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WORKING ON THE PUZZLE: HEALTH CARE COVERAGE FOR LOW-WAGE WORKERS

Louise G. Trubek[†]

INTRODUCTION

IN WINTER 2001, TWO UNLIKELY ALLIES—a health advocacy group (Families USA) and the trade association for health insurance companies (Health Insurance Association of America)—announced an agreement to develop a meaningful proposal to extend health care coverage to the uninsured, stating it “is not an intractable public policy problem but could be addressed if the various health care stakeholders could only find common ground.”¹ The announcement provided few details of the proposal. However, the optimism underlying the announcement of a consumer-health plan alliance is a reflection of events over the last eight years.

The Clinton health plan was an effort to achieve a seamless universal system through an elaborate, federally controlled, all-embracing system. The United States provides health coverage to people in three different systems: employment-based health insurance, public programs, and ad hoc treatment for the uninsured. Each system has its own complex regulatory and eligibility mechanisms that are governed at the state, federal, and local levels, as well as by the private market. The Clinton health plan was defeated in part because it was viewed as an attempt to replace these complex health coverage institutions with a mammoth bureaucracy. When the Clinton health plan failed, a gap was created in possible approaches to achieving the regulatory confluence. It left a public policy vacuum.

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¹ Charles N. Kahn III & Ronald F. Pollack, *Building a Consensus for Expanding Health Coverage*, HEALTH AFF., Jan.-Feb. 2001, at 40, 40.

In the intervening eight years, viable new approaches to expand health care coverage, termed "incremental," are emerging to fill the vacuum. The consumer-health plan alliance proposal reflects the belief that an incremental approach could be politically viable and effective. This belief reflects two major shifts: the movement down and the movement out. The movement down is the devolution of public programs and planning from the federal level in Washington, D.C. to the States. The movement out reflects privatization, which is an increased reliance on private institutions to satisfy public needs. The interaction of these two phenomena is creating a set of institutions that enable a vision of state-based/public-private approaches to expanded health care coverage.

This paper proceeds in three parts. The first part identifies the policy goals, authority, and funding that created the climate for transferring health coverage initiatives to the States. The second part documents the emerging public/private mechanisms that are developing to link the state-based health initiatives, allowing a seamless and horizontal structure. The final section develops proposals for closing the regulatory gap in order to advance the drive for expanded coverage.

I. THE MOVE TO THE STATES - THE MOVEMENT DOWN

The public policy vacuum created by the failure of the Clinton plan is being filled by state-based initiatives that provide coverage and access for low-income people. The moving down to the States for the expansion of health coverage to low-wage people can be viewed as another example of devolution of public services and functions to lower government levels.² There are two major factors for this specific development in health care: welfare reform intersecting with the lack of health coverage in the workplace, and the enactment of a children's health program combined with flexible federal standards. We will discuss these explanations using Wisconsin's BadgerCare as an example.

² See generally George A. Bermann, *Taking Subsidiarity Seriously: Federalism in the European Community and the United States*, 94 COLUM. L. REV. 332 (1994) (discussing President George W. Bush's Executive Order 12,612 and its preference for local governance); Donald F. Kettl, *The Transformation of Governance:*

A. Brief History of BadgerCare

Wisconsin has addressed the needs of the working uninsured with a new program titled “BadgerCare.”³ It is an outgrowth of the Medicaid program, which is the United States public health insurance program for low-income people.⁴ BadgerCare went into effect in 1999 to cover low-income families using a combination of Medicaid and a new federal program, the State Children’s Health Insurance Program (SCHIP). BadgerCare was developed as part of Wisconsin’s welfare reform initiative.

To be eligible for BadgerCare, a family must meet three general criteria. First, the family must be currently uninsured, have an income under \$26,000 for a family of three, and have no access to employer-based health insurance.⁵ Many families in BadgerCare at the higher income levels must contribute towards their health insurance premium. To a limited extent, these premiums help defray the cost of BadgerCare to the State.⁶ However, federal funds pay the bulk of the program.⁷ Those that qualify for BadgerCare receive care under one of the most expansive public health insurance programs in the nation.⁸

Since the program’s inception on July 1, 1999,⁹ BadgerCare has attracted more eligible people than expected.¹⁰ In a

Globalization, Devolution, and the Role of Government, 60 PUB. ADM. REV. 488 (2000) (discussing the federal government’s conscious strategy to avoid increasing its size through indirect administration).

³ The name derives from the State’s animal mascot, the badger.

⁴ KAISER COMM’N ON MEDICAID FACTS, THE HENRY J. KAISER FAMILY FOUND., MEDICAID, THE MEDICAID PROGRAM AT A GLANCE (2001) (on file with author).

⁵ WIS. ADMIN. CODE § 103.03(1)(f)(2) (2000) (requiring, under “non-financial conditions” for coverage, that the family currently not have health insurance and did not have it in the preceding three months).

⁶ See WIS. BUDGET PROJECT, WIS. COUNCIL ON CHILDREN AND FAMILIES, BADGERCARE COMING OF AGE: PROMISE AND REALITY 1 (2000) (indicating the proportion of BadgerCare’s funding from the federal government, Wisconsin, and enrollee premiums), available at <http://www.wccf.org/BC.pdf>.

⁷ See *id.* (indicating 71% for children and 51% for adults).

⁸ *BadgerCare Coverage is Among Nation’s Broadest*, WIS. STATE J., Aug. 27, 2000, at A3 (noting that Wisconsin is one of only ten States that pays for medical social workers’ services; one of twenty-eight states that pays for chiropractors’ services; one of thirty-eight states that pays for dentures; and one of fourteen states that pays for respiratory care services). For a comprehensive list of BadgerCare services, see WIS. STAT. ANN. § 49.46(2) (Supp. 2000).

⁹ See WIS. BUDGET PROJECT, *supra* note 6, at 1.

little over two years, 90,592 people have enrolled in BadgerCare, including 28,665 children and 61,927 adults.¹¹ BadgerCare's popularity extends into the political arena. For example, at the federal level, the focus during the Senate confirmation hearings approving former Governor Tommy Thompson to head the Federal Department of Health and Human Services was on the success of BadgerCare.¹² In Wisconsin, at the state level, politicians from both major parties are heavily invested in BadgerCare and want to see the program continue.¹³ The program is also popular among both rural and urban groups.¹⁴ Some legislators have attributed BadgerCare's bipartisan support to the efforts of local community collaborations and activists.¹⁵

B. Welfare Reform Interacting with Workplace Health Coverage Gaps

The welfare reform efforts of the mid-1990s converged with the lack of workplace coverage to create a driving force for state-based health coverage expansion. The combination of the welfare reformers' commitment to making work pay, the lack of health insurance coverage at the low-wage workplace, and the movement of authority and funding to the state level created an atmosphere for state-based initiatives in providing health coverage for low-wage workers. Change in the welfare system occurred at the federal level under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).¹⁶ This Act eliminated the Aid to Families with Dependent Children (AFDC) program and replaced it with a block grant program (called "Temporary Assistance to Needy Families"—TANF) to help needy parents end their dependence on govern-

¹⁰ See *id.* at 2 (indicating an initial enrollment of 65,147—6% higher than projected).

¹¹ Press Release, Wisconsin Department of Health and Family Services, October MA/BadgerCare Enrollment Maintains Momentum (Oct. 2001) (on file with author).

¹² Senator Peggy Rosenzweig, Address at the Covering Kids conference, in Madison, Wis. (Mar. 21, 2001) (notes on file with author).

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2113 (1996) (codified as amended throughout the U.S.C.).

ment benefits by promoting job training, work, and marriage.¹⁷ The block grant system gave States wide latitude on how to design their own system within broad federal standards. This is part of the trend toward devolution in public programs. Before welfare reform, people who received government income assistance under AFDC were automatically eligible for health insurance under Medicaid.¹⁸ Under the new TANF program, however, Medicaid is separated from government income assistance.¹⁹ Consequently, many former welfare recipients were dropped from Medicaid, even though they were still eligible.²⁰ Furthermore, the separation of Medicaid from income assistance complicated state attempts to “reposition the Medicaid program to help boost the transition to work.”²¹

Parallel to PRWORA, Wisconsin enacted its own legislation to replace the AFDC program with “Wisconsin Works” (or W-2).²² W-2 has been characterized as “an employment and training program, rather than a means of providing income support.”²³ To help make “work pay,” Wisconsin had to create a health insurance program for low-wage workers who were forced off the traditional welfare system and whose income would make them ineligible for the traditional Medicaid program.²⁴ Federal and state welfare reformers realized that people leaving welfare are less likely to work in jobs that offer health insurance, due to low-wage labor market characteristics. In the first years after welfare reform, one study found that “fewer than 25% of families leaving welfare for work reported having employment-based health coverage.”²⁵ Welfare reformers also recognized the importance of health coverage in promoting and

¹⁷ *Id.* § 401(a)(2).

¹⁸ HEALTH CHAIRS PROJECT, NAT’L CONFERENCE OF STATE LEGISLATURES, ISSUE BRIEF: WELFARE REFORM, MEDICAID AND HEALTH COVERAGE (July 1999), <http://ncsl.org/programs/health/forum/tanf2ma.htm>.

¹⁹ *See id.*

²⁰ *Id.*

²¹ *Id.*

²² Wisconsin Works Program Act, 1995 Wis. Laws 289, 1933.

²³ TERESA A. COUGHLIN ET AL., THE URBAN INST., HEALTH POLICY FOR LOW-INCOME PEOPLE IN WISCONSIN 23 (1998).

²⁴ *See* Louise G. Trubek, *The Health Care Puzzle: Creating Coverage for Low-Wage Workers and Their Families*, in *HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA* 143, 149 (Joel F. Handler and Lucie White eds., 1999) (stating that “[w]elfare reformers realized that changes in health insurance for low-income families were essential in order to have a work-based strategy succeed”).

²⁵ HEALTH CHAIRS PROJECT, *supra* note 18.

sustaining work. For example, “[h]ealth care promotes job retention; illness contributes to job loss.”²⁶ Additionally, postponing health care needs results in more costly care later on.²⁷

However, the issue of the relationship between low-wage workers and health care coverage propelled the welfare reformers to develop a program broader than covering those just leaving the AFDC system. They understood the resentment of the low-wage worker struggling without health care coverage who never was a welfare recipient. Thus, the advocates for Badger-Care intended the program to cover any family who had no coverage and was low-income. They were therefore forced to confront the complexity of the relationship between low-wage work and health care coverage. To understand the complexity of the relationship between work and health care in the United States, one must look at the sources of health coverage. Fifty-one percent of low-income people are covered by employer-based health insurance, thirty-five percent are covered by public programs such as Medicaid, and fifteen percent are uninsured. Although they are not required to provide health benefits to their employees,²⁸ U.S. employers carry the primary burden of providing health insurance coverage to workers.²⁹ This burden, however, has translated into a popular desire (and perhaps expectation) by U.S. workers to obtain health insurance coverage through employers, and not the government.³⁰ Unfortunately, employer-based insurance is not uniform across all types of jobs and workplaces. Low-wage workers over the past fifty years have moved from large-employer, manufacturing jobs to small employer, service jobs.³¹ As a result, rather than acquiring a

²⁶ *Id.*

²⁷ *Id.*

²⁸ Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1042 (1996).

²⁹ See *id.* at 1037 n.1 (noting that approximately 60% of Americans rely upon their employers for health insurance).

³⁰ Cathy Schoen et al., *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance*, THE COMMONWEALTH FUND ISSUE BRIEF (The Commonwealth Fund, New York, N.Y.), Jan. 2000, at 5, available at http://www.cmwf.org/programs/insurance/schoen_voteofconf_ib_363.asp.

³¹ See LAURA DRESSER & JOEL ROGERS, CTR. ON WIS. STRATEGY, REBUILDING JOB ACCESS AND CAREER ADVANCEMENT SYSTEMS IN THE NEW ECONOMY 1-2 (1997) (discussing how factors such as work restructuring, economic shifts toward service, declining firm size, and changing governance mechanisms have contributed toward the decline of a rational labor market).

permanent job with upward mobility possibilities, today's low-wage worker finds herself in 'dead-end' jobs.³² These jobs are found, for example, in the service, clerical, hospitality, and health care sectors.³³ Dead-end jobs are characterized as low-wage, having no upward mobility and offering few (if any) fringe benefits.³⁴ Furthermore, these jobs are often contingent (i.e., temporary, leased, or part-time), and are prone to a high rate of turnover.³⁵ Low-wage jobs also offer inadequate health insurance. Although Wisconsin's unemployment rate has been steadily decreasing since 1990 and is below that of the United States as a whole,³⁶ many low-wage employers may still find it difficult or unappealing to offer health insurance to attract low-wage workers.³⁷ "Many employers of part-time and temporary workers either cannot afford to pay insurance for their employees or simply do not want to invest in these workers who will not be around for the long term."³⁸

Thus, the welfare reformers undertook the mammoth job of creating a state-based health insurance program for low-wage

³² *Id.* at 3.

³³ Jennifer Middleton, *Contingent Workers in a Changing Economy: Endure, Adapt, or Organize?*, 22 N.Y.U. REV. L. & SOC. CHANGE, 557, 565 (1996); see DRESSER & ROGERS, *supra* note 31, at 2-10.

³⁴ DRESSER & ROGERS, *supra* note 31, at 3; see Stewart J. Schwab, *The Diversity of Contingent Workers and the Need for Nuanced Policy*, 52 WASH. & LEE. L. REV., 915, 918-19 (1995) (stating inadequate health care insurance is the greatest problem for contingent workers).

³⁵ Sharon Dietrich et al., *Work Reform: The Other Side of Welfare Reform*, 9 STAN. L. & POL'Y REV. 53, 57 (1998); see DRESSER & ROGERS, *supra* note 31, at 3 (providing the employee perspective of a hotel job as 'something to do for a couple of months').

³⁶ Wisconsin's unemployment rate in September 2000 was 3.6%, compared to the national rate of 3.9%. Compare BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, STATE AT A GLANCE: WISCONSIN (2001), <http://stats.bls.gov/eag/eag.wi.htm>, with BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, U.S. ECONOMY AT A GLANCE (2001), <http://stats.bls.gov/eag/eag.us.htm>. Furthermore, Wisconsin's unemployment rate fell from 4.6% in January 1990 to 3.3% in January 2000. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, STATE AT A GLANCE: WISCONSIN (2001), <http://stats.bls.gov/eag/eag.wi.htm>. Nationally, for the same time period, the unemployment rate fell from 5.4% to 4.0%. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, U.S. ECONOMY AT A GLANCE (2001), <http://stats.bls.gov/eag/eag.us.htm>.

³⁷ According to one small business group in Wisconsin, 81% of the group's members indicate that health insurance is needed to attract employees. Interview with Bill Smith, State Director, National Federation of Independent Businesses, in Madison, Wis. (Nov. 14, 2000). But, because of cost pressure, small businesses are struggling to continue with health insurance benefits. *Id.*

³⁸ Patricia Schroeder, *Does the Growth in the Contingent Work Force Demand a Change in Federal Policy?*, 52 WASH. & LEE. L. REV., 731, 735 (1995).

families in order to demonstrate that welfare reform could produce people who were working in decent jobs with health care coverage. BadgerCare was their creation. Since the reformers wanted to market the program to make it successful, they designed it to look like an insurance program rather than a welfare program. BadgerCare marketing reduced the stigma that often attaches to public benefit programs and thus has contributed to the program's popularity. Wisconsin has strategically marketed BadgerCare as an insurance program rather than public assistance. Researchers suspect that the stigma related to enrolling in public assistance programs such as Medical Assistance (MA) deters former recipients from reapplying for coverage.³⁹ Particularly in the wake of welfare reform, studies attributed some of the decline in MA enrollees to the stigma attached to the program.⁴⁰ According to one state official, "no one in the general public thinks of BadgerCare as welfare Medicaid. They think of it as an insurance program without the welfare stigma."⁴¹ A Wisconsin legislator partially attributed BadgerCare's large enrollment to the program's "cute name" and disassociation from welfare.⁴² The brochures that advertise BadgerCare describe the program as "Health Insurance for Working Families," and convey no connection to MA.⁴³ Consequently, more low-wage employees may be willing to participate in BadgerCare, especially since the program is a much better deal than most employer-sponsored insurance and is not viewed as welfare.

A remaining issue is how to interweave the private health care coverage, which is offered by many employers to low-wage workers, while offering BadgerCare to uninsured workers. The welfare reformers had to design a program that would not discourage employers from offering health coverage to workers, since the employer-based system was still necessary in order to reduce the overall number of uninsured families. It is an especially difficult task since even if a low-wage employer offers

³⁹ Bowen Garrett & John Holahan, *Health Insurance Coverage After Welfare*, HEALTH AFF., Jan.-Feb. 2000, at 175, 181.

⁴⁰ See *id.* at 175-76, 181 (describing some of the welfare reform legislation)

⁴¹ Interview with Angela Dombrowicki, Director, Bureau of Managed Health Care Programs, DHFS, in Madison, Wis. (Nov. 3, 2000).

⁴² Interview with Judy Robson, Wis. State Senator, in Madison, Wis. (Nov. 15, 2000).

⁴³ WISCONSIN DEP'T OF HEALTH & FAMILY SERVS.-PROGRAMS & SERVS., WISCONSIN BADGERCARE (June 1999), available at <http://www.dhfs.state.wi.us/badgercare/general.htm>.

health insurance, the cost of that insurance may be prohibitively high or the benefits comparatively low when compared to those offered in public programs such as BadgerCare. According to one study, “low-wage firms tend to pay a smaller percentage of premium costs and to offer policies with fewer benefits.”⁴⁴ For example, one temporary worker who earned \$11.50 per hour paid \$300 per month for health insurance to cover both herself and her children, absorbing a significant amount of each paycheck.⁴⁵ However, to receive the comprehensive benefits offered under BadgerCare, the most a family of three earning about \$27,000 annually would have to pay per month would be \$60.⁴⁶ Therefore, the benefits low-wage workers receive in employer-sponsored plans pale in comparison to the benefits offered in BadgerCare, especially when one compares the cost to the employee.⁴⁷

Wisconsin attempted to weave BadgerCare into the employer-based system through at least two techniques. One technique prohibited the potential enrollee from enrolling in BadgerCare if they had been covered by an employer-based plan in the prior three months. The second technique is the Health Insurance Premium Payment (HIPP) program. If the employer of a BadgerCare applicant pays for at least 80% of the cost of a group health insurance plan, the applicant is not eligible for BadgerCare.⁴⁸ If the applicant’s employer pays between 60% and 80% of the cost of a group health insurance plan, the applicant is eligible for BadgerCare, but may be required to participate in the HIPP or “buy-in” program.⁴⁹ The buy-in program allows the State to purchase the coverage offered by the appli-

⁴⁴ Nancy S. Jecker, *Can an Employer-Based Health Insurance System Be Just?*, in *THE POLITICS OF HEALTH CARE REFORM: LESSONS FROM THE PAST, PROSPECTS FOR THE FUTURE* 259, 262 (James A. Morone & Gary S. Belkin eds., 1994).

⁴⁵ Julia R. Henly, *Barriers to Finding and Maintaining Jobs—The Perspectives of Workers and Employers in the Low-Wage Labor Market*, in *HARD LABOR: WOMEN AND WORK IN THE POST-WELFARE ERA* 48, 65-66 (Joel F. Handler and Lucie White eds., 1999).

⁴⁶ WIS. DEP’T OF HEALTH & FAMILY SERVS., FACT SHEET – BADGERCARE AND FARM FAMILIES (2001), at http://www.dhfs.state.wi.us/badgercare/pdfs/factsheets/BadgerCare_farm_families.pdf (last visited Nov. 5, 2001). BadgerCare monthly income limits for a family of three earning between 185% and 200% FPL range from \$2,271.67 and \$2,438.34 respectively. *See id.*

⁴⁷ Interview with Angela Dombrowicki, *supra* note 41; Interview with Bill Smith, *supra* note 37.

⁴⁸ WIS. ADMIN. CODE § 103.03(1)(f)(3) (2000).

⁴⁹ *See* WIS. ADMIN. CODE § 108.02(13) (2000).

cant's employer if the purchase is more cost effective than providing coverage under BadgerCare.⁵⁰

C. Children's Health Coverage Funding Intersection with Flexible Federal Standards

The ambition of the Wisconsin welfare reformers to create expanded health care coverage for low-income workers might have encountered fiscal constraints if the infusion of additional federal dollars had not occurred. The enactment of the State Children's Health Insurance Program (SCHIP) in 1997⁵¹ created a new federally funded program, tied to Medicaid, for States to expand health care coverage. The quick passage of SCHIP was due in part to the national emphasis on children as a priority and was a direct outcome of the public desire to improve children's lives. The strong public support for coverage of children allowed the SCHIP program to have substantial outreach and consumer-orientation as states developed their programs. The significant outreach and streamlining that are part of the SCHIP program have now affected the view of how to design public programs. Wisconsin has used SCHIP funds to help support BadgerCare. Wisconsin applied for a waiver, which was eventually approved, allowing BadgerCare to cover both children and parents.⁵² Wisconsin argued that covering parents would increase enrollment of children. This waiver pushed BadgerCare into the national limelight, helping the program serve as a model to other states that wanted to expand health coverage to more workers.

The development of relatively easy waivers to obtain significant amounts of federal funding from both Medicaid and SCHIP have allowed the states to develop their own unique health care coverage programs. The use of federal waivers has become popular since 1993 with respect to Medicaid, and state application for federal waivers is steadily increasing. Although the federal government sets the terms and conditions by which

⁵⁰ *Id.*

⁵¹ Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified as amended at 42 U.S.C. §§ 1397aa-1397jj (1994 & Supp. V 1999)).

⁵² See COIMBRA SIRICA, THE MILBANK MEMORIAL FUND, THE ORIGINS AND IMPLEMENTATION OF BADGERCARE (Jan. 2001) (discussing the long negotiations between Wisconsin and the federal government to get the waiver), <http://www.milbank.org/010123badgercare.html>.

States must abide in order to receive federal funding for programs such as Medicaid and SCHIP, the federal government does allow States to apply for waivers to experiment outside the federal rules. According to one health policy expert, “after 1993, you can begin to see that the flexibility has become increasingly visible. The use of waivers to accommodate state diversity is pretty phenomenal under the Clinton administration.”⁵³

Thus, devolution in health care coverage has been rapid and diverse. The concern that welfare reform would leave many uninsured, the strong economy producing low-wage jobs, the availability of new federal funding and the loosening of federal control on the States have allowed the explosion of diverse state-based programs.

II. THE MOVE TO PUBLIC/PRIVATE COORDINATION - THE MOVEMENT OUT

The first section of this paper discusses the devolution of authority and funding to the state level. This “movement down” is allowing a variety of state-based initiatives expanding health care coverage. The second section of the paper describes another phenomenon in health care: the “movement out.” The movement out is a series of systems that link public and private organizations and is related to what is often called “privatization”—an increased reliance on the private institutions of society to satisfy public needs. The institutions involved in this shift are quite diverse, ranging from the marketplace to corporations, to charitable organizations and the family.⁵⁴ A contradictory situation was created when the welfare reformers pushed for state initiatives in health care coverage. The federal legislation known as the Employment Retirement Income Security Act of 1974 (ERISA), which regulates employer-based coverage, limited the regulatory power of the States over employer-based plans. Therefore, the States were given a space in which to provide programs, but have been limited in their abilities to coordinate with employer-based programs. The mechanisms for linking across States are emerging to fill this regulatory gap.

⁵³ *Id.*

⁵⁴ See JOEL F. HANDLER, *DOWN FROM BUREAUCRACY: THE AMBIGUITY OF PRIVATIZATION AND EMPOWERMENT* 6-10 (1996).

These mechanisms that link public and private organizations occur both within States and across States. They create the potential for seamless coverage through encouraging transfer of knowledge, funding, and influence. These linkages overcome the fragmentation of local level experimentation and the isolation of singular state innovation. They accomplish this through the intermeshing of a knowledge base and of actors. These knowledgeable actors are in a position to implement health programs and policies.

A. Collaborations and Delivery Systems Across the Community

1. Local Collaborations

For comprehensive and accessible coverage, it is essential to bring together local actors who share the necessary information. The complexity of local conditions that affect coverage requires detailed knowledge to insure that the system responds both to the local labor force and the types of health care coverage that are available. The collaborative model allows the variety of actors to share their information and “problem-solve” by collectively allocating responsibilities for program development and implementation. These collaborations encompass representatives from traditionally antagonistic or separate spheres.

Wisconsin’s BadgerCare program in Milwaukee has unique needs that required an approach different from the implementation in the rest of the State. Milwaukee has a distinctive experience with the “Wisconsin Works” program (W-2). The W-2 population remaining in the State is almost exclusively in Milwaukee. The entire county was divided into five regions and contracts were given to private for-profit and non-profit agencies to provide welfare services. The State, with the cooperation of local leadership, rapidly dismantled the former public system. One result of the confusion and inadequate community input was a substantial reduction in Medicaid enrollment.

The BadgerCare Coordination Network was formed to “[p]romote healthy individuals and families by providing easy access to publicly funded resources through collaboration and coordination by community organizations and local and state

government agencies.”⁵⁵ The Committee consists of the contracting W-2 agencies, state agencies, schools, HMOs, community clinics, and major health care providers that meet regularly. The Commissioner of Health for the City of Milwaukee indicated, “he has never participated in such a successful collaboration. We all look each other in the eye and won’t leave until we have decided on an approach to a problem.”⁵⁶ The Committee is largely responsible for the development of a simplified form for applying for BadgerCare. The Committee has also lead the initiative to coordinate closely with Milwaukee Public Schools in identifying and enrolling low-income families into BadgerCare.

Providing health care coverage to small businesses is the goal of the Wisconsin Coalition of Health Insurance Reform. Members include small business groups, government agencies, insurers, providers and health advocates. Agencies that administer public health insurance programs such as BadgerCare are unaware of the workplace conditions that the program enrollees and their employers experience. This information, however, is essential if the public and private systems are to merge successfully. The Coalition meets regularly to share information and to agree on advocacy for their proposed programs. Two major initiatives of the Coalition are to ensure that small and rural business voices are heard in the administration of BadgerCare and to secure passage of funding to initiate a small business health insurance pool, which would assist small businesses in obtaining quality and affordable private coverage. The collaboration sees the availability of health insurance as crucial to small and rural business viability.

2. Community-Based Delivery Systems

Community collaboration at the local level reveals the gaps not only in coverage, but also in service delivery. Local knowledge about the problems of access within a community is essential in order to provide accessible services to all people; “[b]ecause they are so local in nature, clinics have the ability to see trends in their communities and to adapt to them.”⁵⁷ Two

⁵⁵ Memorandum from the City of Milwaukee Health Department on a BadgerCare Coordination Network Meeting (Oct. 1, 2001) (on file with author).

⁵⁶ Seth Foldy, City of Milwaukee Health Commissioner, Presentation to the Collaboration for Healthcare Consumer Protection, in Madison, Wis. (Apr. 19, 2001).

⁵⁷ Lewis D. Solomon & Tricia Asaro, *Community-Based Health Care: A Legal and Policy Analysis*, 24 *FORDHAM URB. L.J.* 235, 262 (1997).

particular groups are often identified as having especially distinctive problems in delivery: women and illegal workers. There may be reluctance by women, especially teenage minority women, to use traditional facilities for birth control, abortions, and other health care services.⁵⁸ Community health programs allow secure spaces for clinical and educational services related to reproductive care.⁵⁹ The group with the highest number of uninsured is Hispanic;⁶⁰ undocumented aliens comprise a large percentage of the Hispanic uninsured.⁶¹ This shows not only in lack of insurance coverage, but also the low access and use of health care services among low-income adults.⁶² Community clinics and specialized migrant clinics have developed trust among these communities by providing culturally sensitive services and bilingual providers.

These community programs, sometimes called safety-net providers (hospitals, community health centers, and public health clinics), are often supported through private and public subsidies that enable these providers to deliver accessible and culturally appropriate services to difficult to reach populations.⁶³ These clinics are increasingly emerging as necessary participants in the overall health care delivery and financing system. Many serve as initial entry points into the health care system, and can serve as enrollment and outreach mechanisms as health care coverage expands. The health care delivery mechanism under BadgerCare is the health maintenance organizations (HMOs) that are serving Wisconsin residents, including Medicaid patients. That system encourages the HMOs to collaborate and contract with community clinics to provide services and ensure quality health care.⁶⁴ For example, Wisconsin requires HMOs to use "community groups, public health units,

⁵⁸ See NARAL FOUND., *THE REPRODUCTIVE RIGHTS & HEALTH OF WOMEN OF COLOR 2* (2000) (discussing how minority women face unique barriers restricting their reproductive freedom) (on file with author).

⁵⁹ See generally PLANNED PARENTHOOD FEDERATION OF AMERICA, *RESPONSIBLE CHOICES* (n.d.) at <http://www.plannedparenthood.org/pasadena/action/RespChoices.htm> (last visited Nov. 19, 2001) (discussing Planned Parenthood's agenda of providing services and information concerning reproductive health care).

⁶⁰ Alan Weil, The Urban Institute, Presentation for the Free Clinics of the Great Lakes Region, 5th Annual Conference (April 27, 2001).

⁶¹ *Id.*

⁶² *Id.*

⁶³ Lawrence D. Brown & Michael S. Sparer, *Window Shopping: State Health Reform Politics in the 1990s*, *HEALTH AFF.*, Jan.-Feb. 2001, at 50, 66.

⁶⁴ Trubek, *supra* note 24, at 144-45.

and schools to provide prenatal care, immunizations, and transportation to health care services.”⁶⁵ The contracting process between Wisconsin HMOs and community clinics is a subsidy that allows the maintenance and development of these clinics. Without the specific encouragement by the State to use these community clinics, the clinics may have disappeared because they would have been unable to compete with the traditional providers.

These community clinics are beginning to realize their importance in the overall system and are organizing for increased funding and advocacy. One example of linking community-based delivery systems is the Free Clinics of the Great Lakes Region (FCGLR). The FCGLR was established in 1996 to “formalize a grassroots network of free clinics in the Great Lakes states and draw attention to the hundreds of thousands of uninsured working poor in the United States.”⁶⁶ The FCGLR is producing local and regional data on the uninsured population and distributing this information throughout the network and community. They are also encouraging “partnering” with mainstream hospitals and clinics, linking with educational institutions who prepare health care professionals, and engaging of the community at large through churches, service organizations and media.⁶⁷ The FCGLR has also developed electronic networking using web pages and listservs.⁶⁸ The development of the group has been greatly assisted by small grants from national foundation funders.

B. Networks

The tremendous expansion of networks is notable. These networks provide sharing of experiences and actors across states. These networks overcome the critique that incremental approaches cannot lead to a universal system; they allow scaling up of the local programs. These networks permit knowledge and

⁶⁵ *Id.* at 145.

⁶⁶ FREE CLINICS OF THE GREAT LAKES REGION (2001) (discussing the program which consists of over 200 clinics throughout Illinois, Iowa, Indiana, Michigan, Ohio, Wisconsin, and Minnesota) (brochure on file with author). More information can be found on the organization’s website at <http://www.FCGLR.org>.

⁶⁷ *Id.*

⁶⁸ *Id.*

learning to spread rapidly.⁶⁹ They also allow rapid revisions when problems arise. There are three networks which are having a significant effect: government networks, advocate networks, and policy/foundation networks. It is notable that the three networks are in fact intertwined through shared funding and projects. It is also evident that these networks are significantly involved in local community collaborations and community service delivery.

The government networks include the National Conference of State Legislators (NCSL) and the National Governors Association (NGA). In 1995 NCSL created the Forum for Health Policy Leadership (the Forum) to “improve the capacity for informed decisionmaking and leadership among state legislators with respect to current and emerging critical health policy issues.”⁷⁰ The Forum is funded by private foundations such as Robert Wood Johnson, Kellogg, Kaiser Family, David and Lucille Packard, and Commonwealth.⁷¹ The Forum publishes joint papers with the NGA, the Center on Budget Policy Priorities, and the Alzheimer’s Association. It also hosts audio conferences with state leaders to learn about various approaches to expanding health coverage, such as school-based application processes for SCHIP programs. Their participant list consists of providers, advocates, and insurers, which ensures communication between various stakeholders about major health policy reform. The confidence among state government leaders in their ability to deal with complex health issues is substantially amplified by the staff support they receive from the Forum. The Forum’s publications allow ‘state legislators and others to compare notes and further stimulate innovative and responsive public policy.’⁷²

⁶⁹ For an interesting discussion of a similar phenomenon, which is called “intermediaries”, see Susan Sturm, *Second Generation Employment Discrimination: A Structural Approach*, 101 COLUM. L. REV. 458, 546 (2001) (discussing how “[i]ntermediaries play a pivotal role in the emerging structural regime as cross-boundary problem solvers who mediate the relationship between legal norms and organizational demands”).

⁷⁰ NAT’L CONFERENCE OF STATE LEGISLATURES, FORUM FOR STATE HEALTH POLICY LEADERSHIP (brochure on file with author).

⁷¹ *Id.*

⁷² NAT’L CONFERENCE OF STATE LEGISLATURES, FORUM FOR STATE HEALTH POLICY LEADERSHIP, STATE CHILDREN’S HEALTH INSURANCE PROGRAM CHARTBOOK, 2000, at i (Mar. 2001).

Advocate networks are emerging to share local and state information. The Center for Budget and Policy Priorities has developed the "State Fiscal Analysis Initiative" to build capacity in state-level nongovernmental organizations in state fiscal policies.⁷³ By 1999, the initiative had grown to twenty-two state-based organizations.⁷⁴ For example, Center for Budget and Policy Priorities funding enables the Wisconsin Council of Children and Families staff to track BadgerCare legislation and enrollment progress, and electronically transmit this information to a wide array of community groups. The importance of the Center for Budget and Policy Priorities' project is the use of nonprofit organizations to advocate at the state level using shared information on best practices across states. Thus, States generally viewed as having fiscal policies unresponsive to social needs, such as Alabama, have easy access to data from other States that provide more services. The linkages allow more uniformity in health coverage programs, since the budget process is crucial to health care decisions. The Center for Budget and Policy Priorities is establishing a parallel project on health care reform.

Another important program is the Covering Kids project, funded by the Robert Wood Johnson Foundation. This is a major financial investment in the creation of collaborative networks in many states to monitor and improve outreach and quality of coverage for children under the SCHIP program. Specifically, Covering Kids seeks to increase enrollment of low-income children in available health coverage programs by simplifying enrollment, conducting outreach, and coordinating program coverage.⁷⁵ Nonprofits play an important role organizing and administering these collaborative outreach efforts.

Supporting the governmental and advocate networks are a group of committed foundations that are providing millions of dollars in funding. These foundations also fund policy groups that produce data analyses and proposals on health. One example is the Assessing Federalism Program of the Urban Institute, a multi-year project to monitor and assess the devolution of so-

⁷³ CTR. ON BUDGET AND POL'Y PRIORITIES, THE STATE FISCAL ANALYSIS INITIATIVE (n.d.), at <http://www.cbpp.org/sfai.htm> (last modified Oct. 30, 2001).

⁷⁴ *Id.*

⁷⁵ LOUISE G. TRUBEK & JENNIFER J. FARNHAM, CTR. FOR PUB. REPRESENTATION, INC., HOW TO CREATE AND SUSTAIN A SUCCESSFUL SOCIAL JUSTICE COLLABORATIVE 11 (2001).

cial programs from the federal level to the state and local levels. Of particular interest is the Urban Institute's own national survey of American families, a reliable and targeted statistical indicator on health for low-income families. The Assessing Federalism program provides its report for free and informs thousands of people, by email and web sites, of its availability.

The success of these networks is directly related to developments in technology that allow rapid dissemination of information through audio conferencing, email, listservs, and web sites. In addition, States now provide access to their statutes, regulations, and legislative and administrative processes on government web sites. Previously, such information was very difficult to obtain and share across states.

C. Creating a System for Outcomes and Processes

The emergence of data-driven systems for health care access and quality is a manifestation of the movement out. Starting with the Clinton Administration, the federal grip on what States could do loosened, allowing easier experimentation. This loosened grip allowed States to differentiate their programs and try different ways of providing service. The regulatory gap could have allowed a variety of coverage options to develop without standards for access and quality across states since Congress was unwilling to provide a federal set of standards. This effort to fill the gap has been led by large employers and government agencies in conjunction with other nongovernmental organizations. These actors have created and participated in systems for data collection and analysis that permit health care providers, insurers, state and local agencies and community organizations to participate in, obtain information on, and monitor health care access and quality. There is now an increased use of data collection analysis and benchmarking systems.

State, federal, and private agencies are creating a series of organizations and create standards that provide comparative information that operates across state lines. These allow centralized monitoring of the access and quality of health care delivery at the local level. Private, nonprofit organizations such as the National Commission for Quality Assurance (NCQA) have fostered a system of voluntary certification on quality, used as a benchmark by the industry and increasingly referenced by government agencies. The information is based on standards developed by NCQA in a consensus process. NCQA develops sys-

tems to measure and compare HMOs on quality indicators, dubbed the Health Plan Employer Data and Information Set (HEDIS). Wisconsin now statutorily requires quality assurance standards, and is relying on private accreditation systems. These certification systems not only allow actors to review quality across state lines, but may also affect health care coverage. For example, to earn NCQA certification, HMOs must certify they serve Medicaid enrollees.⁷⁶

State agencies are also using data collection and benchmarking systems to monitor privatized contracting systems. When welfare reform began in Wisconsin, health advocates realized that the new system, which included contracting out of services, could have a potentially negative effect on the number of recipients of health care coverage provided through Medicaid. Since there was confusion about the Medicaid entitlement and the potential for people to have income exceeding the traditional limits, BadgerCare was created specifically to provide a bridge program for those individuals. However, there was the hope that many recipients would obtain jobs that provided private health care coverage. To encourage the contracting agencies to help individuals seek jobs with health care coverage, the advocates sought and obtained evaluative standards in the contracts between the State and the agencies administering the program. It placed responsibility on the private agencies that were administering the benefits program to reach a benchmark figure. To ensure continued efforts to reach and exceed the benchmark, local agencies regularly report on their compliance with the standard. Moreover, there are regular meetings among state officials, contracting agencies, and other community advocates to monitor compliance and progress in meeting the benchmark. The standards and data from these meetings are available to the public and much of the work, including the minutes of the monitoring committee meetings, is made available on the state web site.⁷⁷

⁷⁶ Seth Foldy Presentation, *supra* note 56.

⁷⁷ DEP'T OF WORKFORCE DEV., WIS. WORKFORCE SOLUTIONS, W-2 CONTRACT & IMPLEMENTATION COMMITTEE: MINUTES (2001), available at http://www.dwd.state.wi.us/desw2/w2min/2001_minutes.htm.

III. THE NEXT STEP

The recent consumer-health plan alliance, which places expanded health care on the table, is based on their assessment of the importance of emerging state initiatives and development of horizontal linkages. The alliance notes that the time is ripe for a "common effort" toward expanding health care insurance in America.⁷⁸ They argue that a meaningful proposal should achieve "a balance between public- and private-sector approaches, focus attention on those who are most in need of assistance (low-income workers), and build on systems that work today."⁷⁹

There are three challenges to conceptualizing a workable proposal: linking public and private plans, effectively meeting workplace and workforce needs, and integrating the safety net into the mainstream health care financing system. For the seamless knitting of public and private insurance, data collection about employer health plans is essential. For instance, there are legal and managerial challenges to coordinating BadgerCare with private health insurance. The potential for mixed coverage, where some of the cost to the private employer is subsidized through a buy-in from public programs, can only be achieved through intensive knowledge of employer-based health plans. Wisconsin statute allows a buy-in program, where the State may buy into the employer-sponsored health plan if it is more cost-effective than covering the low-income family solely in the BadgerCare program.⁸⁰ However, the lack of information about workplace coverage is a barrier to using this statutorily allowed program. The rapid turnover of low-wage workers also requires a health care coverage system that can move with the worker from job to job so they do not lose coverage. This requires close coordination between the patterns of employment and character-

⁷⁸ Kahn & Pollack, *supra* note 1, at 47.

⁷⁹ *Id.* at 40.

⁸⁰ Interview with Don Schneider, Chief of Coordination of Benefits Section, Department of Health and Family Services, in Madison, Wis. (Feb. 23, 2001) (noting that cost-effectiveness is based upon the cost of a BadgerCare participant enrolled in a managed care plan compared to the cost of the wraparound coverage and extra administrative costs provided in the HIPP program). The HIPP program pays the wrap-around costs of the employer plan so that the HIPP enrollee receives the same benefits as they would under BadgerCare alone. *Id.* As of the end of February, 2001, approximately thirty-four families were enrolled in the HIPP program, mostly with smaller employers. *Id.*

istics of the workplace with access and cost of health care coverage. Another reason why linking public and private programs is essential and challenging is the disparate reimbursement rate for health care professionals among public and private health plans. Public programs reimburse providers at a much lower rate than private health plans. This has been justified, historically, as a type of “charitable” contribution. This is no longer viable with the increasing number of for-profit provider groups and expanded coverage by public programs. Unifying public and private programs requires the support of these health care professionals. An adequate reimbursement system, not based on whether coverage is public or private, is essential.⁸¹

A second challenge is expanding eligibility non-custodial parents, part-time workers, and self-employed workers. Currently, 18% of the uninsured are people without dependent children.⁸² There is a proposal to expand BadgerCare, for example, to cover people who have an obligation to support children, though the children are not living in their household. These people are currently not covered by BadgerCare. The argument is that these “noncustodial parents” are often unemployed and in poor health because they are uninsured. Expanding BadgerCare to cover this group would encourage them to find and keep steady employment so they could help support their families.⁸³ Another uninsured group are part-time and self-employed workers. Traditionally, no health coverage is available for these workers, though their numbers are increasing.

Finally, incorporation of community delivery systems into the health care coverage financing streams is essential to sustain health care coverage and access for disenfranchised groups. Groups such as teens and undocumented workers are reluctant to access coverage even if they are eligible for programs. The community agencies providing care for these groups are underfunded and often unable to provide in-hospital care.

These challenges can be overcome through clarifying how the health care system is to be governed. ERISA can be amended to encourage state-based approaches. ERISA makes it difficult for States to access pertinent health information and

⁸¹ See generally Sidney D. Watson, *Commercialization of Medicaid*, 45 ST. LOUIS U. L.J. 53, 55-56 (2001) (noting how “Medicaid fee-for-service reimbursements average less than fifty percent of private insurance payments”).

⁸² Alan Weil Presentation, *supra* note 60.

⁸³ Seth Foldy Presentation, *supra* note 56.

coordinate public benefits with employer-sponsored plans.⁸⁴ Any new proposals require federal laws that deal with health coverage organizations to work in conjunction with one another. Secondly, the horizontal mechanisms now developing should be amplified and studied. The intersection of local collaborations with national programs and funding is a move in the right direction.

The foundation for a strong alliance to confront these challenges seems to be emerging. The consumer-health plan initiative demonstrates an assessment that the time may be near to take on these challenges. There are two interest groups who may be interested in joining the consumer-health plan alliance to achieve expanded coverage: businesses and physicians. Large business has been a major beneficiary of the regulatory gap since it has allowed them to control health care costs with little government intervention. Out of this control has evolved innovative quality and benchmarking systems, which are affecting the way health care is delivered through using public and private agencies across the nation. Large businesses may be willing to support some standard setting by the federal government as long as they maintain control over the financing of their health coverage programs. Small businesses realize that in order to compete for skilled workers, they must provide health care coverage. Many small businesses are now willing to endorse proposals that include public programs which enable them to maintain their businesses. Physicians have been ambivalent in their support for public programs since their reimbursement rates are significantly lower in those programs than in employer-based insurance. They may be willing to support expanded public programs that create a more uniform relationship between public and private coverage in order to achieve a more uniform and reasonable reimbursement rate.⁸⁵

CONCLUSION

The failure of the United States to provide universal health care for all residents is a continuing policy disaster. It affects

⁸⁴ See NAT'L GOVERNORS ASS'N, POLICY POSITION HR-37: PRIVATE SECTOR HEALTH CARE REFORM POLICY §§ 37.2-.3 (2000) (stating that ERISA presents "one of the greatest barriers to some state reform initiatives"), http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_555,00.html.

⁸⁵ See generally Brown & Sparer, *supra* note 63 (discussing "catalytic federalism" and its potential as a health care reform strategy).

the health status of many people and contributes to the spread of illness and disease. The attention within the United States to the continuing puzzle of our inability to cover all our residents is now connected to the character of our workforce and our attitude toward welfare policy. Covering all workers has captured bipartisan political attention and is a focus of business concern.

Proponents of expanded health coverage are now seizing on systemic changes in the relationship between local and national governance, and public and private agencies. Proponents envision using these paradigmatic shifts to create a new, broad consensus for health system reform. Many obstacles remain, including economic trends and fiscal constraints. However, the combination of broad collaborations at the local level and new, unlikely alliances among policy leadership demonstrates the potential for solving the health care puzzle.

