

Report from the United States

STATE HEALTH REFORM FLATLINES

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Massachusetts' recent health reform has generated laudatory headlines and a flurry of interest in state-based initiatives to achieve universal health insurance coverage. In 1988, a similar Massachusetts effort was also acclaimed and was imitated by several other states. Unfortunately, none of those efforts can be judged a success. The authors briefly review this earlier experience and caution against premature declaration of victory.

After seeming moribund for a decade, the drive for universal health care coverage shows signs of life. President Bush has proposed federal tax code changes to encourage the purchase of individual private health coverage and discourage very comprehensive, so-called gold-plated, plans. But most legislative activity has taken place at the state level.

Massachusetts' effort has attracted the most attention. Legislation passed in April 2006 promises near-universal coverage through an "individual mandate" requiring the uninsured to purchase their own coverage, with subsidies for poor and near-poor individuals. After the bill's passage, then-governor Mitt Romney declared: "Every uninsured citizen in Massachusetts will soon have affordable health insurance and the costs of health care will be reduced" (1).

Six weeks later Vermont enacted a plan offering subsidized coverage to poor and near-poor individuals, commencing in October 2007. If more than 4 percent of Vermonters remain uninsured in 2010, the legislature promises to consider making coverage mandatory.

California's Governor Schwarzenegger, and officials in several other states, have proposed similar mandatory coverage programs. And President Bush lent his imprimatur to experimentation at the state level, proposing to allow states to

International Journal of Health Services, Volume 38, Number 3, Pages 585–592, 2008
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doi: 10.2190/HS.38.3.k
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shift funds from safety net hospitals to innovative state programs to subsidize private coverage.

Between the late 1980s and the collapse of President Clinton's plan in 1994, several states passed measures intended to dramatically expand coverage. In this commentary we review the impact of this earlier round of reform on the number of uninsured, using time trend data from the U.S. Census Bureau's Current Population Surveys. The Census Bureau changed its survey methods in 1999 and produced estimates for that year using both the old and new methods, which differed by 5.5 percent nationwide (2). Hence, to ensure comparability with the post-1999 Census Bureau figures, we adjusted the earlier state estimates by the percentage difference between the Census Bureau's two 1999 estimates.

ALTERED STATES

The last round of reform kicked off in 1988. Like the present one, it started with Massachusetts legislation shepherded by a governor planning a presidential run. On passage of the legislation, then-governor Michael Dukakis announced: "I am very proud of the fact that Massachusetts will be the first state in the country to enact universal health insurance for all its citizens" (3). The *New York Times* editorialized that "Massachusetts last week ventured where no state has gone before: it guaranteed health insurance for every resident" (4). In 1988, 494,000 people were uninsured in Massachusetts. The number of uninsured has remained higher than that ever since (Figure 1A).

A year later Oregon made headlines with "the most far-reaching health care reform plan in the nation" (5), combining universal coverage with explicit rationing of expensive care. When the plan gained the federal waiver needed for full implementation, the governor said: "Today our dreams of providing effective and affordable health care to all Oregonians has come true" (6). The number of uninsured Oregonians did not budge (Figure 1B).

The year 1992 was the high watermark for state health reform; bills passed in Minnesota, Tennessee, and Vermont. According to the *New York Times*, "Minnesota is enacting a program that will be the most sweeping effort yet to provide health insurance to people who lack it. . . . Joy Wilson of the National Conference of State Legislatures described the Minnesota plan as 'the first complete reform proposal in the United States'" (7). The plan called for universal coverage by July 1, 1997. Between 1992 and 1997 the number of uninsured in the state increased by 88,000 (Figure 1C).

Tennessee's governor unveiled "the most radical health care plan in America" (8) and declared that "Tennessee will cover at least 95% of its citizens with health insurance by the end of 1994" (9). The number of uninsured dipped for two years, then rose to levels higher than ever (Figure 1D).

Also in 1992, "Governor Howard Dean, the only Governor who is a doctor, signed a law here today that sets in motion a plan to give Vermont universal

healthcare by 1995.” “This is an incredibly exciting moment that should make all Vermonters proud,” Dean said (10). The number of uninsured in the state has grown modestly since then (Figure 1E).

The next year Washington State passed “one of the most aggressive health care experiments in the nation, a program that would extend medical benefits to all 5.1 million residents of the state” (11). The bill called for universal coverage by 1999. Between 1993 and 1999 the number of uninsured in the state rose from 661,000 to 898,000 (Figure 1F).

By 1995, the *New York Times* was lamenting that “ambitious state plans to extend health insurance to more people took on importance as possible models for the nation. But nearly a year later most of those plans are dead or stalled as the states turn their attention to cutting budget deficits. Meanwhile the number of uninsured people is growing fast” (12).

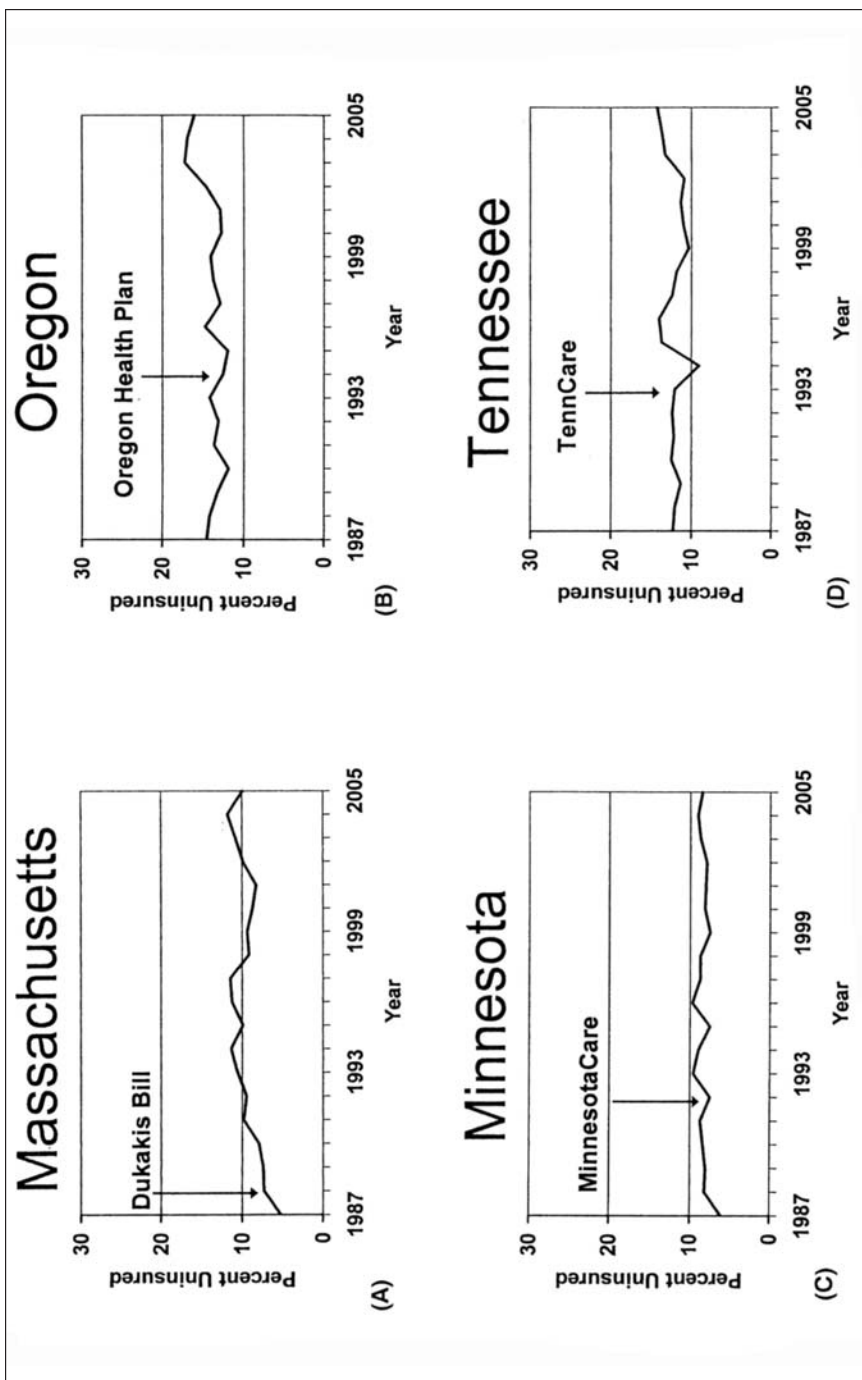
Heralding the new round of health reform, Maine passed its Dirigo Health Program in 2003. A *Boston Globe* columnist opined that “Maine has just become the first state in the union to approve a plan to provide universal access to affordable health insurance” (13). On signing the legislation, Governor Baldacci said: “It’s bold and comprehensive, and it is now the law of our state” (14). In 2006 the Associated Press reported that Dirigo “is now providing coverage to about 5,000 people who previously weren’t insured” (15)—about 4 percent of Maine’s uninsured (Figure 1G).

DOING THE SAME THING AND EXPECTING DIFFERENT RESULTS

The reforms enacted between 1988 and 2003 differed in detail but shared common elements. All offered new public subsidies or expanded Medicaid for poor and near-poor people. All left the bulk of existing private health insurance arrangements undisturbed, although many included new insurance regulations or state purchasing pools to help make affordable coverage available to individuals and small businesses. Dukakis’s Massachusetts legislation, as well as the reforms in Oregon and Washington State, included “employer mandates”—requirements that most employers cover their workers. The Massachusetts and Washington plans also mandated that self-employed individuals purchase coverage—prefiguring the individual mandates in the 2006 Massachusetts bill.

Why did these plans fail? While they made rhetorical swipes at cost containment, none included effective cost-control measures. As health costs soared, legislatures backed off from forcing employers and the self-employed to pay ever-rising premiums, and the mandates requiring employers and the self-employed to purchase coverage were repealed.

While Medicaid expansions incorporated in the state bills swelled Medicaid rolls, the erosion of private coverage continued, offsetting any gains. (Indeed,



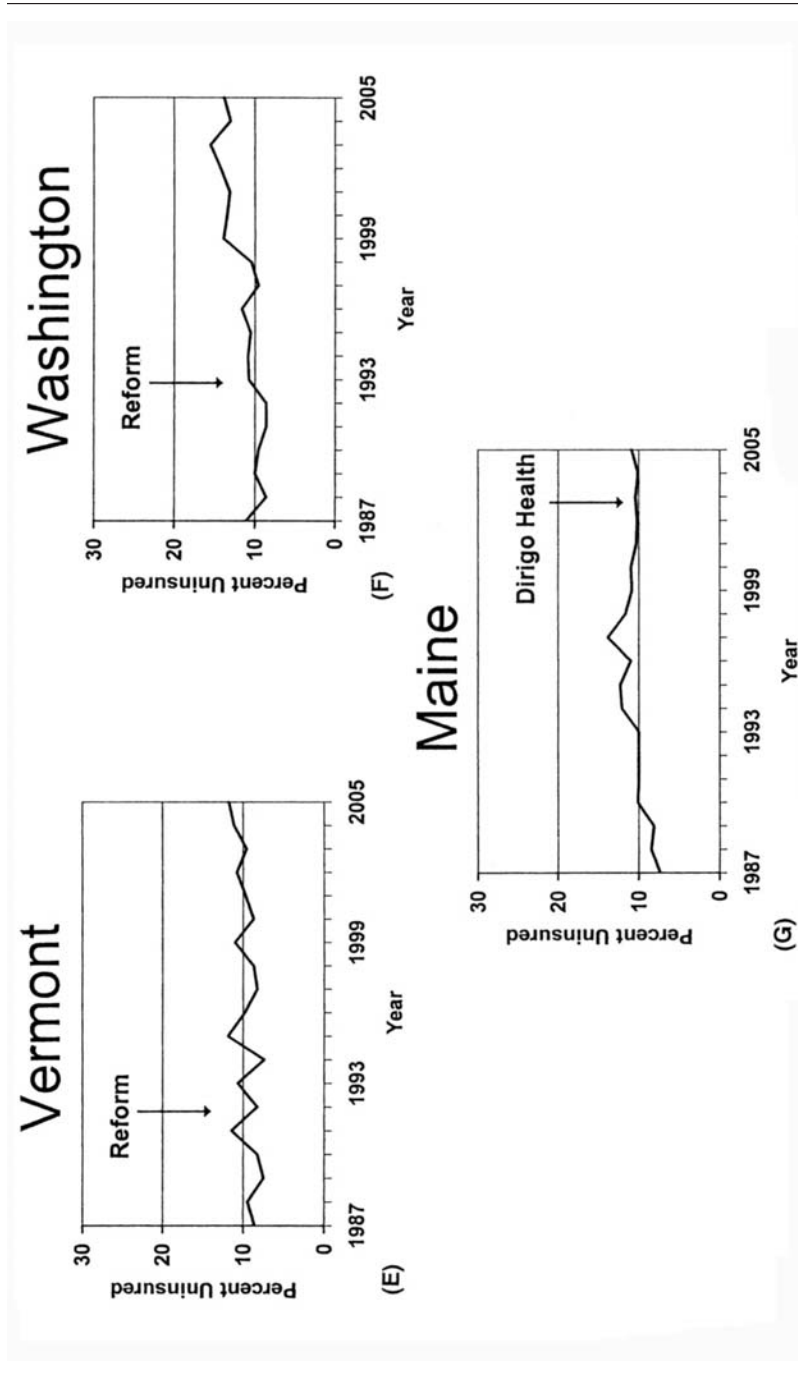


Figure 1. Percentage of uninsured in various U.S. states that have attempted state-level health care reforms, 1987–2005.

despite SCHIP—the State Children’s Health Insurance Program—which has added about 5 million children to Medicaid nationally since 1997, the number of uninsured children has fallen by only 2 million, while the number of uninsured adults has risen by nearly 7 million.) Moreover, relying on Medicaid has proved fiscally problematic for the states; when the economy cools, tax revenues fall just as unemployment pushes families out of private coverage.

Like earlier reforms, the recent Massachusetts reform, and those proposed in California, include expansions of Medicaid and requirements that most employers make at least token contributions toward health coverage. While some earlier bills required self-employed individuals to buy coverage, the new ones will impose this mandate on all uninsured people with incomes above poverty. As in several previous reforms, Massachusetts has organized a purchasing pool to help make coverage available to the previously uninsured, lower overhead costs in the individual insurance market, and spread the costs of high-risk individuals over a large risk pool. The new reforms rely on a new funding stream—the premiums (or fines) that the uninsured will be required to pay. But once again, effective cost controls are absent.

In Massachusetts, any savings from reducing the overhead on individual policies are being eaten up by the 4 to 5 percent surcharge that the new purchasing pool will add to premiums in order to fund its own operations (16). The legislature shifted responsibility for additional cost-control measures to a new council charged with setting goals, identifying quality improvement and efficiency measures, and setting up an Internet site to compare providers. Meanwhile, premiums for the new coverage will cost at least \$1 billion annually—probably much more. Funds diverted from the state’s existing free-care pool will cover only a fraction of this amount. And employer-provided coverage will predictably shrink as costs continue to rise, leaving the new program with an ever-larger responsibility for coverage.

Meanwhile, few of the near-poor uninsured seem able to afford even the newly subsidized policies (17), and the federal funds providing the bulk of the subsidies are set to expire in 2008. The unsubsidized coverage mandated for middle-income individuals (most of whom have incomes between \$30,000 and \$50,000) offers a bitter choice between unaffordable premiums (at least \$7,200 for comprehensive coverage for a single 56-year-old) or plans so skimpy (e.g., a \$2,000 per person deductible with 20% coinsurance for hospital care after that) that they hardly qualify as insurance. The religious coalition that was key to passage of the legislation has already called for a delay in enforcement of the individual mandate, fearing that it will place unbearable financial stress on many of the uninsured (18). In sum, neither government, nor employers, nor the uninsured themselves have pockets deep enough to sustain coverage expansion in the face of rising costs.

We remain convinced that more-radical reforms can simultaneously expand coverage and control costs (19). A shift from our complex and fragmented payment system to a simple single-payer approach could save about 14.3 percent

of total health spending—equivalent to \$323 billion in 2007—on reimbursement-driven bureaucracy (20). Such administrative savings are unattainable with lesser reforms. A nonprofit national health insurance system could also curtail wasteful over-investment in medical technology (e.g., the proliferation of new cardiac care hospitals located near existing ones) and attenuate incentives for unnecessary and even harmful care.

Powerful momentum for health reform is building. Previous reform efforts that built on existing but defective insurance arrangements have quickly succumbed to their faulty economic logic. Added coverage meant added expense, on top of already exorbitant costs. It would be shameful to squander the present opportunity on yet another round of reforms that are politically realistic but economically chimerical.

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