States Lead Way In Healthcare Reform

BY JANE H. WHITE

President Bill Clinton introduced facets of his healthcare reform plan at the National Governors' Association annual meeting on August 16, 1993, in Tulsa. That he chose to speak first to state leaders on this issue is a sign of the important role states are playing in the national healthcare reform effort.

In his speech, the president hinted at the leading role he envisions for states: "The states must have a strong role and essentially be charged with the responsibility and given the opportunity to organize and establish the health groups of people who will be able to purchase health care under the managed care system."

Clinton also appealed to the governors—his former colleagues—for support in the coming battle over the details of his healthcare reform proposal, which was expected to be released in late September. The tug-of-war with Congress over Clinton's economic plan served in some ways as a warning for what might be expected in the even more complex healthcare reform debate. Said Clinton: "Surely to goodness, we can stop wringing our hands and roll up our sleeves and solve this problem. And surely we can do it without the kind of rhetoric and air-filling bull that we hear so often in the nation's capital."

This column is the first of two examining the role of states in healthcare reform. This month I look at some of the states that have forged ahead, without waiting for Washington, as well as some of the early signs that the Clinton administration is eager to work with and learn from the states. Next month's column will look at the role Clinton envisions for states within his national healthcare reform plan.

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THE FRONT LINE

During the past several years, a number of states have pushed ahead with healthcare reform plans of their own. Concerned that the debate in Washington would take too long, and faced with rising costs and legal requirements to balance state budgets, these states have decided they could no longer wait for federal leadership in healthcare reform.

As states seek to balance their responsibilities to their citizens, the trade-offs between two key state functions—funding public education and ensuring access to healthcare for the most needy through Medicaid—have become real fiscal dilemmas. The political inability to raise new taxes has pushed the painful budget trade-offs to the fore in many states.

Indeed, states' healthcare spending has risen so precipitously that in fiscal year 1993 states spent more on healthcare than on higher education for the first time, according to the National Council of State Legislators. The fact that most healthcare is privately financed makes this finding all the more striking. State spending on Medicaid is expected to increase from $31 billion in 1990 to $81 billion in 1995 under current projections.

Rather than continue feeding the healthcare cost spiral, some states have recently enacted healthcare reform legislation. Twenty-seven states have formed commissions or task forces to develop reform proposals. Nearly all have been examining the issues of expanding healthcare access and controlling costs.

A number of elements recur among the pioneering states. Chicago-based health policy analyst Emily Friedman offered her list of common elements at the August 1993 annual meeting of the National Academy of State Health Policy (NASHP) in Pittsburgh. These include:

- A history of activist employers
- A high and well-established rate of group practice
- Some history of capitated payment
- A reasonably fair, effective tax structure
- A largely white population or, conversely, a population so diverse that no one group dominates
- A communal willingness to take care of each other
- Visionary community leaders

HAWAII

Hawaii has led the states in enacting healthcare reform. After passage of Medicare and Medicaid in the mid-1960s, in 1967 the Hawaiian legislature requested studies of temporary disability insurance and an employer-based system of universal healthcare. These studies led to passage of Hawaii's Prepaid Health Care Act in 1974. The act mandates that employers provide health insurance. Although this left a portion of the state's citizens uninsured (11.5 percent to 17 percent), it was a first step toward universal coverage.

Hawaii displays many of Friedman's requisite pioneering elements. The state has a strong history of capitated payment and a near monopoly of the insurance market by two groups (the Hawaii Medical Service Association—Hawaii's Blue Cross/Blue Shield—and Kaiser Permanente). The islands' plantation owners have a history of taking care of their own workers' healthcare needs. And strong public leaders emerged to shepherd reform through passage.

A key feature in Hawaii's effort to provide universal healthcare coverage is its exemption from the Employee Retirement Income Security Act (ERISA), which for many years has served as a barrier to other states. Passed in 1974, ERISA is "a complex federal statute that . . . preempts states from regulating and taxing employee benefit plans," explain researchers Allen Dobson, Donald Moran, and Gary Young of Fairfax, VA-based Lewin-VHI.[1]

More recently, Hawaii has struggled to cover the state's remaining uninsured citizens and to control rising costs. In June 1989 Hawaii enacted its State Health Insurance Program (SHIP) "to further shrink the gap group while providing comprehensive care and attention to prevention," writes University of Hawaii political scientist Deane Neubauer.[2] Under SHIP, the state government subsidizes coverage for those individuals unable to pay.

The SHIP target group includes the unemployed, dependents of low-income workers, part-time workers, immigrants, seasonal workers, and students, among others. Those earning less than the poverty rate are fully subsidized; others pay premiums on a sliding scale. To be eligible, Hawaiians must earn less than 300 percent of the poverty level and not qualify for Medicaid, Medicare, or other federal benefits.

An initial evaluation of the SHIP program in December 1991 showed that the state was far from reaching its enrollment goals because of "the continued difficulties of identifying precisely how many people lack coverage and enrolling these people when found," notes Neubauer. "The report estimates a current gap of 3 to 7 percent, significantly above the official 2 percent level."

In 1990 Hawaii launched its Governor's Blue Ribbon Panel on Health Care to advise the state on controlling healthcare costs and the broader picture of healthcare system needs. By April 1993 the state pushed ahead, announcing a reform of its Medicaid program, whose costs have continued to rise. Under this reform program, titled Health Quest, "the state hopes to contain its costs through promotion of managed competition for all publicly funded coverage, development of a comprehensive purchasing cooperative to be located within the Department of Human Services, and development of a basic benefit package common to Medicaid and SHIP recipients," explains Neubauer.

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It is interesting to follow Hawaii's development from employer mandates to the most recent overtures toward the managed-competition strategy favored by President Clinton. On the positive side, the widespread fear that small business would be devastated by employer-mandated insurance was not borne out in Hawaii's experience. On the downside, after nearly two decades, Hawaii still has not reached universal coverage; the persistent "gap group" should be noted by national reformers.

Although some reformers believe state efforts divert attention from and duplicate national reform plans, an observation by Alpha Center Associate Deborah L. Rogal and President W. David Helms proves insightful:

> In 1974 Hawaii's Chamber of Commerce opposed the Prepaid Health Care Act, believing that since national reform was once again before Congress, the plan soon would become subject to federal preemption. Many assumed then, as now, that universal coverage and health reform were a priority for the federal government and that state efforts, therefore, were unnecessary.[3]

FLORIDA

Among the pioneering states, Florida was the first to pass a managed competition–style reform plan. On April 29, 1993, Governor Lawton Chiles signed the state's Health Care and Insurance

Reform Act. The act creates 11 Community Health Purchasing Alliances; however, use of the alliances to purchase health insurance is voluntary, not mandated. In March 1992 the state reorganized its health agencies and created the Agency for Health Care Administration to eliminate fragmentation of its public health authority and to carry out future reforms. The state's ambitious goal is to cover all Floridians by December 1994. On the downside, Florida has not yet determined how it will pay for such coverage under its 1993 act.

Columbia University political scientist Lawrence D. Brown describes Florida's efforts this way:

> Part of the explanation for Florida's activism lies in "objective conditions" especially (1) a politically portentous split between voluntary and public hospitals and their for-profit competitors; (2) decidedly non-Southern support for governmental activism among the state's numerous liberal senior citizens; (3) a governor willing to extend himself farther than most of his peers in promising state reform and in working to advance it; and (4) a nexus of "blue-chip" (senior and savvy) legislators and staffs committed to forcing action and forging compromise.[4]

Florida offers three lessons to other states and to the nation about the necessary political steps toward reform, according to Brown. "First, most of the leading reform states prefaced their policy work with numerous and protracted inquiries by commissions and task forces." Although some have criticized extensive use of commissions as a delaying tactic, such extended discussions have clearly helped educate the leaders and state constituents in a way that "promoted confident action." Second, leading reform states have turned to the policy "club" of more radical reform, such as a Canadian-style system, as a potent threat that eventually results in more moderate, but serious reform action. Third, "the leading states were all adroit practitioners of the elusive art of legislative-executive relations," concluded Brown.

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WASHINGTON

In April 1993, just after Florida signed its healthcare reform act into law, Washington State passed its own version of reform based on managed competition. Some analysts say the Washington Health Services Act of 1993 is the most extensive state healthcare reform law to date.

As a first step toward covering Washington's low-income uninsured citizens, the state legislature authorized a demonstration project in 1987 that later become Washington's Basic Health Plan (BHP). By April 1992 more than 22,000 people were enrolled in this voluntary insurance program aimed at individual, not employer-based, coverage.

The new law calls for many elements that parallel President Clinton's plan: certified health plans (CHPs) of organized delivery systems offering a uniform benefit package; a state regulatory commission to define the benefit package, set uniform administrative rules, and set maximum premium rates, among other functions; health insurance purchasing cooperatives divided into four state regions (use is voluntary, however); and a phased-in premium cap to control costs.

To achieve near-universal coverage, the law requires all individuals to enroll in a CHP by 1999; employers with more than 500 workers must enroll their employes by 1995, and smaller firms by 1999. Reforms of Medicaid and Washington's BHP, insurance practices (such as preexisting condition clauses), and malpractice law are also in the 1993 act.

Carrying out these extensive reforms will require a federal waiver of ERISA requirements. The help of the provider community, while critical in ensuring passage of the law, will also be necessary in implementation. "Most of the health industry in Washington State believed that the changes were possible and, indeed, were compatible with more stability over time," noted Robert A. Crittenden, MD, who is health policy adviser to former Washington Governor Booth Gardner and currently on the faculty of the University of Washington.[5]

VALUE OF STATE INNOVATION

The Clinton administration has indicated it is anxious to learn from state activities, even while pursuing its own reform agenda. The necessary federal waiver process has been sped up enormously under the new administration. Oregon finally received its waiver on March 19, 1993, to expand its Medicaid benefits to more Oregonians by prioritizing treatments. Hawaii received a Medicaid waiver to proceed with a demonstration of its new Health Quest program in late summer 1993.

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HEALTH POLICY

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At the August 1993 NASHP meeting, Health Care Financing Administration Administrator Bruce Vladeck emphasized his commitment to improving his agency's action on requested waivers. Vladeck, a former New Jersey state health official, spoke of the "need to turn the Medicaid state-federal relationship from a financial one of just writing the checks, to a supportive-assistive, hopefully nonmicromanaged, [relationship] to improve quality and availability of services."

The three states described in this column—Hawaii, Florida, and Washington—represent but the tip of the iceberg in state healthcare reform activity. These three have in common elements of a managed-competition strategy that could provide invaluable insight for the national reform debate, should implementation proceed as envisioned in these states. Other states are pursuing play-or-pay strategies or more incremental reforms, and Vermont is studying a single-payer option. All these efforts will provide us with the critical information required to chart the uneasy course of reform. □

NOTES

1. Allen Dobson, Donald Moran, and Gary Young, "The Role of Federal Waivers in the Health Policy Process," *Health Affairs*, Winter 1992, pp. 72-94.
2. Deane Neubauer, "Hawaii: A Pioneer in Health System Reform," *Health Affairs*, Summer 1993, pp. 31-39.
3. Deborah L. Rogal and W. David Helms, "Tracking States' Efforts to Reform Their Health Systems," *Health Affairs*, Summer 1993, pp. 27-30.
4. Lawrence D. Brown, "Commissions, Clubs, and Consensus: Reform in Florida," *Health Affairs*, Summer 1993, pp. 7-26.
5. Robert A. Crittenden, "Managed Competition and Premium Caps in Washington State," *Health Affairs*, Summer 1993, pp. 82-88.

HEALTHCARE MANAGEMENT ETHICS

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Management of a capitated system calls for innovation and vigilance.

those values. This requires, for instance, measuring the network's quality of care and adopting practice guidelines.

Healthcare managers will need extraordinary leadership skills as they forge new, improved relationships with various care givers to ensure, above all, appropriate, high-quality services. This priority of values will not be realized unless healthcare delivery is understood as primarily a social good, a human service, indeed a ministry, rather than primarily a commercial transaction.

When such an understanding and ordering of priorities prevails, the financial arrangements between and among healthcare professionals and organizations, and the patterns of care that result, will be adjudged satisfactory by communities and individuals to whom healthcare professionals are primarily accountable and by care givers who will be assured they can honor their fiduciary responsibilities to their patients.

Understanding and effecting the right relationship among the values of community and patient well-being, quality, and cost containment are imperative to restore and promote the professional ethos of healthcare. Furthermore, conscientious healthcare managers who succeed in this regard should find their integrity rewarded as their networks are selected by many who recognize that the networks' criterion for decision making is the community's best interests. □

INTEGRATING SERVICES

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THE CHALLENGE OF A NETWORK

Continuing a network of service providers is a challenge, according to Kathleen Wilber, PhD, an assistant professor in the gerontology school at University of Southern California-Los Angeles, because of a "paradox in terms of how we develop services."

"The major problem with coordination of such a network is that we're trying to do two very different sorts of things," Wilber said. "We're trying to develop a systematic approach to service delivery—something that's predictable, that's organized—but we also need services that are adaptable, flexible, responsive. In developing and coordinating a system, we need to encourage diversity and innovation, and we need to have a lot of different kinds of providers."

Wilber said although everyone always talks about the need to eliminate duplication, flexibility and adaptability are more important because of the complex needs of the elderly being served. She advocates a system of "managed chaos" and pointed to the danger of overrationalization. "It's not a jigsaw puzzle," she said. "There will be some gaps, some overlaps."

By establishing a network, Wilber said, providers often assume they can enable the elderly to avoid nursing home placement. She points out, however, that this attitude views the network as a closed system and puts up barriers to ties with nursing home providers. Providers also often think that coordinated services are more efficient. However, the cost of such efficiency is great, she said. And coordinated services will only benefit consumers if they are also flexible.

"People view case management as the magic pixie dust of coordination," Wilber said. But she views fragmentation of services as a reflection of the complexity of the problems faced by the elderly. "We need some glue to bind us together, but not superglue—so that we don't create a system where no one can move independently and the structure creates problems for us." —*Susan K. Hume*