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AS WASHINGTON DITHERS, STATES REFORM HEALTH CARE

INTRODUCTION

That American health care costs are skyrocketing is something that just about every American knows. How much they are skyrocketing is clear from United States Department of Health and Human Services statistics: health spending in America reached $662 billion last year.

These soaring costs are putting enormous financial pressures on America's businesses, causing thousands of small firms to increase the employee share of health care costs or drop coverage altogether. And, of course, when the costs of compensating an employee increase, employers begin reducing the work force. Middle class Americans, meanwhile, find themselves struggling not only with higher taxes, but also with higher health care costs as a drain on family income.

While Washington seems politically paralyzed when dealing with health care, the states are moving. Almost every state legislature is considering some health care reform. And nearly every policy mooted at the national level is being debated in America's state capitals or actually is being put in place. Although these state experiments provide a rich source of information, however, very few state-based reforms address the root causes of out-of-control health care costs and gaps in coverage. Fewer still embrace reforms that would control costs by changing the tax treatment of health care to allow Americans to become health care consumers able to shop around for the best deal.

Straining State Budgets. States are interested in health care reform because health costs are consuming an ever greater portion of state resources. According to the National Association of State Budget Officers (NASBO), state Medicaid expenditures increased by 18.4 percent between 1989 and 1990.[1]

This federal-state health care program for welfare recipients now is the second largest budget item in many states, accounting for an average nationwide of over 14 percent of total state expenditures.[2] If current trends continue, state Medicaid expenditures will have increased more than 480 percent by the year 2000.[3] Programs for care of the indigent, state employee health insurance, and other health care expenditures are also severely straining state budgets.

It is no wonder that state legislatures are taking the initiative in health care reform. The initiatives differ widely from state to state. Some are exploring "employer mandates" that require employers to insure their employees. Many state plans are similar to the "play or pay" model proposed in Congress. Under these plans, such as the Massachusetts program, employers either must cover all their employees and their families with a minimum package of health benefits or pay a tax into a public program to cover uninsured families.

California, Colorado, Illinois, New York, and some other states, are contemplating universal health care or versions of national health insurance. Connecticut and South Carolina, meantime, have enacted laws designed to make health insurance more affordable and available for small businesses. Oregon is even planning to introduce explicit government rationing of Medicaid health care services.

Toward Universal Access. The pace of health care reform in the states should awaken the Bush Administration and Congress that it is time to fashion genuine health care reform. The aims of the reform would be to keep the American health care system the best in the world, to extend coverage to all Americans, to reduce costs, and to continue to allow Americans the freedom to choose their health care while giving them a broader range of choices.

The way to do this is through wider consumer choice of health plans and by reforming the tax treatment of health care to help the uninsured and spur consumer choice. This can be done by ending the tax-free status of company-based plans and introducing instead a system of tax credits for the purchase of basic health insurance and the payment of health care costs. By reforming the tax treatment of health care in this way, the federal government can achieve the objective of universal access to affordable health care without increasing the deficit.

EMPLOYER MANDATE PLANS

Many states feel that the only political and financial way to ensure that their residents have adequate health care is to shift the cost of health programs to the private sector. Because the Employee Retirement Income Security Act (ERISA) of 1974 prohibits states from directly mandating businesses to provide health insurance, several states are trying to do this indirectly through a "play or pay" system. By this, an employer is

1 *State Expenditures Report*, National Association of State Budget Officers, 1991.
2 *Ibid.*
3 *Rising Health Costs in America*, Washington, D.C., Families USA Foundation, October 1990.

taxed to pay for public insurance for the uninsured, with the tax on his business offset by a tax deduction for the cost of paying for private health insurance to his own workers. Thus, private employers either must pay for private health insurance for their employees or must pay a tax that will finance public insurance for them through a public program.

Only Hawaii currently mandates employers to pay for health insurance benefits in this way. Massachusetts did enact an employer mandate in 1988, but the program has never been put into effect because of fears that the measure would raise business costs significantly and create unemployment and an economic slowdown. Oregon includes an employer mandate as part of its controversial Medicaid reform program, but the employer mandate requirement would not take effect until 1995. Other states that considered employer mandates during this year's legislative session included California, Florida, New York, and Pennsylvania. None of the bills, however, passed

"PLAY OR PAY" HAWAIIAN STYLE

Hawaii is the only state ever to mandate directly that employers pay for health insurance for their workers. Under Hawaii's 1974 Prepaid Health Care Act (PHCA) employers must cover all workers who complete at least four consecutive weeks of work, who work at least twenty hours per week, and whose monthly wage is at least 86.67 times the minimum hourly wage. The insurance benefits must equal or exceed a state-defined package of minimum benefits. The employee's premium contribution cannot exceed 1.5 percent of his or her gross income, and co-payments and deductibles also are limited. Each employee must be given the option of purchasing dependent coverage, but the employer is not required to pay for this coverage.

The Hawaii statute grants few exceptions to these general rules. Government employees, seasonal farm workers, and small businesses, comprised of family members, for instance, are exempt from the law. So are employers with fewer than eight employees. Some firms qualify as economic hardship cases and may receive state subsidies to help with the cost of coverage. But the criteria for such cases are extremely narrow, and in practice few companies qualify.

The mandated minimum benefits include: 120 days of hospital care, outpatient surgical, medical, and emergency care; home, office and hospital physician visits; most common diagnostic services; and maternity benefits. The Hawaii law was amended in 1976 to add coverage for drug and alcohol abuse treatment to the minimum package. The law has been amended further since 1983, adding to the minimum package coverage for certain child health services, *in vitro* fertilization, new mental health and psychological services, and most recently, mammography.

Not a Full Mandate. Hawaii's experiment with employer-mandated insurance has not achieved its goals of universal coverage and cost control. Nor can the program be credited with the fact that nearly 98 percent of Hawaiian workers now have health insurance. In fact, Hawaiian employers have had a long-standing practice of giving their employees health care, in large part as a way of attracting workers in what has been a very tight labor market. Some 90 percent of all Hawaiian workers were insured before enactment of the 1974 law.[4] By some estimates, Hawaii's Prepaid Health Care Act

added just 46,000 individuals to the health insurance rolls. The Hawaii statute, moreover, does not mandate coverage of dependents, nor does it apply to the unemployed. As such, it is not, in practice, a full mandate. In fact, nearly 11 percent of the total Hawaiian population remains uninsured. This is only slightly below the national average of 13 percent.[5]

The other face of America's health care crisis is rising costs. Hawaii's reform has not appreciably controlled costs. In fact, health care costs are rising faster in Hawaii than almost anywhere else in the nation. Between 1980 and 1990, total health care spending in Hawaii rose 191 percent, considerably higher than the national average of 163 percent. Per capita health care costs in Hawaii in 1990 were $2,469, above the national average of $2,318.[6]

Unique Situation. Even though the Hawaii program falls far short in meeting its key objectives, some policy makers see it as the model for a national plan or for other states. They point to almost universal employer-paid coverage in Hawaii. Using Hawaii as a model, however, would be unwise, for in many respects, Hawaii is in a unique situation. First, and most important, Hawaii benefits as an island very distant from the U.S. mainland. Its isolation means that it is relatively more difficult for companies to move elsewhere if they feel that the cost of the health care mandate is onerous. This obviously is not the case with other states.

Second, Hawaii's position as a gateway to Asia makes it alluring to business and thus often worth the increased cost of doing business in Hawaii. Third, there were relatively few uninsured workers when the plan was enacted and few employers not already offering insurance. So the mandate was somewhat redundant. And finally, approximately 80 percent of Hawaiians are insured through one of two insurers, Blue Cross and Blue Shield or Kaiser Permanente. From the standpoint of regulatory authority, this makes the program much simpler to manage.

NO MIRACLE IN MASSACHUSETTS

The second major experiment to force employers to provide private health insurance is in Massachusetts. In 1988 the state legislature passed the Massachusetts Healthcare Plan (MHP) and Governor Michael Dukakis signed it into law.[7] The program was designed as a classic "play or pay" proposal. Employers with five or more workers were to pay a "medical security contribution" equal to 12 percent of the first $14,000 dollars in wages of each employee. Employers might deduct from this amount the cost of that employee's health insurance or other health care benefits. The money paid by the employer went to the state's unemployment and medical security funds. These would assure health insurance to individuals without health benefits through an employer.

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4 *Providing Health Insurance in the Workplace*, Washington, D.C., U.S. Department of Labor, 1988.
5 *Health Care in America: State Profiles*, Washington, D.C., American Association of Retired Persons, 1991.
6 Families USA Foundation, *supra*, note 3.
7 *An Act to Make Health Insurance Available to all Members of the Commonwealth and to Improve Hospital Financing*; Chapter 23, 1989.

The Massachusetts Healthcare Plan has never been fully put into place. Though the unemployment insurance fund with its mandated contribution is now functioning, the more important part of the program, the medical security fund, repeatedly has been postponed. It now is scheduled to take effect in 1994. That it will do so is unlikely because William F. Weld, who succeeded Dukakis as governor in January 1990, supports repeal of the law.

No Definitive Evidence. Since it has not gone into effect, there is no definitive empirical evidence of the impact of the Massachusetts Healthcare Plan. Studies indicate, however, that the program's cost to Massachusetts business during the first year of operation would have been $694 million, forcing businesses to increase spending on employee health care by at least 32 percent.[8] State-mandated health care spending also would throw thousands out of work as the cost of health care rose. Economists such as Clark University professors Attiat Ott and Wayne Gray estimate that the program, if fully in operation, would cost Massachusetts more than 9,000 jobs.[9]

Studies also indicate that the Massachusetts plan would not offer health insurance to those who cannot afford it. Of the Massachusetts residents currently without health insurance, meanwhile, some 58 percent have incomes above $20,000 and 15 percent have incomes above $50,000.[10] They would benefit from the program. As such, the program would subsidize health care for the middle class and the relatively wealthy at the expense of jobs for the poor and low-skilled.

As in many states, moreover, Massachusetts already has an uncompensated health care pool. This is a program in which the cost of unpaid hospital bills for those without insurance is distributed among all hospitals and, in effect, among all patients through higher service fees. Because of this program, there is no evidence that the poor in Massachusetts lack access to quality health care or that the new state plan would significantly improve access for the poor.[11]

Bumping Into Economics. The basic problem with mandating employer benefits is that such mandates bump into the wall of simple economics. The amount of compensation each worker receives for his or her work is directly related to that worker's productivity. Mandating an increase in that compensation by requiring the employer to provide health insurance does nothing to increase productivity. Thus one of two things happens: either 1) consumers must pay higher prices for products; or 2) more likely in a competitive economy, employers will be forced to reduce their payroll costs to offset these new and increased costs of health benefits. Payroll reductions may take several forms. One is a reduction in cash compensation, which in practice is unlikely. More probable is a reduction in the number of employees, either through layoffs or by postponing the hiring of new workers. In either case, unemployment increases, especially

8 Attiat F. Ott and Wayne B. Gray, *The Massachusetts Health Plan: The Right Prescription?* Pioneer Institute for Public Policy Research, Boston, Massachusetts, 1988.

9 *Ibid.*

10 *Ibid.*

11 For more detailed information, see John Goodman, Gary Robbins, and Aldonna Robbins, *Mandating Health Insurance*, Dallas, Texas, National Center for Policy Analysis, February 1989.

among low-skilled workers for whom mandated health benefits constitutes a relatively large increase in employee compensation.

Both economic experience and economic analysis thus suggest that governments would be making a serious mistake if they mandated that employers cover employees' health insurance benefits. Not only does such a mandate fail to address the fact that company-based insurance is rising rapidly in cost, but a federal mandate for specific benefit packages would limit the ability of employers to negotiate lower benefits with employees.

ALL-PAYER HEALTH CARE PLANS

Various state legislatures look to the Canadian-style universal health care system as a model, ignoring the mounting problems that the Canadians have been having.[12] The Canadian plan is a variation of what is called an "All-Payer" system, with the government responsible for financing the system and contracting with physicians and hospitals to deliver health care services.

Among the states that this year have been giving serious legislative consideration to such a plan are California, Colorado, Florida, Indiana, Iowa, Kansas, Minnesota, Missouri, New Jersey, New York, Ohio, Oklahoma, Oregon, Vermont, and West Virginia. State legislators supporting Canadian-style health care have formed a national network known as The State Alliance for Universal Health Care. They have found a sympathetic forum with the National Conference of State Legislatures (NCSL), an influential association of state legislators. By the end of the 1991 legislative sessions, however, none of these proposals had become law. Preliminary hearings were held in Rhode Island and Washington.

Although the Canadian system is a "national" health care system, it is actually twelve separate systems operated individually by Canada's ten provinces and two territories. It is financed jointly by the provinces and the federal government, much like the Medicaid system in the U.S.

Government-Operated System. The proposals considered by state legislatures this year varied greatly in their details. But all established a single-payer, government-operated, tax-funded system designed to ensure coverage to all state residents. Such plans generally would ban private insurance for any benefits included in the government plan. In practice, insurance companies would cease to function as insurers, and instead would act simply as reimbursement agencies on behalf of the government. The number of private insurance companies would shrink considerably under such plans. Recognizing this, Colorado's Canadian-style proposal even would have included funding to retrain unemployed private insurance agents.

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12 For a complete discussion of the failures of the Canadian health care system, see Michael Tanner, "Canadian Health Care in America: Prescription for Disaster," *The State Factor*, American Legislative Exchange Council, June 1991; or Edmund F. Haislmaier, "Perception vs. Reality: Taking a Second Look at Canadian Health Care," Heritage Foundation *Backgrounder* No. 807, January 31, 1991.

Another common feature of all the Canadian-style health care programs is that they are all very expensive. Virtually all the state proposals would guarantee expensive health benefits and require massive tax increases on state residents.

Example: In California Senator Nicholas Petris, a Democrat from Oakland, this year introduced a universal health care program giving all Californians a comprehensive package of medical benefits. His proposal included hospitalization, preventive care, primary and tertiary care for acute or chronic conditions, rehabilitative care, long-term care, mental health services, dental care, and prescription drugs. The Petris program would be funded through a 10 percent payroll tax on all employers. For small businesses, the tax would be phased in over three years. In addition, employees and the self-employed would pay a special tax. Also California would increase its tax on unearned income and a special tax would be levied on gross business revenues.

Example: In Ohio, a proposal called for a 9 percent payroll tax on total wages paid out by employers, and a 1 percent tax on employees.

Example: In Kansas, proposed legislation called for an 8 percent tax on the wages paid by firms, plus an 8 percent income tax surtax on the self-employed, and a 2 percent surtax on interest and dividends. Consumers would pay an extra 10 percent tax on beer, alcohol, and tobacco products, and a graduated surtax on the personal income tax running as high as 5 percent.

Example: In Illinois, a plan introduced this year would have cost state residents more than $12 billion per year. The Illinois plan would have been funded through higher personal and corporate income taxes as well as higher taxes on alcohol and tobacco.

Example: In Missouri, a plan costing $6 billion was introduced.

None of these proposals have passed into law.

PROPOSALS TO REFORM THE INSURANCE MARKET

Instead of considering employer mandates or government-financed insurance, some states have sought to reform the small group insurance market. The object of this is to make insurance more affordable to state residents who are uninsured or lack broad coverage, or to make it easier and less expensive for businesses to purchase insurance for their employees.

According to the Employee Benefits Research Institute (EBRI), a Washington-based research organization, nearly 85 percent of all Americans without health insurance are either employed or are a dependent of an employed person. EBRI reports too that nearly half of all uninsured workers are employed by a company with 25 or fewer employees.[13]

This is what prompts many states to find ways to make health insurance more affordable for small businesses. Proposals tend to feature two broad approaches: 1) the elimi-

nation of state-mandated health benefits in employer-based plans in order to bring down the cost of such insurance to businesses; and 2) changes in the laws governing the ways in which insurance companies write insurance benefits packages in order to assure wider coverage of state residents.

State-Mandated Health Benefits

There is a growing consensus that mandated health insurance benefits are a major contributor to rising health insurance costs, pushing health insurance beyond the reach of small businesses. Mandated benefit laws require all health insurance contracts written within a state to cover specific diseases and disabilities and to pay for specific health care services.

During the past two decades, state legislatures have enacted hundreds of such mandates, usually as a result of physicians groups wishing to have their specialty services covered by all insurance policies. In 1970, there were only thirty mandated benefit laws nationwide. Today, there are more than 700. Maryland alone has 49. These mandates cover services of all kinds of medical conditions, from AIDS to alcoholism and from acupuncture to *in vitro* fertilization.[14]

These mandates drive up the cost of health insurance. Blue Cross and Blue Shield of Maryland, for example, estimates that Maryland's mandated benefits requirements account for 13 percent of the costs of all claims paid.[15] Massachusetts Blue Cross and Blue Shield estimates that mandates add $54.74 to the monthly cost of each policy in that state.[16] These increased costs are particularly onerous for small businesses, which typically operate on very tight profit margins and in any case tend to pay more for health insurance coverage. As a result, many small businesses reluctantly choose to forego health insurance for their employees. Surveys show repeatedly that most small businesses would offer health insurance if they could. The Number One reason given for not providing insurance is cost.

No Frills Insurance. Increasingly state legislators are realizing that eliminating specific mandates will reduce the costs and make health insurance more affordable to small businesses. This common sense observation is behind the rapidly growing movement in many states to allow small employers to buy "no frills" or "bare bones" health insurance for their employees, stripped of requirements to provide many extra and costly services.

This means scrapping certain mandated services that are peripheral to a basic health care package for ordinary workers and their families, such as treatment for mental disorders or substance abuse. The National Federation of Independent Business (NFIB), a

13 *Update: Employees without Health Insurance*, Employee Benefits Research Institute, 1990.

14 For a general discussion of the problems of state-mandated health insurance benefits, see Goodman, et al., *State Mandated Health Benefits: The Wrong Prescription*, Washington, D.C., *The State Factor*, American Legislative Exchange Council, January 1990.

15 *Mandated Benefits Study*, Blue Cross and Blue Shield of Maryland, March 1988.

16 *Mandated Benefits Study*, Blue Cross and Blue Shield of Massachusetts, October 1988.

membership organization of some 500,000 small companies, estimates that basic policies free of state mandates could cost 25 percent to 45 percent less than plans containing state mandated benefits.[17]

This year, Arizona, Arkansas, Iowa, Maryland, Montana, New Jersey, North Carolina, North Dakota, and West Virginia enacted legislation to exempt small employers from mandated benefits. Sixteen states now permit "bare bones" policies for small businesses. In addition, Georgia passed legislation permitting such policies for individuals earning less than 200 percent of the poverty level.

Elsewhere, the terms of the debate are clearly shifting against mandated benefits as the social and economic cost of imposing such mandates sinks into the thinking of more and more state legislators. And while existing mandates have not been lifted in most states, lobbyists for physicians groups have found it increasingly difficult to secure new mandates. Typically, legislation establishing a mandated benefit in most states now requires that proposed mandatory benefit to undergo screening first to determine its cost-effectiveness and likely impact on the cost and availability of health insurance.

Underwriting Reforms

Along with limiting mandated benefits, several states have attempted to change those insurance underwriting practices that make it difficult for small employers to purchase health insurance.

Underwriting reforms were pioneered last year in Connecticut, and variations of the approach were passed this year in Colorado, Florida, New Jersey, North Carolina, South Carolina, and Vermont. Reform of health insurance underwriting is being promoted by a number of prominent health insurance and public policy groups, including the Health Insurance Association of America (HIAA), the Blue Cross and Blue Shield Association, the Golden Rule Insurance Company, the National Association of Insurance Commissioners (NAIC), and the American Legislative Exchange Council (ALEC), a membership organization of state legislators.[18]

Although the details of these reform proposals differ significantly in each state, they have certain features in common. These include:

- **Renewability of coverage.** Neither employer groups nor individuals within a group can have their coverage canceled because of deteriorating health of the group of insured or one of its members.

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17 *State Legislative Responses to the Health Insurance Crisis*, Washington, D.C., National Federation of Independent Businesses, August 5, 1991.

18 See, for example, *Health Insurers Finalize Small Business Coverage Reforms*, Washington, D.C., Health Insurance Association of America, March 1, 1991; *Options for Assuring the Availability of Private Coverage to Small Employers*, Blue Cross and Blue Shield Association, April 1991; *Report of the Subcommittee on Insurance Reform, Task Force on Health Care*, Washington, D.C., American Legislative Exchange Council, March 1991.

- **Continuity of coverage.** Once an individual obtains health insurance coverage in the small employer market and satisfies a plan's restrictions, that person should not have to meet those requirements again when changing jobs or when an employer changes carriers. Some variations of this provision for "continuity" go further by making an employee's insurance package "portable," enabling the employee to carry it from job to job.

- **Premium limits.** Carriers are restricted in how much they can vary insurance premiums between similar groups. Most plans and proposals also would limit the extent to which an insurer can increase a group's premium from year to year.

There is much less consensus, however, over another underwriting reform: "guaranteed issue." This is a technical term meaning that no small employer can be refused health insurance coverage by an insurer selling in the small group market. It also means that no employee within a small group can be rejected for coverage. "Guaranteed issue" virtually ends the current insurance practices of "experience rating" and "medical underwriting." By experience rating, an insurance company calculates future premium increases according to the frequency or amount of past insurance usage. By medical underwriting, an insurance company limits or denies coverage or sets the initial premium for coverage on the basis of the health status and expected risk of an insurance applicant.

Experience rating and medical underwriting can be applied either to an individual or a group, or an individual within a group. Because a guaranteed issue requirement increases the risk to the insurer, most such reform measures also include a mechanism to spread this additional risk throughout the entire group insurance market. Typically this is done through a reinsurance pool, in which insurers insure themselves against unusually high costs incurred in covering an individual or group.

Advocates of guaranteed issue reform argue that such a legal requirement is the only way to make sure that all small employers have access to affordable health insurance for their employees. Since small groups, by definition, are less able to spread the risks raised by high-cost employees than are large groups, many small employers cannot hope to meet traditional "experience-based" and medical underwriting standards.

Opponents of the reform warn that by adding these high risk employees to the total insurance pool, whatever the risk-spreading mechanism, the state will increase the cost of insurance for all small groups. This cost increase could be substantial. Some actuaries estimate that premiums could increase as much as 35 percent in some cases, and 15 percent to 20 percent on average. The increased cost thus might literally drive small employers out of the insurance market as fast as the underwriting reforms bring them in.[19]

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19 "Unintended Consequences," *Forbes*, April 1, 1991. See also Ted A. Lyle, "The False Promise of Small Group Reform," *Emphasis*, January 1991; Howard Bolnick, "Here We Go Again," *Best's Review*, 1986.

RATIONING HEALTH CARE

The Oregon legislature this year approved the funding and enforcement of one of the most controversial state health reform proposals in the country. In amending its state Medicaid law this year, Oregon guarantees all state residents under the poverty level a basic level of health care. Currently only residents with incomes below 58 percent of the poverty line are eligible for services under the Medicaid program, which is the federal-state health care plan for welfare recipients. But, while the Oregon program would extend coverage to more residents, it would not cover all services currently provided by the state's Medicaid program.[20] The plan currently is awaiting approval of the U.S. Department of Health and Human Services, which must agree to such changes in Medicaid coverage.

Oregon's Priority List. In accordance with the plan, the Oregon Health Services Commission drafted a priority list for health services ranking the medical services available to Oregonians. Issued this spring, this list ranks 709 health cost services by cost, the duration of a treatment's benefit, improvement in the patient's quality of life, and community values. Preventative services and diagnostic care are to be available to all recipients and were not included in the list.

With the $175 million appropriated by the Oregon legislature for the current fiscal year, the program will pay for the first 585 services on the priority list. This means that treatment for swelling of the esophagus is funded; disk surgery is not. Funded too are most childhood illnesses, treatment of most accidents and injuries, immunizations, services for treatable cancers, and payment for AZT, a drug treating those suffering from AIDS symptoms. Medicaid also will reimburse preventive care services such as mammograms.

Tax on Wages. The Oregon plan, if it goes into effect, will not cover some services currently provided by Medicaid. These uncovered items include treatments for illnesses that usually heal slowly without treatment, like viral sore throats and colds; conditions that respond to home treatment, like diaper rash and mild food poisoning; and treatments that are considered by public health authorities to be either ineffective or not cost-effective like lower back surgery, treatment for severe brain injury, care for very premature babies, advanced cases of certain cancers, and advanced cases of AIDS.

The Oregon program also contains a "play or pay" health insurance mandate on business. Small businesses would be allowed to institute a basic health benefits package similar to the package that the state delivers to the poor. Businesses failing to pay for health insurance for their employees would be subject to a tax on wages paid, as yet undetermined, starting in 1995.

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20 *Prioritization of Health Services: A Report to the Governor and Legislature*, Oregon Health Services Commission, 1991.

The Oregon program cannot take effect until it receives a regulatory waiver from the federal Health Care Financing Administration (HCFA), the division of the U.S. Department of Health and Human Services running the Medicaid program. A federal waiver would grant an exemption from certain Medicaid rules. The waiver request, however, is considered controversial by the Bush Administration. In addition, several liberal members of Congress, including Representative Henry Waxman, the California Democrat who chairs the powerful House Subcommittee on Health and the Environment, have indicated opposition to the Oregon program and may attempt to block it. The Oregon program is also coming under fire from anti-abortion activists and advocates for the disabled, who claim the plan's outcome-based priority decisions makes it discriminatory against premature babies and the handicapped.

Oregon's program is significant because it represents the first deliberate attempt by a government body to ration health care services. It provides a potentially important case study of the problems of providing access to health care within a fixed government budget. Since several reform proposals, such as Canadian-style plans, include a fixed budget, the workability of Oregon's rationing system may determine the fate of these proposals.

Special-Interest Battleground. As an explicit rationing system, the Oregon program already has become a battleground for interests associated with various disease constituencies and health care specialties. Groups are battling with each other to make sure that their needs or services are included in the list of covered services. Even before the program was enacted, legislators bowed to powerful political pressure by senior citizens groups and exempted the elderly from the program's rationing mechanism. AIDS activists and the lobbyists for the disabled are already demanding broader coverage and other groups are likely to follow their lead.

Critics of the plan see the cost control objective eventually being abandoned and relentless group pressure either to be exempted from rationing or to gain expanded coverage. If political pressure forces an expansion of benefits, the Oregon program will end up simply expanding the number of people eligible for state benefits without controlling costs.

LESSONS FOR THE STATES AND THE FEDERAL GOVERNMENT

Some state experiments on health care reform are based on sound ideas; others are not. What is crucial, however, is that the states are laboratories for reform. It is through this experimentation that good health care policy is likely to emerge.

To be sure, some approaches seem more likely to succeed than others. Instead of trying to mimic Canada, imposing employer-mandated health benefits, or adopting rationing, state lawmakers would do better to take actions that will make insurance more affordable for small business employees and their families. The most important reform would repeal state-mandated benefits for insurance packages, bringing down the cost of basic health care in the several states.

Wisely, the National Governor's Association this August emphasized the need for more state experiments. The federal government should give such state action a green

light by speeding up the waiver process—by which states are given temporary exemption from federal rules to permit innovative policies to be tried. The Bush Administration should grant waivers even when it is skeptical of the outcome, because testing theories—even though they may seem invalid—is the essence of experimentation.

Federal action is needed not just to encourage state experimentation, but also to change the perverse incentives in the tax treatment of health benefits. The current arrangement distorts state experiments because ordinary Americans are encouraged to make health benefit choices that guarantee inefficiency, rapid price increases, and gaps in insurance. Under federal tax law, money spent by an employer on a worker's health insurance is not counted as taxable income to the worker. Thus, even though that money is part of the worker's total wages, he avoids paying any income or payroll taxes on it.

Tax Relief. This tax treatment gives American workers and their families very generous tax relief on their medical expenses—but only on two conditions. First, they must purchase their medical care through health insurance. And second, they must purchase their health insurance through their employer.

In many cases, however, it would be more desirable or cost effective to purchase low-cost or routine medical care directly out-of-pocket rather than filing an insurance claim, or to buy a different health insurance plan than the one offered by the employer. Workers are heavily penalized for doing this because they receive no tax relief for doing so.

To make matters worse, a worker who has employer-sponsored health insurance, who is cost-conscious, and seeks out providers who offer good quality at good prices, is not rewarded, since he or she cannot pocket any savings. Moreover, physicians who dispense more services, regardless of their benefit, or charge higher prices, are rewarded with more income.

Weighing Price and Quality. Washington should complement state experimentation by ending the tax incentives that discourage low-cost health care. Specifically Congress should end the tax-free status of company-based health plans, making such plans appear as taxable income in the worker's W-2 form. Instead of this tax exclusion, Congress should enact a system of tax credits so that families can buy any health plan they wish, providing it exceeds at least a basic level of benefits determined by federal law. Such a tax reform would make the cost of plans clearer to families and would give them the incentive to pick the plan with the best combination of quality and price. Today they have little incentive to be concerned about price. It would also give tax help to those without company-based plans, permitting them to pay for a plan.[21] Because the current system is a product of the federal tax code, reform of the current system can be affected only by Congress, not the state legislatures.

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21 Stuart M. Butler and Edmund F. Haislmaier, eds., *A National Health System for America* (Washington, D.C.:The Heritage Foundation, 1989); Stuart Butler, "A Tax Reform Strategy to Deal with the Uninsured," *Journal of the American Medical Association*, May 15, 1991.

CONCLUSION

While health care policy analysts have focused on the debate in Washington, D.C., an intense battle is underway in America's state capitals over how to reform America's health care system. Virtually every state legislature this year has considered or enacted some type of health care reform legislation. Some have been good. Some bad. Many will affect the future of health care in America.

Driven by an understandable concern over the impact of skyrocketing health care costs on already fragile budgets, state legislators have sometimes reached for drastic solutions, such as rationing or employer-mandated insurance, which make matters even worse. The best reforms—such as a change in federal tax policy—can only take place in Washington, while many of the worst, such as Canadian-style universal care or mandated employer benefits, would be realized at the state level.

Important Guidance. While state legislators should be applauded for taking the initiative on health care reforms, they should nevertheless carefully examine the consequences of any reforms on access and quality and consider the economic consequences on businesses, employees, and taxpayers. The debate at the state level and the experience of programs already introduced provide important guidance.

Health care is an emotional issue. Since it accounts for one-eighth of the American gross national product, health care changes could also have a profound effect on the U.S. economy. It is important, therefore, that federal and state legislators pay close attention to the lessons of the reform movement at the state level.

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