


Advancing Toward Universal Coverage: Are States Able to Take the Lead?

Lisa Dubay

Christina Moylan

Thomas R. Oliver

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>

 Part of the [Health Law Commons](#), and the [Health Services Administration Commons](#)

Recommended Citation

Lisa Dubay, Christina Moylan, & Thomas R. Oliver, *Advancing Toward Universal Coverage: Are States Able to Take the Lead?*, 7 J. Health Care L. & Pol'y 1 (2004).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol7/iss1/2>

This Article is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

ARTICLES

ADVANCING TOWARD UNIVERSAL COVERAGE: ARE STATES ABLE TO TAKE THE LEAD?*

LISA DUBAY, Sc.M.*
CHRISTINA MOYLAN, M.H.S.**
THOMAS R. OLIVER, Ph.D., M.H.A.***

INTRODUCTION

The number of Americans without health insurance exceeds forty-three million, and leaders at all levels of the political system are again raising the question of whether the United States can and should pursue universal health coverage through public policy. A second but equally important question is whether the pursuit of universal coverage is best initiated at the federal or state level. National, comprehensive strategies to assure health coverage for all Americans have had little success over the past century.¹ While federal

* This article is based on the presentation of the same name by Thomas R. Oliver at the conference, *State Efforts to Expand Health Care Coverage: Current Realities, Future Possibilities?* held at the University of Maryland School of Law Baltimore, MD, on November 18, 2002.

* Lisa Dubay, Sc.M., is a Principal Research Associate at the Urban Institute where she directs research on the effects of expansions in public programs on insurance coverage, access and use, and on health outcomes. Ms. Dubay is an expert on Medicaid and SCHIP eligibility and is the Co-Director of the Urban Institute's SCHIP evaluation. She is also a doctoral student at the Johns Hopkins Bloomberg School of Public Health.

** Christina Moylan, M.H.S., is a doctoral student at the Johns Hopkins Bloomberg School of Public Health. Previously, she worked for the Michigan Public Health Institute helping to develop and implement community-based models for expanding health care access. She has also worked on implementation of the State Children's Health Insurance Program at the Centers for Medicare and Medicaid Services.

*** Thomas R. Oliver, Ph.D., is Associate Professor of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. Professor Oliver attended Stanford University where he received his bachelor's degree in Human Biology. He received a master's degree in health administration from Duke University and a doctorate in political science from the University of North Carolina at Chapel Hill. His most recent work focuses on the political history of Medicare and prescription drug coverage; state efforts to expand health insurance coverage; the role of foundations in shaping health policy; variations in Medicare payments for graduate medical education; and, generally, the roles and strategies of leaders in health policy innovation.

1. See generally THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* (2d ed. 2000); THEDA SKOCPOL, *BOOMERANG: CLINTON'S HEALTH SECURITY EFFORT AND THE TURN AGAINST GOVERNMENT IN U.S. POLITICS* (1996); David J. Rothman, *A Century of Failure: Health Care Reform in America*, 18 J. HEALTH POL., POL'Y & L. 271 (1993) (noting the failure of a national health care

policymakers debated and ultimately defeated proposals to provide universal coverage, a few states demonstrated that the obstacles to comprehensive reform can be overcome and that it is possible to approach, if not completely reach, the goal of universal coverage. What was it about these states that made such action possible and can it be replicated in others? What role would the federal government have to play to assure success of a state-based strategy to achieve universal coverage?

This article explores three alternative strategies for achieving universal coverage, debates the merits and limitations of each, and examines lessons learned from previous federal and state initiatives. The article concludes with observations about the most feasible course of action to achieve the goal of universal coverage and sets forth the elements of a successful federal-state partnership in this regard. The analysis that follows sets forth the reasons why, for the foreseeable future, comprehensive reform is not likely to be enacted at the federal level. We argue that a state-based path to universal coverage is plausible, but without a considerable federal commitment of resources and perhaps relief from the Employee Retirement Income Security Act (ERISA), universal coverage for the nation will remain a dream for its advocates.

THE INCREMENTAL BIAS IN AMERICAN HEALTH POLICY

Universal health insurance coverage remains elusive in the United States, not because the American public disagrees with universal coverage as an appropriate end, but because of entrenched interests and disagreement over the means for achieving this goal. A recent poll conducted by the Kaiser Family Foundation found that two-thirds of Americans agree that the federal government should guarantee universal health coverage for all Americans.² However, the same poll found that Americans were divided about whether government should make a limited or a major effort to provide coverage for the uninsured.³

Over the years, a wide range of proposals have been floated to address the problems of the uninsured, including new public insurance programs, insurance market reforms, tax credits, and comprehensive overhauls of the entire health care system. Yet efforts by several presidents over a span of five decades to establish a national system of health insurance have failed and, despite some comprehensive

system to develop throughout the past century); Sven Steinmo & Jon Watts, *It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL., POL'Y & L. 329-372 (1995).

2. THE HENRY J. KAISER FAMILY FOUND., KAISER HEALTH POLL REPORT: PUBLIC OPINION ON THE UNINSURED (Jan./Feb. 2003), available at <http://headlines.kff.org/healthpollreport/templates/summary.php?feature=feature3> (last visited Jan. 31, 2004).

3. *Id.*

legislative initiatives, few states have come close to providing universal coverage. In the past decade, federal action moved swiftly from the comprehensive reform plan of the Clinton administration and Republican proposals to radically overhaul Medicare and Medicaid, to a more selective, incremental series of initiatives such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁴, the State Children's Health Insurance Program (SCHIP)⁵, the Medicare+Choice program, and proposals to provide outpatient prescription drug coverage for Medicare beneficiaries.⁶

The inability of the United States to achieve universal coverage at either the federal or state level is perhaps best explained by Charles Lindblom's theory that public policy typically develops through a process of "disjointed incrementalism."⁷ He argues that policy makers accomplish change by limiting their focus to incremental alternatives, differing only slightly from status quo policies.⁸ They are constrained by "bounded rationality," and do not consider all possible policy options or weigh all possible consequences.⁹ Instead, policy is remedial rather than proactive, and policy makers tend to seek agreement on current, discrete problems that need to be addressed (e.g., uninsured children, seniors without prescription drug coverage, portability of insurance across jobs) rather than attempt to reach agreement on more fundamental policy goals (e.g., the desirability of expanding coverage through public versus private insurance programs).¹⁰

The incrementalist perspective also recognizes the role of interest groups and negotiation in policy making. Due to what Lindblom calls the "social fragmentation of analysis," even when everyone agrees there is a problem, the

4. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of 29 U.S.C. and 42 U.S.C.).

5. Balanced Budget Act of 1997, § 4901, 42 U.S.C.A §§ 1397aa – 1397jj (West 2003).

6. See generally DAVID G. SMITH, ENTITLEMENT POLITICS: MEDICARE AND MEDICAID, 1995-2001 (2002) (arguing that both the ambitious Clinton health care plan and the Republican sponsored Contract with America tried to enact sweeping policy reforms which were unsuccessful; instead, future reform must be the product of bipartisan efforts which constitute small alterations to the current health care system rather than sweeping change); Mark A. Peterson, *The Politics of Health Care Policy: Overreaching in an Era of Polarization*, in THE SOCIAL DIVIDE: POLITICAL PARTIES AND THE FUTURE OF ACTIVIST GOVERNMENT 181 (Margaret Weir ed., 1998) (detailing the politics surrounding the health care reform proposals under President Clinton and a Republican Congress).

7. See Charles E. Lindblom, *The Science of "Muddling Through,"* 14 PUB. ADMIN. REV. 79, 84-87 (1959) (discussing incrementalist theory as a means for public policy formulation) [hereinafter Lindblom, *Science of Muddling Through*]; Charles E. Lindblom, *Still Muddling, Not Yet Through*, 39 PUB. ADMIN. REV. 517, 518-19 (1979) (further clarifying incrementalist theory by distinguishing simple incremental analysis, disjointed incrementalism, and strategic analysis) [hereinafter Lindblom, *Still Muddling*].

8. Lindblom, *Still Muddling*, *supra* note 7, at 520.

9. Lindblom, *Still Muddling*, *supra* note 7, at 518.

10. Lindblom, *Science of Muddling Through*, *supra* note 7, at 84.

solution is crafted by way of negotiation and compromise.¹¹ Michael Hayes notes that this process generally leads to watered-down policy outcomes, “given a lack of consensus on means or ends, outcomes will represent little more than lowest common denominators acceptable to a sufficient number to permit action.”¹² Under these conditions, “[l]arge policy change will occur gradually, if at all, through a process of feedback or ‘successive approximations’ as experience with minor policy changes gives rise to new demands for modification or expansion, setting off a new policy cycle.”¹³ In essence, the policy process is never-ending.

The theory of incrementalism is often used not only to explain but also to justify policy outcomes. Hayes, for example, acknowledges the argument that incremental or small changes produce better results than comprehensive reforms because it gives policymakers the opportunity to propose solutions, learn from their errors, and make corrections downstream.¹⁴

Hayes also argues that other features in the U.S. political system create a significant bias in favor of incremental policy change.¹⁵ These include the disproportionate political resources and influence of interest groups that oppose redistributive and regulatory reform; the lack of cohesive political parties; and the constitutional design of American government, which fragments power and establishes procedural hurdles that require large majorities to enact major reforms.¹⁶ Some critics consider these institutional barriers to be the primary culprit in the death of the Clinton health plan, for example.¹⁷

This theory, however, does not account for the fact that, in the last two decades, the federal government and a handful of states have adopted important reforms—many of them quite comprehensive—in a short time period. At the federal level, the enactment of the State Children’s Health Insurance Program (SCHIP) as part of the Balanced Budget Act of 1997 was a major milestone that established a new basis for public health insurance coverage and opened up a new stream of federal funding for that purpose. The initial scope of the program is modest—overall enrollment of SCHIP hovers around four million while the Medicare and Medicaid programs each have around forty million beneficiaries.¹⁸

11. See DAVID BRAYBROOKE & CHARLES E. LINDBLOM, *A STRATEGY OF DECISION* 104 (1963) (noting that policy formulation is fragmented between many points, hence, compromise and negotiation are required between the participating actors).

12. MICHAEL T. HAYES, *INCREMENTALISM AND PUBLIC POLICY* 13 (1992).

13. *Id.*

14. *Id.* at 20.

15. *Id.* at 27.

16. *Id.* at 27-40.

17. See, e.g., Hugh Hecl, *The Clinton Health Plan: Historical Perspective*, 14 HEALTH AFF. 86, 94-97 (1995); Steinmo & Watts, *supra* note 1, at 334-36; 361-65 (1995).

18. CTRS. FOR MEDICARE & MEDICAID SERVS., FY 2003 FIRST QUARTER EVER ENROLLED DATA BY STATE – TOTAL SCHIP, available at <http://www.cms.gov/schip/er2003q1.pdf> (last visited Jan. 31, 2004) (listing the total number of children ever enrolled in SCHIP for the first quarter of 2003); CTRS.

However, SCHIP sets an important precedent, and if children's health insurance or expansions to other populations became an even higher priority, the institutional framework to incrementally expand insurance to well over ten million beneficiaries is now in place. In the 2004 presidential campaign, indeed, several Democratic candidates have proposed guaranteeing coverage to all children and in some cases, young adult dependents.¹⁹ At the state level, a few states were able to initiate complex overhauls of their health care systems to provide near-universal coverage.²⁰

These major initiatives support John Kingdon's contention that deviation from incrementalism is possible when an abrupt shift in how a problem is perceived, or in who controls the levers of governmental power, opens a "window of opportunity" for policy innovation.²¹ If advocates are able to couple their preferred policy alternative with the prevailing problem definition and political conditions, then robust change can occur within a short timeframe.²² These early successes lead us to question what factors were in place to facilitate change and whether they can be replicated in the near future.

STRATEGIES FOR ADVANCING TOWARD UNIVERSAL COVERAGE

Jonathan Oberlander and Theodore Marmor surveyed past and current proposals for reform and concluded that there are three basic strategies for achieving universal coverage.²³ They categorize these options as "federalist," "pincer," or "single payer" in design.²⁴ Although this is not an exhaustive set of strategies, Oberlander and Marmor provide an excellent organizational framework from which to launch a discussion about how to achieve universal health care coverage in the United States and the essential role of the states if there is to be any immediate progress toward that goal.

The "federalist" strategy, according to Oberlander and Marmor, relies on a combination of state-driven innovation and substantial federal resources, rules, and

FOR MEDICARE & MEDICAID SERVS., 2002 DATA COMPENDIUM, available at <http://www.cms.gov/researchers/pubs/datacompendium/2002> (last visited Jan. 31, 2004) (listing enrollment figures for the Medicare and Medicaid programs).

19. See SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, HEALTH CARE REFORM RETURNS TO THE NATIONAL AGENDA: THE 2004 PRESIDENTIAL CANDIDATES' PROPOSALS (2003), available at http://www.cmwf.org/programs/insurance/collins_reformagenda_671.pdf (last visited Jan. 31, 2004).

20. See *infra* notes 144-47 and accompanying text (discussing the efforts by several states toward universal health coverage).

21. JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 165-70 (2d ed. 1995).

22. *Id.*

23. Jonathan Oberlander & Theodore R. Marmor, *The Path to Universal Health Care*, in THE NEXT AGENDA: A BLUEPRINT FOR THE NEW PROGRESSIVE MOVEMENT 93, 110-16 (Robert L. Borosage & Roger Hickey eds. 2001).

24. *Id.*

oversight.²⁵ While states can enact comprehensive reforms entirely on their own, this strategy relies on the federal government to provide states with financial incentives and a legal framework to encourage broad-based coverage and benefits.²⁶ The federal regulatory role is limited; however, states would ultimately decide whom to cover, what benefits to offer, and how to structure the delivery system.²⁷ Depending on conditions in the state's health care system and political leadership, some states might put primary emphasis on expanding employer-based insurance, others might expand existing public insurance programs, and still others might create a single-payer system. In 2003, the Institute of Medicine recommended such a strategy: it proposed that the U.S. federal government assist several states to establish universal coverage programs to demonstrate their feasibility and assess alternative program designs.²⁸

The overarching premise of the federalist strategy is that once a sufficient number of states develop systems of universal coverage, other states will be compelled to follow and consequently, the federal government will be persuaded to facilitate the transition to universal coverage in every state.²⁹ This is, in fact, the strategy that led to the present-day Canadian health insurance system. Beginning with Saskatchewan in 1947, other provinces adopted universal coverage and in 1971 the federal government in Ottawa approved the development of provincial health plans across the country.³⁰

Oberlander and Marmor note that the federalist strategy is consistent with contemporary political ideology in the U.S.³¹ It stresses state autonomy and federal flexibility, and allows room for state-to-state variation.³² They also argue that it "offers an opportunity to unify advocates of reform who agree on the goal of universal coverage but disagree on which plan should be adopted to reach that goal."³³ The researchers caution, however, that it would require a significant investment of federal funding to assure coverage for all segments of the population

25. *Id.* at 110. For a similar approach, with a stronger federal role, see James Tallon, Jr. & Richard Nathan, *Federal/ State Partnership for Health System Reform*, 11 HEALTH AFF. 7-16 (1992).

26. Oberlander & Marmor, *supra* note 23, at 111.

27. Oberlander & Marmor, *supra* note 23, at 111.

28. INST. OF MED. OF THE NAT'L ACADEMIES, FOSTERING RAPID ADVANCES IN HEALTH CARE: LEARNING FROM SYSTEM DEMONSTRATIONS, 69-78 (Janet M. Corrigan et al. eds., 2002); *cf.* Henry J. Aaron & Stuart M. Butler, *Four Steps to Better Health Care*, WASH. POST, July 6, 2003, at B7 (arguing that the federal government should encourage the proliferation of state health care plans by making an increase in federal funds received by the state contingent upon increasing the number of individuals insured).

29. *See* Oberlander & Marmor, *supra* note 23, at 122.

30. *See* HEALTH CANADA, CANADA HEALTH ACT OVERVIEW (2002) at http://www.hc-sc.gc.ca/english/media/releases/2002/health_act/overview.htm (last updated Aug. 1, 2003) (providing evolution of the Canada Health Act, Canada's federal health insurance legislation).

31. Oberlander & Marmor, *supra* note 23, at 110.

32. Oberlander & Marmor, *supra* note 23, at 112.

33. Oberlander & Marmor, *supra* note 23, at 110.

and there has not been, as of yet, a political willingness to put these dollars on the table.³⁴ They also acknowledge that state-by-state variation is a double-edged sword and that critics would argue that the federalist strategy, with its potential to allow even more variation than the status quo, exacerbates an already inequitable system.³⁵ Finally, they question whether the main result of such a strategy would be to shift the burden of breaking political deadlock from the federal to the state level.³⁶

Oberlander and Marmor describe the “pincer” strategy as a more incremental approach than the federalist strategy.³⁷ It builds upon the status quo by expanding coverage in two directions: 1) by raising age and income eligibility from current Medicaid and SCHIP guidelines and removing categorical restrictions; and 2) by lowering age and income eligibility from Medicare guidelines.³⁸ It emphasizes expansion of Medicaid and SCHIP to include coverage for working adults with low-incomes, a population that currently represents the largest portion of the uninsured.³⁹

The federal government’s role is more prominent under this strategy because states would need to negotiate with the federal government for changes in the many rules governing coverage and financing in public insurance programs. As the recent history of Medicaid expansion and SCHIP development illustrates, the pincer strategy also relies upon federal mandates or generous subsidies to encourage state expansion of coverage.⁴⁰ The advantages of the pincer strategy, according to Oberlander and Marmor, are: 1) that modest expansions of eligibility have the potential to make a significant dent in the number of uninsured; 2) that it builds upon existing programs so there is no additional “administrative innovation” required; and 3) that covering low-income working adults and soon-to-be retirees could be politically appealing, yielding additional support and votes from these populations.⁴¹ Their primary caution is whether building on these programs will be as successful as believed, given that Medicaid and SCHIP already have millions of individuals and families who are eligible but not enrolled in the programs.⁴² In addition, providers sharply criticize low payments for services and poor program administration, especially in Medicaid, and their low participation rate limits the accessibility and quality of care available to beneficiaries. This raises the question

34. Oberlander & Marmor, *supra* note 23, at 112.

35. Oberlander & Marmor, *supra* note 23, at 112.

36. Oberlander & Marmor, *supra* note 23, at 112.

37. Oberlander & Marmor, *supra* note 23, at 112.

38. Oberlander & Marmor, *supra* note 23, at 112.

39. Oberlander & Marmor, *supra* note 23, at 113.

40. Oberlander & Marmor, *supra* note 23, at 113.

41. Oberlander & Marmor, *supra* note 23, at 113.

42. Oberlander & Marmor, *supra* note 23, at 113-14.

of whether building on a “flawed system” to expand coverage will yield desired results.

Oberlander and Marmor liken the proposed “single-payer” strategy to the development of the U.S. Medicare program: its proponents needed over a decade to move the idea from conception in 1951 to enactment in 1965.⁴³ Its success required building a strong, sustained coalition that could persist until the larger political environment shifted and convinced key public officials that expanding health coverage would reap political benefits.⁴⁴

The goal of the single-payer strategy is to establish the federal government as the sole payer for, and decision maker about, covered health benefits and services.⁴⁵ Oberlander & Marmor note that single-payer systems tend to emphasize comprehensiveness of care, accessibility to services, low administrative costs, and portability of coverage.⁴⁶ Such systems are also more easily understood by the public, have more professional autonomy and patient choice, and develop broad political support once they are enacted.⁴⁷

Oberlander and Marmor recognize some disadvantages of single-payer systems, including centrally-imposed limitations on health care services and items such as prescription drugs, constant media attention, and immense pressure on politicians with respect to budgets, access to services, and other issues.⁴⁸ They also concede that the single-payer strategy would likely be a lengthy, uphill battle in the United States, as it has been defeated many times in the past and would certainly meet fierce resistance from a wide array of influential interest groups.⁴⁹

THE LIMITS OF THE SINGLE PAYER STRATEGY: FEDERAL DISTRACTION AND DISINTEREST

What is the most likely strategy for achieving universal coverage? For a number of reasons, progress in the near future must rely heavily on state action. The following section outlines how competing issues, a deepening fiscal crisis, and partisan priorities will almost certainly prohibit concerted federal action on behalf of the uninsured.

43. See Oberlander & Marmor, *supra* note 23, at 114-15, 117-19; MARMOR, *supra* note 1.

44. Oberlander & Marmor, *supra* note 23, at 114-15, 117-19.

45. Oberlander & Marmor, *supra* note 23, at 114.

46. Oberlander & Marmor, *supra* note 23, at 114. (using the Canadian Medicare program as an illustration of the dominant model of a single-payer health insurance program).

47. Oberlander & Marmor, *supra* note 23, at 115.

48. Oberlander & Marmor, *supra* note 23, at 114-15.

49. Oberlander & Marmor, *supra* note 22, at 115.

Focus on International Terrorism and Homeland Security

Since the events of September and October 2001, the Bush Administration and Congress have focused heavily on security concerns and the subsequent wars with Afghanistan and Iraq. Foreign policy has dominated the policy agenda and domestic issues have taken a backseat, including concerns about the economy and the corresponding increase in the already large ranks of the uninsured.

Republican Dominance in Federal Policy

Even absent the current security concerns and war, it is doubtful that universal coverage enacted from the federal level would be a priority for the current Republican administration or the Republican leadership in Congress. Carol Weissert and William Weissert explain that comprehensive reform tends to be the policy choice of Democrats, while Republicans opt instead for incremental proposals, “typically offering voluntary participation, voluntary risk pools with subsidies to states to form pools for those at high risk, means testing, substantial co-payments or catastrophic coverage, and a limited range of benefits.”⁵⁰ Indeed, the recent resurgence of interest in universal coverage has occurred almost exclusively within the Democratic Party, triggered by former Senator Bill Bradley’s proposals in the 2000 presidential campaign and a host of proposals from Rep. Dick Gephardt and other Democratic presidential contenders for the 2004 election.⁵¹

Federal Budget Deficits

The economic prosperity of the late 1990s yielded budget surpluses that provided sufficient wiggle room for both the federal and state governments to explore various alternatives, even alternatives that cost the government a significant amount of money. In fact, state planning grants supported by the Health Resources and Services Administration (HRSA) required states to conduct analyses and develop implementation plans for achieving universal insurance coverage.⁵² Kingdon notes that “When the economy is growing . . . more slack resources are available to government for innovation.”⁵³ The return of large

50. CAROL S. WEISSERT & WILLIAM G. WEISSERT, *GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY* 296 (1st ed. 1996).

51. See, e.g., COLLINS ET AL., *supra* note 19 (highlighting and comparing the health care reform proposals of the six Democratic candidates with the proposal submitted by President Bush as part of his FY 2003 Budget submission).

52. See generally KINGDON, *supra* note 21.

53. KINGDON, *supra* note 21, at 108.

federal budget deficits, however, makes it close to impossible that any health-related initiative requiring large federal financial commitments will occur in the near future.

The U.S. economy began to slide into a recession in 2000 after almost a decade of robust growth, a decline hastened and deepened by the events of September 2001.⁵⁴ In Fiscal Year 2002, the United States posted its first year of deficit since 1998, and the deficit numbers have been growing ever since.⁵⁵ In Fiscal Year 2003, the Congressional Budget Office (CBO) reported that the deficit was \$401 billion and that number was projected to grow substantially to support the war and occupation in Iraq.⁵⁶ The deficit is compounded by federal tax cuts enacted in 2001 that are to be phased in for the rest of the decade. The CBO projects that in Fiscal Year 2004, the federal budget deficit will reach a record \$480 billion.⁵⁷ Since Congress and President Bush have agreed on additional tax cuts, the deficit will likely rise even higher.

Although federal politicians are no longer officially setting limits on budget deficits, pressure to bring deficits under control is likely to increase, and as a result, put major new high-cost initiatives at a disadvantage compared to more incremental options.

Current Federal Health Proposals and Priorities

The health policy initiatives put forth by the Bush Administration to date clearly indicate that it has no plans for the federal government to play a significant role in moving toward universal coverage. Although the American public prefers taking care of those without any health insurance first,⁵⁸ politicians of both parties have focused primarily on addressing the inadequacies of Medicare—particularly, its lack of coverage for outpatient prescription drugs.⁵⁹

54. See generally Robert J. Shiller, *A Recession Unlike Any Other*, WALL ST. J., Nov. 27, 2001, at A22 (commenting on the nature of the recession and the effects of September 11th).

55. CONGRESSIONAL BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2005-2014 APP.F (2003), available at <http://www.cbo.gov/showdoc.cfm?index=1821&sequence=0> (last visited Feb. 4, 2004).

56. CONGRESSIONAL BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: AN UPDATE 1, 2 tbl.1 (2003), available at <http://www.cbo.gov/showdoc.cfm?index=4493&sequence=0> (last visited Jan. 31, 2004).

57. *Id.*

58. THE HENRY J. KAISER FAMILY FOUND., *supra* note 2.

59. For a comparison of the prescription drug coverage portions of the two Medicare reform bills, see THE HENRY J. KAISER FAMILY FOUND., A SIDE-BY-SIDE COMPARISON OF THE PRESCRIPTION DRUG COVERAGE PROVISIONS OF S. 1 AND H.R. 1 (2003), available at <http://www.kff.org/rxdrugs/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14390> (last visited Jan. 31, 2004).

In early 2003, President Bush proposed a \$400 billion plan over 10 years to improve Medicare prescription drug coverage and expand the role of private insurers in the program.⁶⁰ Republicans concluded that they could claim credit for a prescription drug benefit and, since they control both the legislative and executive branches of government, they would face negative consequences at the polls in 2004 if they failed to deliver on President Bush's pledge on this issue in the 2000 campaign. Sensing that bipartisan cooperation in the Senate limited the chances for a Democratic filibuster, the President lobbied heavily and made major concessions to win over skeptical allies and quickly enact legislation.

The Senate and House of Representatives passed different versions of a new Medicare prescription drug benefit program in June 2003 and convened a conference committee in an effort to get a bill for the President to sign by the end of the year.⁶¹ Several months of protracted negotiation were required to address opposition from those who felt the new prescription drug benefits were inadequate, those who felt the overall Medicare program required more radical reform, and those who wanted to leverage the Medicare bill for favored constituencies. In November 2003, both houses of Congress narrowly approved the Medicare Prescription Drug Improvement and Modernization Act with a host of new benefits, subsidies, payment changes, and expansions of private plans.⁶² As one of the president's leading domestic policy priorities, Medicare reform has consumed both the financial resources and political capital needed to expand coverage to those under age sixty-five.

The administration's key policies for expanding coverage to the uninsured have primarily built on the status quo, providing states with greater flexibility but little infusion of additional federal dollars. The three major areas of action include: 1) augmenting state flexibility in state Medicaid and SCHIP programs; 2) providing tax credits for the purchase of health insurance by individuals with low-incomes; and 3) increasing funding for community health centers.

60. Press Release, The White House, Fact Sheet: President Bush's 2004 Budget (Feb. 3, 2003), available at <http://www.whitehouse.gov/news/releases/2003/02/print/20030203-6.html> (last visited Jan. 31, 2004).

61. Lee, Philip R. et al., A History of Medicare and Prescription Drug Coverage: A Persistent Issue in a Changing Political Climate 35-37 (June 2003) (unpublished report to the Kaiser Family Foundation, on file with the Journal of Health Care Law & Policy); JOCELYN GUYER, THE HENRY J. KAISER FAMILY FOUND., THE PROPOSED MEDICARE PRESCRIPTION DRUG BENEFIT: A DETAILED REVIEW OF IMPLICATIONS FOR DUAL ELIGIBLES AND OTHER LOW INCOME MEDICARE BENEFICIARIES (Sept. 2003), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21805> (last visited Jan. 31, 2004). There were two versions, the Senate Bill, S.1, known as "Prescription Drug & Medicare Improvement Act of 2003" and the House Bill, H.R.1, known as "Medicare Prescription Drug & Modernization Act of 2003."

62. 2003 Legislative Summary: Medicare Prescription Drug Coverage, CONG. Q. WKLY 3121 (Dec. 13, 2003); Press Release, DHHS, Secretary Thompson Applauds Final Passage of Medicare Bill (Nov. 25, 2003), available at <http://dhhs.gov/news/press/2003pres/20031125.html> (last visited Jan. 31, 2004).

In August 2001, the Bush Administration took section 1115 authority a step further when Secretary Tommy G. Thompson announced the Health Insurance Flexibility and Accountability Initiative (HIFA).⁶³ Under HIFA, states were given unprecedented flexibility to limit benefits and impose cost sharing on significant portions of their Medicaid and SCHIP populations. In addition, states were given the authority to use Medicaid savings from such limitations and excess SCHIP funds to expand coverage to populations not traditionally covered under these programs.⁶⁴ No new federal dollars would be provided unless states chose to expand coverage to categorically eligible groups under the Medicaid program.⁶⁵

In January 2003, the Bush Administration announced a plan to modernize Medicaid, which it described as giving states “the upfront investment and flexibility to design health care programs that best meet the needs of their citizens and expand coverage to more people, including the mentally ill, chronically ill, those with HIV/AIDS, and those with substance abuse problems.”⁶⁶ Little progress has been made on this reform proposal. While the National Governors’ Association (NGA) initially applauded the proposed reforms, it has since raised concerns with the Administration’s desire to limit federal Medicaid spending in exchange for additional state flexibility.⁶⁷ Critics of the plan cautioned that the reforms would limit federal funding, potentially harming states and recipients in the long run. Additionally, concerns were raised that reforms could have dire consequences for the nursing home population supported by Medicaid funding, and that they might further threaten fundamental protections traditionally guaranteed to low-income populations.⁶⁸ This debate reflects the classic tension between federal and state authority over social programs — states want more federal funding with

63. Press Release, DHHS, HHS to Give States New Options for Expanding Health Coverage: New Initiative Promotes State Innovations to Expand Access for the Uninsured (Aug. 4, 2001), *available at* <http://dhhs.gov/news/press/2001pres/20010804.html> (last visited Jan. 31, 2004).

64. *See id.*

65. *See id.*

66. Press Release, DHHS, Bush Administration Will Propose Innovative Improvements in States’ Health Coverage for Low-Income Americans (Jan. 31, 2003), *available at* <http://dhhs.gov/news/press/2003pres/20030131d.html> (last visited Jan. 31, 2004).

67. Press Release, NGA, NGA Statement on HHS Medicaid Proposal (Jan. 31, 2003), *available at* http://www.nga.org/nga/newsRoom/1,1169,C_PRESS_RELEASE^D_4978,00.html (last visited Jan. 31, 2004) (applauding the Bush Administration’s proposed Medicaid reforms); NAT’L GOVERNORS’ ASS’N, POLICY POSITION DETAIL ON HR-43: MEDICAID REFORM PRINCIPLES, *available at* http://www.nga.org/nga/legislativeUpdate/1,1169,C_POLICY_POSITION^D_5113,00.html (last visited Jan. 31, 2004) (detailing new policy positions developed at winter meeting, including the position that the federal government should pay for 100 percent of the cost of any new Medicaid mandates).

68. CINDY MANN, INST. FOR HEALTH CARE RESEARCH & POLICY, THE BUSH ADMINISTRATION’S MEDICAID AND STATE CHILDREN’S HEALTH INSURANCE PROGRAM PROPOSAL 4-7 (2003), *available at* <http://www.georgetown.edu/research/ihcrp/pdfs/mannbushproposal.pdf> (last visited Jan. 31, 2004).

fewer strings attached, while the policy community voices concern that greater flexibility at the state level may lead to a race to the bottom.

In February 2003, Secretary Thompson announced that the President's budget proposal included \$89 billion in new tax credits for individuals who purchase health insurance coverage.⁶⁹ Eligible families with two or more children could receive up to \$3,000 in credits and eligible individuals would receive up to a \$1,000 tax credit.⁷⁰ While tax credits may result in new coverage for some of the uninsured, Jonathan Gruber and Larry Levitt have argued that, because the credit falls well short of the cost of insurance premiums, this strategy will principally serve to provide subsidies to those that are already purchasing coverage in the non-group market rather than extend coverage to the uninsured.⁷¹

Finally, in March 2003, the Bush administration announced that it would provide \$16 million to community health centers in the United States to "help provide care for many uninsured Americans and others who otherwise would have had no place to turn to get help. . . . Health centers play a critical role in this effort by providing a safety net for patients, regardless of their ability to pay."⁷² While this only amounts to about four cents per uninsured person, the Bureau of Primary Health Care, which administers the grants to federally qualified community health centers, expects to use these funds to significantly increase the capacity of health centers in the next five years.⁷³ By the end of this period, health centers expect to increase the number of uninsured that they care for from about four million to eight million annually, still only a small fraction of the nation's uninsured.⁷⁴

ASSESSING THE PROSPECTS FOR A STATE-BASED PATH TO UNIVERSAL COVERAGE

For the reasons outlined above, the single-payer strategy outlined by Oberlander and Marmor is at best a long-term strategy, probably years or decades in the making. Given the large and ever-growing number of uninsured Americans

69. Press Release, DHHS, Budget to Continue President's Initiatives for the Uninsured (Feb. 11, 2003), available at <http://www.hhs.gov/news/press/2003pres/20030211.html> (last visited Jan. 31, 2004).

70. *Id.*

71. Jonathan Gruber & Larry Levitt, *Tax Subsidies for Health Insurance: Costs and Benefits*, 19 HEALTH AFF. 72, 76-78 (2000).

72. Press Release, DHHS, HHS Awards \$16 Million to 31 Health Centers to Expand Access to Comprehensive Health Care Services for the Uninsured (Mar. 24, 2003), available at <http://www.dhhs.gov/news/press/2003pres/20030324.html> (last visited Dec. 3, 2003).

73. Personal communication with Leiyu Shi, Johns Hopkins University, Bloomberg School of Public Health, in Baltimore, MD, June 2003. For general information about community health centers, see THE BUREAU OF PRIMARY HEALTH CARE, PROGRAM HISTORY, at <http://bphc.hrsa.gov/programs/CHCPrograminfo.asp> (last visited Feb. 4, 2004).

74. Personal communication, *supra* note 73; see also THE BUREAU OF PRIMARY HEALTH CARE, at <http://bphc.hrsa.gov/chc/CHCmain.asp> (last visited Feb. 4, 2004).

and the enormous personal and social costs of their plight, it is necessary to pursue other strategies for expanding health coverage even if the single-payer strategy is judged to produce the best long-term outcomes in terms of equity, efficiency and personal security.

This leaves the federalist and pincer strategies as options to consider. Thomas Oliver notes that, “[i]n the natural order of our political system, inaction at the top begets action below.”⁷⁵ In fact, a select number of states have already demonstrated they are fully capable of tackling the complex and costly problems of the uninsured.⁷⁶ These states enacted comprehensive health care system reforms in the late 1980s and early 1990s, while Republican presidents and a Democratically-controlled Congress were gridlocked on the issue.

Even though few states adopted universal coverage initiatives, the vast majority of states took a number of incremental steps to expand health insurance coverage. Nearly every state undertook reforms to improve the affordability and availability of insurance products for small groups.⁷⁷ However, these reforms have had limited success in expanding health insurance coverage for the uninsured and in some cases these reforms have resulted in loss of insurance.⁷⁸ In addition, many states expanded Medicaid coverage for children beyond the federal mandates prior to the enactment of the State Children’s Health Insurance Program (SCHIP), and a number of states used section 1115 demonstration waiver authority to expand coverage significantly to adult populations.⁷⁹ Finally, a number of states pursued programs funded with general revenue or foundation dollars to expand health insurance coverage to higher-income children.⁸⁰

75. Thomas R. Oliver, *Ideas, Entrepreneurship, and the Politics of Health Care Reform*, 3 STAN. L. & POL’Y REV. 160, 160 (1991).

76. See *infra* notes 144-56 and accompanying text.

77. See Thomas R. Oliver, *The Dilemmas of Incrementalism: Logical and Policy Constraints in the Design of Health Insurance Reforms*, 18 J. POL’Y ANALYSIS & MGMT. 652, 665-674 (1999); see also Christopher Stream, *Health Reform in the States: A Model of State Small Group Health Insurance Market Reforms*, 52 POL. RES. Q. 499, 499 (1999).

78. See Stephen Long & Susan Marquis, *Have Small-Group Health Insurance Purchasing Alliances Increased Coverage?* 20 HEALTH AFF. 154, 160-62 (2001); see also Len M. Nichols, *State Regulation: What Have We Learned So Far?* 25 J. HEALTH POL., POL’Y & L. 175 (2000); Linda J. Blumberg & Len M. Nichols, *First, Do No Harm: Developing Health Insurance Market Reform Packages*, 15 HEALTH AFF. 35 (1996) (offering evaluations and case studies of several states’ efforts to regulate insurance for small groups); Stephen Zuckerman & Shruti Rajan, *An Alternative Approach to Measuring the Effects of Insurance Market Reforms*, 36 INQUIRY 44 (1999) (finding that small group reforms have had little effect on health insurance coverage, but that individual market reforms have resulted in increased rates of uninsurance and have reduced private coverage).

79. Lawrence D. Brown & Michael S. Sparer, *Window Shopping: State Health Reform Policy in the 1990s*, 20 HEALTH AFF. 50, 56 (2001); John Holahan & Mary Beth Pohl, *States as Innovators in Low-Income Health Coverage*, in ASSESSING THE NEW FEDERALISM DISCUSSION PAPERS 02-08, June 2002, at 33-34, available at <http://www.urban.org/url.cfm?ID=310519> (last visited Jan. 31, 2004).

80. Brown & Sparer, *supra* note 79, at 56.

In recent years, state governments have greatly enhanced their policy expertise, which has fueled their ability to develop innovative policy activities and has prompted an increased demand for devolution of authority from the federal government. Prior to the mid 1960s, state governance was unsophisticated and decision making was spread out over numerous agencies and positions with little centralized accountability.⁸¹ Supreme Court decisions in 1965 required that states make changes to their constitutions and the composition of their legislatures to comply with the one person, one vote principle, which in turn facilitated additional broad-based change in many states to clarify the roles of the executive, judicial and administrative branches.⁸² The two decades following these systemic state-level overhauls were a period of growth in the authority and sophistication of governors, evolution of more professional legislative bodies that met more often, and the hiring and retaining of highly trained staff in all branches of government, particularly in administrative agencies.⁸³ The growing sophistication of state governments ultimately led to better information and capacity for planning and program design,⁸⁴ and increased the likelihood of more successful outcomes when policy initiatives—large or small—were undertaken.

The critical role of states under the federalist and pincer scenarios naturally leads us to question whether states can handle the responsibility of taking the lead on universal coverage. The answer is a heavily qualified yes. While most states have the interest and expertise to develop new health insurance initiatives, only a few will have the resources and leadership to solve a problem of such magnitude. Without considerable federal financial support, rapid progress toward universal coverage is unlikely. The following sections explore how past initiatives highlight both the promise and limits of state action on the path to universal coverage.

THE LIMITS OF THE FEDERALIST STRATEGY: LESSONS FROM THE EARLY INNOVATORS

State adoption of new and innovative programs often leads observers to claim that states can serve as the “laboratories of democracy,” developing solutions that

81. CAROL S. WEISSERT & WILLIAM G. WEISSERT, *GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY* 192-241 (2d ed. 2002).

82. Frank J. Thompson, *Federalism and Health Care Policy: Toward Redefinition?* in *THE NEW POLITICS OF STATE HEALTH POLICY* 41-70 (Robert B. Hackey & David A. Rochefort eds., 2001). See also WEISSERT & WEISSERT, *supra* note 81, at 192-94.

83. WEISSERT & WEISSERT, *supra* note 81, at 192-94.

84. See Thomas R. Oliver & Pamela Paul-Shaheen, *Translating Ideas into Actions: Entrepreneurial Leadership in State Health Care Reforms*, 22 *J. HEALTH POL., POL'Y & L.* 721, 742-88 (1997); See generally Thompson, *supra* note 82; WEISSERT & WEISSERT, *supra* note 81, at 192-94.

other states and the federal government can adopt to address common problems.⁸⁵ The viability of the federalist strategy, in particular, rests on the assumption that a sufficient number of states have the capacity to formulate complex public policies, as well as the fiscal capacity and political will to set an irreversible course toward universal coverage. It also assumes that the state political process will not fall victim to the limitations of disjointed incrementalism that is often present in the political process at the federal level.

As noted above, few states have succeeded in enacting innovative programs that attempted comprehensive reform of their health care system, including an effort to achieve or nearly achieve universal insurance coverage. Even fewer, moreover, have managed to sustain their efforts over time. In light of these efforts, it is somewhat doubtful that a federalist strategy for universal coverage will succeed across all fifty states. The following sections summarize the research of Thomas Oliver and Pamela Paul-Shaheen, who analyzed the experiences of Massachusetts, Oregon, Florida, Minnesota, Vermont, and Washington State, the six states identified as early innovators due to their efforts to enact comprehensive reforms in the late 1980s and early 1990s.

States are Typically Not Laboratories

Based on their research, Oliver and Paul-Shaheen refute the common characterization of states as “laboratories of democracy.”⁸⁶ They disagree with the use of the “laboratory” metaphor, explaining that the state innovations are not subject to rigorous evaluation or testing.⁸⁷ Innovations are seldom adopted in a wholesale fashion, rather policy development tends to be piecemeal and accomplished through a long process of trial and error; and the models adopted often reflect institutional legacies or local priorities rather than scientific knowledge.⁸⁸

Oliver and Paul-Shaheen demonstrate instead that states tend to take very different approaches from one another based more on internal politics, leadership and existing programs.⁸⁹ They argue that rather than thinking of states as laboratories, “it is more accurate to think of states as specialized political markets, or niches in the national political market, in which individuals and groups can develop and promote an array of policy innovations.”⁹⁰

85. WEISSERT & WEISSERT, *supra* note 81, at 226-236. See also Brown & Sparer, *supra* note 79, at 52.

86. See Oliver & Paul-Shaheen, *supra* note 84, at 723-24.

87. Oliver & Paul-Shaheen, *supra* note 84, at 723-24.

88. Oliver & Paul-Shaheen, *supra* note 84, at 723-24.

89. Oliver & Paul-Shaheen, *supra* note 84, at 723-24.

90. Oliver & Paul-Shaheen, *supra* note 84, at 724.

Common State Characteristics

Oliver and Paul-Shaheen identified several common traits of states that were successful in pursuing comprehensive reform. These factors included: 1) relative economic wealth; 2) a political culture that allowed consideration of redistributive policies; 3) Democrats taking the initiative; 4) committed, high-level leadership (governors and key legislators); 5) commissions or other ad hoc arenas created to study health care issues and formulate technically sophisticated proposals; 6) a “try and try again” philosophy—comprehensive reforms built upon earlier incremental reforms and some defeats; and 7) a persuasive argument for reform based on social justice, even during difficult economic times.⁹¹

Importance of Policy Entrepreneurs

According to Oliver and Paul-Shaheen, the key factor that enabled a few states to successfully enact plans for universal coverage was strong and skilled leadership from senior politicians—“policy entrepreneurs” and “investors,” who were able to negotiate the design and implementation of an innovative model.⁹² In these states, the leadership came from the governor or key members of the state legislature.⁹³ Legislators often had specific ideas and had the technical skills to understand different options on the table, but ultimately became more concerned with “piecing together a set of tangible and politically viable reforms than with engineering an intellectually coherent product.”⁹⁴

As the issue of health insurance coverage rises on the national agenda in 2003, the same general pattern holds. In June 2003, Maine adopted a plan that is intended to establish universal coverage by 2009. The plan was a major feature of Governor John Baldacci’s election campaign in 2002. It will expand the state’s Medicaid program and provide sliding scale premiums to the self-employed and workers in firms that do not offer coverage.⁹⁵

In October 2003, the California Legislature enacted the Health Insurance Plan of 2003 (Senate Bill 2), which requires firms with over 200 employees to provide health insurance to workers and their dependents as of 2006, or pay a fee to a state

91. Oliver & Paul-Shaheen, *supra* note 84, at 737-42.

92. Oliver & Paul-Shaheen, *supra* note 84, at 724. See also WEISSERT & WEISSERT, *supra* note 81, at 218.

93. Oliver & Paul-Shaheen, *supra* note 84, at 745.

94. Oliver & Paul-Shaheen, *supra* note 84, at 746.

95. *Maine Passes Nation’s First Universal Health Plan*, available at <http://covertheuninsuredweek.org/news/index.php?NewsID=338> (last visited Jan. 22, 2004).

fund to help cover the costs of coverage.⁹⁶ As of 2007, firms with 50 or more employees must provide coverage for their workers (but not their dependents) or pay the state fee.⁹⁷ If the state establishes subsidies, firms with 20 or more employees will also be subject to the “pay or play” mandate in 2007.⁹⁸ The plan was spearheaded by Senate President Pro Tem John Burton (D) and by a highly unusual alliance between the California Medical Association and California Federation of Labor.⁹⁹ It was signed by Governor Gray Davis (D) two days before voters elected to recall him. Preliminary estimates are that up to 1.5 million uninsured Californians will receive coverage under the plan, if it is successfully implemented under the new Republican governor, Arnold Schwarzenegger.¹⁰⁰

The presence of skilled leaders does not always guarantee successful implementation, but Oliver and Paul-Shaheen found that state-level policy entrepreneurs have advantages over their counterparts at the federal level because they are still close to the action.¹⁰¹ These advantages include a close working relationship with officials from administrative agencies; their willingness to be educators about the history and intent of the policy; involvement in the feedback loop to correct implementation problems; and finally the shift of some legislators into administrative roles once their time as a legislator is complete.¹⁰²

The Disproportionate Burden of Uninsurance

Analysis of the early innovators suggests that the federalist strategy is limited by the fact that only a relatively few number of states at any given time have the right combination of economic and political conditions to take on the redistributive politics of universal health insurance. The viability of the federalist strategy is also heavily dependent on where the uninsured reside. As shown in Table 1, close to half of the uninsured, 46.4 percent, reside in just five states—California, Texas, New York, Florida, and Illinois—which represent 36.5 percent of the nation’s

96. Lisa Rapaport, *Davis Approves Health Care Bill*, SACRAMENTO BEE, Oct. 6, 2003; Press Release, Office of the Governor, Governor Davis Signs Historic Health Care Legislation for Working Californians (Oct. 5, 2003) (on file with the Journal of Health Care Law & Policy) [hereinafter Governor Davis Signs Historic Legislation].

97. Governor Davis Signs Historic Legislation, *supra* note 96.

98. Governor Davis Signs Historic Legislation, *supra* note 96.

99. Governor Davis Signs Historic Legislation, *supra* note 96.

100. Lisa Rapaport, *supra* note 96; see also Carl Ingram, *Governor Expected to Sign Health Bill; Measure Would Require More Employers to Provide Insurance*, L.A. TIMES, Oct. 1, 2003 at B1, available at 2003 WL 2438357. Under the provisions of SB 2, employees who have worked for an employer for three months and work at least 100 hours per month are eligible. CALIFORNIA HEALTHCARE FOUNDATION, HEALTH INSURANCE ACT OF 2003 (SB2), at <http://www.chcf.org/sb2/index.cfm> (last visited Feb. 4, 2004).

101. Oliver & Paul-Shaheen, *supra* note 84, at 745.

102. Oliver & Paul-Shaheen, *supra* note 84, at 742-46.

population.¹⁰³ All but Illinois have uninsurance rates that are higher than the national average of 14.6 percent.¹⁰⁴ For the federalist strategy to trigger universal coverage for the nation, some of these critical states would almost certainly have to take the lead to establish the momentum needed for the rest to follow. The extent of the challenge is illustrated by the fact that under California's major new plan, four to five million state residents would remain uninsured even if the legislation survives political and legal attacks during its implementation.

TABLE 1

Distribution of the Uninsured in Selected States, 2000

State	Uninsurance Rate in State	Uninsured in State as a Share of Total Uninsured in U.S.	Population in State as a Share of Total U.S. Population
California	19.5%	16.3%	12.2%
Texas	23.5%	12.0%	7.5%
New York	15.5%	7.1%	6.7%
Florida	17.5%	6.9%	5.8%
Illinois	13.6%	4.1%	4.4%
Total		46.4%	36.5%

Source: U.S. Census Bureau, Current Population Survey, 2001 Annual Demographic Supplement.

The Fading ERISA Barrier

Another potential barrier to the federalist strategy is the Employee Retirement and Income Security Act (ERISA), which was enacted by Congress in 1974 to prevent pension fraud.¹⁰⁵ ERISA is widely perceived to be an important barrier to state health care innovation, particularly efforts such as the one in California to expand employer-sponsored health coverage.¹⁰⁶ Of particular concern is the fact

103. Authors' calculations are based on data from the BUREAU OF LABOR STATISTICS & BUREAU OF THE CENSUS, ANNUAL DEMOGRAPHIC SURVEY MARCH 2002 SUPPLEMENT, CURRENT POPULATION SURVEY. Estimates reflect uninsurance for the entire year and include elderly populations in both the numerator and denominator.

104. *Id.*

105. Employee Retirement and Income Security Act of 1974, 29 U.S.C. §§ 1001- 1461 (2000).

106. See, e.g., Mary Ann Chirba-Martin & Troyen A. Brennan, *The Critical Role of ERISA in State Health Reform*, 13 HEALTH AFF. 142 (1994) (evaluating the preventative effect of ERISA on states ability to reform health insurance); PATRICIA A. BUTLER, NAT'L ACAD. FOR STATE HEALTH POL'Y, REVISITING PAY OR PLAY: HOW STATES COULD EXPAND EMPLOYER-BASED COVERAGE WITHIN ERISA CONSTRAINTS (2002), available at http://www.nashp.org/Files/ERISA_pay_or_play.PDF (last visited Jan. 31, 2004).

that ERISA preempts state laws that “relate to” employee benefit plans, including health plans.¹⁰⁷ While ERISA does allow states to regulate insurance, employers’ self-insured plans cannot be deemed to be insurance under ERISA, thus preempting such self-insured plans from state health insurance regulation.¹⁰⁸

It is widely accepted that state mandates, requiring that employers provide insurance to their employees are preempted by ERISA under the authority of *Standard Oil v. Agsalud*.¹⁰⁹ Therefore, ERISA preemption eliminates state mandates as a possibility for states interested in expanding coverage. What appears to be untested, however, is whether “pay or play” initiatives under which a state would tax employers in order to finance a state-sponsored insurance program, or pool and give tax credits to employers who provide insurance coverage to their employees, would be preempted by ERISA.¹¹⁰ This is a key issue now being advanced to challenge the new California law. Another version of such a plan is currently being considered in Maryland.¹¹¹ According to Patricia Butler, such initiatives are likely to withstand an ERISA challenge so long as the state maintains no preference as to whether employers offer the coverage or pay the tax, and if the legislation does not require a minimum benefit package in order to receive a tax credit.¹¹² If this is the case, “pay-or-play” initiatives may provide an untapped opportunity to finance state insurance pools for the uninsured.¹¹³

Both employer-mandates and “pay-or-play” options provide benefits to states beyond their ability to finance insurance coverage. In particular, the use of these mechanisms allows states to require some sort of effort on the part of employers and individuals. Specifically, strategies such as “pay-or-play” initiatives or targeted employer mandates can be designed to help assure that current private expenditures on health insurance remain in the system. While these

107. See Chirba-Martin & Brennan, *supra* note 106, at 144-45. The preemption provision has three sections. First, ERISA preempts state laws that “relate to” an ERISA qualified plan. Second, state laws that regulate insurance are “saved” from preemption. Third, state laws may not regulate ERISA plans that are self-insured. The first and third sections have been read broadly, maximizing the provision’s preemptive effect. Margaret G. Farrell, *ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism*, 23 AM. J. L. & MED. 251, 261 (1997).

108. Chirba-Martin & Brennan, *supra* note 106 at 145-46; BUTLER, *supra* note 106, at 2.

109. 633 F.2d 760, 764 (9th Cir. 1980); see also Chirba-Martin & Brennan, *supra* note 106, at 147-50 (discussing a number of court cases continuing to illustrate the effect of ERISA preemption on state attempts to reform health care financing). One state, Hawaii has an employer mandate. This mandate was enacted in 1974, prior to ERISA, and is thus exempt from its provisions. Congress amended section 514(b) of ERISA in response to Agsalud by explicitly exempting Hawaii’s Prepaid Health Care Act from ERISA preemption. See Act of Jan. 14, 1983, Pub. L. No. 97-473, § 301(a), 96 Stat. 2605, 2611-12 (codified at 29 U.S.C. §1144(b)(5) (1988)).

110. See BUTLER, *supra* note 106, at 5-8.

111. MARYLAND CITIZENS’ HEALTH INITIATIVE, A PUBLIC-PRIVATE PARTNERSHIP FOR HEALTH CARE FOR ALL MARYLANDERS: COST AND COVERAGE IMPACTS ANALYSIS (Oct. 28, 2003), at <http://www.healthcareforall.com> (last visited Feb. 4, 2004).

112. BUTLER, *supra* note 106, at 7-8.

113. BUTLER, *supra* note 106, at 7-8.

mechanisms will likely generate considerable political opposition from the business community, assuring that public expenditures on health insurance coverage do not substitute for private expenditures may be necessary in order to achieve the political capital needed if universal coverage is to be enacted.

Other External Constraints

Even if states have favorable internal conditions, they often face severe external constraints on their efforts to expand health insurance. Before reforms can be fully implemented, states are vulnerable to shifts in broad public support, changes in leadership and key supporters, and economic uncertainty and fiscal stress.¹¹⁴ This proved to be the case when, in the wake of the disastrous fallout from the failed Clinton plan, nearly all of the states with plans for universal coverage drastically scaled back their initiatives.¹¹⁵

LIMITS OF THE PINCER STRATEGY: THE HIGH WATER MARK IS STILL A LOW TIDE

The pincer strategy—using the existing Medicaid, SCHIP, and Medicare programs to achieve universal coverage—shares many common characteristics and limitations with the federalist strategy. While both strategies require a partnership between the federal and state governments, the pincer strategy provides less programmatic flexibility at the state level. In the following sections, we describe the mechanisms available to states to expand insurance coverage to new populations under the Medicaid and SCHIP programs. We also document state efforts to date to use these mechanisms to expand coverage in an era that saw increased flexibility afforded to states, a major financial commitment at the federal level, and the largest economic boom in recent history. We conclude that a state-based pincer strategy without significant federal funding is unlikely to achieve dramatic expansions toward universal coverage in many states.

Strategies for Covering Children, Pregnant Women, Parents and Childless Adults

Children and Pregnant Women. Until the mid 1980s, Medicaid coverage of children and pregnant women was limited to those living in families that received Aid to Families with Dependent Children (AFDC). Beginning with the

114. See Oliver & Paul-Shaheen, *supra* note 84, at 782.

115. Oliver & Paul-Shaheen, *supra* note 84, at 782.

Omnibus Budget Reconciliation Act (OBRA) of 1986,¹¹⁶ a series of federal legislation gave states the option to cover certain low-income children and pregnant women who were either ineligible for or not participating in AFDC.¹¹⁷ The Medicare Catastrophic Coverage Act (MCCA) of 1988¹¹⁸ began another series of legislation that ended with OBRA 1990¹¹⁹ which mandated that states expand eligibility for certain children incrementally.¹²⁰ Under these mandates, broadly referred to as the poverty-related expansions, states were required to cover children under age six and pregnant women in families with incomes up to 133 percent of the federal poverty level (FPL), and children born after September 30, 1983 in families with incomes up to 100 percent of the FPL.¹²¹ As a result of this legislation, all states were required to cover children under age nineteen in families with incomes under the poverty level by October 1, 2002.¹²² States were allowed to phase in the expansions in coverage at a faster rate than mandated, and were also given the flexibility to cover children at higher income levels than mandated by disregarding a portion of the families' income using methodologies outlined in section 1902(r)(2) of the Social Security Act, enacted in 1988, and amended in

116. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9401, 100 Stat. 1874, 2050 (1986) (current version codified in scattered sections of 42 U.S.C.).

117. See *e.g.*, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330-159 (1987) (allowed states to cover pregnant women and young children up to age 5 in families with incomes at or below 100 percent of the federal poverty level); Family Support Act of 1988, Pub. L. No. 100-485, 102 Stat. 2343 (1988) (required states to extend Medicaid coverage for twelve months to families leaving AFDC rolls due to earnings from work, and required states to cover two-parent unemployed families meeting state AFDC income and resource standards); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2273 (1989) (required states to cover pregnant women and children under age 6 in families with incomes at or below 133 percent of federal poverty level). See *infra*, note 121, for an explanation of the federal poverty level.

118. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, §§ 301, 302, 102 Stat. 683 (1988).

119. Omnibus Reconciliation Act of 1990, Pub. L. No. 97-473, § 301(a), 96 Stat. 2605, 2611-12 (codified at 29 U.S.C. § 1144(b)(5)(1988)).

120. Omnibus Budget Reconciliation Act of 1990, Pub. L. No.101-508, § 4601, 104 Stat. 1388, 1388-166 (1990) (current version codified at 42 U.S.C. § 1396a (2000)).

121. Families and unrelated individuals are classified as being above or below the poverty level using the poverty index originated at the Social Security Administration in 1964 and revised by Federal Interagency Committees in 1969 and 1980. The poverty index is based solely on money income and does not reflect the fact that many low-income persons receive non-cash benefits such as food stamps, Medicaid, public housing, etc. Whether the income of a family or household is above or below the poverty level depends on income and the number of persons in the household. The poverty thresholds are updated every year to reflect changes in the Consumer Price Index. An individual or a family is said to be at 100% of the federal poverty level if their total income is equal to or less than the current federal poverty level.

122. Omnibus Budget Reconciliation Act of 1990, Pub. L. No.101-508, § 4601, 104 Stat. 1388, 1388-166 (1990) (current version codified at 42 U.S.C. § 1396a (2000)).

subsequent years.¹²³ The section 1902(r)(2) methodologies essentially allowed states to cover children at virtually any income level under the Medicaid program.¹²⁴ As of June 1997, thirty-two states had expanded coverage for infants and children above the federal mandates and eight had expanded coverage for infants and pregnant women above the federal mandates.¹²⁵

SCHIP, created in 1997, provided states with a vehicle to expand eligibility for children beyond their current Medicaid levels and receive a higher federal match than under the Medicaid program. All states took advantage of this opportunity. By SCHIP's five year anniversary, twenty-six states and the District of Columbia were covering children with incomes up to 200 percent of the FPL, thirteen states had set eligibility thresholds higher than 200 percent of the FPL, and only eleven had eligibility thresholds lower than 200 percent of the FPL.¹²⁶ As a consequence, all but 16 percent of low-income uninsured children are now eligible for coverage under either Medicaid or SCHIP.¹²⁷

Parents. States' authority to cover parents under the Medicaid program has lagged far behind their authority to expand coverage for children. Coverage of non-elderly adults under Medicaid has historically been limited to parents receiving cash assistance under Aid to Families with Dependent Children (AFDC), disabled adults receiving Supplemental Security Income (SSI), and, since the mid-1980s, pregnant women.¹²⁸ Many poor and near-poor parents were ineligible for Medicaid because AFDC eligibility was restricted to very low-income, single-parent families and two-parent families where either one parent was incapacitated or the principal wage earner was unemployed.¹²⁹

123. See JOCELYN GUYER & CINDY MANN, CTR. ON BUDGET POL'Y & PRIORITIES, TAKING THE NEXT STEP: STATES CAN NOW TAKE ADVANTAGE OF FEDERAL MEDICAID MATCHING FUNDS TO EXPAND HEALTH CARE COVERAGE TO LOW-INCOME WORKING PARENTS 19-21 (1998).

124. Brian K. Bruen & Frank Ullman, *Children's Health Insurance Programs: Where States Are, Where they Are Headed*, in ASSESSING THE NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES 1 (Urb. Inst., Series A, No. A-20, Wash., D.C.), May 1988. Pregnant women and qualified Medicare beneficiaries with higher incomes can also be made eligible for Medicaid under these provisions.

125. See *id.*

126. Lisa Dubay et al., *Five Things Everyone Should Know About SCHIP*, in ASSESSING THE NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES 2 (Urb. Inst., Series A, No. A-55, Wash., D.C.), Oct. 2002.

127. Lisa Dubay et al., *Children's Eligibility for Medicaid and SCHIP: National and State Estimates*, in ASSESSING THE NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES 3 (Urb. Inst., Series B, No. B-41, Wash., D.C.), Mar. 2002.

128. Lisa Dubay et al., *Extending Medicaid to Parents: An Incremental Strategy for Reducing the Number of Uninsured*, in ASSESSING THE NEW FEDERALISM: NATIONAL SURVEY OF AMERICAN FAMILIES 2 (Urb. Inst., Series B, No. B-20, Wash., D.C.), Mar. 2002.

129. *Id.* In order to be considered unemployed, the principal wage earner must have worked fewer than 100 hours a month and have had a history of work-force participation, further restricting coverage. *Id.* at 6 n.2.

Five federal changes—one legislative, the others administrative—dramatically expanded the options available to states for covering low-income parents under Medicaid and/or SCHIP.¹³⁰ First, after being elected President in 1992, Bill Clinton significantly enhanced state opportunities to use Medicaid to expand coverage to parents and other populations not traditionally eligible under Medicaid using section 1115 demonstration waiver authority.¹³¹ It is under section 1115 authority that Oregon, Tennessee, and Hawaii expanded Medicaid eligibility for children and adults, and Rhode Island expanded Medicaid eligibility for children and pregnant women in the early to mid-1990s.¹³²

Second, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created a new category of Medicaid eligibility in section 1931 of the Social Security Act, which expanded state options for covering parents.¹³³ It required states to grant such eligibility to those adults and children who would have been entitled to AFDC under the income and resource standards in effect on July 16, 1996.¹³⁴ It also gave states the option to use less restrictive methodologies for counting income and resources when determining eligibility—thus allowing states to make higher income families that meet the categorical requirements under the old AFDC program - eligible for Medicaid.¹³⁵

Third, DHHS issued a regulation in August 1998 that permitted states to use less restrictive rules to define unemployment for two-parent families, essentially allowing states to cover all two-parent families that meet the section 1931 income

130. For a more complete discussion of this issue, see GUYER & MANN, *supra* note 123; Dubay et al., *supra* note 128.

131. Clarke Cagey, *Health Reform, Year Seven: Observations About Medicaid Managed Care*, 22 HEALTH CARE FINANCING REV., Fall 2000, at 127.

132. See Press Release, Leighton Ku & Matthew Broaddus, Center on Budget & Policy Priorities, The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms (Sept. 5, 2000), available at <http://www.cbpp.org/9-5-00health-rep.pdf> (last visited Jan. 31, 2004) (noting that Oregon, Tennessee, and Hawaii expanded Medicaid eligibility for children and adults); NATIONAL GOVERNOR'S ASSOCIATION, MCH UPDATE: STATE MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN 3 (Sept. 30, 1997), available at <http://www.nga.org/cda/files/MCHUPDATE0997.pdf> (last visited Jan. 31, 2004) (noting Rhode Island's expansion of Medicaid eligibility for children and pregnant women).

133. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, § 114, 42 U.S.C. § 1396u-1 (2000); See also Dubay et al., *supra* note 128, at 2 (analyzing the various provisions of the PRWORA).

134. Dubay et al., *supra* note 128 at 2. States also have the option to use a lower resource standard for determining eligibility under Section 1931, but these standards cannot go below those in effect on May 1, 1998. States can also adjust their income and resource standards upward in accordance with the consumer price index. Dubay et al., *supra* note 128 at 2.

135. Dubay et al., *supra* note 128 at 2. "In essence, the latter provision allows states to disregard income and resources, effectively making certain families eligible for Medicaid at higher incomes than under old AFDC rules. This provision is similar to § 1902(r)(2) provisions that allowed states to cover children and pregnant women with incomes above the mandated and optional levels." Dubay et al., *supra* note 128 at 6 n.6.

and resource requirements.¹³⁶ Importantly, section 1931 eligibility provisions apply only to families, making it impossible for parents to be made eligible without their children.¹³⁷

Fourth, in July 2000 the Clinton Administration opened the door for states to use section 1115 authority in SCHIP to expand coverage to parents of SCHIP-eligible children using excess SCHIP funding.¹³⁸ Four states took advantage of this initial offering.¹³⁹

And fifth, as mentioned earlier, the Bush Administration further stretched the use of section 1115 authority in August 2001 under HIFA by providing states with broad authority to expand to new populations, including parents.¹⁴⁰ To date, five states—Arizona, California, Illinois, New Mexico, and Oregon—have authority under HIFA to expand coverage to parents, but not all have implemented the planned expansions.¹⁴¹

Childless Adults. Coverage of childless adults under Medicaid has historically been limited to disabled and elderly individuals, and in certain circumstances, such coverage extends to patients with acquired immune deficiency syndrome (AIDS) or those covered by the more recent breast and cervical cancer treatment programs.¹⁴² However, under both the Clinton and Bush Administration, states have had the option to use section 1115 demonstration authority to cover childless adults of any age provided sufficient state funding is available.

136. 45 C.F.R. § 233.100-1 (2001). “Specifically, states can now eliminate the 100-hour rule, effectively making all two-parent families that meet the income and resource standards under the Section 1931 provisions eligible for Medicaid.” Dubay et al., *supra* note 128 at 6 n.7.

137. Dubay et al., *supra* note 128, at 2.

138. Letter from Timothy Westmoreland, Director, Center for Medicaid & State Operations, Centers for Medicare & Medicaid Services, to State Health Official (July 31, 2000), *available at* <http://www.cms.hhs.gov/schip/sho-letters/ch73100.asp> (last visited Jan. 31, 2004) (providing guidance on proposed demonstration projects under the authority of section 1115 in the SCHIP program).

139. Embry Howell, et al., *Early Experience with Covering Uninsured Parents Under SCHIP*, in ASSESSING THE NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES 2 (Urb. Inst., Series A, No. A-51, Wash., D.C.), May 2002. Since then, Arizona and California have obtained waivers to cover parents, and Utah has obtained a waiver to cover only primary care for adults. *Id.*

140. *See supra* notes 63-65 and accompanying text (discussing the Bush Administration’s use of Section 1115 waiver authority under HIFA to help states expand coverage).

141. CTRS. FOR MEDICARE & MEDICAID SERVS., SCHIP APPROVED SECTION 1115 DEMONSTRATION PROJECTS, *available at* <http://www.cms.gov/schip/1115waiv.pdf> (last updated July 25, 2003).

142. *See* Sara Rosenbaum, *Health Policy Report: Medicaid*, 346 NEW ENG. J. MED., 635, 636-38 (2002); *see generally* Cindy Mann, *The Flexibility Factor: Finding the Right Balance*, 22 HEALTH AFF. 62, 65-67 (2003) (also discussing Medicaid eligibility and covered populations); Alan Weil, *There’s Something About Medicaid*, 22 HEALTH AFF. 13, 16, 20-22 (2003) (discussing Medicaid eligibility and various populations the program covers).

Progress To-Date Toward Universal Coverage

Table 2 outlines the steps that states have taken in expanding coverage using both state and federal program dollars. As can be seen, Minnesota and Washington cover all children and adults with family incomes up to 150 percent of the FPL. Both of these states initially expanded coverage by creating state funded programs. As federal flexibility increased and federal matching funds became available to cover more populations, both states ultimately elected to use a combination of Medicaid and SCHIP waivers to cover children and parents and state-only funds to cover childless adults.

TABLE 2¹⁴³

Expansions of Eligibility for Public Health Insurance Programs

Coverage of all adults and children to 150% of FPL	MN, WA
Coverage of all adults and children to 100% of FPL	AZ*, DE, HI, MA, NJ, NY, OR, TN, VT
Coverage of parents and children to 150% of FPL	CA*, CT, ME, RI, UT**, WI
Coverage of children above 200% FPL	GA, MD, MO, NH, NM, PA

* These states have received federal approval, but have not implemented all of the planned expansions.

**Utah covers primary care services only for childless adults up to 150% of FPL.

Nine states—Arizona, Delaware, Hawaii, Massachusetts, New Jersey, New York, Oregon, Tennessee, and Vermont—cover all children and adults up to 100 percent of the FPL.¹⁴⁴ With the exception of Oregon, these states also cover children with family incomes at or above 200 percent of the FPL and generally cover parents up to 150 percent of the FPL.¹⁴⁵ Interestingly, by the early 1990s four of these states—Hawaii, Massachusetts, Oregon, and Tennessee—had enacted or implemented plans for universal or near-universal health insurance coverage.¹⁴⁶

143. Holahan & Pohl, *supra* note 79, at 33-34, as updated by data from CMS, including for SCHIP. See <http://www.cms.gov/schip/enrollment/fy02sqer.pdf> (last visited Feb. 4, 2004); CTRS. FOR MEDICARE & MEDICAID SERVS., STATE WAIVER PROGRAMS AND DEMONSTRATIONS, at www.cms.gov/medicaid/waivers/waivermap.asp (last visited Feb. 4, 2004).

144. See *tbl.2*

145. *Id.*

146. BUREAU OF TENNCARE, WHAT IS TENNCARE, at <http://www.state.tn.us/tenncare/whatis.html> (last visited Feb. 4, 2004); Oliver & Paul-Shaheen, *supra* note 84, at 725-29 (outlining the plans for universal coverage developed by Massachusetts, Oregon, and Vermont).

Ultimately, Massachusetts and Oregon were not able to obtain legislative or administrative approval to implement the employer mandates that were integral components of the states' universal coverage strategy, and instead developed innovative programs that included broad expansions to both children and adults using Section 1115 authority and state funds.¹⁴⁷ Hawaii and Tennessee scaled back eligibility dramatically in the mid 1990s as enrollment growth and program costs rapidly outgrew expectations.¹⁴⁸ Finally, in addition to the expansions mentioned above, six states have authority to cover parents and children up to 150 percent of the FPL or more: California, Connecticut, Maine, Rhode Island, Utah and Wisconsin.¹⁴⁹ Six more states cover children with family incomes above 200 percent of the FPL.¹⁵⁰

The SCHIP program also provides important evidence about the ability of states to implement universal coverage. Two years after the Balanced Budget Act of 1997 was passed, all states had implemented a SCHIP program.¹⁵¹ States took a variety of approaches to implementing SCHIP; thirty-five states developed separate child health programs and sixteen expanded Medicaid.¹⁵² Twenty-six states and the District of Columbia expanded eligibility by covering children with incomes up to 200 percent of the FPL, thirteen states set eligibility thresholds higher than 200 percent of the FPL, and only eleven had eligibility thresholds lower than 200 percent of the FPL.¹⁵³ As a result of these expansions in eligibility, about half of all children and 90 percent of all low-income children are estimated to be income eligible for Medicaid or SCHIP.¹⁵⁴ More importantly, only 23 percent of all uninsured children and 16 percent of low-income uninsured children are ineligible for one of these programs.¹⁵⁵ This offers tremendous potential to solve the problem of uninsured children and leaves only two to four percent of all children uninsured and ineligible for coverage.¹⁵⁶

147. Oliver & Paul-Shaheen, *supra* note 84, at 725-29.

148. See STATE OF TENNESSEE, TENNCARE PROGRAM DESIGN AND WAIVER MODIFICATIONS, at www.cms.hhs.gov/medicaid/1115/tnewaiverfeb11fnl.pdf (last visited Feb. 4, 2004); HAWAII'S SECTION 115 DEMONSTRATION FACT SHEET, at www.cms.hhs.gov/medicaid/1115/hi1115fs.pdf (last visited Feb. 4, 2004).

149. See *tbl.2*.

150. See *tbl.2*. The six states covering children with family income above 200% FPL are Georgia, Maryland, Missouri, New Hampshire, New Mexico, and Pennsylvania.

151. Dubay et al., *supra* note 126, at 8 n.1.

152. Dubay et al., *supra* note 126, at 2.

153. Dubay et al., *supra* note 126, at 2.

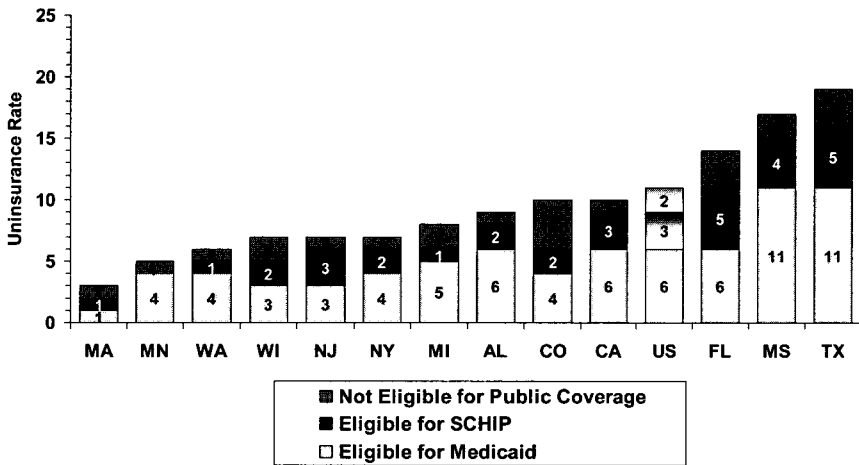
154. Dubay et al., *supra* note 127, at 5.

155. Dubay et al., *supra* note 126, at 2-3.

156. Dubay et al., *supra* note 126, at 3. Estimates based on a detailed Medicaid and SCHIP eligibility simulations model that uses the July 2001 eligibility rules to estimate eligibility on the 1999 National Survey of America's Families (NSAF). Dubay et al., *supra* note 126, at 3.

In fact, increasing participation among eligible children would provide near-universal coverage of children in this country. Based on data from the 1999 National Survey of America’s Families (NSAF), uninsurance rates for children varied dramatically across the thirteen states studied in depth under the Urban Institute’s Assessing the New Federalism project.¹⁵⁷

**Figure 1:
Increasing Participation is Critical to Equalizing Uninsurance Across States**



Source: Dubay, Hill and Kenney (2002) 1999 National Survey of America’s Families, using 2000 SCHIP eligibility rules.

Figure 1 shows that, nationally in 1999, 11 percent of all children were uninsured. Yet the rate of uninsurance for children ranged from a low of 3 percent in Massachusetts to a high of 19 percent in Texas.¹⁵⁸ As mentioned earlier, the

157. Genevieve Kenney et al., *Health Insurance, Access, and Health Status of Children: Findings from the National Survey of America’s Families*, in *ASSESSING THE NEW FEDERALISM, SNAPSHOTS OF AMERICA’S FAMILIES II*, at 3, available at <http://www.urban.org/pdf/child-health.pdf> (last visited Jan. 31, 2004); see also Alyssa Wigton & Alan Weil, *Foreword, Snapshots of America’s Families II: A View of the Nation and 13 States from the National Survey of America’s Families*, in *ASSESSING THE NEW FEDERALISM, SNAPSHOTS OF AMERICA’S FAMILIES II*, at 1, available at <http://www.urban.org/pdf/99foreword.pdf> (last visited Jan. 31, 2004). The NSAF is a nationally representative sample of households and families that focuses on the non-elderly population. The NSAF over-samples low-income households in the thirteen states participating in the Assessing the New Federalism (ANF) study. This sampling strategy allows analysts to make national and state level estimates in both the study states and the balance of the nation.

158. Dubay et al., *supra* note 126, at 7. Texas and Mississippi had only implemented Phase 1 of their SCHIP programs which phased in the coverage of older children living in poverty by 1999. These states’ Phase 2 expansions were not implemented until 2001. Uninsurance rates in these states undoubtedly declined after implementation of Phase 2. Dubay et al., *supra* note 126, at 7.

share of children who are both uninsured and ineligible for Medicaid or SCHIP is only 2 percent.¹⁵⁹ Since 1999, states have implemented unprecedented efforts at outreach and simplification of enrollment procedures.¹⁶⁰ In addition, during the Clinton administration, the federal government put enormous pressure on states to identify and enroll uninsured eligible Medicaid and SCHIP children. Since 1999, more than 3.4 million children were enrolled in SCHIP and this picture likely looks quite different.¹⁶¹ In 2001, uninsurance among children was at an all time low of 11.7 percent having fallen from 15.7 percent in 1998.¹⁶² So while the Medicaid and SCHIP programs together do not assure complete universal coverage of children, these federal-state programs offer the potential to reach this goal in the near future.

The Bind of Budget Neutrality

A major limitation of the pincer strategy as a mechanism to achieve universal coverage is the budget neutrality requirement, which is in effect whenever section 1115 demonstration waiver authority is used (this requirement therefore applies under HIFA as well).¹⁶³ This statutory requirement mandates that section 1115 demonstration waivers be budget neutral with respect to the federal government.¹⁶⁴ Thus, in order to finance expansions in coverage to new populations, states must show that the federal share of costs will not be greater under the waiver than they would have been in the absence of the waiver. Coverage of expansion populations

159. Dubay et al., *supra* note 127, at 3. National estimates of eligibility under Medicaid and SCHIP for all children and for uninsured children adjust for the fact that a share of foreign born non-citizen children that appear to be eligible actually are not due to their immigration status. National estimates are adjusted because the data are not available through the NSAF, or any other national survey, to reliably estimate children's immigration status by state, and state estimates are presented only for children who are citizens. Dubay et al., *supra* note 127, at 3.

160. Ian Hill, *Charting New Courses for Children's Health Insurance*, POL'Y & PRAC. OF PUB. HUM. SERVICES, Dec. 2000, at 30, 34; Donna Cohen Ross & Ian T. Hill, *Enrolling Eligible Children and Keeping Them Enrolled*, 13 THE FUTURE OF CHILD. 81, 83-84 (2003).

161. CTRS. FOR MEDICARE & MEDICAID SERVS., THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) AGGREGATE ENROLLMENT STATISTICS FOR THE 50 STATES AND THE DISTRICT OF COLUMBIA FOR FEDERAL FISCAL YEAR (FFY) 2000, available at <http://cms.hhs.gov/schip/enrollment/fy2000.pdf> (last visited Feb. 4, 2004).

162. John Holahan, et al., *Which Children Are Still Uninsured and Why?* 13 FUTURE OF CHILD., 55, 57 (2003); ROBERT J. MILLS, U.S. CENSUS BUREAU, CURRENT POPULATION REP. PUB. P60-220, HEALTH INSURANCE COVERAGE: 2001, 1, 3 tbl.1 (Sept. 2002), available at <http://www.census.gov/hhes/www/hlthin01.html> (last visited Jan. 31, 2004). Uninsurance rates from the CPS cannot be directly compared to those on the NSAF. See generally Shruti Rajan et al., *Confirming Insurance Coverage in a Telephone Survey: Evidence from the National Survey of America's Families*, 37 INQUIRY 317 (2000) (examining whether individuals with no reported insurance coverage are, in fact, uninsured).

163. 42 U.S.C. § 1315(e)(6) (2000).

164. *Id.*

must therefore be financed by either cost savings obtained from the traditional Medicaid populations (for example by placing these groups in managed care arrangements), by re-allocating disproportionate share (DSH) program dollars that in the absence of the waivers would have gone to providers, or by using unspent SCHIP allocations.¹⁶⁵

States do not negotiate budget neutrality on equal financial footing. For example, states vary widely in the extent to which they utilize DSH payments to finance care for the indigent. DSH payments – as a share of total Medicaid spending – range from less than 1 percent in twelve states, to 22 percent in Louisiana.¹⁶⁶ DSH spending per Medicaid recipient and per uninsured person ranges from zero in some states, to \$1,306 per Medicaid recipient in New Hampshire and \$1,167 per uninsured person in Missouri.¹⁶⁷

SCHIP funding allocations also vary considerably from state-to-state and, from the programs' inception, there has been concern regarding both the size of the SCHIP allotment and its allocation methodology.¹⁶⁸ In addition, while some states have nearly exhausted their allotment, others have large surpluses available. New York, for example, has legislative authority to expand coverage to parents up to 250 percent of the FPL, but has no SCHIP allocations available for the federal match, while California has enough unspent SCHIP funds to meet the budget neutrality requirements while expanding coverage of parents up to 250 percent of the FPL.¹⁶⁹

With the passage of time, satisfaction of budget neutrality requirements has proved more difficult for states given that most savings available from placing populations into managed care have been realized. Furthermore, the availability of DSH dollars and unspent SCHIP allocations have become increasingly limited. The Center for Budget and Policy Priorities (CBPP) estimates that by fiscal year 2004, five states will have SCHIP allocations that are lower than needed to sustain

165. CINDY MANN, THE HENRY J. KAISER FAMILY FOUND., THE NEW MEDICAID AND CHIP WAIVER INITIATIVES, 16-17 (2002).

166. Teresa A. Coughlin & Stephen Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences*, in ASSESSING THE NEW FEDERALISM, DISCUSSION PAPERS 02-09, June 2002, at 13, tbl.1, available at http://www.urban.org/UploadedPDF/310525_DP0209.pdf (last visited Jan. 31, 2004).

167. *Id.* at tbl.1.

168. See Frank Ullman et al., *The State Children's Health Insurance Program: A Look at the Numbers*, in ASSESSING THE NEW FEDERALISM, OCCASIONAL PAPER NO. 4, Mar. 1998, at 1-2, available at <http://www.urban.org/UploadedPDF/occ4.pdf> (last visited Jan. 31, 2004); see also Genevieve M. Kenney, et al., *Three Years into SCHIP: What States Are and Are Not Spending*, in NEW FEDERALISM ISSUES AND OPTIONS FOR STATES 1 (Urb. Inst. Series A, No. A-44, Wash., D.C.), Sept. 2000, available at http://www.urban.org/UploadedPDF/anf_a44.pdf (last visited Jan. 31, 2004).

169. See Howell, et al., *supra* note 139 (discussing New York); CTRS. FOR MEDICARE & MEDICAID SERVS., HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY (HIFA) INITIATIVE FACT SHEET, at <http://cms.hhs.gov/hifa/cafactsh.asp> (last modified May 23, 2002) (detailing California's Parental Coverage Expansion Program); Kenney et al., *supra* note 168, at 3, tbl.1.

enrollment of children at projected levels, and that the number of states in this circumstance will increase to twelve in fiscal year 2005.¹⁷⁰ CBPP further estimates that by 2007 as many as eighteen states could have spending levels that are higher than their allotted funding.¹⁷¹ Cutting benefits or eligibility for Medicaid or SCHIP populations to achieve savings to finance further expansions seems likely to be a politically unpalatable option.

Finally, the characteristics of the uninsured easily illustrate the dilemma imposed by the budget neutrality requirements. Using data from the 1999 NSAF, Figure 2 presents information on the characteristics of the non-elderly uninsured. Nineteen percent of non-elderly uninsured are children who are eligible for either Medicaid or SCHIP under the eligibility rules in place in July of 2002.¹⁷² Twenty percent of the uninsured are parents of these eligible children, some of whom are eligible for Medicaid or SCHIP themselves.¹⁷³ Children who are ineligible for either Medicaid or SCHIP and their parents constitute an additional 9 percent and 6 percent of the uninsured, respectively.¹⁷⁴ Finally, 46 percent of all non-elderly uninsured are childless adults who would be considered expansion populations under HIFA waivers.¹⁷⁵ Expansions to childless adults and parents who would be served by separate child health programs would have to be financed through the mechanisms mentioned above.

Cost savings from the existing program are unlikely to be found and those that are available are unlikely to be utilized to finance expansions in coverage of the non-elderly. Many of the services that have experienced rapid spending growth in recent years, such as prescription drug coverage and nursing home care, are optional services that are primarily provided to elderly and disabled populations with strong political influence and high health care needs. These groups of Medicaid enrollees are principally served at the option of states, which do not have plans to cut eligibility or benefits. Since states have not previously cut these

170. EDWIN PARK ET AL., CENTER ON BUDGET & POL'Y PRIORITIES, OMB ESTIMATES INDICATE THAT 900,000 CHILDREN WILL LOSE HEALTH INSURANCE DUE TO REDUCTIONS IN FEDERAL SCHIP FUNDING 11 tbl.3 (Nov. 2002), available at <http://www.cbpp.org/7-15-02health.pdf> (last revised Nov. 7, 2002).

171. *Id.*

172. See fig. 2. The share of non-elderly uninsured who are children eligible for Medicaid or SCHIP is likely lower now given the increase in SCHIP, and possibly Medicaid, enrollment that has occurred since 1999. Lisa Dubay et al., *supra* note 127, at 5-6.

173. See fig. 2.; Dubay et al., *supra* note 127, at 5.

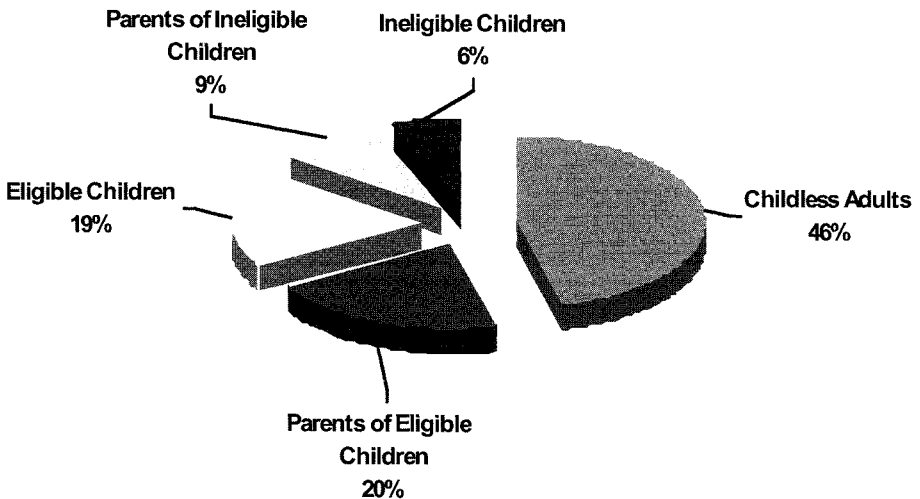
174. See fig. 2. A share of ineligible children and their parents, as well as parents of eligible children would be ineligible for Medicaid and/or SCHIP due to their immigration status. Dubay et al., *supra* note 127, at 3.

175. See fig. 2.; Dubay et al., *supra* note 127, at 4. See also CTRS. FOR MEDICARE & MEDICAID SERVS., GUIDELINES FOR STATES INTERESTED IN APPLYING FOR A HIFA DEMONSTRATION, available at <http://www.cms.gov/hifa/hifagde.asp>. (last modified May 23, 2002).

optional services and optional coverage groups to date, they are unlikely to do so to finance expansions in coverage for the non-elderly in the near future.

Figure 2¹⁷⁶

Uninsured Non-Elderly in America, 1999



Differing State Burdens and Fiscal Capacity

Even with a political commitment to expanding Medicaid and SCHIP to cover a larger share of the uninsured, it is unlikely that all states could achieve near-universal coverage because both the size of the uninsured population and the fiscal capacity to solve the problem vary tremendously across states. Using data

176. Dubay et al., *supra* note 127; Lisa Dubay & Genevieve Kenney, *Addressing Health Insurance Coverage Gaps for Parents*, HEALTH AFF. (forthcoming, 2004); Stephen Zuckerman et al., *Shifting Health Insurance Coverage, 1997-1999*, 20 HEALTH AFF. 169, 169-75 (2001).

from the 1997 through 1999 Current Population Survey (CPS), John Holahan estimates that, on average, 18.2 percent of all non-elderly Americans were uninsured and that the median state had an uninsurance rate of 15.9 percent.¹⁷⁷ The uninsurance rate varied considerably across states ranging from 9.8 and 10.7 percent in Minnesota and Rhode Island, respectively, to over 22 percent in Nevada, Arkansas, Florida, Louisiana, California, New Mexico, Arizona, and topping off at 26.7 percent in Texas.¹⁷⁸

Variation in the rate of uninsurance across states is due to a number of different factors including the extent of employer-sponsored coverage and state policies that cover low-income populations.¹⁷⁹ According to Holahan, states' uninsurance rates are principally determined by the extent to which employer-sponsored coverage exists rather than by eligibility for Medicaid and other state coverage of individuals.¹⁸⁰ For low-income populations, the uninsurance rate is driven by both the extent of employer-sponsored coverage and coverage of individuals under Medicaid and other state programs.¹⁸¹

A recent study by Yu-Chu Shen and Stephen Zuckerman found that differences between states in family income, education, race-ethnicity, and citizenship of residents drive the variation in employer-sponsored coverage across states, resulting in tremendous coverage gaps in states with low human capital and only small gaps in those with high human capital.¹⁸² At the same time, states that expand public coverage to fill the gap left by the employer-sponsored insurance market are those with higher per capita incomes, a greater share of residents with a college education, a lower share of the population under 200 percent of the FPL, a lower federal medical assistance percentage (FMAP), and a higher share of the population voting for Gore or Nader in the 2000 election.¹⁸³

These findings imply that the states that have the smallest uninsurance problem and the greatest fiscal resources are those most likely to try to fill in the gap left by employer-sponsored coverage with public health insurance programs.

177. John Holahan, *Variations Among States in Health Insurance Coverage and Medical Expenditures: How Much is Too Much?*, ASSESSING THE NEW FEDERALISM, DISCUSSION PAPERS 02-07, June 2002, at 9 tbl.1, 34 app.1, available at <http://www.urban.org/template.cfm?sections=research&NavMenuID=141&template=/taggedcontent/viewpublication.cfm&publicationID=7802>. (last visited Jan. 31, 2004).

178. *Id.* at 34 app.1.

179. *Id.* at 10.

180. *Id.* at 11-12.

181. *Id.* at 12.

182. Yu-Chu Shen & Stephen Zuckerman, *Why Is There State Variation In Employer-Sponsored Insurance?*, 22 HEALTH AFF. 241, 241 (2003).

183. See Holahan & Pohl, *supra* note 79, at 33-34; see also Frank Ullman, et al., *CHIP: A Look at Emerging State Programs*, in NEW FEDERALISM ISSUES AND OPTIONS FOR STATES 3-4 (Urb. Inst. Series A, No. A-35, Wash., D.C.), Sept. 1999, available at http://www.urban.org/UploadedPDF/anf_a35.pdf (last visited Jan 31, 2004).

Evidence from other studies supports these findings. In particular, Christopher Trenholm and Susan Kung showed that states with higher per capita income spend more than states with lower per capita income on filling the gap left by private insurance and spend a greater share of every \$1000 dollars of per capita income on the populations at risk for being uninsured.¹⁸⁴

The FMAP is designed to ameliorate these differences in fiscal capacity across states by providing a higher federal match to states with lower fiscal capacity.¹⁸⁵ However, the FMAP does not address the fact that those states with greater fiscal capacity have more expansive programs. As a result, states such as New York, Rhode Island, Vermont, Maine, Massachusetts, and the District of Columbia receive more than \$1,500 in federal contributions for acute care services per person under 200 percent of the FPL, while Montana, one of the poorest states in the nation receives only \$728.¹⁸⁶ While some poor states do receive higher levels of federal contribution per person under 200 percent of the FPL, such as Mississippi at \$1,300, the FMAP does not appear to compensate states equitably for their ability to finance care for the uninsured.¹⁸⁷

It is clear from these analyses that states with low uninsurance rates tend to be those that have the willingness and ability to address the problem. These states tend to have greater fiscal capacity and allocate a larger share of resources to solving the problem of the uninsured. In contrast, states with high uninsurance rates face numerous obstacles to solving their uninsurance problem. States with high uninsurance rates are more likely to have low per-capita income.¹⁸⁸ States with low per-capita income spend less per person at risk of being uninsured and also have lower fiscal efforts given their capacity.¹⁸⁹ The FMAP accounts for some, but not all of these differences.¹⁹⁰ Thus states in these circumstances that are interested in expanding coverage will likely need to develop different solutions to the problem than those that work for states with smaller problems and greater resources.

184. CHRISTOPHER TRENHOLM & SUSANNA KUNG, ACAD. FOR HEALTH SERVS. RESEARCH & HEALTH POLICY, DISPARITIES IN STATE HEALTH INSURANCE COVERAGE: A MATTER OF POLICY OR FORTUNE? 15 (Dec. 2000), available at <http://www.statecoverage.net/pdf/disparities.pdf> (last visited Jan. 31, 2004).

185. *Id.* at 23.

186. John Holahan & Alan Weil, *Block Grants are the Wrong Prescription for Medicaid*, 6 HEALTH POL'Y ONLINE 9 tbl.1 (2002), at http://www.urban.org/UploadedPDF/900624_HPOnline_6.pdf (last visited Jan. 31, 2004).

187. *Id.* at 9-10.

188. TRENHOLM & KUNG, *supra* note 184, at 15, 23; Holahan & Pohl, *supra* note 79, at 2.

189. See TRENHOLM & KUNG, *supra* note 184, at 19.

190. TRENHOLM & KUNG, *supra* note 184, at 15, 19. Differences between states in per capita income, educational attainment, race-ethnicity composition, citizenship, and political affiliation contribute to disparities in health care coverage.

The Current Fiscal Crisis and Others That May Come

With the economic expansion in the late 1990s, all states made unprecedented efforts to expand coverage to new populations. The downturn in the economy, changes within the health care system, and increasing Medicaid spending growth makes it unlikely that states will take the lead in expanding public insurance coverage. It is more likely that states will struggle to maintain enrollment in their current programs.

Almost all states have balanced budget requirements that require them to balance their budgets by the close of the Fiscal Year, and therefore, they may not carry a deficit.¹⁹¹ State political officials take this requirement seriously and it often limits their willingness to commit funding from state coffers for significant public service expansions.¹⁹² The balanced budget constraint is even tighter when one considers the fact that most state laws require supermajorities to approve certain tax or expenditure decisions.¹⁹³ As a result, state political officials are wary of putting their state in a position of increased expenditures when they have little ability to raise additional revenues (aside from cutting spending on existing programs) in the face of budget deficits. The results of a survey conducted by the National Conference of State Legislatures (NCSL) in April 2003 showed that, in order to balance their budgets, two-thirds of the states needed to reduce their budgets by nearly \$26 billion by June 30.¹⁹⁴ This is an increase from the previous estimates made in the fall of 2002, resulting in a gap of \$17.5 billion.¹⁹⁵ NCSL reports that states have had to use rainy day or other funds, delay capital projects, and cut Medicaid, education and corrections spending (twenty-nine states imposed across-the-board budget cuts) to balance their budgets.¹⁹⁶

Changes taking place within the health care sector have also had important ramifications on state budgets. The squeezing of some of the “excess fat” out of the health care system—which has occurred within both the public and private sector—has also played a role in exacerbating state budget deficits. For example, many states were able to control Medicaid costs in the early 1990s when they moved to mandatory enrollment of Medicaid recipients into managed care arrangements.¹⁹⁷ After a decade of efficiency gains, states are no longer reaping

191. WEISSERT & WEISSERT, *supra* note 81, at 208; Thompson, *supra* note 82, at 47-48.

192. Thompson, *supra* note 82, at 47-48; WEISSERT & WEISSERT, *supra* note 82, at 208.

193. Thompson, *supra* note 82, at 48.

194. NAT'L CONFERENCE OF STATE LEGISLATURES, STATE BUDGET UPDATE: APRIL 2003 1-2 (2003).

195. NAT'L CONFERENCE OF STATE LEGISLATURES, STATE BUDGET UPDATE: NOVEMBER 2002 (2002); Press Release, Nat'l. Conference of State Legislatures, New National Survey Reports State Budgets Fall \$17.5 Billion Short, (Nov. 22, 2002).

196. NAT'L CONFERENCE OF STATE LEGISLATURES, *supra* note 194, at 1-4.

197. WEISSERT & WEISSERT, *supra* note 81, at 222-24.

considerable cost savings from Medicaid managed care.¹⁹⁸ The federal government also tightened rules around DSH payments, funding for graduate medical education (GME) and the upper payment limit (UPL).¹⁹⁹ Rising pharmaceutical costs are driving costs up for all state-funded programs, including benefits for state employees, Medicaid recipients, and SCHIP enrollees.²⁰⁰ Finally, the 1999 U.S. Supreme Court decision *Olmstead v. L.C.*²⁰¹ required states to provide community-based alternatives to institutionalization, and may also prove to be a financial burden for states. Many states have not made significant changes to their delivery systems as a result of this decision, believing that existing programs for home and community based services were sufficient for compliance. However, there are a number of cases working their way through the courts that may change how states must respond and in the process require significant financial investment.²⁰²

In Fiscal Years 2001 and 2002, the percentage increase in state Medicaid spending grew at a rate of about 12 percent, while the percentage increase in total state spending grew at a rate of about 6 percent.²⁰³ Spending increases did not occur consistently across the populations or the services covered by Medicaid.²⁰⁴ According to Vern Smith, Medicaid enrollment growth is occurring faster than at

198. See WEISSERT & WEISSERT, *supra* note 81, at 224.

199. NAT'L ASS'N OF URBAN HOSP., POSITION STATEMENT ON: MEDICAID DISPROPORTIONATE SHARE (April 2003), at http://www.nauh.org/Docs/positions/pp_medicaid_dsh.pdf (last visited Jan. 31, 2004); Press Release, Department of Health and Human Services, HHS Issues Upper Payment Limit Regulation (Jan. 5, 2001), at <http://www.hhs.gov/news/press/2001pres/20010105.html> (last visited Jan. 31, 2004).

200. See WEISSERT & WEISSERT, *supra* note 81, at 224.

201. 527 U.S. 581 (1999). The *Olmstead* decision requires states to make additional expenditures unless the state can prove that requiring to make the additional expenditures "would be so unreasonable given the demands of the State's mental health budget." *Id.* at 595.

202. See, e.g., *Susan J. et al. v. Riley et al.*, No. 00-CV-918 (M.D. Ala.) (alleging that Alabama failed to furnish intermediate care facilities for mentally retarded individuals or home and community-based services to eligible individuals); *Tessa G. v. Arkansas Department of Human Services et al.*, No. 03cv493 (E.D. Ark.) (challenging Arkansas' practice of wait listing individuals for its HCBS waiver program for people with disabilities rather than letting them submit an application); *Bruggeman et al v. Blagojevich et al.*, No. 00-cv-5392 (N.D. Ill.) (alleging Illinois does not furnish Medicaid services to eligible individuals with reasonable promptness nor afford individuals freedom of choice in selecting between ICF/MR and HCB waiver services). For more information, see GARY A. SMITH, HUMAN SERVS. RESEARCH INST., STATUS REPORT: LITIGATION CONCERNING HOME AND COMMUNITY SERVICES FOR PEOPLE WITH DISABILITIES (Oct. 2003), (discussing over 20 state cases that have arisen after *Olmstead*).

203. MILBANK MEMORIAL FUND ET AL., 2000-2001 STATE HEALTH CARE EXPENDITURE REPORT (Apr. 2003), available at <http://www.milbank.org/reports/2000shcer/index.html> (last visited Jan. 31, 2004).

204. RONALD K. SNELL ET AL., NAT'L. CONFERENCE OF STATE LEGISLATURES, STATE SPENDING IN THE 1990'S 5-6 (2003), at <http://ncsl.org/programs/fiscal/stspend90s.htm> (last visited Jan. 31, 2004).

any time since 1992.²⁰⁵ While enrollment growth is concentrated among low-income families and children, spending growth is concentrated among the elderly and disabled who account for approximately 70 percent of all Medicaid spending.²⁰⁶ Of special concern to states are increases in prescription drug spending with annual increases of 19.7 percent between 1998 and 2000 and accounting for a large share of Medicaid costs.²⁰⁷ These increases are likely to continue and are consistent with overall trends occurring in the private market.²⁰⁸ In addition, the increase in Medicaid spending comes at a time when state tax revenues are falling rapidly—by about 20 percent between the second quarter of Fiscal Year 1999 and the second quarter of 2002.²⁰⁹

A number of studies have examined the response of states with respect to these recent fiscal crises and each report somewhat different findings.²¹⁰ Findings from case studies conducted in early 2002 suggested that states were not planning to implement broad reductions in payments to providers or cuts in eligibility, although these types of reductions in spending were being used.²¹¹ A more recent survey of states, however, indicates that since fiscal year 2002, fifty states reported reducing or freezing provider rates for at least one provider group, while forty-six implemented prescription drug cost controls.²¹² Medicaid benefits were reduced at

205. Robin Toner & Robert Pear, *Cutbacks Imperil Health Coverage for States' Poor*, N.Y. TIMES, April 28, 2003, at A1.

206. *Id.*

207. BRIAN K. BRUEN & JOHN HOLAHAN, THE HENRY J. KAISER FAMILY FOUND., ACCELERATION OF MEDICAID SPENDING REFLECTS MOUNTING PRESSURE, 6 (May 2002), available at <http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14133> (last visited Feb. 4, 2004).

208. *Id.* at 1.

209. Julie Hudman, Medicaid and SCHIP for Children: Progress and Challenges, Presentation Johns Hopkins School of Public Health and University of Maryland School of Law Conference on State Efforts to Expand Coverage: Current Realities, Future Possibilities? (Nov. 18, 2002) (presentation on file with the Journal of Health Care Law & Policy).

210. See, e.g., VERNON SMITH ET AL., THE HENRY J. KAISER FAMILY FOUND., MEDICAID SPENDING GROWTH: RESULTS FROM A 2002 SURVEY (Sept. 2002), available at http://www.kff.org/medicaid/upload/14139_1.pdf (last visited Jan. 31, 2004) (explaining the trends that account for spending in Medicaid); John Holahan, et al., *Health Policy For Low-Income People: States' Responses to New Challenges*, HEALTH AFF., W187, W189 (May 22, 2002), at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.187v1.pdf> (last visited Jan. 31, 2004) (describing how changed budgetary circumstances have affected states and how states have adapted); Embry Howell, et al., *SCHIP Dodges the First Budget Ax*, 3 HEALTH POL'Y ONLINE (Oct. 1, 2002), at http://www.urban.org/UploadedPDF/900558_HPOnline_3.pdf (last visited Jan. 31, 2004) (describing budgetary pressure affecting SCHIP and the way states have or plan to change their system); Kenneth Finegold, et al., *How Are States Responding to Fiscal Stress? in NEW FEDERALISM: ISSUES AND OPTION FOR STATES*, (Urb. Inst., Series A, No. A-58 Wash., D.C.), March 2003., available at http://www.urban.org/uploadedPDF/310658_A-58.pdf (last visited Jan. 31, 2004).

211. Holahan et al., *supra* note 210, at W189.

212. VERNON SMITH ET AL., HENRY J. KAISER FAMILY FOUND., STATES RESPOND TO FISCAL PRESSURE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2003 AND 2004: RESULTS FROM A 50-STATE SURVEY 19, 20 (Sept. 2003), available at <http://www.kff.org>

least one time during the period Fiscal Year 2002 through Fiscal Year 2004 by thirty-five states and thirty-four reduced or restricted Medicaid eligibility during the same tie period.²¹³ During Fiscal Year 2003, seventeen states increased beneficiary cost sharing, and twenty-one states instituted new or higher copayments in Fiscal Year 2004.²¹⁴ In addition, some states have cut outreach efforts in order to reduce enrollment growth among low-income children.²¹⁵ Estimates by the Center on Budget and Policy Priorities indicate that as many as 1.7 million individuals would lose their Medicaid, SCHIP or state-sponsored health insurance coverage if all of the proposed cuts were implemented.²¹⁶

WHAT WOULD IT TAKE FOR STATES TO TAKE THE LEAD?

The debate regarding the tradeoffs inherent in solving the problem of the uninsured at the federal or the state level has roots in Madison's *Federalist Paper No. 10*.²¹⁷ The entitlement nature of Medicaid gives the federal government tremendous authority over the program and allows state flexibility to the extent that such flexibility is consistent with federal objectives. A distinct advantage of this approach lies in the greater ability of the federal government to redistribute income. In contrast, the block grant nature of SCHIP provides more flexibility to states than does Medicaid, but caps the federal financial commitment to the program and offers fewer protections to beneficiaries.

This current maze of Medicaid and SCHIP programs, including the HIFA waivers that encompass both programs, is unlikely to produce solutions to the problem of the uninsured by states or an equitable distribution of federal resources across states. As noted, prior to SCHIP states were given the option to extend eligibility for Medicaid to all of the children that are now eligible for SCHIP but failed to do so. Based on extensive case studies in eighteen states, Ian Hill reported that states were consistent in the reasons they cited for choosing to take advantage of covering children under SCHIP, but that they varied in the weight they attributed to the reasons.²¹⁸ Among the key incentives mentioned by public officials and other stake-holders were the enhanced federal match, the increased

/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=22126 (last visited Jan. 31, 2004).

213. *Id.* at 21, 24.

214. *Id.* at 30.

215. Howell et al., *supra* note 210, at 8.

216. MELANIE NATANSON & LEIGHTON KU, CTR. ON BUDGET & POLICY PRIORITIES, PROPOSED STATE MEDICAID CUTS WOULD JEOPARDIZE HEALTH INSURANCE COVERAGE FOR 1.7 MILLION PEOPLE: AN UPDATE 1 (Mar., 2003), available at <http://www.cbpp.org/3-20-03sfp.htm> (last revised Mar. 21, 2003).

217. THE FEDERALIST NO. 10 (James Madison).

218. Hill, *supra* note 160, at 31.

flexibility with respect to benefits and cost-sharing, the option to cover children under a program that was not an entitlement, and the ability to develop strategies to prevent crowd-out.²¹⁹

Hill argues that the flexibility offered under SCHIP encouraged states to take ownership of the program and to be more creative in its design and implementation, which, in turn, made governors and other stakeholders more committed to its success.²²⁰ Moreover, as more states implemented programs and advocates clamored for expansions in eligibility, political pressure was asserted on governors who might otherwise have been less inclined to expand coverage.²²¹ Finally, the strong economy and, in some states, the presence of tobacco settlement revenues made it easier for states to finance the program than it would have been in the early 1990s.²²² All of these factors combined to encourage the creation of SCHIP programs in each state and the District of Columbia.

The SCHIP program provides an important example of federal-state partnership in addressing the problem of the uninsured. Unfortunately, at least part of states' success can be attributed to the significant financial commitment at the federal level, the strong economy, the growing political momentum to cover children, the low medical cost inflation during the late 1990s, and, in some states, the availability of tobacco settlement funds to finance their programs.²²³

Today, states face quite different circumstances. The U.S. is experiencing slow economic growth, so while Medicaid budgets are growing at the fastest rate since the mid-1990s, state revenues are falling (and will fall further because state income taxes are linked to federal tax rates, which are going through another round of cuts).²²⁴ At the same time, federal resources to expand coverage under Medicaid and SCHIP are all but frozen. Together, these trends suggest that only states that are politically committed to universal coverage and have high fiscal capacity, are likely to take the lead in the near future. It will be critical to follow the progress made in California and Maine toward universal coverage, as well as other states where the groundwork has been laid through state planning grants from HRSA.

Due to the issues outlined above, the pincer strategy of health insurance expansion is unlikely to allow states to take the lead in solving the uninsurance

219. Hill, *supra* note 160, at 31.

220. Hill, *supra* note 160, at 32.

221. See Hill, *supra* note 160, at 31.

222. See, e.g., 42 U.S.C.A. § 1396b (West 2003) (granting states leeway in dispersing funds achieved after the November 1998 settlement with tobacco manufacturing companies); *Cardenas v. Anzai*, 311 F.3d 929 (9th Cir. 2002) (holding that tobacco settlement funds can be used "for any expenditures deemed appropriate by the state").

223. Hill, *supra* note 160, at 31; Weil, *supra* note 142, at 13-26; *States Approve Ballot Initiatives Requiring Use of Tobacco Funds for Health Purposes*, 9 HEALTH L. REP. 1756, 1756 (Nov. 16, 2000).

224. Weil, *supra* note 142, at 14.

problem in today's environment. And while HIFA waivers offer a partial federalist strategy to solve the problem by granting increased flexibility for states, the lack of federal financial commitment to expand coverage to new groups and the legal constraints of ERISA preclude this option from achieving anything but marginal gains in insurance coverage. Moreover, the use of HIFA waivers has the potential to institutionalize interstate inequities in federal financing that are inconsistent with national objectives.

The path to universal coverage cannot rest solely on state leadership. It requires a national commitment to provide greater state flexibility and to supply additional federal dollars to states willing to initiate action towards universal coverage. This would require legislation at the federal level to allocate resources to cover uninsured populations that, as a nation, we have been unwilling to cover—in particular, adults with and without children.²²⁵

The problem of the uninsured cannot be solved through costs savings under the Medicaid and SCHIP programs. Even in the best of economic times, states were unable to solve the problem of uninsured children in the absence of increased federal funding. In addition, the methodology regarding the use of reallocated DSH payments and unspent SCHIP allocations to achieve budget neutrality would have to be reformed to reflect a more rational system based on state burdens and fiscal capacity.

Even if additional federal funds were authorized, not all states would expand coverage. Some states would be unable to come up with the state share of spending needed to expand coverage, while others would not have the political will to solve the problem.²²⁶ Moreover, unless a successful challenge to ERISA occurs, states will be unable to assure that private dollars already in the system remain there and will be unable to rely on employers as a source of revenues to finance care for the working uninsured.

In Lindblom's analysis, government is typically only capable of incremental adjustments to the status quo because the many participants in the policy process can only reach agreement on discrete problems, not basic goals.²²⁷ This suggests that without a major shift in economic or political conditions, a comprehensive single-payer system is unlikely to occur in the U.S. in the near future. Nevertheless advocates of such a policy would be well served by starting to build the political agenda for universal coverage now. Barring an unexpected major federal initiative, the only hope for obtaining universal coverage is through federally-

225. See also Joseph White, *Three Meanings of Capacity: Or, Why the Federal Government is Most Likely to Lead on Insurance Access Issues*, 28 J. HEALTH POL., POL'Y & L. 217 (2003); Michael S. Sparer, *Leading the Health Policy Orchestra: The Need for an Intergovernmental Partnership*, 28 J. HEALTH POL., POL'Y & L. 245 (2003).

226. Thompson, *supra* note 82, at 47, 50; Holahan & Pohl, *supra* note 79, at 38.

227. Lindblom, *Still Muddling*, *supra* note 7, at 517.

supported and potentially mandated state action. This strategy has the potential to allow states to develop unique insurance systems that are appropriate to their political and structural circumstances and to achieve a necessary redistribution of financial support across states. However, this strategy would require a major restructuring of state options and financing and a federal commitment to universal coverage. In the absence of these changes, tens of millions of individuals and their families will continue to suffer the health and economic consequences of being uninsured, and tremendous variation in insurance coverage across states will remain.