[With Treatment] [Without Treatment]

$$\text{with} \quad QWB_{ik} = 1 + \sum_{j=1}^{30} d_{ijk} w_j$$

where

B_n = the net benefit value ratio for the n^{th} condition/treatment pair to be ranked. This value will be used in determining the actual rankings of health services from highest(0) to lowest(-∞).

c = cost <u>with</u> treatment, including all medications and ancillary services as well as the cost of the primary procedure.

Y = the years for which the treatment can be expected to benefit the patient with this condition. This may be the remainder of the patient's lifetime or some shorter amount of time.

P_{i1} = the probability that the i^{th} outcome will occur five years hence <u>with</u> treatment.

d_{ijk} = an indicator variable denoting the presence (=1) or absence (=0) of the j^{th} health limitation (MOB, PAC or SAC) or chief complaint for the i^{th} outcome either <u>with</u> treatment (for k=1) or <u>without</u> treatment (for k=2).

w_j = the weight given by Oregonian's to the j^{th} health limitation or chief complaint ranging from 0=no significant effect to -1=death.

P_{i2} = the probability that the i^{th} outcome will occur five years hence <u>without</u> treatment.

Source: OHSC 1991.

This test was representative of several methodologies developed by the commission which relied heavily on the expertise of its own members to find answers to difficult questions. Quantitative studies of medical situations were combined with professional and moral interpretations.

Prioritized List. The final list was released in 1991. It contained 709 services ranked in order of importance. Below is a partial listing from the rankings (see Figure 4.3). The number on the left indicates ranking while the terms listed are those used on the diagnosis line of the list. Those health problems at the top of the list are not likely to be candidates for any future cuts in services as are those from the middle. The medical problems from the bottom lines were not originally funded and are unlikely to be covered in the future. Originally, the Oregon Health Plan was set to fund 507 of the 709 medical services listed (OHSC 1991), but the federal government set up several roadblocks which forced the state to alter the program.

This initial version of the prioritized list was widely criticized as was the concept of rationing itself. One argument was that rationing health care services forces moral choices which are difficult to legitimize in a society that emphasizes equality (Menzel 1989). An article in JAMA saw little cost savings in the Oregon plan and questioned the methodology used to arrive at the rankings (Eddy 1991). The commission did change the list somewhat relying more on

FIGURE 4.3 Samples From The Top, Middle And Bottom Of Oregon's Priority List For Health Services.

Top

1. Pneumonia (various types)
2. Tuberculosis
3. Peritonitis
4. Foreign body in Pharynx
5. Appendicitis
6. Ruptured Intestine
7. Hernia with Obstruction
8. Croup Syndrome
9. Acute Orbital Cellulitis
10. Ectopic Pregnancy

Middle

350. Avoidant Disorder of Childhood or Adolescence: Elective Mutism
351. Separation Anxiety Disorder
352. Adjustment Disorders
353. Conversion Disorder
354. Tourette's Disorder And TIC Disorders
355. Hyperplasia of Prostate
356. End State Renal Disease
357. Giant Cell Arteritis, Kawasaki disease
358. Dermatomyositis, Polymyositis
359. Systemic Sclerosis
360. Unwanted Pregnancy

Bottom

700. Gynecomastia
701. Cyst of Kidney
702. End State HIV
703. Chronic Pancreatitis
704. Superficial Wounds Without Infection
705. Constitutional Aplastic Anemia
706. Prolapsed Urethral Mucosa
707. Central Retinal Artery Occlusion
708. Extremely low birth weight (under 500 grams)
709. Anencephalous and Similar Anomalies

Source: Oregon Health Services Commission 1991.

citizen input. But the most threatening criticism came from a report by the federal Office of Technology Assessment (OTA) which expressed "serious reservations" about the entire Oregon project (Pear 1992). The plan proposed expanding Medicaid eligibility beyond categories allowed by federal law, but also would not fund some benefits enjoyed by current Medicaid recipients. Both cases would require federal waivers from the HCFA.

Waiver Submission. The first waiver proposal was submitted in 1991 and was denied in 1992 when the Bush administration claimed that the prioritized list violated the ADA. In response, the commission again revised the methodology for the list by placing primary emphasis on the ability to prevent death, relieve symptoms, control costs and preventative care. The list was modified again in 1993 as part of a deal struck with the federal Department of Health and Human Services (DHHS). The DHHS had refused to grant the necessary waivers for a demonstration project because the agency felt the state's prioritized list still violated some portions of the Americans with Disabilities Act (ADA). In ranking treatments, the Oregon commission had devalued health states with disabling results. In other words, treatments in which permanent disability was a likely outcome were ranked lower than treatments which produced the full recovery. The DHHS ordered the Oregon commission to define medical effectiveness in ways which did not violate

ADA. Though the commission disagreed with the assessment, the criterion was incorporated and federal waivers were granted in 1992 (OHPA 1996). The final list contain 745 items with Medicaid coverage provided for 606 of them (Conviser 1996).

Pay or Play

The employer mandate provision of the Oregon plan not only conflicted with federal law, in particular ERISA, it also faced strong opposition in the state legislature as well. The original bill called for the mandates to take effect in 1995, but was delayed by legislative action in 1993. The 1995 legislature even went so far as to vote to abolish the employer mandate altogether, but the governor vetoed the bill. In the end the legislature was successful in killing the employer mandate provision through a sunset provision in the original bill. By delaying implementation, the state legislature prevented the state from seeking the needed federal waiver similar to the one granted to Hawaii. Since an implementation bill was not passed by January 1, 1996, the employer mandate section automatically died.

The Oregon Culture: A Brief History

Oregon is a state of paradoxes. Settled mainly by pioneers of European descent, the state became famous early in the twentieth century for passage of a number of progressive reforms. Known collectively as the Oregon System, the group of legislation introduced the initiative

petition, referendum and recall. Women received voting rights in 1912, a full seven years before the federal government acted. But in 1922, one Oregon county passed an initiative measure sponsored by the Klan which was aimed at closing Catholic schools (MacColl 1979). The measure was later declared unconstitutional by the U.S. Supreme Court, but idea of a state using liberal reforms to forward ultra-conservative views caused one observer to remark that on the progressive movement in Oregon "the promise was superb and the performance relatively indifferent" (Gunther 1977).

The state first passed a progressive income tax in 1923. It was repealed in 1924 and then reinstated in 1930. When immigration from Japan and China began to increase in the 1920s, the state passed a law prohibiting aliens ineligible for citizenship from owning land. When blacks from Arkansas, Texas and Oklahoma began to migrate into Portland in the 1940s to work in defense plants, they were often met with open hostility. Today, the largest minority in Oregon are the Mexican-Americans (Abbot 1983).

To further confuse matters, in the 1930s the state gained a reputation as a conservative anti-union, anti-radical, anti-communist stronghold when the state joined with big business to end strikes in the timber industry and along the waterfront. However, in 1944 the state elected Wayne Morse to the U.S. Senate. A very liberal Republican, Morse eventually switched to the Democratic Party and

supported a number of liberal causes. Morse was an early supporter of environmental issues in a state where the timber industry was king. The state of Oregon was one of the first states to put environment legislation on the books in the late 1960s and early 1970s.

This history of paradoxical behavior should make it easier to understand why a state that began with a plan for universal health coverage centered on an employer mandate eventually dropped the mandate provisions, but is still attempting to increase the scope of coverage.

Conclusions

Several conclusions can be drawn from the universal efforts in Hawaii and Oregon as a result of the case studies. First, the culture of each state and other political intangibles seem to combine to make each state program unique. Hawaii's plantation culture and the influence of the Japanese immigrants cannot be found in any other state. Native Hawaiian culture also contributed to an atmosphere that expects a government presence in health care insurance. Oregon's direct call for rationing reflects that state's cultural history of conflicting legislation. While the expansion of health care services follows a liberal ideology, the idea of limiting services based on total cost has a conservative appeal.

No other state has tried to copy the universal programs created by either state. As noted earlier, public health

officials and politicians in other state often allude to the unique cultural history of Hawaii as one reason they feel the plan simply would not work in any other state. The domination of the Aloha state by two large health insurance carriers has also contributed the plans viability. There is competition between HMSA and Kaiser, but it is somewhat limited. As a result, reforms such as community rating have been introduced via a gentlemen's agreement rather than mandated by the state legislature. In a more competitive market, with a larger number of players, it is unlikely that community rating would be financially feasible. Finally, the geographic location of Hawaii has made it possible for the state to experiment with universal coverage without the fear of becoming a health care magnet to those with fewer benefits in other states. It is not practical for the poor or uninsured to move to Hawaii solely to take advantage of increased health care benefits.

Oregon's rationing plan would likely be a political disaster in other states. Though most other state programs include some sort of de facto rationing, this study has found no other state where the term is used to identify a reform proposal. Rationing implies, at the very least, some sort of limit on services. The Republican Party's recent experience at the federal level shows how unpopular any type of cut in health care services can be. A effort to slow growth, but not actual cuts, resulted in heavy criticism of

Republican congressional leaders from supporters of Medicare and Medicaid. On the other hand, Oregonians seem to accept rationing as a legitimate cost control mechanism and have chosen to focus their attention on the prioritization process.

Hawaii and Oregon have also shown other states considering large scale reforms that they must be ready to deal with the federal government if they wish to institute change. So far, only Hawaii has managed to obtain the necessary federal waivers to implement employer mandates. Though the Oregon legislature essentially killed employer mandates in that state, it is unclear whether Congress would have granted another ERISA exemption anyway. Even without the mandate question, the state still experienced significant delays in implementation when the priority list was found to violate the ADA. Not only did the state have to satisfy the DHHS, it also had to receive waivers from the HCFA for alteration of Medicaid benefits.

This combination of state culture and federal oversight would seem to make it unlikely that any other state could successfully devise a universal care system without some sort of enabling federal legislation. By comparison, more limited reform efforts seem to be more practical. All eight of the reforms discussed in Chapter Three have already been adopted by more the half of the states. While individual reforms usually have only a limited impact on the number of

people receiving increased coverage, as a whole these reforms can lay the groundwork for future universal programs.

These case studies identified geography, culture, and elite sponsorship as variables which inhibit the diffusion of health care innovations. Both Oregon and Hawaii had pursued universal care as a goal. In the next chapter, a case study is made of Oklahoma, a state which ranks near the middle as a health care innovator and a government whose reform goals were much more in line with those of other states.

CHAPTER FIVE
OKLAHOMA: AN INCREMENTAL APPROACH

Like the majority of states, Oklahoma has chosen the incremental approach to health care reform. In the study of eight health policy innovations discussed in Chapter Three, the Sooner state ranked 28th, near the middle of the 50 states studied. The variety of reforms considered combined with mid-range rankings makes Oklahoma an excellent subject for a case study on incremental reform. Political factors also can play a role in health care implementation. Generally regarded as a conservative state, Oklahoma is among a number of southern states which have seen rapid growth of the Republican party after years of domination by Democrats. The purpose of this chapter is to identify historical, cultural and political variables which led the state to select an incremental approach to health care over universal reform.

Brief State History

Admitted to the union as the 46th state in 1907, Oklahoma's early history reflects social progressivism and activism which seem out of character compared to the state's strong conservatism over the last 50 years. The Oklahoma constitution, roughly ten times longer than the U.S. version, includes provisions for eight-hour work days for state employees, abolishment of child labor in mines and factories, as well as significant health and safety

regulations. Progressives participating in the writing of the document sought to address the expanding powers of business by expanding the role of government (Baird 1994, 127). Progressives from other states convinced the state founders to include initiative and referendum. Eight percent of registered voters could initiate legislation by petition while 15 percent could initiate a constitutional amendment (McReynolds 1954, 317).

Transplanted Politics

Early settlers "transplanted" their politics into Oklahoma with bordering states being especially influential. Northern Oklahoma saw many settlers from Kansas, and as a result Republicans came to dominate regional politics. In the south, Texas democrats arrived in large numbers and became the dominant political party in that region of the state (Key 1956, 220). Democrats held a large numerical advantage from the outset and dominated state politics during the first half of the 20th century. Regardless of party affiliation, conservatism became a hallmark of Oklahoma politics after the initial surge of progressivism at the time of statehood.

Political Culture

Though external forces have forced some recent changes, the political culture which evolved after statehood remains virtually intact (Morgan, England and Humphreys 1991). Daniel Elazar (1972) has categorized Oklahoma's political

culture as "traditionalistic" with strong "individualistic" tendencies. This TI label is one which the state shares with Texas Kentucky, West Virginia and Florida. A traditionalistic political culture sees "good government" as "the maintenance and encouragement of traditional patterns with the least possible upset" (Elazar 1972, 94). Political leaders in such a culture are chosen to play "conservative and custodial roles."[24]

Traditionalistic culture is most pronounced in the eastern and southern parts of Oklahoma while the northwestern sector is more individualistic. Morgan, England and Humphreys (1984 9) support Elazar's TI classification with following evidence:

(1) Oklahoma's organic roots are still quite conspicuous
(2) institutional change comes slowly and usually only after much debate, political conflict, or pressure from the federal government
(3) politics in the state is characteristic of a ""southern style" conservatism
(4) governments, particularly local units, often perform caretaker roles
(5) one party has dominated the halls of the state capitol since 1907
(6) historically, party unity has been less important to legislators than taking care of the needs of constituents back home
(7) the state has experienced its share of political corruption throughout its history
(8) funding for many public services and the salaries paid to public servants fall below national averages-indicators of both fiscal conservatism as well as an ambivalence about the role of

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[24]Elazar (1966) categorizes Oregon as having a "moralistic" political culture which chooses activists politicians who may use government power to promote the public good. Hawaii was not included due to a lack of data.

bureaucracy in state affairs.

These characteristics certainly seem to label Oklahoma as a follower rather than an innovator in health care reform.

Health Care Reform Efforts

The state's health care system in the early 1980s was much like that in other states; the growth in medical costs far exceeded other costs of living increases. The state had begun to experience trouble in the management of Medicaid even in the 1970s, but the huge increase in health costs was not seriously addressed until the 1990s. Faced with ever increasing costs for health care, Governor David Walters began Oklahoma's reform efforts in ernest when he empaneled the Oklahoma Commission on Health Care in February 1992. Dr. Garth Splinter, a staff member of the Department of Family Medicine and Medical Director of the Oklahoma Insurance Board, was named chairman. From the beginning, the 21 member group sought to contain costs through a consumer oriented model. They also intended to utilize the current health insurance system rather than create any entirely new program. Splinter outlined the goals of the commission as

1. Cost containment for health services
2. Portability of health coverage
3. An emphasis on primary care
4. Making children's health a priority

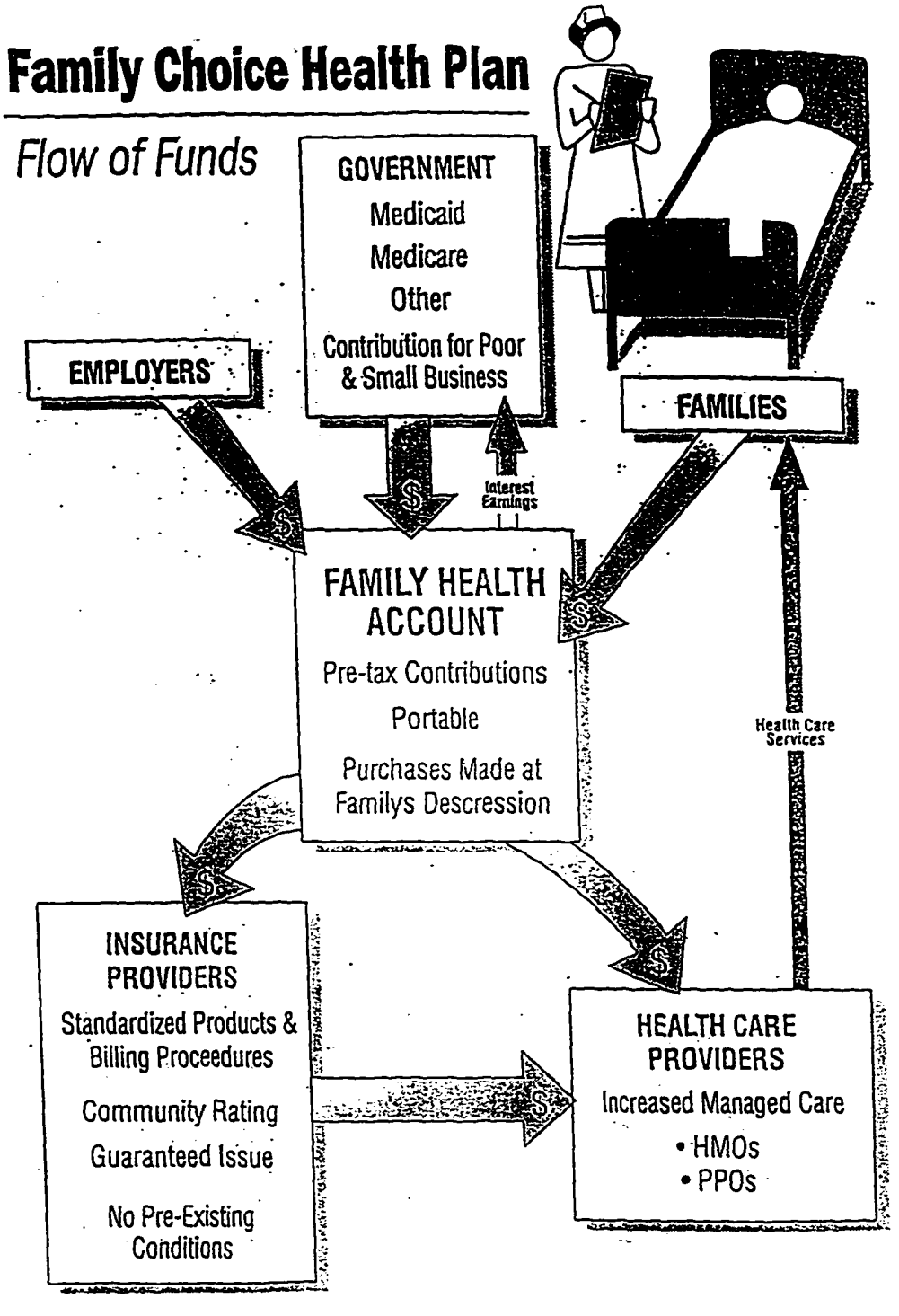
At the very beginning, the panel received two

important boosts which helped it to carry out its mission. First, the Oklahoma legislature passed a bill in the 1992 session which assured the short-term existence of the panel (McReynolds 1992). More importantly, the state applied for and received a two year $854,595 grant from the Robert Woods Johnson Foundation, a nonprofit organization based in Princeton, New Jersey. Oklahoma was one of only 12 states chosen to receive funds to aid in the development of health care reforms at the state level.

The grant proposal focused mainly on development of a Medical Savings Account (MSA) program. A version of this plan was eventually passed by the Oklahoma state legislature. However, the original Family Choice Plan first discussed by the commission was much more far-reaching in scope (Splinter 1996). Under the Family Choice Plan families would still have a tax exempt health account to pay for medical expenses as well as any health insurance plan of their choosing. In addition to personal contributions, employers and even the government would contribute to the accounts though the coverage would be completely portable (See Figure 5.1). Part of the interest generated by these accounts would be used by the state to purchase health insurance coverage for the uninsured. Other new revenues would be combined with the interest money to achieve universal coverage (Barber 1993).

This comprehensive program was never adopted. When the

FIGURE 5.1



Source: Barker 1993.

grant money ran out, the legislature chose instead to pass a much more modest MSA program based upon the popular Individual Retirement Accounts (IRAs). Every person or family (regardless of income) would have an account from which they would pay health insurance costs as well as all other health-related expenses. Health insurers would be required to provide a low cost basic coverage package with a high deductible. The rationale behind the idea is that persons paying their own medical bills are more likely to shop around for the best price and to utilize medical services more prudently (Oklahoma State Legislature 1995). Specifically, an individual can put up to $2,000 a year into an account that is exempt from state income tax. Each person may also set aside $2,000 for his/her spouse and $1,000 for each child (Mulkins 1993). As an added incentive, money deposited in the accounts is tax-free with unused funds automatically rolling over in the account for future use.

To aid consumers, the panel hoped to create a data bank which would allow consumers to compare the costs of health insurance and medical services. Splinter believed such information would allow consumers to make a rational choice of insurance carriers and physicians. Medical decisions regarding treatments would continue to be left up to medical professionals. Splinter also believed the MSA model would eventually lead to a drastic reduction in the number of

health insurance carriers in the state. He projected the number could fall from 600 to as low as 25 (Barker 1993).

The plan is especially attractive to young single workers. A company insurance plan with a $500 dollar deductible, for example, requires the insured to pay that amount out of pocket before he or she sees any benefits. Healthy individuals complain that they never realize any benefit from coverage since they seldom reach the deductible threshold (Mulkins 1993). Though the accounts only offered breaks from state taxes, its proponents hoped that future national legislation would grant similar tax relief from federal taxes as well.[25]

Criticism of MSAs

MSAs have been implemented in a number of states, but recently they have come under criticism from several groups. While proponents of MSAs (mainly conservative policymakers) claim giving individuals more responsibility will lead to a wiser use of health care dollars, critics worry that some insurers will resort to "cherry picking" strategies. Most worrisome is the prospect of adverse selection which occurs when young, healthy people opt out of the traditional comprehensive insurance market. Older and sicker

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[25] In 1996 Congress did pass an experimental MSA program which will allow a limited number of Americans (about 750,000) to create health savings accounts. It is unclear at this time how many Oklahomans will be part of the program. The program will be evaluated after five years and will then either be expanded or ended.

individuals are left to pay much higher premiums for conventional coverage. In this regard, MSAs seem to be the antithesis to community rating.

The American College of Physicians is also skeptical about MSAs, but is more concerned with the possibility of negotiating fees with hundreds of individual patients rather than HMOs. A Congressional Budget Office study warns that adverse selection could make it more difficult for small businesses to obtain health insurance coverage (Brook, Kamberg and McGlynn 1996). This seemingly would undo much of the progress states have achieved through the recent passage of small business reforms.

Provider Tax Fails

Oklahoma's reform effort suffered a severe financial setback when State Question 647, the health provider tax, was defeated by the voters on November 3, 1992. Governor David Walters saw the tax as a stop-gap measure to keep state health services financially afloat until the state reform efforts or a national program were in place. The measure would have imposed a tax on health care providers to finance health programs. Projected to raise $92 million a year, the money would be used to attract an additional $172 million in federal matching funds.

The idea of a health care provider tax did not originate in Oklahoma. While speaking in support of the measure, Governor Walters noted the proposal "isn't some

hare-brained scheme we cooked up in Oklahoma. It is something that 30 other states have done and we suspect all states will do" (Ford 1992, D1). There was opposition to the tax from several fronts. At the federal level, the Office of Management and Budget had begun to question the ethics behind such taxes viewing them as little more than legislative gimmicks meant to attract more federal dollars. OMB Director Richard Darman went so far as to characterize some state efforts along these lines as "scams." Nevertheless, Walters pushed hard for passage of the tax. He overcame the objection of most nursing home owners by including a grant program which would have returned some funds directly to nursing home residents.

Still, many health providers were unhappy with the proposed tax. State Question 647 would have required hospitals to pay a tax of 1.83 percent on certain revenues while nursing homes would have paid a flat $3 per patient per day. Taxes would also have been collected from mental health facilities and pharmacies. Opponents of the measure called the bill a tax on the sick and believed the costs would be passed on directly to consumers (Neal 1992, 1D).

The state legislature supported the provider tax and was counting on the increased revenue to fill a hole in the budget of the Department of Human Services (DHS). The DHS has oversight over Medicaid programs as well as long term care for the elderly. Legislators had already tapped the

state's "rainy day" for supplemental funding, but the department was only fully funded through December. In spite of a well-financed campaign supporting passage, the measure was defeated by a 61%-39% margin (Ford 1992, 1A). There were some mitigating circumstances that may have contributed to the defeat of the proposal. During his tenure as governor, Walters was constantly criticized for questionable campaign practices during his run for office. Some political insiders speculated that his lack of popularity may have contributed to the bill's defeat.

Other political observers point out that Oklahoma voters are notorious for opposing any tax increase. State Question 646, which would have allowed counties to increase property taxes for the benefit of county extension centers, was defeated by a similar margin on the same ballot. However, Oklahoma voters did approve two other proposals which authorized $350 million in capital improvement bonds for higher education (Ford 1992, 1A). One can only speculate that Sooner citizens were more willing to pay for education than health care. In any case, the state was now under some pressure to find alternative solutions to the problems of health care.

1992 Health Care Reform

Regardless of the reason for the failure of the provider tax, 1992 was still a key time in the history of health care reform in Oklahoma. Earlier in the year,

several reforms had been introduced in the legislature with varying degrees of success. Probably most surprising is that Oklahoma was one of 22 states to introduce a Canadian-style universal coverage bill (Monson 1992). The bill was not successful in Oklahoma City or any other state capitol. In fact, universal bills only made it to the floor for debate in two states (New York and Missouri), where the plans were ultimately defeated.

Though comprehensive legislation failed in the state, a number of smaller reforms did pass. In almost every case the state passed versions of legislation already in place in a number of other states. HB 1484 addresses policy conversion and attempts to make it easier for individuals to switch carriers. In an effort to create a uniform payment system, HB 2042 requires insurers to compensate health providers directly when benefits are assigned and claims submitted on a uniform claim form generated by the state's Insurance Commissioner. For many health insurance reforms, standards adopted by the National Association of Insurance Carriers (NAIC) were used (IHPP 1993).[26]

Also in 1992, the legislature passed a small group insurance reform package which became effective on September 1 of that year. The legislation defined a small business as

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[26]The 1990 federal Omnibus Budget Reconciliation Act required states to adopt the NAIC's Medicare Supplemental Insurance Minimum Standards Model Act by the end of July 1992. Many health related reforms in Oklahoma were simply amendments made to gain compliance.

one having no less than two or more than twentyfive employees. To help keep insurance rates affordable, the bill included limits on rating factors. The state prohibited insurers from using medical history, claims history, or length of time a group has been covered in the rating process. Variation in rates for different industries was limited to 15 percent, in line with the NAIC numbers. Under this model, the number of classes an insurer creates based on claims experience is regulated. No class can have insurance rates 20 percent above any other class when comparing the means of the highest and the lowest rates. Within each class, the high and the low cannot be more the 25 percent from the mean. Also, once a company is covered a carrier must renew the coverage except in cases of fraud, non-payment of premiums or misuse of benefits (IHPP 1993).

The groundwork for much of the legislation that would follow in the next two years can be traced to the formal report to the governor by the Commission on Oklahoma Health Care (COHC). Not surprisingly the Commission identified "skyrocketing health care costs and inadequate access to health services" as the two major problems facing the state. Recommendations included consideration of reform in the areas of billing, community rating, guaranteed issue and pre-existing conditions. This was not new ground. Other states had already reached similar conclusions and gone on to pass a variety of reform bills.

Town Meetings

The strong point of the 1992 COHC report was its unique look at the Oklahoma perspective on health care reform. The views of Oklahoma citizens were solicited in a series of town meetings held in fourteen cities and towns throughout the state. A total of 409 adult Oklahomans attended these question and answer sessions to express their views on the form that health care reform in the state should take. At the end of each meeting, attendees were asked to complete a survey on health care reform (See Table 5.1). Though the number of persons who attended these meetings represented only a small portion of the population, their differing views on the role on government in health care indicated that finding a single solution would be very difficult.

The seemingly contradictory responses to the questions in the survey seemed to indicate that Oklahomans strongly agreed changes were needed in current system, but were divided on what form a new system should take. The first two questions in Table 5.1 deal with the need for change. Nearly 70 percent of those questioned answered that major changes should be made and only 3 percent wanted to keep the current system. These responses are even more impressive when compared to a similar survey at the national level conducted by the Kaiser Family Foundation and the Commonwealth Fund. In that study, 57 percent of Americans questioned favored major change in the present system or a

TABLE 5.1 Selected Questions And Responses From The Commission On Oklahoma Health Care's Report To The Governor 1992.

Question/Statement	Percent Yes	No
1. We should make major changes in the way we finance health care.	69%	21%
2. We should keep the system we have now.	3	96
3. We should hold down costs by decreasing services.	10	90
4. We should require employers to contribute into funds for the purchase of health insurance for their employees.	18	82
5. Government should provide for people at the greatest financial risk even if taxes go up.	18	82
6. The government should be involved in setting rates for health services to keep health care costs from going up.	32	68
7. Individuals/families should make the choice of their insurance rather than the government or employees choosing.	32	68
8. Everyone should have equal access to health care even if taxes go up.	45	55
N=409		

Source: Report to the Governor (COHC 1992)

move to a new health system altogether (Kaiser Family Foundation and Commonwealth Fund 1992). Oklahomans were much more supportive of change than the nation as a whole.

Employer mandated coverage and government provided coverage were opposed by fairly wide margins, but only 32 percent of the respondents believed individuals (rather than employers or the government) should make the choice for health insurance coverage. Oklahomans also strongly opposed holding down costs by decreasing services, but did not believe the government should step in to provide coverage for the poor. And on the question of equal access, state citizens did not believe equal access should be available if it meant raising taxes.

Transcripts of the town meetings seemed to cloud the issue even more. Some speakers favored a system completely controlled by the government while others wanted a system driven by the market, with little or no government interference. Others promoted a system with overt rationing and capitation while some wanted to expand access to all those not currently covered by private or public health insurance (COHC 1992). The disagreement should have been brought to the attention of the White House. As President Clinton would soon find out at the national level, there was agreement that the current health care system needed to be changed. However, there was no mandate as to the form such change should take. Health care policymakers in Oklahoma

interpreted these results as a signal to proceed in an incremental manner. Clearly the large-scale reform programs undertaken in Hawaii and Oregon would not be feasible in the Sooner state.

1993 Health Care Reform

An information booklet distributed to state legislators by the governor's office in February of 1993 outlined the path the state would follow over the next three years.[27] The authors of the work correctly predicted that the Clinton administration's health care plan would face tough opposition and probably not grant full relief to the state if it did pass. Oklahoma would have to go ahead with its own series of reforms. The number of uninsured Oklahomans had risen from about 400,000 in 1980 to approximately 593,000 in 1992. This increase had pushed the state near the top of the list of states with over 22 percent of the non-elderly population lacking health insurance coverage.

A disproportionate number of the uninsured resided in rural counties where access was also a significant problem. These statistics were supported by a study of how Oklahomans pay for their health services (See Table 5.2). Out-of-pocket payments in the state were above the U.S. average, while the percentage of health services paid for by several

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[27] Interestingly the booklet mentioned contains an appendix devoted entirely to sample legislation from other states such as Florida, Kentucky, Vermont and Minnesota. None of the bills seemed to have been used verbatim, but certainly parts of several were incorporated into Oklahoma health reform legislation.

TABLE 5.2 How Oklahomans Financed Personal Health In 1990 Compared To National Spending.

	Oklahoma	U.S
Out-of-Pocket	29.7%	26.7%
Employer Sponsored	20.2	28.4
Non-Group Insurance	4.2	4.5
Other Private Insurance	1.2	1.4
Medicaid. State Share	4.3	4.5
Medicaid. Federal Share	5.9	5.9
Medicare	18.7	19.2
Other Public (includes local, county, state and federal health programs)	15.8	9.4
	100%	100%

Source: Commissioner of Health, State of Oklahoma 1993.

types of private health insurance was below the national average. Most troublesome was the fact that 15.8 percent of Oklahoma health care was paid for through a safety net of local, county, state and federal programs. At the national level, only 9.4 percent of services was paid for in this manner.

According to the report, the main solution was to enroll as many Oklahomans as possible into managed care programs. The savings to the state would be substantial as managed care would take advantage of an economy of scale and community rating. The first important step in the plan was the establishment of the Oklahoma Health Care Authority (OHCA). Creation of the OHCA would bring together under one entity responsibilities currently being performed by the Oklahoma State Employees Benefits Council, the Division of Health Care Information in the State Department of Health, the Basic Benefits Board, the Office of Rural Health and the Physician Manpower Training Commission. However, the most important responsibility for the OHCA would be its role as administrator of the state's Medicaid program. The purpose of the latter assignment would be to convert the current fee-for-service system to a managed care system (State of Oklahoma 1992).

HB 1573, sponsored by Angela Monson, Ed Crocker and James Hamilton, was signed into law in May 1993. The legislation established the OHCA and outlined the structure

of the agency. The OHCA is composed of seven members; the administrator, two members appointed by the governor from a list supplied by the state senate, two members appointed by the governor from a list supplied by the house and two members appointed by the governor with the consent of the senate. The authority has the power to purchase health care benefits for state and education employees, develop a basic health plans package and assist the Insurance Commissioner in creating a uniform claims processing system for health care providers (HB1573 1993).

1994 Health Care Reform

Small group health insurance reforms passed in 1992 were modified again in 1994. The original proposal had required insurers to make it easier for small businesses to supply coverage for their employees. The 1994 Accountable Health Company Act expanded the definition of small businesses to include those employing at least two but no more than one hundred persons. The 1994 act also provides for guaranteed issue, portability and reinsurance. The guaranteed renewal provision requires an insurer to renew coverage for a company already covered regardless of claims history or changes in the health status of employees. Under the portability section, workers who change health plans (or jobs) do not have to fulfill a new waiting period before being covered for pre-existing conditions.

In a variation of community rating, rules were put in

place to limit the differences between the lowest and the highest premiums charged to companies with different risks characteristics. Insurers were allowed to make allowances for case characteristics such as age and gender. A basic health plan was indirectly addressed through the passage of the Oklahoma Quality Jobs Program Act of 1994 which required companies participating in the program to offer a basic benefits health plans to all employees.

Women's Health Care Bills

Two bills passed by the legislature in 1994 dealt specifically with women's health care. SB772 prohibits deductibles, co-payments or co-insurance limits for women seeking routine mammography screening. SB774 requires group health plans to include coverage for ultrasound breast exams for women over 35 and coverage for annual pelvic exams and pap test for women 21 years and over. HB1377 requires HMOs and other insurers providing prescription drug as a benefit to open up the pharmacy services to bidding every three years. Insurers that already have open pharmacy networks are exempt (Atchison 1994).

Health reforms of any kind are useless if citizens are denied access to basic preventative care. As noted earlier, the populations of rural counties were much more likely to lack health insurance coverage than those living near the state's larger metropolitan areas. These problems were partially addressed through a program which offers financial

assistance to medical students who practice for a specified period in an underserved area. The Physician Manpower Training Commission was directed to require that no less than 40 percent of all medical residents and intern eligible to participate in each medical school year train in a rural-based program (IHPP 1994).

1995 Health Care Reform

Three main issues were addressed in the 1995 session of the Oklahoma legislature, the future of the University Hospitals in an ever more competitive market; implementation of managed care for Medicaid; and reducing the costs of treating the state's uninsured. Adjacent to the University of Oklahoma's Health Science Center in Oklahoma City, the University Hospitals include University Hospital, Children's Hospital, the O'Donoghue Rehabilitation Center and the Child Study Center. Legislators hoped to strike a balance between making the hospitals competitive and retaining the traditional roles of teaching facility, research center and the state's largest facility for indigent care.

This is a difficult proposition from several standpoints. The most likely scenario for the University Hospitals was a merger with a large private sector health provider. Previous mergers between private hospitals and HMOs often required an exchange of stock or combining of assets. Any such merger by the University Hospitals would require complex negotiations and legal changes to make such

a venture viable and attractive to private providers. The legislature's answer to these potential problems was to create a trust and give the board the power to negotiate in the state hospital's name. To protect the public's interest, all agreements reached by the hospital trust would have to be reviewed by the Contingency Review Board (CRB)[28] and the state's Attorney General.

The bill which created the trust also anticipated a reduction in the work force at the University Hospitals if a lease agreement was reached. To cushion the blow for state employees who would be released, a system of extended benefits was created. Two other measures were also passed which dealt with the conversion period. In one, the OHCA was authorized to make adjustments in the patient volumes to maintain an adequate load for the teaching hospitals. Legislation was also put in place which would allow leases to be made for ambulatory care sites away from the Health Science Center complex.

High Risk Pool

HB1346 creates a high risk pool which would

[28]The CRB is composed of three voting members; the Governor who serves as chair, the Speaker of the House, and the President Pro Tempore of the Senate. The Director of Finance serves as secretary in a non-voting role. The board's usual duties include approving the transfer of funds between state agencies and disbursement of monies from the Governor's Emergency Funds in case of a disaster. The state legislature specifically required that the CRB meet within 15 days after a management agreement is reached by the University Hospitals. After the Attorney General signs off on such an agreement, the CRB has the power to disapprove the contract (Maddy 1996).

theoretically offer health insurance coverage to about 600,000 Oklahomans not covered by private or public plans. To qualify, applicants must have been rejected twice by a private insurance company and must have lived in the state for one year. Premiums cannot be higher than 25 percent of the average market rate and the plan is administered through a private entity. If premiums fail to cover operating costs, private insurers are assessed the difference based upon their share of the Oklahoma market (Boyd 1996).

SoonerCare: Managed Care Medicaid

The introduction of managed care into Oklahoma's Medicaid program again reflected the state's incremental approach to health care reform. Rather than attempting to enroll residents from the entire state at one time, the OHCA instead chose to create demonstration projects in the three largest metropolitan areas of Oklahoma City, Tulsa and Lawton. Rural areas would begin to be integrated into the three pilot programs only after the networks in the three cities had been in place for a year. The three urban areas were chosen because they met three criteria considered essential for program success:

1. They had a sufficient Medicaid population base to support multiple health plans (referred to as Managed Care Organizations, or MCOs).[29]
2. They had fully integrated networks in operation

[29] MCOs and HMOs are basically the same. In this study the terms are used interchangeably.

or in the process of being formed.

3. They served as referral centers for surrounding rural communities, thereby offering the potential for plans formed within them to affiliate formally with rural providers over the next several years (OHCA 1995).

The OHCA, using the power granted by the state legislature, signed one year contracts with BlueLincs, Community Care, Foundation Health and Heartland Health (the University of Oklahoma's HMO) in Oklahoma City; BlueLincs, Community Care and Foundation Health in Tulsa; and BlueLincs, Foundation Health and PacifiCare in Lawton (OHCA 1995, 3). These HMOs would serve as health providers in their assigned geographic area providing care for that area at a predetermined price.

The SoonerCare plan was fiscally sound and extremely conservative posing little financial risk. The state was in effect utilizing health care networks already in place. To ensure interest among HMOs, the first areas selected for contracts were urban areas which had already proven to be profitable for other health provider organizations. Expansion to rural areas would be slower and carefully controlled by the OHCA.

First expansion would be to counties contiguous with the three model areas. A "Rural Partner" provision of the SoonerCare master plan sets minimal enrollment requirements for participating HMOs and provides contract preferences for those that exceed enrollment goals. The state hopes to make rural areas attractive for steady expansion and lessen the

economic strain on contracting providers (OHCA 1996).

Conclusions

Oklahoma has passed a substantial number of health care reforms over the last five years, but it is difficult to trace the origin of most. The managed care/Medicaid program in Oklahoma is based on a similar program in Arizona. However, even this model has been modified to make it unique to Oklahoma (Boyd 1996). The majority of the bills dealing with small business reform were adapted from NAIC guidelines, but they too were customized to meet state needs. This study failed to uncover any reform efforts which originated in the Sooner State.

Even the medical savings account program for which the state received a sizable grant to implement was first authorized in Mississippi. MSA proposals were promoted simultaneously in several states by the head of a major private insurance group as well as several conservative policy groups (IHPP 1992, 45). This seems to reinforce the perception that Oklahoma is a "follower" rather than a "leader" among states when it comes to health care innovation. It would also seem to support the observation on the conservative nature of both the general population and the legislature. Every bill considered by the legislature had been tried before in another state.

A cautious, incremental approach still does not assure that reforms will be successful. The managed care

implementation phase for rural areas has already been delayed for a year, and parts of the program in place have experienced mixed results. It was expected that the move to managed care would save the state around $9 million in the 1995-96 fiscal year. In fact, the total savings are estimated at only about $3 million. The OHCA blames the shortfall on the fact that bringing in AFDC clients into the program took nearly nine months instead of six months as originally projected.

Tracking SoonerCare

Traditional government health care providers, such as the Indian Health Care Resource Center in Tulsa, have already seen their client base shrink from 1,500 patients to 900 patients in less than a year (Winslow 1996). And there has been confusion among patients about how SoonerCare works. In the past, many Medicaid patients waited to seek care until they were seriously ill. Their treatment center of choice was the hospital emergency room. Managed care programs emphasize preventive care and require patients to regularly visit their primary physician for office visits. For illiterate patients, even making a choice of health providers is nearly impossible yet alone having to comprehend the many rules concerning physician visits.

Oddly enough, the recent surge in the Oklahoma economy may have saved the state more money than SoonerCare ever will. In Tulsa county alone, the number of people eligible

for Medicaid benefits has dropped from about 33,000 in 1995 to 25,000 in 1996. Still the OHCA is satisfied with the progress of managed care to this point. Pilot programs in three rural counties (Hughes, Okfuskee and Seminole) have had few problems, and the commission hopes to have the entire state involved in the program by 1998 (Winslow 1996). A final note of irony is that a substantial portion of the funding for the transition comes from a fee assessed on all health insurers and providers participating in SoonerCare. The common name for such a fee...a provider tax.

Problems With High Risk Pool

Oklahoma's effort toward creating a high risk pool has fared no better than programs in other states. Insurance commissioner John Crawford admitted that the pool will probably benefit less than 1 percent of the state's population. Two main problems have arisen. First, premiums have been too high for even medium-wage workers. Premiums for the program are determined by averaging the rates from the state's top five health insurers. The rates for high risk pool applicants is then capped at 25 percent above that average. In Oklahoma, this meant the cost for coverage has been between $300 and $400 per month, a figure out of reach for many workers who need coverage the most.

Potential participants also face a one-year wait for claims on pre-existing conditions. All of those applying have been denied coverage by at least two private insurers

in the state. One of the reasons most were denied was because of chronic illnesses which made them poor risk. The pool is expected to lose $200,000 to $300,000 in its first year. Those losses will be assessed to all 1,161 licensed health insurers in the state on a pro-rated basis according to the volume of business done in Oklahoma. Participation is not optional. Companies declining to contribute to the pool will not be allowed to continue doing business in the state (Rutherford 1996).

Future Reform

Though the number of bills introduced dealing with health care reforms has dissipated somewhat over the last two years, it is likely a new flurry of legislation will emerge as the state attempts to fine tune SoonerCare. It should be noted that legislators did not hesitate to make some changes to the small business reforms package when they felt it was necessary. These adjustments were made just two years after the original reforms were passed.

Will managed care in Oklahoma serve as a precursor for some type of universal coverage system? While the state has been extremely conservative in its approach so far, the notion should not be completely ruled out. OHCA Director Garth Splinter said early on that the number of health care providers in the state would eventually shrink dramatically as SoonerCare reached its full potential. In Hawaii, one of the few states with a universal program, the health insurer

market is dominated by two large HMOs. Limiting competition (or at least lessening the number of competitors) would seem to be a necessary step for universal coverage. If a few other states adopt universal programs which guarantee substantial financial savings, look for the Oklahoma legislature to give it serious consideration.

CHAPTER 6

CONCLUSIONS

Early on in this study, a colleague questioned the wisdom of following the progress of a number of smaller health reform bills rather than concentrating on universal models. At that time, several states seemed poised to pass universal coverage programs. And if the states hesitated, it seemed sure that the federal government would legislate a universal plan of its own and force the states to follow. He honestly wondered just how important individual "innovations" would be. Yet, following the defeat of President Clinton's plan for a massive overhaul of the system, many such assumptions regarding major changes in U.S. health care reform began to change. Now it seemed that any attempt at a federally-initiated universal care system would be doomed to fail. Almost by default, the states were in the spotlight. If cost control and expanded coverage were to be realized, it appeared the states might have to lead the way. But which states, and why those particular ones? These were the questions prompting this investigation. In short, what forces help shape health care innovations among American states?

Universal coverage is the ultimate innovation in health care reform. It should not, however, be associated only with liberal policy proposals. Both liberal and

conservative market-driven innovations seek to eventually expand coverage to a substantial portion of the population. Whether a universal system is controlled by the public or private sector is where differences in ideology come into play. For liberals, expanded coverage is a right of citizens, and the government is the preferred vehicle of administration. For supporters of market-driven innovations, expanded coverage by the private sector means creation of economies of scale which tend to lower costs for consumers. Both groups consider preventive care programs an essential method of reducing overall costs and making the system more efficient. Thus, virtually all reforms, whether initiated at the federal or state level, seek to modify the existing health care system in two basic ways, by lowering costs and increasing access.

As it turned out, no state passed universal legislation, single-payer or otherwise, and several of the smaller incremental bills passed by the states have now been adopted by the federal government in lieu of change on a grander scale. The lack of change at the federal level comes as no surprise. The first two chapters of this study revealed the lack of a national health care policy and exposed the somewhat haphazard development of the current health care system. While countries such as Germany and Great Britain began to implement government sponsored health coverage as early as the turn of the century, the United

States has continued a fee-for-service system which forces the uninsured to rely upon charity from the private and public sectors.

In the last hundred years, four major efforts toward universal health reform at the national level have occurred. All have failed due to strong opposition from conservative politicians and various special interest groups. The first such movement gained momentum in the early 1900s, partly a product of the Progressive movement in that era. Passage of a national health insurance plan seemed likely, but the beginning of World War I interrupted the effort. After the war, opponents compared the proposed program with the German system, successfully arguing that no plan originated by an "enemy" could possibly be good for Americans. The AMA also voiced opposition to such change as well, taking a position against government health insurance which continues today.

Even the crisis of the Great Depression was not enough to bring about change. President Franklin Roosevelt and his advisors chose not to include national health care insurance as part of the New Deal proposals. This was a political tradeoff made to appease conservatives and gain support for other parts of the program. National health care reform bills were routinely (and unsuccessfully) introduced in Congress over the next 15 years. This second effort ended with the failure by President Truman to push through his version of a national health plan through Congress.

Huge increases in the costs of health care and the number of uninsured put health care reform on the agenda in the late 1980s. As reported in Chapter One, in 1992 the president was elected on a platform which included a promise of universal coverage, but two years later the Clinton proposal was dead. That the Clinton idea for national health coverage failed should have come as no surprise. This research revealed that the core opposition to this type of reform had remained constant since the turn of the century. Well-organized opposition, coupled with a lack of policy cohesion in the American federalist system, seemed to suggest that major modifications in health care coverage at the national level would continue to fail.

Why the States?

But why should the states be seen as sources for change? The systems in Germany and Great Britain, which were mentioned previously, had their origins at lower levels of government. More compelling, however, is the experience of Canada. The Canadian health care system paralleled that of the United States until the government implemented a single-payer system in 1972. As a result, health costs in Canada increased at a much lower rate than those in the U.S. during the 1980s even while coverage expanded. More important, the single-payer model had been developed by the provinces and later adopted by the federal government. Even today, the provincial and territorial governments are given

some discretion in how health services are delivered and paid for. The continued activity of American states in the face of reform failures at the federal level supports a hypothesis that experimentation at the state level could be the precursor for a successful national reform effort.

Identifying the Innovators

A first step in following through on this hypothesis was to attempt to identify states which were innovators in health care reform. Walker's (1969) approach to the study of policy diffusion seemed the perfect vehicle. In Chapter Three, eight health care innovations were used to rank the states according to how quickly programs were adopted. The findings seemed to support the results of Walker's study: states which he found to be innovators in several other policy areas continued to be leaders in health care reform as well.

Next, an attempt was made to identify independent variables which might help explain why some states were more innovative than others. The study determined that problem environment (particularly the aged population in a state) has a modest correlation with health care legislation. General policy liberalism of a state has a positive influence on the early adoption of health care reform, and regional influences are apparent in a few reform areas.

These findings also show that the communications networks between state governments may diminish the

significance of geographic location on health care innovation. Case studies in chapters four and five confirmed this view. In 1993, for example, a report on health care to the Oklahoma legislature featured a number of bills already passed by other states. An entire appendix of the document was dedicated to copies of such legislation, presumably to serve as a model for legislation in the Sooner State. Parts of several bills were included in legislation later passed by the Oklahoma lawmakers. In no instances was it apparent that Oklahoma adopted any of this legislation verbatim. Also absent was any sense of regional cue-taking. Oklahoma legislators were given models from literally every region of the country. Their goal was to pattern legislation after programs which had been successful (and politically viable) regardless of geographic origin.

Other Case Study Findings

As noted in Chapter Three, Hawaii ranked 49th in innovation scores for the eight policy innovations measured in this study. But the Aloha State has come closer to achieving universal coverage than any other state. How can this be? The case study revealed that Hawaii's reforms were passed in 1974 as part of a single comprehensive bill. State legislators enacted the program fully expecting Congress to pass a similar bill. The federal effort failed. Instead, Congress passed ERISA which actually made portions of the Hawaii Prepaid Health Care Act (PHCA) illegal. Most

damaging was the part of ERISA which prohibited states from requiring minimal health coverage outlined in the PHCA. The state was forced to seek a waiver which was signed into law by President Reagan in 1983. The waiver allowed provisions of the 1974 act to stand, but has prevented the state from incorporating many of the changes introduced by other states.

This not only helps to explain the state's low ranking in the aggregate study, but also offers an explanation as to why other states have been unwilling to adopt the Hawaiian model. In addition to unique geographic and political characteristics, diffusion has also been inhibited by federal preemption which has left the state unable to modify the PHCA in a manner which might make it more attractive to other state's seeking proven health care programs.

Oregon, rated fifth in Table 3.2, also attempted universal coverage, but like Hawaii, has not seen any other states adopt a similar program. The state would seem to be much more similar to a number of other American states, especially lacking the geographic and cultural factors which cause many to dismiss the Hawaiian model as impractical. The case study showed that many policymakers from other states had reservations about Oregon's emphasis on rationed care. Other states routinely ration health care indirectly by limiting access. Oregon chose to openly ration health services by putting a cap on the amount of money the state

would spend each year on health care services. The case study revealed a distinct political culture which enabled state politicians to find the political will to create and pass a program which might induce political suicide in most other states.

The final case study examined Oklahoma. Ranked near the middle of the aggregate study at number twenty-six, the Sooner State's conservative political culture is similar to that of several other southern states. The result has been an incremental approach which has seen the state adopt a number of programs based on legislation already in place in other states. There is no clear "Oklahoma model" other than a pattern of enacting programs which favor an open market approach to reform with an emphasis on participation by the private sector.

The Role of Technology

Improved technology (such as the internet, fax and e-mail) has made information easily available to nearly all legislators, staff members and bureaucrats. Also noticeable is a spirit of cooperation among policymakers and a willingness to share ideas across state boundaries. The growth of professional organizations among these groups has certainly aided this flow as well. Conferences that focus on single policy issues often bring together department heads, policy analysts and politicians in a setting which encourages the exchange of ideas. There does not seem to be

a chance that a successful health care reform will go unnoticed by other states.

The influence of technology is also evident in the speed of adoption by states. Walker's original study examined 86 different programs adopted by at least 20 states over a period of 115 years. In some cases, it took a century for 20 states to adopt an innovation. Diffusion was often a steady process, but states seldom shared information except with their neighbors. Improved communications seems to have expedited the process. Savage's (1985) study of 45 geographic-based diffusion efforts in the 1970s and 1980s shows diffusion occurring at a much more rapid pace across a number of policy areas. With few exceptions, the analysis in Chapter Three showed health care reforms examined in this study were passed within a four-year period. The threshold of passage by 20 states was usually reached within two years. Savage's (1985) research also seems to support the theory that the diffusion process is accelerating in a number of policy areas other than health care. Policymakers are much more aware now of legislative activity in other states and seem to be much more willing to exchange ideas and information.

Playing It Safe: Managed Care

While initially this new technology and a spirit of cooperation seemed to inspire the passage of a number of far-reaching health reforms, more recently speedy adoption

has also led to the quick passage of plans that are very conservative and politically expedient. The best example of this practice is the adoption of managed care programs for Medicaid patients. All but one state has now received or is in the process of receiving the federal waivers necessary to implement such programs.

In 1995, the number of Medicaid recipients in managed care grew 67 percent to almost 12 million people nationally. States have only recently begun to regulate the health care networks which administer these programs. Conservative Republicans, such as Wisconsin Governor Tommy Thompson, have warned against state or federal government efforts to micromanage these organizations. He argues that under managed care, preventative medicine has meant better health care for recipients and huge savings for taxpayers. According to Thompson, anything beyond minimal regulation would upset the market forces which have allowed competition to hold down costs (Thompson 1996).

Questions About Managed Care

Some segments of the health care community are beginning to voice serious reservations about the trend toward managed care. While they recognize the short-term savings for taxpayers, they have begun to question long-range implications. A recent article in JAMA (Brook, Kamberg and McGlynn 1996) asked physicians to consider eight questions relating to the tradeoff between cost savings and

quality of care in managed care systems. The authors did not attempt to answer their own question, they simply ask policymakers and others to consider the following:

1. Will quality care even remain on the agenda if the focus turns predominately to cost control?
2. How will physicians adapt to being concerned with the health of a population (HMO members) rather than individuals?
3. Will limits on contact between physicians and patients affect the quality of care?
4. Will cost containment be a clinically rational process?
5. How much regulation of health plans will the public be willing to accept?
6. How will the number of general practitioners and specialists be determined?
7. Will enough data be made available to patients for them to make major health choices?
8. Will high quality care eventually be made available to all segments of society?

These are questions which must eventually be dealt with, but presently, few states seem concerned with such issues.

Managed Care and Diffusion

When this study began, managed care was only one of several health care reform efforts being considered among the states. Now, managed care seems to have become the dominant choice of states. As a result, the entire health policy diffusion process seems to have slowed down and even stopped in some regions. States have chosen to address the problem of cost before access, yet the number of uninsured in the United States has continued to grow in spite of all

efforts. The fact that managed care does nothing (in the vast majority of plans) to deal with the uninsured population strengthens the argument that incremental plans may never lead to any type of universal health care coverage.

The most recent figures available show that the non-elderly uninsured population grew from about 33.5 million in 1988 to about 40 million in 1994. This represents a percentage increase from 15.9 percent to 17.3 percent of the population in those years. This increase occurred in spite of unprecedented reforms at the state level and a huge expansion of Medicaid coverage in the 1990s (Weissman 1996). If this growth continues at its current pace, another health care crisis will occur mainly due to the costs of uncompensated care.

Managed care indeed has been effective in reducing costs, but in the process has also eliminated the monies that have routinely been used for cost shifting in the past. Cost shifting is the practice of charging more to patients (or their insurers) who can pay for care to make up for the costs of uncompensated care those who either cannot afford to pay or refuse to pay. As the number of uninsured continues to grow, it is rational to expect the cost of uncompensated care to grow as well. When hospitals begin to close because of the cost of uncompensated care or an entire integrated network collapses due to these expenses, a new

health care crisis will emerge. It should be remembered that doctors and hospitals are required by law to render care in many cases regardless of the ability to pay (Splinter 1996). Clearly, states need to consider innovations which attempt to expand access to a larger segment of the population.

Medicaid Expansion

Even the expansion of Medicaid coverage by some states has done little to truly expand access. While Hawaii has few restriction on prospective patients, other states have established rules that often hinder participation. In Oregon, clients must now have incomes below the poverty level. In Minnesota, a person must be uninsured for the previous 12 months to enter the managed care system. In Tennessee, the TennCare demonstration program has been touted as the program with the most ambitious coverage goals. But TennCare requires that participants pay at least a portion of their health care premiums. In a recent one week period, the state dropped 21,000 people from coverage who failed to pay their share of the premiums (Weissman 1996).

Even if these types of waiver programs were extended in all states, it is estimated that as few as one-sixth of the previously insured population would participate (Weissman 1996). Proposed cuts in Medicaid at the federal level could force states to drop the number of participants in the

program rather than expand the numbers. The limitations of managed care are sure to become more evident as the program becomes more widely implemented. The cost savings currently being experienced could disappear under the weight of expanded uncompensated care.

Theoretical Implications of Managed Care

The proliferation of managed care can be explained by the growing acceptance of market solutions to public problems. The most complete articulation of this position can be found in public choice theory. Privatization, competition among states, market-driven programs, and subnational control are all tenants of public choice reviewed in Chapter One (Tiebout 1956; Breton 1991; and Wildavsky 1990). Managed care incorporates these components as well, making it the reform of choice for conservative governors and state legislators. The increased popularity of market approaches to social issues reflects the growing conservative movement in the U.S. which has seen the Republican Party make substantial gains in Congress and at the state level.

In its purest form, health care reforms based on public choice rely on citizens to "vote with their feet" by moving to other states when health services are deemed inadequate or too expensive. But the current state-managed care systems are populated mainly by Medicaid recipients and other segments of society unable to afford private

insurance. As a result, state policymakers have no incentive to provide health care services which are superior to those of other states. In fact, the opposite may be true.

The Race Toward the Bottom

The combination of block grants, welfare reform and managed care seem to greatly reduce the chances of a universal model emerging from the states. But more troubling is the possibility that states might reduce coverage and health benefits to avoid becoming health care magnets. An excellent future study would be the expansion of Peterson and Rom's (1990) theory on welfare magnets to the health care arena. Their study concluded that because states set benefit levels for welfare assistance in some programs, there is a wide disparity in the amount of money states disperse to poor families. States with comparatively higher benefits are likely to become "welfare magnets," states which both attract and retain the poor.

Several earlier studies support the idea of welfare magnets. Peterson and Rom use a case study of Wisconsin to relate how Republicans used the threat of welfare in-migration to lead a movement to reduce the state's welfare benefits. Other states have followed suit resulting in poor families being restricted in following job opportunities to other states. Peterson and Rom's solution is for the federal government to establish a minimum national welfare

standard. They theorize a reduction in interstate variation would reverse the current decline in benefits. Their plan would make some allowances for cost of living differences, but extreme variation in benefit levels among the states would be reduced.

There is mounting evidence that the "race to the bottom" in health care may have already begun. The fact that the only state to make significant strides toward universal coverage is Hawaii implicitly supports the magnet theory. Hawaii's unique geographic status and high cost of living would seemingly make it immune to welfare in-migration. Operating in isolation, it stands to reason that the state has been able to experiment with expanded coverage without worrying about attracting recipients from states with lesser coverage.

Residency Requirements

Managed care may even make it more difficult for Medicaid recipients to access health care. States had originally attempted to discourage welfare immigrants through the use of residency requirements. In the 1950s and 1960s, states often denied benefits to newcomers until they had lived in the state for 12 months. But in 1969, the U.S. Supreme Court ruled that practice unconstitutional and allowed new residents who were eligible to begin receiving benefits immediately.

Managed care, in effect, has further privatized public

health coverage. As noted previously, providers routinely deny coverage to persons who have not had health insurance coverage in the past year, and often establish waiting periods for persons with pre-existing conditions. Again, poor families may be less likely to move in search of a job if it means giving up health insurance coverage for up to a year.

Market-Driven Innovations

The fact that market-driven innovations have begun to dominate the diffusion arena should come as no surprise to those who even casually follow the American political scene. The conservative movement in the country has grown by convincing the public that government is not the answer to the health care problem. Politicians have been quick to acknowledge this call and have begun to temper plans for universal coverage. From a practical standpoint, however, it is difficult to imagine any type of universal care plan which does not have substantial government participation.

This study noted that the political culture and political ideology of a state are strong factors in determining the direction taken for health reform. But in the short term, a state's political culture may not be static. Oregon's rationing plan originally was to include a pay-or-play element for financing, but newly elected conservatives in the state legislature killed that portion of the plan. Health care policymakers have found out just

how strong the interest groups who profit from health care can be. If a state is spending a billion dollars on health care and attempts to change the delivery system, those groups whose livelihood are threatened often bring political pressure to bear on legislators. For the most part, these groups are well organized and regular contributors to political campaigns. When they speak, lawmakers listen.

Federal Welfare Reform

Though the Kennedy-Kassebaum bill indicates that the federal government can be responsive to innovation if enough states participate, recent welfare initiatives may cause states to rethink any future comprehensive reforms. It is unclear at this point exactly how much money states will lose in the new program, but the basis for the change is to set time limits for recipients of public support. It would seem that after five years, the federal government will allow states to keep people on the welfare rolls, but will not contribute any federal dollars. The block grant nature of the new welfare program may have implications for Medicaid as well. It may eventually force states to either abandon any open-ended Medicaid programs or substantially increase state taxes to sustain the current level of participation.

Familiar Faces

The same faces leading the political charge for reduced welfare benefits are also strong supporters of managed care.

For example, Wisconsin's Governor Tommy Thompson is a strong proponent of open market managed care. As Wisconsin's Assembly minority leader in 1986, Representative Thompson pushed through welfare cuts cited by Peterson and Rom (1990). He used the benefits issue as a base to capture the governor's seat. Thompson received serious consideration as Bob Dole's running mate in 1996 gaining national attention for his welfare reform efforts. His unabated support of managed care as a vehicle for public health reform should be viewed as a conservative version of health care reform which will likely be embraced by Republicans seeking elections to national and state offices.

Federal State Cooperation

The last few years have shown that not only is cooperation among the states on the increase, cooperation between federal agencies and the states has also been on the rise. Federal cooperation is essential for states when it comes to health care reform. Any access or cost containment plan which attempts to be truly universal in nature is going to have to integrate Medicare (a federal program), Medicaid (a joint state and federal program) and self-insured payers currently regulated by the federal government under provisions of ERISA. Managed care has been relatively easy to implement thus far because it only dealt with one segment of the population in an area where states already had administrative expertise. And as noted in Chapter One,

ERISA has stopped more changes in health care legislation at the state level than any other federal provision.

Final Observations

This paper used the framework of Walker's (1969) diffusion study in an attempt to identify independent variables which help explain why some states are more likely than others to be innovative in the health policy arena. The central conclusion reached is that diffusion of health care policy occurs most quickly in states which have traditionally been innovators in other policy areas. The study also found that innovation among states seems to be more frequent when federal preemptions are lifted usually through the waiver process.

The case studies went beyond the original parameters of Walker's study by attempting to trace the source of three states' innovations and making an effort to evaluate these efforts. States that have been the most active in creating and passing innovations have not necessarily been the leaders in cost control and/or improved access. To put it simply, innovation does not always equate with success.

This study also suggests that while states are proceeding with innovations in the health care arena, a lack of federal action will likely result in fifty separate health systems. Competition may actually tempt states to reduce access and coverage. Other stated goals of reform such as portability also become problematic when workers

attempt to move health insurance coverage from one state system to another. The same lack of federal oversight which encourages states to seek solutions to health care service problems may eventually lead to another health care "crisis" in the near future.

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