The Politics of Health Reform and Coverage Expansion in Oregon: A Comparison with Other States

by

Brian D. Collins

MPP Essay

Submitted to

Oregon State University

In partial fulfillment of

the requirements for the

degree of

Master of Public Policy

Presented February 9, 2010
Commencement June 13, 2010

Master of Public Policy essay of Brian Collins presented on February 9, 2010

APPROVED:

Robert Sahr, representing Political Science

Stephanie Bernell, representing Public Health

William Lunch, representing Political Science

Brian Collins, Author

Table of Contents

Introduction 5

Previous Work 6

Goals and Means of Reform 6

Lessons for Health Reform from Abroad 17

Politics of Reform in the United States 22

Reform in the States 26

The Advocacy Coalition Framework and Health Care Reform 29

Table 1 – Coalition beliefs 31

Table 2 – Examples of coalition members, 2009 32

Incompletely Theorized Agreements 32

Table 3 – Examples of Incomplete Agreements (Ruger) 35

Methods 35

State Attempts at Health Care Reform 36

Demographics 36

Table 4 – Demographics of States Attempting Health Care Reform 37

Massachusetts 37

California 42

Other States 44

Case Study: The Politics of Health Reform in Oregon 45

A Brief Overview of Previous Efforts to Increase Health Coverage in Oregon 45

Creation of the Oregon Health Fund Board 48

Plan development process 50

The Final Report of the Oregon Health Fund Board: "Aim High, Building a Healthy Oregon" 51

Coverage 52

Information and Transparency 54

Cost 55

Quality 57

Other Recommendations 58

The Governor's Response 59

The Legislative Response 59
The Final Legislation: HB 2009 61
The Final Legislation: HB 2116 62
Table 5: Summary of Greenlick-Bates legislation as enacted 64
Politics and Policy: Drivers of Change 64
Discussion 71
Health Reform in the United States 71
Oregon and the ACF 72
Table 6 – Members of Universal Coverage and Free Market coalitions in Oregon 73
Oregon and ITA 73
The Oregon Health Fund Board as a Policymaking Tool 73
Comparison of Oregon with Other States 74
Evaluation of Theories (ACF and ITA) 77
Practical Political Implications 78
Conclusion 79
List of Works Cited 81
Appendix: Interviews 86
Appendix: Definitions of Terms 87

Introduction

In 2009, in the midst of a deep recession, Oregon legislators passed the Greenlick-Bates[1] health reform legislation, providing near-universal insurance coverage to Oregon children and making significant structural changes to state government's approach to health care policy, including the creation of a new agency, the Oregon Health Authority. This legislation was the culmination of a multi-year process, which included the appointment of a citizen-led commission to recommend health care reform policies for Oregon. Recently, several other states have also attempted health care reforms. These state-level efforts provide a unique opportunity to better understand the political and policy dynamics of health reform, particularly as the nation embarks upon a similar effort in the wake of the 2008 election.

Reform of the health care system to increase insurance coverage, control costs and improve quality and health outcomes is and has been a major issue in our national political discourse for decades. Since the failure of President Clinton's effort to enact national health care reform in 1994, the focus of many efforts to enact policy to address the problems with our health care system has been at the state level. States offer a natural, but limited, arena for health care policymaking, as they all serve as the operators of the joint federal-state Medicaid health insurance programs for the poorest Americans and have the primary role in regulating the individual and small group portions of the commercial insurance market.

In the 2000s, major reform efforts were attempted in states including Massachusetts, California and Oregon. Many of these reforms have been thoroughly studied, although Oregon's have not. Oregon's approach has been nearly unique, as it has relied on a citizen-led commission which was given a wide-ranging mandate to study and issue recommendations to the legislature for health reform to expand coverage, control costs and improve quality. This essay includes a case study of the reform process in Oregon and surveys the efforts of other states in an attempt to address the following questions:

[1] Representative Mitch Greenlick, an emeritus professor of public health, and Senator Alan Bates, a primary care physician, introduced the package of health reform legislation including HB 2009, HB 2116, SB 451, SB 452, SB 455 and SB 457.

- What were the strengths and weaknesses of Oregon's commission as a political and policymaking process?
- How did the results of Oregon's health reform policymaking process compare with those of other states that have attempted significant health reform, as measured by the enactment of reform legislation, expected results and actual results?
- What do these results portend for future reform efforts?

A better understanding of health reform processes and policies at the state level could help to predict the effects of and possibly aid future reform efforts in the states. It could also shed light on possible strategies for and consequences of future national level health reform, as many of the most groundbreaking reform policies are being pursued at the state level.

Previous Work

There is no shortage of literature about health care reform. This review presents general reform concepts and proposals, emphasizing policies that are relevant to state-level efforts at reform, and studies that specifically address state actions to increase coverage, reduce costs and improve quality within the health care system.

Goals and Means of Reform

Berwick, Nolan and Whittington (2008) present common criticisms of the U.S. health care system, such as costs double per capita of any other developed country, relatively poor outcomes and the lack of universal health insurance. They propose a "triple aim" framework of goals for health care reform, including improving the health care experience, improving population health and reducing per capita costs, arguing that these goals are interdependent, and they have not been achieved because individual rational interests are not aligned with collective interests.

Berwick, Nolan and Whittington believe the solution is to create institutions to serve as integrators that are accountable for the triple aim. Organizations like Kaiser Permanente, where health care financing and delivery are included in the same organization, are well-positioned to be integrators, as are single payer health care systems. Integrators would change the culture, focusing on preventative care, follow up and reducing long term costs. They suggest that HMOs failed at this role because they were focused only on cutting costs and had to compete against fee-for-service and preferred provider plans that covered everything. The key to cost control is not to deny coverage more often, but to counsel against treatments that have little value as part of excellent primary and preventative care that results in less need for expensive procedures.

Fuchs and Emanuel (2005) argue that reform is necessary because one in six Americans is without insurance, medical spending is increasing at an unsustainable rate, administrative costs are too high and errors are prevalent. They believe that these problems are systemic. Our employment based insurance system is in decline and government insurance programs for the poor and aged have not closed the coverage gap or controlled costs. Incremental reform proposals could include employer mandates, subsidies to the uninsured to buy coverage, expanding Medicaid by increasing income limits, expanding Medicare by decreasing the minimum age, health savings accounts to encourage people to save for health care expenses and pay out of pocket, managed competition and quality incentives. Fuchs and Emanuel conclude that none of these approaches would achieve universal coverage or solve medical cost problems alone.

Fuchs and Emanuel present three paradigms for comprehensive reform: personal mandates with subsidies, single-payer and their preferred proposal, universal health vouchers. An individual mandate is a requirement that everyone purchase a minimum level of health insurance, and this requirement must be coupled with subsidies based on income. Some versions of this plan would include an employer role in providing health insurance; others would place everyone in the individual health insurance market, which may include an insurance exchange, minimum standards and other regulatory reform. Fuchs and Emanuel question the ability of this kind of a system to control costs and argue it would be difficult to enforce.

Under a single-payer health care arrangement, where the government would pay for all care, everyone would have access and benefits would be paid for through new or increased taxes. The voucher system that Fuchs and Emanuel promote would grant every individual an equivalent, risk-adjusted voucher to pay for a basic level of health care. Anything beyond that would be the responsibility of the individual to pay for. The system would be financed with a value-added tax. They envision that only a handful of insurance companies would be qualified to accept the voucher in exchange for coverage. Fuchs and Emanuel believe that incremental reforms will not achieve universal coverage or address the other major problems in health care. Incremental reform has brought us SCHIP and Medicare prescription drug coverage and little else. Changes in financing and organizations need to occur, including incentives for providers to reduce costs.

Fuchs and Emanuel acknowledge many obstacles to reform, including the concerns of single-issue groups, our system of government in which significant change is slow, and strong differences of opinion about what change would be desirable. They believe that a war, depression, or major civil unrest could be necessary to precipitate reform, or alternatively a confluence of developments such as the business community deciding they no longer want to pay for health insurance, state budget crises related to Medicaid or a financial crisis on the federal level with Medicare.

Baicker and Chandra (2008) address popular myths related to health insurance reform from an economics perspective. Confusing health, health care and health insurance is often at the center of these myths. Insurance is a risk-pooling mechanism in which a large group pay a regular premium for the security that if they get sick and have very high costs, their costs will be covered. The reason we buy insurance is not just because health care can be expensive (many things are expensive that we don't insure against), but because health care costs are unpredictable. Our system is often criticized because sick people can't find affordable health insurance. Baicker and Chandra argue that uninsured sick people do not need insurance; they need health care. No one will insure them (for less than the cost of care) because they are certain to need insurance; a sick person buying health insurance after the fact is as unworkable as allowing people to buy car insurance after they've had an accident. However, because of the cost of caring for sick people,

insurers have an incentive to try to get rid of the sick people who are enrolled in their health plans, a problem that calls for regulation.

It is important to recognize the difference between private insurance and social insurance. Private insurance redistributes from the healthy to the sick; social insurance redistributes from the high income to the low income. Because insurance is expensive, many low income people cannot afford it and therefore, if we want universal insurance, high income people will need to subsidize low income people. Private markets do not do this; it takes government intervention, such as through means-tested, cash subsidies to help people buy insurance. Alternatively, government can play both roles and provide insurance in a single-payer system. Providing insurance, and therefore health care, for the sick can be accomplished by a system of community rating, subsidies and an individual mandate to buy health insurance. It can also be achieved by a single-payer system, although Baicker and Chandra argue that there are disadvantages, including less flexibility and choices, reduced innovation and higher taxes.

Baicker and Chandra believe that covering the uninsured will not be self-financing because of reduced expensive emergency room care. The ER is an expensive and inefficient way to provide care in many cases, especially if preventive care could have avoided the visit. But there is no evidence that savings from reduced ER utilization are enough to pay for insurance, as insured individuals still use more care than uninsured individuals use the ER. The reason to increase coverage is it will improve health outcomes. Additionally, insurance with low cost-sharing encourages increased use of care, driving up costs.

Insurance coverage does not ensure high quality care. Geographical location is a better predictor of high quality care than spending; considering Medicare, many regions of the country with high costs are associated with lower quality care. High spending is associated with expensive diagnostic and imaging services and more use of specialists, as well as more interventions at the end of life. And some low cost, effective preventative care, such as flu shots, is used less in high cost areas.

Employers do not ultimately pay for insurance. Baicker and Chandra and others argue that the incidence of employer contributions toward insurance falls on workers and result in lower wages and

employment. Our employer-based system is encouraged by tax advantages and the benefits of large pools to spread out risk. Baicker and Chandra doubt high deductible health plans will save much, as these often result in less usage of important and high value care, such as outpatient treatment for chronic conditions like diabetes, which untreated can result in expensive ER visits. They suggest health plans base cost-sharing on the value of procedures.

Finally, Baicker and Chandra do not believe that reform must be perfect. Doing something to improve the situation is more important than waiting for the ideal solution. The combination of widespread uninsurance and unsustainably rising costs demands comprehensive action, not band-aid solutions. Ultimately, many of the decisions are really political and philosophical, not dictated by economics.

Furman (2008) presents various tax reform proposals that could create incentives for expanded coverage and generate savings to help finance reform. The current tax system provides an exclusion for employer-provided health care, which means that an employee who receives a $10,000 health plan from their employer reports no income and pays no taxes on that benefit, whereas an individual who takes $10,000 from earnings to purchase an individual insurance policy receives no tax benefit and must continue to pay federal and state taxes on that income. This system is biased in favor of employer-provided health insurance, and it is also biased in favor of generous insurance plans with little cost sharing, as anything covered by the employer-paid health plan is tax free for the individual. Copayments, coinsurance and deductibles are all paid from after-tax earnings. There is evidence from previous research that this results in higher spending on health care with no or minimal increases in quality. Perhaps most importantly, the tax benefits for health insurance were estimated to cost the federal government $200 billion in lost tax revenue in 2008, and if repealed or scaled back could provide a major source of revenue to pay for universal coverage expansion, but, politically, are almost impossible to touch.

The four main approaches to health reform via tax reform include: creating new tax incentives for people who buy health insurance in the individual market; tax incentives as part of a comprehensive plan

for universal coverage; tax incentives designed to reduce spending (Health Savings Accounts); and removing or replacing current tax incentives. Furman examines finds problems or uncertainties about trying to "level the playing field" through tax benefits for individual insurance, which could draw people from the employer-based insurance market and result in more uninsured. He is also not convinced HSAs would necessarily result in much improvement in coverage or cost savings, especially since they are most attractive to high income individuals and families. He also argues that removing or limiting the tax benefits for employer-provided health insurance must be combined with new pooling and regulation, such as the Massachusetts-style exchange and individual mandate, along with subsidies, such as a tax credit to purchase health care on a sliding scale based on income, for the change to be efficient and effective.

Feldstein (2006) is insistent that cost-control in our health care system is made very difficult by our reliance on insurance, because insurance reduces or eliminates the process of cost-benefit analysis for the patient. If a patient has to pay the full cost of a procedure, say $100, but the patient values the procedure at only $25, they will conclude it is not worth the expense. But if the procedure is no additional cost, or a minimal co-pay (say, $10), the customer will be less price sensitive and is likely to consume health care for which the cost outweighs the benefit.[2] His solution is more co-pays and deductibles (or 50% coinsurance), which would reduce consumption. However, Feldstein acknowledges affordability limits, and believes at some point catastrophic coverage must pick up all the costs.

Oberlander (2008) argues that financing is much of the battle in relation to any health reform and examines a variety of options from the perspective of political viability. Raising the money to pay for reform is hard because the current financial framework of the health care system is entrenched with defenders who benefit from current provisions. The funding for health insurance is invisible to many Americans, as employers pay untaxed premiums of which employees may not be aware. It is difficult to raise taxes in the U.S., and additional resources will be needed for universal coverage. Congress is committed to pay-as-you-

---

[2] Feldstein's analysis assumes that patients are aware of the value of specific medical procedures, which is probably not a safe assumption.

go, so deficit spending is unlikely, although Oberlander notes that deficit spending was deemed acceptable for many recent policies, including wars in Iraq and Afghanistan, Medicare Part D and the Bush tax cuts. Savings must be scored by the Congressional Budget Office, so many policies that could save money, such as adoption of electronic medical records, are difficult to count because the savings are highly uncertain and may be far in the future.

Changing the tax treatment of health insurance could raise significant amounts of money for reform while controlling costs. Capping the tax exclusion for insurance at $4,000 for individuals and $11,000 for families would generate $1 trillion over ten years. The existing exclusion is regressive, benefiting higher income families a greater proportion of their income than lower income families. However, it is politically challenging because the idea of taxing health benefits can easily be framed in a negative light. It would affect certain professions and geographic areas more than others, and unions oppose the idea since their members often have generous benefits. Reducing the exclusion is believed to be an effective form of cost control, as it will discourage plans that have limited cost sharing.

An employer mandate, Oberlander argues, would mostly be paid by employees, but nevertheless many employers oppose because they think it would cost them or because they oppose mandates on business in general. Politically, an employer mandate has advantages because most people associate health insurance with employers anyway. A modified version is the pay-or-play payroll tax in which employers could either provide a health insurance benefit or pay a tax. This tax will probably be opposed by businesses, particularly if it is set high. If it is too low there is the danger that employers would drop coverage because they find it cheaper to pay the tax and so would leave more uninsured without the requisite resources to fund their coverage.

A value-added tax (VAT), a form of consumption tax that is incorporated into the price of goods and services, could replace a large portion of health care financing, however this would require very high rates; to raise the $2 trillion annual cost of the U.S. health care system would require a 40% tax rate (p.

w551[3]). A VAT is common in many other countries, but that does not mean that the U.S. would adopt it easily. It will attract opposition from both conservatives who see it as a means to expand government and liberals who oppose regressive taxes.

Finally, general revenues could fund reform, through increased income taxes or offsetting savings. Offsetting savings would most likely be changes to Medicare and/or Medicaid, such as reducing payments, increasing premiums, or other reforms. Of course, this could be controversial with seniors and AARP. On the other hand, reforms have previously been enacted that have cut the cost of Medicare, such as the move to prospective payment systems.

Politically easy ways to generate revenue, such as tobacco taxes, will not raise enough to fund reform (Oberlander, 2008, p. w553). As a result, funding comprehensive reform will require politically difficult decisions. Alternatively, Congress could opt for stronger cost control measures to reduce the need for revenue, but even those may be as controversial as new or increased taxes.

Cogan, Hubbard and Kessler (2005) make recommendations to improve the market for health insurance. They frame the main problem as one of value; we spend too much, yet availability and quality of care is spotty. They acknowledge that market reforms are not the only solution necessary. The health care market is distorted by our tax policy; they are critical of low deductible, low-copayment policies that encourage wastefulness and argue that all out-of-pocket costs should be deductible to eliminate tax disadvantages. They also want to expand HSAs and provide refundable tax credits for low income people to purchase health care services.

Regarding market reform, Cogan, et al. dislike the fragmented, fifty-state approach to insurance regulation, and would prefer one federally-regulated national market. This would provide customers with choices, standards and costs similar to those provided by large group, self-insured plans. They propose that insurance should be subsidized for the chronically ill, but not catastrophically ill, to help encourage insurance availability. Cogan, et al's reasoning is that insurance is best at protecting against unexpected,

[3] Refers to web edition pagination for *Health Affairs*

expensive problems that could occur in the future, such as an accident or illness, whereas insurance companies will always try to avoid covering individuals with existing problems that are unlikely to abate, such as diabetes. If these chronic conditions are subsidized by the government, it is more likely that individuals will be able to obtain coverage to insure against future unexpected medical costs. Finally, they advocate information transparency, malpractice reform and a crackdown on anti-competitive actions by providers and insurers.

Ginsburg (2008) addresses the role of employer-provided coverage under health care reform, and argues that proposals to end employer-based coverage and move all Americans to individual coverage on insurance exchanges are premature. He notes that many of the conditions that are motivating reform today are similar to conditions the last time national reform was seriously considered in 1994, especially sustained cost increases greater than increases in earnings. However, in 1994 the focus was on employer mandates and managed care. Now, there is interest in moving away from employer provided insurance. The viability of the employer-based system is questionable given the increases in cost, global competitiveness and less employment stability. Some desire stronger involvement of markets in health care, and employer based coverage prevents that, as choices are limited by what employers are willing and able to offer. If individuals have more choice in health plans, plans may be more responsive to individual preferences, rather than the preferences of employers, and additional competition could put downward pressure on premiums. Single-payer advocates want coverage to be provided by the government, not employers, which would make the government the price-setter and could potentially be very effective at controlling costs. The Wyden-Bennett proposal envisions that employers would no longer directly provide insurance, but would continue to subsidize the premiums of workers, who would pick plans offered on state-operated health insurance exchanges.

The employer-based system persists because of favorable tax treatment, economies of scale and the preference of employers to have workers insured to increase productivity. Large employers have enormous advantages as they have larger risk pools that enable coverage for high and low risk individuals at lower

rates. Yet employment-based insurance has been eroding (59.7% of the population in 2006, versus 62.8% in 1999) (Ginsburg, 2008, p. 677) and increasing costs along with the trend toward more part-time, contract and self-employment threaten to erode employer-provided coverage even more. However, there are potentially great benefits to an expansion of individual coverage, including more plan choice and an increase in international competitiveness.

The existing individual health insurance market has many problems, and many people who currently receive health care from employers would not be able to find affordable coverage in the individual market. Many states have reformed small group markets to require guaranteed issue[4] and community rating[5]. Fewer have enacted such reforms in individual markets, and those that have experience adverse selection[6], higher premiums and lower enrollment; this has been the case in Washington state (Ginsburg, 2008, p. 681). Significant expansion could make community rating and guaranteed issue feasible. Reforms would include an individual mandate and subsidies for low income people to purchase insurance. Regulation is necessary to discourage insurers from designing plans that only attract healthy people. Ginsburg argues that government supported insurance exchanges[7] are essential to a viable individual insurance market. Massachusetts' Connector, a website where any Massachusetts resident can go to purchase health insurance, is the only exchange currently operating in the United States, although the Federal Employees Health Benefits Plan, a system by which federal employees may select from a variety of nationwide health plans, has some aspects of an exchange. Risk adjustment could be incorporated into

---

[4] Under a guaranteed issue insurance market, insurance companies are required to sell (issue) insurance policies to anyone, regardless of their medical history or demographics, and cannot deny coverage for a preexisting condition.

[5] Pure community rating means that insurance companies are required to charge all customers the same premium for a given policy. It is common for states to require community rating in general but allow certain exceptions, such as for tobacco use, and to allow for limited variation of premiums among different age group.

[6] In health insurance, adverse selection is when people with medical needs purchase insurance and make claims, causing premiums to rise and healthy people to cancel their coverage, which continues to place upward pressure on premiums as there are fewer healthy people in the risk pool to cover the costs of claims. Insurance companies avoid adverse selection by engaging in medical underwriting, which is the process of only selling insurance to people who are currently healthy and charging higher premiums for certain risk factors, such as tobacco use and age.

[7] A government regulated marketplace in which all citizens can easily compare available insurance plans and purchase coverage. The exchange serves as a gateway between the people and insurers as well as a mechanism to distribute subsidies to help low and middle income families obtain insurance. The Massachusetts Connector (www.mahealthconnector.org) is an example of an insurance exchange.

exchanges to help ensure that plans are not incentivized to cherry pick the healthiest customers; premiums would be redistributed among plans based on the health of their membership. Ginsburg believes that Medicare Advantage has successfully employed risk adjustment and could be a model for the exchange. He also believes that an appropriate base level of coverage is important to ensure affordability and that the Massachusetts Connector has been damaged by including mandates for coverage of elective procedures, such as in vitro fertilization.

There are two models for insurance exchanges in the U.S. Either there could be exchanges for Americans who do not have access to employer coverage, or exchanges could be available for everyone. Ginsburg prefers to establish exchanges only for Americans who do not receive health insurance from their employer and is skeptical about relying on untested exchanges for everyone right away. Design and operational problems could be worked out with a smaller population, where it would still be an improvement for individuals and small businesses that lack good options for insurance now. It is also important not to subject people to disruptive change when they are satisfied with their existing coverage, mostly those working for big companies or governments. Additionally, while the exchange will be a source for policy innovation, so can employers, thus having multiple large risk pools could continue to be desirable. It would be important to design the rating rules so that young, healthy people with employer coverage are not able to get very cheap individual health insurance, causing adverse selection for employer risk pools. In the future, when there is more experience with exchanges, we will be able to make an informed decision about whether more or all of employer-based insurance should be moved to the exchange.

Gawande (2009) compares health care spending in McAllen and El Paso, Texas, the former being one of the highest cost markets and the latter being among the lowest cost, as measured by Medicare spending per beneficiary. He finds that the issue is a difference in cultures within the health care community. Some areas seem to have patient-centered cultures where physicians focus on the best care for patients and attempt to minimize unnecessary tests and procedures, whereas McAllen has a money-centered

culture where physicians see tests and procedures as an opportunity to enrich themselves and, when in doubt, order tests and procedures. Additionally, agency problems abound in places like McAllen where physicians have ownership stakes in hospitals, and therefore have additional incentive to maximize the performance of procedures. Gawande compares McAllen to good models of quality care and cost control, such as the Mayo Clinic, where doctors are salaried, and the community of Grand Junction, Colorado, where doctors have chosen to share revenue so that they are paid the same whether they see a Medicaid patient or someone with commercial insurance, and have collaborated on EMR systems and other continuous improvement projects in order to increase quality and lower costs. As El Paso and Grand Junction show, it is possible to have low cost/high quality medical delivery systems even when payments are fee-for-service (in a traditional or revenue-sharing form), but it is obvious that the incentives of fee-for-service can encourage greed and overuse of care. Gawande's main point is that cost control will not be solved by who pays for health care but will be determined by how we pay for health care, along with the expectations and practices among physicians and others in the health care industry. Potential solutions include financial incentives for integrating care, working as a team and implementing collaboration. Essentially, policy needs to encourage the Mayo Clinic and Grand Junction-style systems of health care delivery, and penalize, or at least not subsidize, the McAllen-style systems.

Lessons for Health Reform from Abroad

Jost (2004) provides an overview of health care in developed countries, explaining that most countries fit into either a social insurance or national health insurance model. Under a social insurance model, the government is generally responsible for paying for most medical expenses, but the delivery system, including hospitals and physicians, are generally private, independent organizations that contract with governments or publically subsidized insurance companies to provide service. The national health insurance model includes more government involvement in the delievery system. For instance, the government might own the hospitals and employ doctors in addition to paying for most medical expenses.

In the U.S., Medicaid, Veteran's Affairs, military, and Indian Health Service systems resemble the national health insurance model. Medicare is an example of the social insurance model. Social insurance programs are generally more expensive than national health insurance because the government has less control over costs in a decentralized system with independent providers than in an integrated system where the government runs the hospitals and employs physicians. Jost emphasizes that the U.S. does not lack rationing, although care is not rationed for those who can afford to pay for it or have good insurance. He also points out that national health system nations with higher levels of spending don't have as many problems with waiting lists as lower spending nations.

In national insurance countries, funding for health care may be provided in a single, global budget that competes with other national spending priorities. Social insurance systems do not have a single budget and costs are harder to control, resulting in higher spending. The U.S. has far more revenue streams for health care than in other developed countries, making discipline extremely difficult.

Jost argues that political institutions, social culture, a weak left and unions, powerful interest groups and path dependency explain why the U.S. has not achieved universal coverage. Change is slow in Congress, laws like ERISA[8] make it impossible for states to establish universal coverage on their own and Americans are averse to government solutions to problems, so reforms have typically been incremental. Since the left has not been as dominant in the United States as in other western democracies, and there have been interesting historical twists regarding health care, such as the labor movement's role in defeating national health insurance when it was proposed in the early 1900s, the U.S. is left with a peculiar system compared with other developed nations. Change is made harder by the fact that there are many people and businesses invested in the current system, especially the health insurance industry, but also the AMA and

[8] The Employee Retirement Income Security Act is a federal statute that governs private pension plans and the health benefit plans of large companies that self-insure and often operate in multiple states. The law exempts these self-insured plans from the regulatory control of state governments. ERISA greatly complicates the efforts of states to enact health care reform policies, as attempts to establish employer mandates are vulnerable to charges that they violate the law.

businesses. The author notes that countries that established social insurance systems generally co-opted insurers by making it possible for them to continue operating in some form.

Jost emphasizes path dependency as being a critical explanation of the state of health care in America. In short, America is in the situation it is because of everything that has happened in the past, which is true for other nations as well, as all have unique systems. There is tremendous inertia in political systems, and most nations keep doing things the way they have always been done. On the other hand, change is possible, particularly at times when a variety of events converge. The author, writing in 2004, says it is unlikely this will happen any time soon because conservative Republicans control the U.S. government. [Since then, Democrats have won commanding majorities in Congress and retook the Presidency, and key Congressional leaders as well as the President are actively working on health care reform.] Jost also points out that many advanced, industrial democracies achieved universal health care only recently, including Switzerland in 1996, Spain in 1986, and Australia in 1984. He suggested that universal health care might come in the U.S. in response to problems with the employer-based system, growth in the uninsured and anxiety among the middle class about health insurance. This might be combined with some degree of support from providers who are worried about getting paid and business that is having trouble satisfying employees, and insurers might decide to try to find a role in a universal system.

Southby (2004) provides suggestions for reform in the U.S. based on the Australian experience. Until 1984, Australia had a voluntary system of health insurance that received some government support. This system was not functioning well and liberal politicians attempted and failed to replace it with universal care in the 1970s. In 1984, they were successful at creating Medicare (they use the same name as the U.S.), which covers all Australians using a fee-for-service, mixed-public/private approach, including preventative, primary, hospital, pharmaceutical and mental health care. However, there is a cost sharing system (Medicare pays only 75% of the cost of some health services), so many Australians (44%) also have private insurance, which covers the gap between what Medicare pays and what doctors and hospitals charge. Additionally, the private health insurance enables policyholders to use private hospitals (most hospitals in

Australia are run by the states) and to not have to wait for elective procedures. The Australian system is financed by general taxation, a 1.5% charge on taxable income, state revenue and patient fees.

Southby provides policy suggestions for how the U.S. might approach reform, including that the coverage must be universal, the system must be comprehensive and integrated, health promotion should be emphasized, it should not be employment based, it should be designed to be responsive to the diverse needs of aging, urban and rural populations and should include population-wide health improvement targets along with a system to monitor access and quality of care. He also recommends a reform process of setting a clear commitment to establishing universal coverage and appointing a commission to find ways to achieve that goal while also reforming the system in general. Southby is unequivocal about rejecting the "band-aid" approach of small changes to the existing system to expand health care around the margins.

Herzlinger and Parsa-Parsi (2004) view the Swiss health care system as an important example for the U.S. as it embarks on health reform. The Swiss system is consumer driven in that individuals are required to purchase insurance and may do so from a variety of private sources, whereas in the U.S. employers act as the gateway to the purchase of insurance, and may only offer one insurance option to employees. In Switzerland, universal coverage has been achieved at a lower cost than the U.S. spends on health care, but without a single payer system and, according to the authors, related concerns about "quality, responsiveness, equity, and provider compensation." In Switzerland, individuals are free to choose a health plan and those who cannot afford health insurance receive subsidies from the government. The supply side is highly regulated; many Swiss hospitals are owned by the public, certain benefits are mandated and prices are controlled. The compulsory insurance is not-for-profit. Insurance companies may sell supplementary insurance covering additional benefits on a for-profit basis. The Swiss system has achieved positive results, with health status competitive with the U.S., lower costs (30% lower per capita) and universal coverage. Small insurers are commonplace in the Swiss system, suggesting that a consumer driven health care system would not necessarily lead to massive consolidation.

Herzlinger and Parsa-Parsi offer some lessons for reform in the U.S. from the Swiss example. They believe that individuals should be required to purchase insurance and the state should offer subsidies for those who cannot afford the premiums in order to achieve universal access. To control costs and improve customer responsiveness, experimentation in coverage, benefits and terms along with risk-adjustment of insurers is necessary. Health care providers should be able to innovate in care delivery and pricing. Coverage requirements should be based on dollars (all expenses over a certain amount), not benefits to allow consumer choice. Quality results for health care providers should be available to consumers.

Van de Ven and Schut (2008) provide an overview of the Health Insurance Act that was enacted by The Netherlands in 2006. This reform requires individuals to purchase a standardized, basic health insurance plan from private companies, which are required to sell anyone a policy (guaranteed issue) for the same price (community rating) with the exception that premiums may vary geographically (by province). Premiums are subsidized on a sliding scale by income, and individuals also pay a tax that goes into a government fund for extraordinary care. This fund is used to pay for long term care, very long hospital stays and is also used to make risk-based payments to private insurers, so insurers that attract relatively more expensive populations are not disadvantaged. The Dutch may also purchase supplementary insurance, which is usually offered by the same private insurers to cover procedures not included in the basic benefits package. The supply side in The Netherlands has historically been heavily regulated with price controls and set budgets for hospitals. The system has rapidly been adopted and has resulted in strong price competition, which has resulted in losses for insurance companies for the first two years. Uninsurance is estimated at 1.5%. As of 2008, the government had not implemented efforts to enforce the individual mandate, but planned to cross-reference insurance enrollment with government records to find people who have not signed up. The uninsured will first be sent a warning reminding them to purchase insurance. If they do not comply, they will be automatically enrolled in a plan, but at a higher rate than if they had signed up on their own. The Dutch insurance market is dominated by four firms that have 90% of the

market. The authors conclude that the Dutch reform is a work in progress, but could be a good model for the United States.

Politics of Reform in the United States

Feder (2004) argues that the political will to achieve universal coverage does not exist in the U.S. because most people already have insurance. If most people are happy with their benefits, and changes to expand health insurance would impact the insured with redistributive new taxes or changes to their existing coverage, there is the potential for opposition. In political terms, this could mean taxing those who vote for the benefit of those who do not. On the other hand, anyone with health insurance is at risk of losing it if they lose their job or their employer drops coverage. Feder asserts that it is impossible to achieve universal coverage without having some effect on the previously insured.

Senators Ron Wyden, Democrat of Oregon, and Bob Bennett, Republican of Utah (2008), offer reasons health care reform is now viable at the national level. They cite bipartisanship evidenced by support for their Healthy Americans Act from Republicans and Democrats, an ideological truce with agreement that universal coverage and a strong involvement of markets are necessary, common ground among business and labor that reform is necessary, the realization that states cannot solve the problem on their own due to federal requirements such as ERISA, Medicare, and Medicaid, increasing costs of employer-based health care which needs modernization and the accessibility of today's health care reform process, which is being conducted in the open, as compared to the secretive Clinton process.

Bodaken (2008), the CEO of Blue Shield of California, a major insurer, argues that, unlike in 1994, health insurers are now poised to support major reforms to the health care system, such as mandates and guaranteed issue. He says that inclusion of insurers in the policy development process is vital, and was a key part of the success of the Massachusetts reform plan, as well as California's plan, which was not implemented (it failed in the California Senate, but attracted significant support and passed the California

Assembly). In Massachusetts, the Blue Cross Blue Shield of Massachusetts Foundation was widely credited with doing much of the policy development groundwork that led to reform.

California's proposed reform was similar to the Massachusetts plan, including individual mandates and guaranteed issue, but it also would have included a pay-or-play payroll tax and requirements that insurers spend at least 85% of premium dollars on medical services, limiting administrative costs. Aetna, Blue Shield, CIGNA, Health Net, Kaiser and UnitedHealthcare were all involved in creating the plan. It failed, however, amid opposition from some business groups, labor unions, Blue Cross of California (not all insurers were united), single-payer advocates and the tobacco industry, not to mention California's budget problems. Bodaken asserts that universal coverage cannot be achieved without mandates. He says that health plans can contribute a lot to the policy development process and will be supportive of reform that maintains the industry's viability. Bodaken suggests that universal coverage must change the insurance business model from one based on risk-avoidance to one based on quality, service and cost-effectiveness. Insurers can provide input on reform policy to ensure it cannot be gamed. For instance, it is not enough to establish guaranteed issue; the services included in basic policies must be determined so that insurers do not offer coverage that only appeals to the young and healthy. While agreeing to and passing a reform are the main focus of legislators, the transition is equally important and insurers are well-positioned to provide advice for how a difficult process can be smoothed. Health plans have expertise that is useful toward the development of health reform policy. Including health insurers in the policy development process can only improve the effectiveness and political support for the policy. Demonizing health plans accomplishes nothing and should be stopped.

Joseph Antos (2008) of the American Enterprise Institute, an ideologically conservative organization, argues for incremental reform because comprehensive plans are too costly. He criticizes Massachusetts for exempting 60,000 residents from the individual mandate, because they lacked the political will to fund sufficient subsidies to make insurance affordable for these residents, and says their reform is financially unsustainable. He suggests that policymakers give up on universal coverage, but

believes that tax incentives supporting employer-based health care should be removed and endorses modest market reforms, including enforcing anti-trust laws and disseminating information about insurance and provider options.

Ferguson, Fowler and Nichols (2008) present a political strategy for health care reform at the national level with the goal of having legislation passed by Congress leading to all Americans having health insurance. They argue that health reform must be a top priority, but that the President should seek to develop consensus on major policy goals and Congress should work out the details on specific legislation.

Hacker (2008) argues that the danger of health reform is in spending too much time on policy and not paying enough attention to politics. Policy development cannot be prioritized ahead of coalition building and public support. Reformers must address fears associated with losing coverage, paying more for less, higher taxes and creating hope. Simplicity and the ease of communicating reforms are important as well. Hacker says that there are promising trends, including grassroots action for health reform, a pragmatic approach from organized labor and potential support for reform from businesses, which are struggling with the rising cost of health care.

Oberlander and Lyons (2009) argue that the State Children's Health Insurance Program (SCHIP) is a good example of how incremental reform can be helpful, but also limited in its ability to solve the problems with our health care system. The program, which was enacted in 1997 in the wake of the failure of the Clinton plan, was in many ways diametrically opposed to SCHIP. SCHIP was bipartisan (Senators Kennedy and Hatch were the sponsors), developed by Congress, incremental, inexpensive, focused on a sympathetic population, conservative in structure (block grants to the states rather than a federal entitlement) and it passed Congress and became law. SCHIP was successful at significantly reducing uninsurance among U.S. children, and some thought it could be a template for addressing other groups. However, when the program expired in 2007, Congress was unable to reauthorize and expand the program by increasing the cigarette tax, probably the most politically attractive funding mechanism. Despite support from liberal groups, the insurance industry, hospitals, the AMA, many governors, key Republicans Charles

Grassley and Orrin Hatch and strong majorities in both the House and Senate, President Bush vetoed the expansion, arguing that it would displace employer-provided health care (the CBO says that between 25% and 50% of children enrolling in SCHIP come from employer plans, although for some the SCHIP plan is significantly more generous) and was a step toward socialized medicine. Congress was unable to override the veto, passed a modified version of the SCHIP expansion, which Bush also vetoed, and, once again, Congress was unable to override. It was not until after the 2008 election when the executive and legislative branches were in firm Democratic control that SCHIP expansion, this time without some of the provisions that were added to attract Republican support, was enacted into law.

Oberlander and Lyons conclude that several lessons can be learned from SCHIP. The obvious one is that it is possible to make incremental improvement in health coverage with bipartisan support, but there are also many limitations to this approach. For instance, there is evidence that children are more likely to be enrolled in health insurance and use medical services if their parents have insurance, but SCHIP did not address this problem. Additionally, many children are eligible for SCHIP but not enrolled. And while SCHIP was able to cover seven million children and four million more are expected to be added with the expansion, almost nine million will remain uninsured. Incremental reform has not achieved universal coverage among children, certainly the most inexpensive and probably the most sympathetic group to cover. The bipartisan support for SCHIP was weak; much of it fell away after the 2008 election, and significant ideological differences between the parties suggest that more comprehensive attempts to expand coverage will be harder to achieve. Also, it is questionable whether there are any more easy incremental expansions available, because populations like children, seniors, the extremely poor and people with disabilities have already been addressed at least in part by government programs. Cost control has not been addressed by incremental reform. The authors point out that "a decade of incrementalism and inaction has left us with higher costs and rising numbers of uninsured Americans; absent decisive action, those trends will only worsen in coming years (p. w409)."

Reform in the States

Barrilleaux and Brace (2007) examined state health insurance reforms, dividing them into two categories: (1) state-based reforms, such as extensions of Medicaid to non-mandated groups health insurance programs for children, subsidies for individuals to purchase insurance and efforts at universal coverage; and (2) market-based reforms, such as guaranteed issue, community rating, and other insurance market regulatory reforms, along with efforts to encourage competition or assist buyers in forming purchasing alliances. States are more likely to attempt market-based reforms because they usually have little cost to the state and are less politically controversial than expensive state-based insurance programs that are redistributive and may be seen negatively by voters who perceive them as welfare.

State-based policies were associated with stronger liberal parties in the legislature, uncompetitive elections, strong institutions (well-funded legislative staff) and states that have been active in passing health care reforms. High income states and states with higher uninsurance actually have fewer state-based policies. Market-based reforms were correlated with more electoral competition, higher incomes, lower insurance coverage and more prior policy adoptions. The authors argue that market-based solutions have generally been less effective at reducing uninsurance than state-based solutions, and point out the irony that states with higher levels of uninsurance often prefer the market-based solutions.

McDonough, Miller, and Barber (2008) survey state level action on health care reform in 2006 and 2007. States are experiencing a wave of activity in health reform at the state level not seen since the late 1980s and early 1990s, and that state reform "can serve as clues and cues to action in other states and in the federal government (p. 105)." They consider five areas: expansion of coverage for children, adults, insurance market reform, individual and employer mandates and comprehensive reform, which they define as an effort to expand coverage to at least half of the uninsured population. The most common reforms were expansions to children's health care, which is politically popular and less expensive than expanding coverage to adults. Twenty-six states expanded coverage to children, while eighteen expanded eligibility to Medicaid or other programs for adults, although some of these actions were to rescind previous cuts.

Tobacco tax increases were a common way to fund programs, and these expansions occurred in good economic years. Fifteen states enacted some form of insurance market reform, some very small, such as increasing the age children can stay on their parent's policies, some more important such as changing premium rating. Three states imposed or considered imposing mandates, Massachusetts with a strict individual mandate and a smaller employer mandate. Vermont also had an employer mandate. California proposed an individual mandate with automatic enrollment, which was never enacted.

Massachusetts and Vermont were the only two states to enact a comprehensive reform agenda as of 2007, but that thirteen other states, including Oregon, had started the process of crafting comprehensive reform, with some states relying on commissions to design or evaluate reform proposals, and other states tasking reform work to the legislature or governor. The authors are not surprised that comprehensive reforms have not yet been realized as reform takes a long time. They note that states are trying new ideas, such as individual mandates, insurance exchanges, employer mandates, including play-or-pay payroll taxes, and other market reforms, along with a focus on cost control and quality improvement. Reform will take time, federal money and delicate work to avoid ERISA trouble.

Aaron and Butler (2008) argue that the states are best positioned to move health reform forward, but that federal restrictions make it difficult to effect comprehensive change. They suggest that Congress create a legislative waiver process, a stronger version of the administrative waiver that many states have used to attempt innovative health care reforms. However, they are not clear on what exactly the legislative waiver would involve, as they suggest that large group, self-insured plans and union trusts would not be included in such a waiver, and that represents a good portion of the health insurance market that states would not be able to reform. They envision some states trying a single-payer approach, others using individual and employer mandates and others focusing on tax incentives. It would be an opportunity for conservative and liberal ideas to be tried, and the ones that do the best job of expanding coverage for the least money could be used for a national program after consensus has been built. They acknowledge that funding reform is a challenge for states.

Weil (2008) argues that state action on health care reform will be most effective if the federal government provides key financial and regulatory supports. He argues that conditions were particularly favorable in Massachusetts, and that only three states (MA, ME, and VT) have adopted comprehensive reforms. He itemizes the downsides to a state-by-state approach, including inefficiency and the fact that many organizations operate across state lines. He rejects the characterization of the states as laboratories of reform. Very few of the reforms, if any, are true experiments with hypotheses tested against data, and policymakers tend not to view the results as conclusive. He cites SCHIP, which was heavily studied and successful, but renewal and expansion of SCHIP were held up for ideological reasons, not on the basis of empirical results. Weil addresses the issue of ERISA and concludes that repeal or ERISA waivers are not politically possible, so he supports creation of a series of ERISA safe harbor policies, including pay-or-play payroll taxes and requirements that self-insured plans participate in data gathering. He also concludes that states won't be able to achieve comprehensive reform without significant federal funds. Weil is concerned that leaving reform to the states will result in substantial variance in results, with some states achieving high levels of coverage and other states achieving poor results. For instance, the current Medicaid system results in a few wealthy states that receive lower federal matches, such as Minnesota and Connecticut, achieving high rates of coverage, while other states receive high federal matches but have low coverage, such as Arkansas and New Mexico.[9] Weil also suggests that state level experimentation will not necessarily lead to positive results, particularly if states are expected to achieve reforms but lack resources and regulatory authority. Failures could be very damaging to national movements for better health coverage, even though they may be an indictment of implementation rather than the merits of the policy. Finally, he acknowledges that the political difficulty of enacting financial and regulatory changes to allow states to pursue reform could be as difficult as adopting a national policy for universal health care.

There is a wealth of health care reform policy ideas and examples of innovative reforms that have been attempted on the national level, within the states and in other nations. The challenge for health

---

[9] See http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4 for Medicaid match rates by state.

reformers at both the state and federal level is to select a policy approach that will be effective at resolving the social and economic problems with health care in the United States (uninsurance, escalating costs and uneven quality of care) and be politically viable within the context of our system of government. Given that health care is an issue that impacts everyone and is of concern to a large set of interest groups, this is a very difficult feat to accomplish.

The Advocacy Coalition Framework and Health Care Reform

Sabatier's Advocacy Coalition Framework of Policy Change (ACF) is based on the idea that the various players in the policy process, including interest groups, institutions, politicians, bureaucrats, journalists and researchers, organize themselves into advocacy coalitions based on core and secondary beliefs, and then work to achieve their policy goals (Sabatier, 1993). Analysis of a limited number of coalitions takes the focus away from individual actors and institutions and places it on the dynamic actions of many participants who contribute to the policymaking process. This acknowledges that there are numerous players involved across many institutions. Other important factors in policymaking, according to the ACF, include policy-oriented learning, which can include the efforts of scientists, journalists, commissions and others to improve the understanding of policy problems, external shocks that force or encourage action, such as wars, recessions and other major events, and changes in the system wide governing coalition, which can determine which policy options are possible and which are not.

In U.S. health care reform politics, I argue that there are two dominant coalitions:

- The Universal Coverage coalition is united by the core beliefs that the United States needs major changes to its health care policy with the primary goal of securing health insurance coverage for all Americans. Coalition members see health insurance as, at least in part, a societal responsibility and believe that government action, including regulation and funding, will be required to achieve universal coverage. Members of the coalition often disagree on many of the secondary issues related to health care reform, including the mechanism by which it will be delivered (single payer,

expanded Medicaid, an individual mandate with strengthened regulations for private insurers, a public plan) and how it will be paid for (taxing employers, individuals, corporations, eliminating tax breaks, other kinds of cost control, deficit spending).

- The Free Market coalition is united by the core beliefs that individuals should be held responsible for securing health care services and insurance if they so choose, and that problems in our health care system are related to too much government regulation and involvement in the health care sector. Free Market coalition members tend to see the U.S. system as superior to that of more heavily regulated and socialized European health systems, especially in the areas of specialized care and medical/pharmaceutical research. While coalition members will defend the status quo over reforms that would increase government regulation and spending on health care, they are also not satisfied with the current situation and have their own set of preferred reforms. There is disagreement among members of the Free Market coalition regarding secondary beliefs on health care reform, but this disagreement is of a lesser magnitude of that within the Universal Coverage coalition. Free Market coalition members are likely to be interested in decreasing the size and cost of government insurance programs (Medicaid and Medicare) and, where government programs exist, relying on private contractors (such as Medicare Advantage and the Medicare Part D prescription drug benefit). They generally prefer reduction in government regulation of health care, such as requirements that health plans cover certain procedures, and push reforms that would weaken state regulation of health plans, such as association health plans (which would allow small businesses to escape state regulatory authorities) and a federal law that would enable individuals to purchase a health plan in any state, which would make the state with the weakest regulation of health insurance the de facto national standard. They also feel that the malpractice system needs reform (often through limits on size of judgments) as they believe it is distorting the health care market by producing unjust judgments that encourage wasteful defensive medicine. Some prefer to promote expanded health coverage by offering additional tax breaks for individuals and businesses

that provide health insurance, although others in the coalition would prefer to eliminate all tax preferences associated with health insurance. They are also suspicious of the role that insurance has played in driving up health care costs, and many are supportive of health savings accounts (HSAs), which enable individuals to save for health care costs tax free with the idea that smaller costs, such as doctor's visits and routine tests, would be paid with cash from the HSA, while more expensive procedures would be covered by a catastrophic insurance policy. Proponents believe that this would result in lower costs as individuals comparison shop and take price into consideration before they choose to consume medical services.

Table 1 – Coalition beliefs

	Universal Coverage Coalition	Free Market Coalition
Policy core	Goal of reform is to cover all Americans	Goal of reform is to limit government involvement, control costs

Secondary	▪ Single-payer
	▪ Market reforms
	▪ Public option
	    o Pay Medicare rates
	    o Pay negotiated rates
	▪ Subsidies to help low and middle income families buy insurance
	▪ Fund with
	    o Tax on millionaires
	    o Tax on high-cost health insurance policies
	    o Increased payroll tax
	    o Cuts to Medicare
		▪ Tax breaks to help individuals, small business purchase health care
		▪ Remove all tax preferences for health insurance
		▪ Reduce or eliminate government regulations
		    o Mandated benefits
		▪ Allow insurance policies to be sold across state lines
		▪ Association Health Plans
		▪ Vouchers for basic coverage
		▪ Medical error liability reform
		    o Caps on judgment awards
		    o Workers' compensation model

The Universal Coverage coalition generally takes the lead in advocating for reform, since its members believe the current prevalence of uninsurance in the United States is unacceptable. Free Market coalition members are not necessarily pleased with the current state of the U.S. health care system either, but are likely to reject solutions that involve increased government involvement, and therefore are often cast as the opponents of reform.

The Universal Coverage and Free Market coalitions have changed in membership and power over the years on the national level. While opponents of the Clinton health reform proposal prevailed in 1994, some of these opponents have come to be able to support some kinds of universal coverage proposals,

including hospitals, the AMA and, especially, small and medium-sized health insurers, who were fierce opponents to the Clinton plan, which would have put them out of business (Skocpol, 1996, pp. 134-143). With this new found support, and a change in the system wide governing coalition to favor chances for health reform, an empowered Universal Coverage coalition appears positioned to win significant reforms on the national level. Similar coalitions appear to be present in the politics of state level reforms, although the players and secondary issues may be different.

Table 2 – Examples of coalition members, 2009

	Universal Coverage coalition	Free Market coalition
Academics	Jacob Hacker, Jonathan Gruber	Martin Feldstein
Think tanks	The Urban Institute	American Enterprise Institute
Parties	Most Democrats in Congress, Oregon Legislature	Most Republicans in Congress, Oregon Legislature
Politicians	Barack Obama, Senator Ron Wyden, Senator Robert Bennett	John McCain
Interest groups (Self-interested)	Health Insurers, Hospitals, Some Business, AMA, PHARMA, AARP, Unions	Some Business (particularly NFIB)
Interest groups (Ideological)	Liberal (National Coalition on Health Care, Democracy for America)	Conservative (Freedomworks, Family Research Council)

Incompletely Theorized Agreements

Another theoretical approach comes from Ruger (2007), who argues that values and norms have not received enough attention in analysis of health care reform politics. She suggests that Incompletely Theorized Agreements (ITA), a theory developed to explain judicial decision-making, could be used to examine health care policy debates. The failure of health care reform thus far, Ruger says, is related to the way a particular norm has, or has not, been internalized: an ethical obligation for those with means to finance health care for those who lack it.

The ITA framework considers three levels of agreement. The highest level is the theoretical or philosophical level. Ruger suggests that beliefs in utilitarianism or communitarianism might belong at this level, where various tradeoffs might occur, such as efficiency versus equity, the individual versus the group, freedom versus security and many others. The middle level of agreement regards principles that are more defined than a theory but not a specific program. For example, universal health care is a potential area for

middle level agreement; it could be implemented in various ways and justified by various higher level beliefs. The lowest level of agreement involves particular policies or programs. A program such as Medicare Part D, the prescription drug benefit, is an example of a low level agreement that was achieved in our political system among parties who disagree on high and even middle levels.

Ruger's larger point is that it is rare for agreement to be achieved on all three levels, and this in many ways explains the successes and failures of the health care policy landscape in the United States. Agreement is possible, indeed common, at individual levels of the hierarchy but not at others. For example, high level agreement does not necessarily translate into low level agreement. This is known as an Incompletely Specified Agreement. For example, liberal groups might agree on a communitarian philosophy regarding social welfare, that we are all in this together and must help each other. But that agreement may not translate into mid level agreements on a general policy. Some may argue for universal health care, others may argue for incremental changes in the current system.

Probably the more common source of conflict is agreement at middle levels but disagreement at lower and higher levels, known as Incompletely Specified and Generalized Agreement. In this situation, suppose that a variety of political actors agree that we need to move to universal health care coverage. But they don't agree on the higher level philosophy, given that some participants' core values are more focused on equality and others are more concerned about efficiency losses due to an irrational and bifurcated system. Fortunately, these high level disagreements don't need to be resolved to get to an agreement for a new policy; the policy players see eye-to-eye on the need for universal coverage and it is not particularly important why they have come to that conclusion. Unfortunately, the lower level disagreements are very important and will prevent policy change if they are not resolved. While the policymakers in this example agree on the need for universal coverage, some of them may support a government run single-payer health care system, others may support an employer mandate, and others may support an individual mandate with subsidies and regulatory reform of the insurance market. Even if agreement can be obtained on one of these approaches, there may be disagreements on the sublevels of implementation Supposing agreement

could be reached on pursuing an individual mandate model with insurance market reform, there may well be, as there is currently in Congress, disagreement about whether a public plan of some sort should be one of the options in the new market for individual insurance, whether the exchanges should be run by the states or the federal government, what the minimum level of benefits should be for the plans offered in the exchange, and so on.

Finally, it is possible for there to be agreement on lower level items but disagreement on mid-level and higher level principles. This is known as an Incompletely Theorized Agreement on Particular Outcomes, and Ruger uses the State Children's Health Insurance Program as an example. Congress was able to agree to implement and expand SCHIP despite disagreement on these higher level principles. Many different high level philosophies were involved, and many middle level principles led to the support of SCHIP. Some policymakers who support universal coverage voted for it because they see it as a step toward universal health insurance. Politicians who do not have universal coverage as a goal supported it because they believe that children are deserving of special protection from society. Additionally, there was disagreement at even lower levels, which was resolved by the decision to allow states to implement SCHIP in a variety of ways, including the expansion of public programs, such as Medicaid, and private programs, such as premium support.

To enact a policy, it is necessary to have low level agreement, but it is not necessary to have middle or high level agreement. Most, if not all, health care policies enacted in the United States in recent decades have been low level, Incompletely Theorized Agreements on Particular Outcomes. Because they lack higher level agreements, they tend to be highly incremental reforms. Examples include SCHIP, COBRA and Medicare Part D. One could make the argument that the original enactment of Medicare and Medicaid were Incompletely Theorized Agreements, although they were certainly more momentous than today's vastly more incremental reforms. Ruger argues that comprehensive reform will require both low level and middle level agreement, for instance, agreement on the principle of universal coverage and agreement on an policy to implement universal coverage.

Table 3 – Examples of Incomplete Agreements (Ruger)

Level of agreement	Incompletely Theorized Agreement on Particular Outcomes	Incompletely Specified and Generalized Agreement	Incompletely Specified Agreement
High (theoretical)	Disagreement	Disagreement	People who can't afford medical care should get help
Middle (policy goals)	Disagreement	Health insurance coverage should be universal	Disagreement
Low (policy specifics)	Expand Medicaid to cover more children (SCHIP)	Disagreement	Disagreement

Ruger's approach of analyzing health care reform politics by level of agreement approximates aspects of the ACF. What Ruger describes as a high or middle level belief would be a deep or policy core belief to Sabatier; the low level of agreement of the ITA model is analogous to the secondary beliefs within a particular advocacy coalition.

Both Sabatier's and Ruger's approaches to policy analysis imply that multiple levels of agreement will be necessary to achieve comprehensive health care reform. Because it is so difficult to find agreement on both an ambitious goal, such as universal coverage, and a means to implement that goal, it can be expected that successful comprehensive attempts at health care reform will be rare, and adoption of incremental reforms will be more common.

Methods

The comparison of health care reform in Oregon between 2007 and 2009 and other states is based on three major sources of data, including previous research, document analysis and personal interviews. Major reform efforts in Massachusetts in 2006, California in 2007 and a variety of other states including Maine in 2004, Vermont in 2006 and Hawaii in 1974 have been well documented by other researchers, and this analysis relies on their work to compare the process of reform in these states to each other and to Oregon's experience. The recent attempt at health reform and coverage expansion in Oregon, beginning with the creation of a commission to address the issue in 2007 and with a legislative process in 2009, has not been addressed in the literature and is the focus of original research in this essay. Understanding of the events and processes that led to reform in Oregon come from document analysis, including the reports of

the Oregon Health Fund Board, related legislation and journalistic accounts, and interviews with key players in the policy process. Participants were promised anonymity to encourage candid responses and comply with the stipulations of IRB approval. Persons interviewed include legislators involved with health reform from both the Oregon House and Senate and from both the majority and minority parties, a member of the Governor's staff and representatives from key interests.

Limitations to the study include the small number of states that have attempted significant health care reforms, as well as potential sample biases among sources of information regarding reforms. While care was taken to interview individuals who represent diverse viewpoints and interests in the health reform process in Oregon, it is not a random sample and participants may or may not be representative of all people with influence in the policymaking process.

State Attempts at Health Care Reform

Since the failure of the Clinton plan for comprehensive, national reform in 1994, much of the effort to expand coverage and reform health care systems has taken place at the state level. Most of these efforts have been extensively studied already. This section focuses on the substantial efforts at reform in Massachusetts in 2006 and California in 2007, with an overview of attempts in other states, including Hawaii in 1974, Maine in 2004 and Vermont in 2006. There are other states, such as Minnesota and Tennessee, which have significantly lowered their uninsurance rates through relatively straightforward expansions of Medicaid. This analysis does not includes these states and instead focuses on states that have attempted more fundamental reforms in pursuit of expanded coverage.

Demographics

The states where health reform has been attempted are a disparate lot: large and small, wealthy and poor, highly insured and highly uninsured. Table 4 provides key demographics.

Table 4 – Demographics of States Attempting Health Care Reform

	% uninsured 2005-2006	% uninsured 2007-2008	Population (2008)	Median Income (2007)	% below poverty (2007)	% white, non-Hispanic (2008)	State and local taxes (% income, 2008)
California	18.8%	18.4%	36,756,666	$59,928	12.4%	42.3%	10.5%
Hawaii	8.7%	7.7%	1,288,198	$62,613	8.5%	24.9%	10.6%
Maine	9.8%	9.6%	1,316,456	$45,832	12.2%	95.3%	10.0%
Massachusetts	9.8%	5.4%	6,497,967	$62,383	10.0%	79.2%	9.5%
Oregon	16.7%	16.5%	3,790,060	$48,735	13.0%	80.0%	9.4%
Vermont	10.9%	10.2%	621,270	$49,698	10.1%	95.2%	10.3%
United States	15.5%	15.3%	304,059,724	$50,740	13.0%	65.6%	9.7%

Sources: Uninsurance: U.S. Census Bureau, Current Population Survey, 2006 to 2009 Annual Social and Economic Supplements. Population, Income, Poverty, and Race: U.S. Census Bureau, Quickfacts, http://quickfacts.census.gov/qfd/index.html. Taxes: Tax Foundation, State and Local Tax Burdens, http://www.taxfoundation.org/taxdata/show/336.html.

Massachusetts

The following summary draws on the case study of Massachusetts health reform by McDonough, Rosman, Phelps and Shannon (2006), written shortly after it became law. After summarizing the history of health reform efforts in the state, they explain what the reforms entail and the political process that led to the successful enactment of sweeping legislation.

The Reforms: Massachusetts previously had made successful and unsuccessful attempts at expanding coverage, including a plan for an employer mandate to lead to universal coverage that was repealed before it could be implemented. Most importantly, before the most recent reforms, Massachusetts had already established guaranteed issue and modified community rating policies for its individual and small group health insurance markets, so theoretically everyone had access to insurance, although premiums were high due to adverse selection. Additionally, Massachusetts had a generous Medicaid plan and some unique uncompensated care funds which were paid directly to hospitals and community health centers. Massachusetts' Medicaid plan operated under a Section 1115 waiver from the federal government. Therefore, much groundwork had been laid for a reform to expand coverage.

The 2006 set of reforms included several features that were designed to work together:

- Low income (up to 300% FPL) uninsured people would be eligible for subsidized health insurance.
- A new marketplace, called the Connector, was designed for people to shop for insurance in a standardized, regulated central market, essentially an insurance exchange. The Connector could be

designated as an employer benefit, even if the employer didn't contribute to the cost, so individuals could buy insurance with pre-tax dollars.

- The plan married components of individual and employer mandates.
    - Individuals without insurance would have to pay a penalty on their income taxes, up to half the cost of the cheapest monthly coverage.
    - Employers who do not offer health insurance must pay an annual $295 per employee fee, which does not come close to covering the cost of insurance. Some employers would have to pay more, if their workers use the uncompensated care pool (the free-rider surcharge).
- Small changes were made to the insurance market, including the addition of smoking as a permissible rating factor.
- Medicaid was expanded for children.

Half of the cost of coverage expansion was paid for by federal funds through the Medicaid waiver, which had been threatened with elimination by the Bush administration. The rest was covered by diverting money from the uncompensated care pool and $220 million in general and employer revenues, about half of which was from the employer assessment and free-rider surcharge and half was from reallocated general funds. Not all of the funds dedicated to reform were used to increase coverage; Medicaid provider reimbursements were increased as well.

The Political Process: Rosman, et al. argue that the process was initiated by the work of one insurer, Blue Cross Blue Shield of Massachusetts, which started a foundation to address the uninsured. They began a Roadmap to Coverage initiative in 2003, which led to much of the policy development work for what eventually became the Massachusetts health reform. When Mitt Romney took office as Governor the same year, he also promoted reform of the health system in the state with the goal of universal coverage by redirecting existing subsidies for providers to help individuals buy their own insurance. In 2005, Governor Romney released his legislative proposal and his role was limited after this point. A coalition of interest groups founded Affordable Care Today (ACT), including patient advocates, religious groups, health care

providers, businesses and unions. Some ACT members started work on an initiative petition for health reform that included a significant payroll tax to fund coverage expansion. This campaign, which never came to a vote, was used to motivate legislators and interest groups to strike a deal.

The Massachusetts Senate leadership introduced a modest, fiscally conservative proposal. The Massachusetts House produced a more ambitious plan, including the Connector insurance exchange, individual and employer mandates, expansion of Medicaid and insurance subsidies. Business was divided, with some supporting an employer mandate and others adamantly opposing. Ultimately, there was sufficient political support for the $295 per employee assessment to include a modest employer contribution in the bill. The federal government played a major role by threatening to take away payments to providers from the Medicaid waiver. These payments had been negotiated during the Clinton years and the Bush administration was not enthusiastic about special funding for Massachusetts hospitals. But the administration was willing to let the state keep the payments if they were redirected to subsidies to help people buy insurance, expanding coverage.

A very long House/Senate conference resulted in an agreement on a health reform bill. The main sticking point was whether to include an employer mandate, and negotiators agreed upon a $295 per employee fee for employers that do not offer insurance, along with a free-rider surcharge that would be levied on employers whose employees use the state's uncompensated care pool. The revised reform bill passed the Massachusetts House and Senate. Parts were vetoed by Governor Romney, including the $295 employer assessment, but all of his vetoes were overridden by the legislature.

Rosman, et al. emphasize that Massachusetts was in a very good position for reform, with many of the hard parts achieved, including guaranteed issue, community rating, and a $300+ million dollar source of funds unique to Massachusetts. However, they also view it as a political model for reform, including ideas with conservative support or conservative sources (the exchange concept was promoted by the Heritage Foundation), a combination of individual and employer responsibility, with the former usually appealing to the right and the latter usually appealing to the left, and the conversion of subsidies for

institutions to subsidies for individuals. They also note that key interests worked together in good faith and constructively throughout the process, which was essential.

Holahan and Blumberg (2006) address several issues with the Massachusetts reforms. The individual mandate is potentially a path to universal or near-universal coverage, but it must be affordable if it is to be effective. Legislators did not determine a goal for affordability or what levels of subsidies would be made available to enable low and middle income people to comply with the mandate without an undue burden. Affordability will also be affected by the cost of the health plans available in the Connector, which is dependent on the way the exchange is managed. Premiums will be lower if plans include options with smaller, low-cost networks of providers and higher levels of cost-sharing. And for some plans serving subsidized enrollees, the legislature limited the number of plans that could initially be offered. This limitation places great responsibility on the Connector to negotiate for quality, low-cost plans. Cost comparison may be difficult for consumers because there is not a standard benefits package that all plans must meet. Holahan and Blumberg also question if the funds committed by the legislature would be sufficient to approach universal coverage; they argue that it would be economically feasible and desirable, but could run into political challenges. They conclude that the key insight of the Massachusetts reform is the combination of several pieces, establishing an individual mandate, exchange, subsidies and Medicaid expansion all at once, and could be a model for other states. Jonathan Gruber (2006) agrees that the model could work in other states or at the federal level, but also acknowledges that funding the plan in Massachusetts was much easier due to the below average proportion of uninsured, federal funds and the already-existing uncompensated care pool that could be redirected.

McGlynn and Wasserman (2006) argue that the Massachusetts reform demonstrates the promise of bipartisan collaboration whereby the outcome of universal coverage is agreed upon, but the means to achieve the outcome are subject to negotiation. However, they acknowledge that the results in Massachusetts were also driven by external forces, such as potential loss of federal funding and key political support from a major insurance company. They agree with Holahan and Blumberg that reform must be a

combination of multiple mechanisms. At the same time, they are skeptical that other states would be able to achieve the same results using the Massachusetts plan because of the differences in circumstances in individual states. Finally, the quality of the implementation is very important to the quality of the outcome in such a complex reform. Rather than asking how the Massachusetts reforms could be brought elsewhere, they suggest that other states begin their own discussions about reform based on their present trajectory of access, cost and quality.

Tom Miller (2006) of the American Enterprise Institute criticizes the Massachusetts plan, arguing that it not possible to implement in other states. He suggests that the financial rationale for coverage expansion is based on false arguments about reducing cost-shifting from the uninsured to insured people. Miller also believes that Massachusetts has a flawed implementation of an insurance exchange and that the individual mandate will be unenforceable. Most importantly, it maintains an inefficient system with too much regulation and government subsidies and not enough cost control, reflecting AEI's conservative ideological views.

Haislmaier and Owcharenko (2006) divide the Massachusetts reforms into a regulatory component and a subsidy component, and argue that either could be implemented, separately or together, by other states, although there are synergies in adopting both. They characterize these reforms as system-focused rather than product-focused, as most state and federal health reforms in the past have been based on designing a specific product for an underserved market or to serve a public policy purpose (i.e. HSAs, benefit mandates, expansion of Medicaid to new populations). On the contrary, a system-focused reform addresses how insurance is bought and sold and how subsidies are distributed.

Blendon, et al (2008) review public opinion data on the Massachusetts reforms and find majority support, even for the most controversial aspect, the individual mandate, which 58% of residents supported in 2008 (p. w560[10]). Additionally, support for the law has grown over time, reaching 69% by 2008. Republicans were the only demographic surveyed whose support for the law has dropped; in 2006, 56% of

[10] Refers to web edition pagination for *Health Affairs*

Republicans supported the reforms, falling to 44% by 2008 (ibid). The authors note that Massachusetts residents, predominantly liberal and Democratic, were predisposed to support these kind of reforms. Gabel, et al (2008) surveyed Massachusetts employers and found that a slight majority agreed that reform was good for the state.

Steinbrook (2008) provides a mixed review of the reforms, noting a rapid and largely smooth addition of about 350,000 people (5.5% of the state's population) to the insured and the maintenance of political support for the program. However, about 5% of the population is still uninsured, and many have been exempted from the individual mandate because of concerns about affordability and insufficient subsidies. There is also evidence that low income beneficiaries are having trouble getting appointments to see a doctor. And some question whether the cost of the subsidies is sustainable.

California

Mulkey and Smith (2009) review California's "Year of Reform" in 2007 and draw conclusions about what California's experience means for the rest of the nation. California attempted but failed to enact legislation that would have covered 3.6 million of California's 5.1 million uninsured. It was developed by the Republican Governor and Democratic Speaker, would have imposed a pay-or-play requirement on employers, started a state-run purchasing pool, established an individual mandate, guaranteed issue and expanded Medicaid.

Mulkey and Smith argue that California began with a disadvantage given high levels of uninsurance, less employer coverage and a greater proportion of low-income residents than other states. Bipartisan buy-in is necessary, especially given that attempts at bipartisanship do not satisfy the extremes, such as Democrats who wanted single-payer and Republicans who wanted tax incentives alone. Despite Governor Schwarzenegger's support, no Republicans in the state assembly voted for his bill. Additionally, reform efforts must appeal to those who already have insurance. Short and long term goals must be considered, and coverage expansion should be coupled with reforms in the delivery and financing systems

for health care, with an outcomes-focused system. And because expanding coverage is so costly, ultimately reform policy results in the question of who pays and how much. There was strong opposition to California's proposed funding sources, such as the Chamber of Commerce and Restaurant Association's resistance to the pay-or-play payroll tax.

Federal policy is an impediment to health care reform, as complying with Medicaid rules and the federal tax code make it much harder for states to control costs. The details are very important in reform, and reform may be easier if many of those details are left to an implementation stage, but that requires strong executive institutions. At the same time, states expect the federal government to pay for much of the reform effort; reforms are designed to attract federal dollars through Medicaid waivers, which may or may not lead to the best policy. The federal ERISA statute, which regulates self-insured health benefit plans typical of large businesses, is also a barrier to reform at the state level, preempting states' ability to regulate and rationalize the entire insurance market. The volatility of state budgets is another disadvantage; after reform failed in California, the budget went into crisis due to the recession, and health care safety net programs were cut significantly. While states do not provide a perfect example for federal policymaking, they do offer important lessons.

Curtis and Neuschler (2009) believe that the California plan of shared responsibility for financing reform among individuals, employers and the government was viable. Subsidies would have been provided for adults up to 250% of poverty, annual deductibles limited to $2,500 and tax credits would be provided for anyone facing coverage costs above a certain percentage of income (5.5% for people between 250% and 300% of poverty). California would allow premiums to vary by age, within limits, increasing affordability for young people. Unlike Massachusetts, which established a small fee for employers not offering insurance, California envisioned employers as a major source of funds for the system, so they proposed a pay-or-play payroll tax, which was also intended to discourage employers from dropping coverage. The authors conclude that the California plan offers good policy ideas for the nation, but ultimately federal intervention and money are necessary to establish such a plan.

Other States

Maine enacted a set of reforms called the Dirigo Health Reform Act in 2004 with an ambitious goal: provide coverage for the 130,000 uninsured Mainers by 2009, which it did not come close to meeting, covering fewer than 19,000 people by 2007 (Belluck, 2007), and as few as 9,300 people by 2009 (Vesely, 2009). The reforms included an expansion of Medicaid and a state-sponsored but privately-administered option called DirigoChoice, which offers comprehensive coverage for individuals and small groups, with subsidies based on income. The subsidies were to be funded by an assessment on insurers based on savings generated through reductions in charity care, but the complex funding mechanism has been fraught with legal problems. In 2008, the Maine legislature replaced the problematic funding mechanism with a combination of tax increases on alcohol and soft drinks and a new 1.8% tax on paid claims for health insurers and third party administrators (Kilbreth & Fox, 2008), but those taxes failed at the ballot box in a referendum (General Election Tabulations, 2008). In 2009, the legislature tried again and established a 2.14% tax on paid claims to fund the program of subsidies (Vesely, 2009). Maine has implemented guaranteed issue and community rating policies, but no individual mandate (Harris, 2009). Because the program is voluntary, premiums are very high as people who enroll tend to be older and with more health problems. The new rating rules have made individual insurance less profitable, and now the market is dominated by one insurer.

In 2006, Vermont enacted a health care reform plan with a focus on increasing coverage and better management of chronic diseases (Wilson, 2008). A new plan with subsidized premiums, known as Catamount Health, is available for uninsured residents. Like Maine, enrollment is voluntary as there is no individual mandate. Unlike Maine, Catamount is less generous and does not cover preexisting conditions. The funding for the new plan is mostly from tobacco tax increases and a new assessment on employers. Ten percent of the Catamount budget will be spent on statewide improvements to chronic care, with the purpose of controlling costs in the wider health care system and making insurance more affordable. Vermont has a statewide plan for health information technology and is exploring policies based on

accountable care organizations. Thorpe (2007) argues that Vermont's reforms may be a better model for other states than Massachusetts. In 2005, Vermont created a legislator-led commission to examine health care reform possibilities for the next session, which led to a focus on lowering costs for the majority of residents with insurance. These policies are less controversial than finding a way to fund coverage expansions to reduce uninsurance.

Hawaii has not recently attempted health reform, but is a notable example because it has required employers to provide health insurance for their employees since 1974. This longstanding arrangement has been facilitated by a specific exemption in the federal ERISA law, which complicates the efforts of other states to force employers to contribute to coverage expansions. Buchmueller, DiNardo and Valletta (2009) found that the employer mandate in Hawaii has substantially increased coverage, but that it also has encouraged employers to use part-time employees, which are exempt from the requirement to provide health insurance. While workers who are not likely to get health coverage from their employer in the other 49 states are significantly more likely to have coverage in Hawaii, the employer mandate is not an effective universal coverage policy by itself, as it leaves out several groups, including part-time employees, self-employed and unemployed persons.

Case Study: The Politics of Health Reform in Oregon

A Brief Overview of Previous Efforts to Increase Health Coverage in Oregon

Over the last three decades, Oregon has been the scene of several efforts to reform the health care system in which coverage expansion was a major goal. These efforts set the stage for the creation of the Oregon Health Fund Board in 2007 and the ensuing Greenlick-Bates legislation that was crafted and passed during the 2009 session. What follows is a brief summary of the history of health reform in Oregon, drawing heavily on Lunch (2005).

Oregon's modified version of Medicaid, known as the Oregon Health Plan, was developed in the late 1980s with leadership from John Kitzhaber, an emergency room physician who served as the Oregon Senate President. Kitzhaber, with support of the legislature and governor, enacted a plan to increase coverage with two strategies: expand Medicaid to cover more low income Oregonians, but with less generous benefits, and establish a mandate to require employers to provide coverage for employees. The Medicaid expansion would rely on a prioritized list of services. Available funding would dictate the level of services provided, with high-value procedures funded first and lower-value or experimental procedures slated at a lower priority level. The plan was considered radical in some quarters and was criticized as a form of rationing. Because the Oregon Health Plan would not guarantee all of the benefits normally provided under the federal-state Medicaid program, it required a waiver from the federal government to enact. Obtaining a waiver delayed implementation of the plan. Initially, Oregon's waiver request was denied by the George H.W. Bush administration; partisan politics between Oregon's Democratic governor and the Republican President played a role. Following Bush's defeat in the 1992 election, Bill Clinton took office and Oregon's waiver was granted. The Oregon Health Plan was implemented, expanding coverage to over 130,000 Oregonians who would not have been eligible for traditional Medicaid. On the other hand, the employer mandate was repealed before it could take effect.

Kitzhaber ultimately was able to manage the implementation and growth of the Oregon Health Plan, as he won the Governorship in 1994, serving for two terms. This was a time of economic growth in Oregon coinciding with the boom in high technology companies, which Oregon had recruited in the 1970s and 80s to diversify the state's economy from its reliance on natural resources. By the time Oregon's Medicaid waiver was due to expire in 2001, the election of George W. Bush had placed Republicans in control of the executive branch of the federal government, and it was not guaranteed that the waiver would be renewed. Governor Kitzhaber personally lobbied Health and Human Services Secretary Tommy Thompson, who was a former Governor of Wisconsin and generally supportive of allowing states to

experiment with innovative programs. A deal was struck and the waiver allowing continued operation of the Oregon Health Plan was extended.

It turns out that the biggest threat to continued expansion of coverage under the Oregon Health Plan was not denial of the federal waiver, but the volatility of Oregon's economy. The state was hit hard by the collapse of the technology bubble as the stock market dropped, employment shrunk and the post-September 11 recession took hold. Oregon's state government is funded primarily by personal and corporate income taxes, along with profits from the state-run lottery. The state has no general sales tax. Income tax receipts plummeted along with personal income and capital gains. Balancing the state budget in 2002 and 2003 was extremely difficult; voters rejected two proposed income tax surcharges to limit cuts to state services. Ultimately, the legislature made large cuts to all areas of state government, but especially the Oregon Health Plan, which was reduced to only about 25,000 more covered lives than traditional Medicaid would require, funded by a small hospital provider tax.

In the meantime, the 2002 election cycle was underway with a term-limited Kitzhaber leaving an open seat in the gubernatorial race. Additionally, citizen activists using Oregon's initiative system collected signatures and qualified a universal health care proposal for the 2002 ballot. This proposal, known as Measure 23, would have created a health insurance plan for all Oregon residents funded by new payroll and income taxes. Measure 23 was trounced at the polls, with 79% of voters opposed (Secretary of State, 2002). Democrat Ted Kulongoski won a close election for Governor. With a struggling economy, an electorate strongly opposed to tax increases, a minimized Oregon Health Plan and a new governor who was not likely to prioritize health care as highly as Kitzhaber, health coverage expansion was clearly off the agenda for the time being.

The legislature put health reform back on the table in 2005, when it appointed a bipartisan commission to study healthcare access and affordability in the interim. The commission, known as the Bates-Westlund Commission after its co-chairs, State Senators Alan Bates and Ben Westlund, included legislators, activists, industry representatives and stakeholders. It created a conceptual proposal for health

care reform which would have involved pooling funds from a variety of sources and providing each Oregonian with an "Oregon Health Card" which could be used to purchase insurance from a regulated health plan (ISCHCAA, 2006).

Reelected in 2006 along with a new Democratic majority in the legislature, Governor Kulongoski promoted a plan to expand the Oregon Health Plan to cover all uninsured Oregon children, paid for by an increase in tobacco taxes. The 2007 legislature took up the Governor's plan, but did not have the votes to enact it directly. While Democrats had majorities in both the House and Senate, legislation to raise revenue requires a 3/5 supermajority to pass, and Democrats could not secure enough Republican support to enact the tobacco tax. Instead, legislators took advantage of an alternative that only required majority support; they referred an amendment to the voters, Measure 50, that would have established a new tobacco tax in the Oregon Constitution to fund the expansion of health care coverage for children. In a special election, voters rejected the tobacco tax increase 59% to 41% (Secretary of State, 2007). During the same session, the legislature also passed Senate Bill 329, which created the Oregon Health Fund Board and initiated the policymaking process that led to more comprehensive health care legislation in 2009.

Creation of the Oregon Health Fund Board

After leaving elected office, John Kitzhaber founded The Archimedes Movement, a not-for-profit organization dedicated to advocating for health reform. At their request, several legislators introduced Senate Bill 27 at the beginning of the 2007 legislative session. The approach advocated by the Archimedes Movement and within SB 27 was to pool all state and federal health care expenditures, including funds previously dedicated to Medicare, Medicaid and the tax exemption for employer-provided health care, into a state account, the Oregon Health Fund, to be managed by the Oregon Health Fund Board. The fund would be dedicated to providing health services for all Oregonians, and the board would be responsible for contracting with providers to facilitate universal access (Senate Bill 27, 2007).

This was a very ambitious proposal. While Medicaid demonstration waivers had become commonplace in that federal-state joint program, the exclusively federal Medicare program does not provide for such waivers, nor was there any indication that Congress would repeal the tax exclusion for employer-provided health plans and remit those funds to the states. And the political consequences of radical changes to Medicare and the implications for senior citizens who rely on it are obvious. Legislators chose to pursue a different approach, drafting and passing SB 329, which was based on the approach of the Bates-Westlund Commission.

The Healthy Oregon Act (Senate Bill 329, 2007) built on some of the ideas of SB 27, but excluded controversial proposals such as requesting a state waiver from the Medicare program. The stated goal of the legislation was "to include the current uninsured population in Oregon to the greatest extent possible (p. 3)," ensure access to a basic set of essential services, provide financing, and pursue several other goals related to cost and quality. The primary basis for the coverage expansion would be the existing Medicaid program, and the Oregon Health Fund Board was created to develop a comprehensive plan to achieve these goals. The board would be composed of seven members appointed by the Governor and confirmed by the Senate. No more than half of the members could be employed by, or have significant family income from, the health care industry. In practice, only one did, a physician from Eastern Oregon, although others had previously served in health care-related positions of employment or on boards of directors. The legislation did create an Oregon Health Fund, but it would be limited to federal health care funds from Medicaid, SCHIP, state matches and potentially employer, employee and individual health insurance premiums. The bill provided for an executive director, staff and appropriations to support the board's work. It included a lengthy list of proposals the board might address, but no requirements or limitations. Finally, it set a deadline: a comprehensive plan was due October 1, 2008. SB 329 was approved by the legislature in late June 2007 and subsequently signed by the Governor, leaving just over a year for the board to be appointed and the comprehensive plan to be written.

Plan development process

The Governor's Office moved quickly to appoint the seven-member Oregon Health Fund Board, which included two businesspeople, an attorney, a physician and three activists: the state presidents of the AFL-CIO and AARP and the president of the Urban League of Portland. Barney Speight, a veteran of Oregon health care policy, was hired to serve as Executive Director, along with a large staff and an assortment of consultants, including prominent health economist Jonathan Gruber of MIT, who conducted econometric modeling for the board. A total of nine committees and work groups were appointed to address specific areas of health care reform and report back to the full board with recommendations. Committees were established to consider what benefits should be included, changes to the health care delivery system, the creation of a quality institute, systems of eligibility and enrollment for subsidized health insurance, potential changes to federal laws in order to facilitate Oregon's reforms, a means of financing the expansion of coverage, how an insurance exchange could be implemented, ways to reduce demographic inequities in health outcomes and a strategy for health information technology. Of the 130 Oregonians were appointed to serve on the nine committees, the vast majority (68%) reside in the Portland metropolitan area, 18% in the Willamette Valley and the remaining few in the rest of the state. While individuals working in the health care industry were restricted from serving on the full board, there was heavy participation of industry insiders and experts on the committees, with 38% of participants working for or as health care providers and 14% employed by insurers, managed care organizations or brokers. Activists and representatives of interest groups were also well represented, accounting for 24% of committee slots, and there was significant participation of government officials at 8%. Subcommittees delivered their reports to the full board, and the board provided a draft report by the statutory deadline of October 1, 2008. After conducting a series of public meetings throughout the state and an online survey to provide feedback, the board revised and released its final report in late November 2008.

The Final Report of the Oregon Health Fund Board: "Aim High, Building a Healthy Oregon"

The report identified three major problem areas in Oregon's health care system: (1) costs that are too high and rising too fast, (2) too many uninsured Oregonians and (3) uneven quality of care. It set forth goals to address each of those. The role envisioned for the state is that of a system coordinator that would act as a "smart purchaser, integrator of services, and instigator of innovation (OHFB, p. 6)." The key recommendation was to establish an Oregon Health Authority (OHA) that would be responsible for regulating and building a system for 100% access to health care within a decade, given changes in infrastructure and successful efforts at cost control. Specifically, the board set forth the goal of covering all children and Medicaid-eligible adults by the end of 2009, establishing the OHA and implementing initial recommendations by 2011 and establishing an insurance exchange, including a public plan, by 2013. They did not specify a timeline for insurance market reforms such as guaranteed issue or an individual mandate, but instead recommended that they be implemented after the achievement of cost control and system improvement efforts, essentially the approach of controlling costs first and universal coverage later. The report specifically rejects a single-payer approach, arguing it is not possible due to ERISA constraints.

The main goals of the reforms include expanded coverage, controlling costs, improving quality of care and improving the health of Oregonians. The board identified the uninsured in Oregon as being 576,000 individuals, including 116,000 children. An additional 300,000 Oregonians experienced a health insurance gap in the last year (OHFB, p. 11). And those with coverage have experienced premium increases far outpacing income growth. The board recommended that coverage be expanded initially to 216,000 Oregonians, consisting of 116,000 children and 100,000 low income adults during the 2009-2011 biennium and to 96% of Oregonians during the 2013-2015 biennium (OHFB, p. 13).

The board adopted a series of recommendations to address cost control, which they refer to as "bending the cost curve." They would promote evidence-based guidelines, require reporting on administrative costs, establish uniform forms and processes for transactions, focus the system on primary care, generate savings on pharmaceuticals through joint purchasing of public coverage programs and

provide more resources for public health (tobacco, obesity and wellness) programs. All state health plans, including state employees, educators, local government, subsidized care and Medicaid, should employ common contracts. The state should set uniform standards for electronic medical record systems and contract with selected vendors to lock in lower prices. The Oregon Health Authority would be charged with implementing these recommendations, and it would develop a variety of tools to facilitate reform, including an all-payer, all-claims database that would include every health insurance transaction within the state to serve as a data source to identify and control costs, a Quality Institute which would promote evidence-based medicine, a health insurance exchange with a public plan to rationalize the insurance market, new financial reporting requirements, payment reform to reward low cost, high quality, high value care and other changes to invest in the health care workforce and reform the medical liability system.

In addition to being a new and powerful regulator, the Oregon Health Authority represents a major reorganization of state government. Existing state agencies would be consolidated under one organizational home with a new focus and set of goals. The OHA would have a citizen board advised by an expert staff and industry representatives, and is intended to be comparable to the Oregon Transportation Commission, the powerful citizen panel which determines transportation policy for the state. The Authority is not intended to be an advisory board but a commission with "actual authority and substantial delegated power to develop, implement, and enforce health policy (p. 23)."

Coverage

The report concludes that increased coverage is justified by many benefits, including improving access to cost-effective primary care, as opposed to expensive ER care, improved health outcomes resulting from continuous relationships with providers and reducing the cost shift to private payers. The board advocates for the expansion of access and the transformation of the delivery system at the same time, in pursuit of higher quality and lower cost care, with a multi-year process that would build on existing systems (Oregon Health Plan, employer-provided coverage and Medicare) and add premium assistance through a

new health insurance exchange. Econometric modeling predicts that this approach will cover 96-97% of Oregonians at a cost of $1-1.6 billion to the state, funded through a payroll tax and a provider tax. The board argues that increased reimbursement and lower health insurance costs would offset the provider and payroll taxes. Also considered are increased taxes on tobacco and alcohol.

The board recommends that coverage first be expanded to children and low income adults, reducing uninsurance by about one-third and restoring coverage that was lost in the 2001-2003 recession. This coverage expansion would be implemented through the existing Oregon Health Plan and Family Health Insurance Assistance Program (FHIAP), which helps higher income people purchase insurance on the private market. These subsidized programs would be restricted to children from families earning less than 300% of the Federal Poverty Level (FPL); those earning more could purchase insurance for their children through the program but would pay the full cost. Simultaneously, the board argues that the OHP should be opened to all adults with income less than 100% of FPL, adding coverage to about 100,000 adults, while also improving plan benefits. Eventually, eligibility should be increased to 185% of FPL. The report includes a variety of recommendations to improve the operation of the Oregon Health Plan, including simplifying enrollment and switching from semiannual to annual applications, increasing promotion and adding health centers in schools, a nurse hotline and a disease management program.

The Fund Board tasks the Oregon Health Authority with developing an Essential Benefit Package (EBP), which would determine minimum standards for insurance coverage. The board believes that effective services, as demonstrated by evidence, should receive higher levels of coverage than services of unknown benefit, which will have more cost sharing, thereby encouraging treatments that do the most to improve health. The EBP is to establish a baseline set of benefits, and all insurance plans in the state must meet these minimum requirements. The prioritized list used by the Oregon Health Plan is to serve as a model for the EBP.

The financing plan for the initial expansion of coverage to all Oregon children and some low-income adults relies on provider taxes. The funding for OHP comes in part from hospital and insurance

taxes, which were due to expire in 2009. Redesigning the provider taxes to obtain a federal match of about $1 billion could expand coverage to 175,000 uninsured Oregonians with the cost to the state an estimated $635 million during the 2009-11 biennium. These funds would not only be used to expand coverage, but to increase benefits, improve payments to providers and facilitate system reform. In particular, the board members were concerned that without improved payment rates to providers there would not be widespread participation in the Oregon Health Plan. Ultimately, the mix of taxes and rates must be an agreement among the Governor, Legislature, and interested parties. The report includes a significant caveat to the endorsement of provider taxes, arguing that the taxes should be designed so they are not passed on to purchasers of insurance and health care services. As such, the board recommends rigorous oversight and new regulations to prevent pass-through of the tax. Finally, the board provides recommendations for the financing of future coverage expansions, on the condition that cost control efforts have been successful. Expansion to approach universal coverage should include an individual mandate, reform of the individual insurance market, premium subsidies from the state, a pay-or-play payroll tax with higher rates for employers who do not provide health insurance and an insurance exchange. The OHA would use 2009 and 2010 to develop plans to implement these further reforms between 2011 and 2015.

Information and Transparency

The board provided a set of recommendations in the report focused on establishing the means to collect data that can be used to set standards for quality and control costs. The central data collection effort is the establishment of an all-payer, all-claims database, which will include every health insurance claim transaction in the state. The purpose of the new database will be to better understand and track changes in the use of health services. Providers will be able to benchmark their performance compared to others, and buyers of insurance could find providers who succeed at high quality, high value care. The database will also be useful in comparing care and costs geographically. Other transparency recommendations include the reporting of contracted rates between insurers and providers, along with information about

membership by geographic area. To facilitate these processes and generate savings, administrative forms and processes should be simplified.

Some measurement initiatives will require the establishment of quality standards. The board recommends that these be developed in collaboration among the state and health care providers, setting "evidence-based guidelines and best practice clinical standards (44)." They envision that comparative effectiveness research would contribute to this process and recommend the creation of an Oregon Quality Institute to coordinate such efforts.

Cost

The board's strategy for cost control begins by coordinating health benefits for public employees. State and local governments should adopt policies to purchase health insurance in a way that decreases costs and improves quality. The OHA would be responsible for developing uniform purchasing standards that involve adopting reforms, such as evidence-based medicine and comparative effectiveness research, quality measures to compare providers, integrated health homes, wellness programs, electronic medical records and the Oregon Prescription Drug Program, the state drug purchasing pool that provides discounts to enrolled Oregonians. Because state and local governments provide health insurance for 500,000 employees and dependents and an additional 420,000 Oregonians are currently on the Oregon Health Plan, with more to come from the expansion of coverage, nearly a million Oregonians get their insurance through state and local government. This purchasing should be coordinated. The membership scale can be used to initiate reforms, such as financial incentives to use integrated health homes, that smaller buyers could not. The expectation is that, eventually, private buyers would voluntarily adopt some of these reforms.

The creation of an Oregon Health Insurance Exchange, to be run by the authority, could reduce costs by standardizing administration, provide transparency for consumers and promote quality. Plans sold over the exchange would have to meet minimum requirements to prevent the sale of junk policies.

Information on all plans would be available on a central website, providing for easy comparison. The report initially endorses an exchange to replace the individual insurance market (all individual policies would be sold over the exchange), with eventual broadening to include premium assistance and potentially the small group market. The subcommittee of the board that studied insurance exchanges recommended that the exchange be established as part of comprehensive market reform, including an individual mandate, guaranteed issue and premium subsidies for lower income Oregonians who would otherwise be unable to comply with the mandate. The Health Fund Board ignored this recommendation and instead argued for the creation of an exchange under the current (non-guaranteed issue) medical underwriting system. Applicants who are denied due to preexisting conditions would be left to the existing state high risk pool. For policies sold over the exchange, a risk-adjustment mechanism would be used to spread risk among plans. The board also suggested considering a statewide reinsurance program. While the section of the report addressing insurance exchanges is somewhat confusing, it is clear that the board intends for an exchange to be the key mechanism for the expansion of health coverage in the future.

An endorsement of a public plan by the Fund Board is included in the report, with the expectation that it would be sold within the insurance exchange and meet the same standards as private insurance policies. The board assumes that the public plan would be cheaper, as it would have lower administrative costs than competitors and no need to earn a profit. However, they are concerned that the public plan would attract sicker people under the current system of medical underwriting. As a result, they believe a guaranteed issue market and individual mandate are necessary before the public plan can be opened. Their initial recommendation is that a business strategy for the plan be developed by 2011.

Finally, the board recommended that the state be granted sweeping new powers to regulate the price of health care. Insurer administrative expenses would be subject to direct regulation, rather than as a percentage of total costs, and a ceiling would be established on total price increases by providers.

Quality

A variety of recommendations aimed at health care quality improvement are included in the report. Perhaps the centerpiece of quality improvement is the promotion of the Integrated Health Home (IHH) model for care delivery, which is focused on primary care, prevention, disease management and wellness. The model requires a continuous relationship between provider and patient, a team of doctors and nurses providing care, the integration of care with other providers and a focus on quality and safety. The State of Illinois now requires all Medicaid members to enroll with an IHH and they estimate the model could save $190 million over ten years.

The Oregon Health Authority will establish the definition of an IHH along with a qualification process. This will be a prerequisite for higher payment levels and payment systems combining fee-for-service with risk-adjusted bundled payments. All government plans, not just Medicaid, will need to coordinate to promote this new model. The IHHs should be evaluated for the next six years and will be required to participate in a learning collaborative to share best practices. An extension of this model would be to integrate behavioral and physical health through co-location with primary care. For instance, OHP currently contracts with different parties for physical, addiction and mental health services. The goal is one organization with all three services. A further extension is the Accountable Health Communities concept. Data would be published, allowing costs and outcomes to be compared among different communities.

The board argues that substance abuse is very costly to Oregon and that higher alcohol taxes would decrease the societal costs of abuse while generating revenue for prevention and treatment. The Essential Benefits Package must have parity between coverage of physical and mental health services. Increased investments in public health, including culturally-specific approaches, are recommended in the report, along with expansion of language access. A statewide comprehensive plan for public health should be developed prioritizing reduction in tobacco use, increasing physical activity and promoting healthful diets. The report endorses higher tobacco taxes, smoking bans and insurance coverage of smoking cessation.

Payment systems should be reformed to focus on quality of care, not quantity, according to the board. A Payment Reform Council will pursue these new systems and make recommendations, with advice from a working group of private sector payers and providers.

The board made two recommendations regarding end-of-life care. A voluntary, electronic POLST (Physician Orders for Life Sustaining Treatment) registry should be established in order to ensure that the wishes of patients are respected. A paper-based system is currently in use, but is ineffective because the forms often are not available. Finally, reimbursement must be ensured for end-of-life care decision support.

Part of the OHA's responsibilities will include promoting and regulating health information technology. A Health IT Oversight Council will encourage standards and adoption. A system for statewide exchange of health data should be established. Electronic medical records should be subsidized for small and rural providers, and Medicaid reimbursements should be higher for providers using EMR.

Other Recommendations

The board suggested that a group of stakeholders study the medical liability system and make recommendations for reform.

Outreach efforts must include multicultural communities, including rural areas, people with disabilities and addictions, and the homeless. In the opinion of the board, federal citizenship documentation requirements have become a barrier to accessing Medicaid that excludes actual U.S. citizens, and such requirements should be relaxed. Additionally, creation of a statewide pool of interpreters would increase access to the health care system for non-English speaking populations.

The Oregon Health Authority should be responsible for producing a statewide health workforce strategy. This should involve data collection and making recommendations to increase and improve the health care workforce, with a focus on increasing primary care providers in all geographic areas. OHA will collaborate with educational institutions to provide cultural competency training.

Finally, the board recommended a laundry list of changes in federal law to facilitate the implementation of their state-level recommendations. These proposed federal changes include reform of Medicare payments to reward evidence-based care, primary care and IHHs, expansion of Oregon's Medicaid waiver, preservation of Medicare Advantage, cancellation or relaxation of citizenship documentation requirements, modification of ERISA to specifically allow states to enact pay-or-play payroll taxes, new tax breaks for individuals who purchase health insurance, increased funding for health care education, increased federal funding for the Indian Health Service, an increased number of Federally-Qualified Health Centers and changes to anti-trust laws to enable providers to work together to reform the delivery system. Additionally, the board recommends that state leaders participate in the national health reform debate.

The Governor's Response

The Governor included an expansion of health coverage in his 2009-11 budget, funded by a 1.5% tax on insurance premiums and a 4% tax on the revenue of Oregon's 25 large (over 50 beds) hospitals (Graves & Cole, 2009). The new revenue, along with a federal match, would be used to pay for expansion of coverage to all uninsured children (about 80,000) and another 75,000 low income adults.

The Legislative Response

The legislature responded to the report of the Oregon Health Fund Board through the introduction of several pieces of legislation. The House of Representatives began work on the structural reforms (HB 2009), including the creation of the Oregon Health Authority, expanded coverage and new provider taxes, while the Senate began work on delivery system and transparency reforms (SB 451-457), including the electronic POLST registry, claims database and Integrated Health Homes. The most controversial parts of the legislation were the provider taxes on hospitals and insurance companies. In the beginning, hospitals were not supportive of the taxes, and some local newspapers throughout Oregon, including the Bend Bulletin (2008) and the Salem Statesman Journal (2009), editorialized against the hospital tax, arguing that it could harm local hospitals or ultimately be passed on to patients. Two hospital

board members, writing in the Medford Mail-Tribune, said that the Governor's proposed tax could not "be absorbed by hospitals without dire consequences, layoffs, and service reductions (Heysell & Mackin, 2009)." The state's largest newspaper editorialized in favor of the approach, arguing that providers would be reimbursed through reduced uncompensated care (The Oregonian, 4/23/2009). Towards the end of the legislative session, a deal had been struck and hospitals were willing to support a compromise hospital tax, which would leverage a federal match and be returned to the hospitals through increased Medicaid reimbursements. Insurance companies agreed to a deal as well to accept a tax on health insurance premiums in return for the explicit permission to pass the tax along to customers. Business groups were split. Associated Oregon Industries, which represents many industrial and smaller businesses, opposed the insurance tax, as did the Oregon branch of the National Federation of Independent Businesses, both of which felt that the taxes would unfairly fall on their members (House Revenue Committee, 2009). The Oregon Business Association, representing, among others, large, self-insured businesses like Intel and Nike, supported the taxes. The hospital and insurance taxes were split off from the reform pieces into HB 2116. The delivery system and transparency pieces from the Senate were added to HB 2009, which passed the House with a vote of 38 to 22, with all Democrats in favor along with two Republicans (The Oregonian, 12/13/2009). The omnibus reform bill passed the Senate with an overwhelming 23 to 6 vote, including all Democrats and five Republicans. The votes on coverage expansion and hospital and insurance taxes included in HB 2116 were significantly closer, passing the House 36 to 24 on a straight party-line vote with no votes to spare because a three-fifths majority is necessary for all revenue raising legislation (The Oregonian, 2009). The Senate passed HB 2116 with 20 in favor, including all Democrats and two Republicans, and nine opposed.

The Governor signed both bills into law. The process was not over yet. Anti-tax activists threatened to collect signatures to force a referendum on all of the tax measures adopted by the legislature in 2009, including a personal income tax increase, a set of increases to corporate taxes and a gasoline tax increase, along with the taxes included in HB 2116. Ultimately, activists were not able to collect enough

signatures to send the hospital and insurance taxes to the voters. The group fighting the health care taxes, the Taxed Enough Already Coalition, relied on volunteer labor and did not have the financial backing necessary to mount a credible signature-gathering campaign, which in Oregon almost always requires paid circulators (Willamette Week, 2009). In contrast, a campaign to repeal the income and corporate taxes funded by business interests and individuals with over $1 million was successful at sending those measures to the voters for a January 2010 election, in which the measures were upheld. In the case of the income and corporate tax legislation, affected parties had not agreed to the tax increases and had not received anything in return, so they had little incentive to hold back from supporting a referendum campaign. In contrast, with Greenlick-Bates the most affected interests, hospitals and insurers, were actively involved with the development of the legislation and agreed to compromises that included important concessions from both sides. As a result, they had no incentive to provide financial support to a referendum campaign. Therefore, the taxes in HB 2116 had dodged the bullet that ended the previous effort to expand health care coverage, the tobacco tax defeated at the polls in 2007.

The Final Legislation: HB 2009

The reforms enacted by the legislature in 2009 closely track the recommendations by the Oregon Health Fund Board. A new state agency, the Oregon Health Authority, will assume responsibility for the Oregon Health Plan, insurance for state employees and other health care related programs from throughout state government, most of which were previously housed in the Department of Human Services (House Bill 2009, 2009). The OHA will be overseen by a nine-member Oregon Health Policy Board, which will have related advisory and technical committees. Eileen Brady, a member of the Oregon Health Fund Board, testified at the May 28, 2009 work session of the Joint Ways and Means Subcommittee on Human Services that a key goal of the Oregon Health Policy Board is to have one body that is responsible for quality, access and cost, whereas traditionally our health care system is divided among institutions that are focused only on one of those goals. The board is charged with developing several plans, including a plan to establish

universal health care in Oregon by 2015, a premium assistance program, a plan of recommended policies for an Oregon Health Insurance Exchange, a plan for a publicly owned health benefit plan and a report to the legislature on the feasibility of an individual mandate and a pay-or-play payroll tax funding source. The board is also given many other duties as suggested by the Health Fund Board, including the restructuring of reimbursement rates to reward quality outcomes, oversee implementation of interoperable electronic medical records, establish evidence-based clinical standards and practice guidelines and work with public employee benefit purchasers to develop uniform contracting standards. The legislation establishes the electronic POLST registry, a new oversight council for health information technology, data reporting requirements for insurers and hospitals, including the all-payer, all-claims database, and a new office to promote integrated health homes.

The Oregon Health Authority is not endowed with all of the powers and responsibilities suggested by the Fund Board. The Oregon Quality Institute is left out and the limits on insurance rates were replaced with softer language. The Authority can recommend standards for review of health insurer administrative expenses and rates, which will continue to be handled by another state agency, and there are more requirements for disclosure of administrative expenses and opportunities for public comment on rate filings. Additionally, rather than immediately create an insurance exchange, as suggested by the Health Fund Board, the Authority is directed to pursue a planning process for such an exchange along with a potential public option, both of which will require further statutory authority to implement.

The Final Legislation: HB 2116

The Oregon Health Fund Board endorsed generic provider taxes, but did not present a detailed proposal for how such taxes would work, other than to argue that they should be internalized by the health care system and not passed on to consumers. They did not get their wish. HB 2116 establishes a one percent tax on individual and small group insurance premiums, and insurers are explicitly allowed to increase their rates to recover the cost of the tax (House Bill 2116, 2009). Medicaid Managed Care

Organizations will pay an assessment of one percent of the gross amount of capitation payments they receive. State employees will also contribute through a one percent assessment on all of their insurance claims. For example, if a state employee makes an insurance claim for a $100 doctor visit, the insurance fund for state employees will pay $1 into the fund to provide insurance for Oregon children. The legislation imposes an assessment on the net revenue of a hospital that is not a waivered hospital, meaning the tax is only assessed on large hospitals in urban areas and regional centers. The rate is variable and will be determined by the director of the Department of Human Services, in consultation with the hospitals. Unlike in the past, hospitals are not guaranteed by the State of Oregon that additional payments will equal or exceed the amount of the assessments. Taxes will flow into a Health System Fund, which will pay for coverage expansion for children, and a Health Quality Assurance Fund, which will be used to increase reimbursement rates to providers and expand coverage through the medical assistance program. The provider taxes begin October 1, 2009 and sunset after four years. While the provider taxes are in force, the state is required to reimburse in-patient hospital care through fee-for-service Medicaid at levels similar to what Medicare would pay. While Medicaid and Medicare use different payment systems making it impossible for reimbursements to be identical for a given service, the hospitals believe that the increases in Medicaid payments and increased payments to Medicaid Managed Care Organizations will result in overall Oregon Health Plan reimbursement levels that are competitive with what Medicare pays. After the expiration of the provider taxes, Oregon Health Plan reimbursement rates will drop to around 70% of what Medicare would pay. Local governments are prohibited from taxing or regulating health insurers.

The same legislation establishes the coverage expansion programs and defines eligibility. The Oregon Health Plan will be open to children from families earning less than 200% of the federal poverty level, and a private, subsidized option will be available under 300% of FPL. As recommended by the Fund Board, administrative requirements are simplified and children are automatically reenrolled. The Department of Human Services is required to conduct outreach and marketing with the goal of enrolling all children in the state. In testimony at the House Revenue Committee on May 28, 2009, Dr. Bruce

Goldberg, Director of the Department of Human Services, said that the insurance taxes would support coverage for about 80,000 children and the hospital taxes would pay for coverage for 60,000 adults. Compared to the previous version of the hospital provider tax, this is an increase of about 35,000 adults. The insurance tax is entirely new and will result in an increase of 80,000 covered children.

Table 5: Summary of Greenlick-Bates legislation as enacted

House Bill 2009 (Structural Reform, Cost control and quality)	House Bill 2116 (Incremental coverage expansion)

▪ Create Oregon Health Authority (OHA)
    o Move Oregon Health Plan, other programs from Department of Human Services
▪ Create Oregon Health Policy Board
▪ Coordinate state/local government health care plans
    o Focus on cost control, paying for quality
▪ Establish all-payer, all-claims database
▪ Electronic POLST (Physician Orders for Life Sustaining Treatment) registry
▪ Regulate and support adoption of interoperable Electronic Medical Records
▪ Encourage Integrated Health Homes
	▪ Expand coverage to almost all Oregon children who are uninsured (80,000)
	    o Funded with 1% tax on individual and small group insurance premiums, 1% assessment on state employee health benefits and federal matching funds
	▪ Expand coverage to 35,000 additional low income adults
	    o Fund with variable tax on hospital revenues, federal matching funds
	    o Increase in Oregon Health Plan payment rates to compensate hospitals
	▪ Uses existing programs to deliver coverage expansion
	    o Oregon Health Plan
	    o Subsidized private insurance

Politics and Policy: Drivers of Change

Key participants in the Oregon health reform policymaking process were interviewed to learn their perspectives on the Oregon Health Fund Board and the subsequent legislation. Interviewees included legislators from both the House and Senate and both the majority and minority parties, a member of the governor's staff, a representative of Oregon hospitals and executives at Oregon insurers. Some of the people interviewed had participated on subcommittees of the Health Fund Board.

Attitudes about the usefulness of the commission approach varied with agreement with the Fund Board's recommendations. Advocates for single-payer or for reduced government involvement in health care were not going to change their perspectives as a result of a commission report. On the other hand, many participants were impressed with the amount of work completed by the commission in a relatively short timeframe and the breadth of the recommendations, covering almost all of the relevant topics related to health care reform. While there was broad participation among various stakeholders at the

subcommittee level, including many people with important positions in business, government, nonprofit and activist groups, the Health Fund Board only included one person working in the health industry (a physician) and was generally populated by people who were sympathetic to more liberal approaches to reform. There was some criticism that the Fund Board was not knowledgeable enough on health policy issues and should have been more deferential to recommendations made by subcommittees. While the commission earned praise for addressing the key issues related to health care reform, it also was criticized for not providing a clearer pathway for actually implementing those reforms. Many interviewees felt that the ultimate product of the Health Fund Board was less important than the process itself. A thorough, open, public process with significant involvement from interested parties helped to provide political cover for the legislature to act on health reform by creating momentum and the expectation that something had to be accomplished. It is remarkable that the vast majority of the recommendations in the Board's report are reflected in some way in the Greenlick-Bates legislation, even though some were scaled back or set to be developed over a longer timeframe. While some of the parts of HB 2009, such as the insurance exchange and public plan, are represented in the form of planning processes that the new Oregon Health Authority will undertake and will require further legislative action to implement, some of the participants felt that it is highly likely that they will be established, as there is now an institutional home to develop and promote these policies.

The commission and its report were not the only important factors in the enactment of Greenlick-Bates. Democratic control of the legislature and the governorship were necessary preconditions. Minority Republicans had some involvement in the legislative process, but it was limited and the vast majority of Republicans voted against HB 2009 and HB 2116. While there were parts of the legislation that some Republicans could support, such as the electronic POLST registry and some of the reorganization, other aspects, such as the individual mandate, endorsement of a public plan and especially the tax increases, were anathema. No House Republicans voted for the tax increases in HB 2116, leaving its success entirely dependent on the Democratic supermajority and their unity as a caucus.

But Democratic dominance of the legislature was not sufficient by itself to ensure passage. Key interest groups, particularly the hospitals, played a very important role, as did the fact that the existing hospital tax was about to expire and a straightforward extension was not possible, due to changes in federal rules.[11] Hospitals are popular and located in most legislative districts; most legislators will take concerns of their local hospital seriously, and their opposition to the initial provider tax proposal was unanimous. Without striking a deal with the hospitals to win their support for the package, it is unlikely that Greenlick-Bates would have become law. Long and difficult negotiations among the hospitals, key legislators, legislative leadership and executive branch officials continued for much of the session. Before the session had even begun, hospitals had offered a proposal to the Governor's staff to extend the tax, which was declined. The initial gubernatorial and legislative proposals for a hospital tax entirely devoted to coverage expansion were not acceptable to hospitals. They felt the tax would be ruinous if it could not be passed on to customers, meaning commercial insurance, as the other major revenue sources for hospitals, Medicare and Medicaid, use fixed pricing. Ultimately, a deal was agreed to. The major compromise was that the revenue generated by the tax and federal matching funds would be split between expanding coverage to low-income adults and increasing Oregon Health Plan payments to hospitals. As a result, the coverage expansion would be smaller than under the original proposal, but the financial cost to hospitals would be feasible without the need to recoup the tax from other payers.

The contours of the payment increases are actually quite complicated, but in general OHP payments to hospitals will increase so they are roughly equivalent to Medicare payment levels, and payments

[11] Historically, the hospital tax has not been a true tax. Under the existing hospital tax (before passage of HB 2116), the tax was collected from hospitals, used to leverage federal matching funds to expand coverage and returned, making it essentially a no-interest loan. For example, if a hospital were charged a $40 tax, the State of Oregon would use that revenue to claim $60 in matching funds from the federal government. Oregon would then return $40 to the hospital and spend the $60 in federal funds on expanding coverage. Federal rules were changed to prohibit states from promising hospitals reimbursement for the taxes they paid, making it impossible to extend the existing tax. Under HB 2116, when a hospital pays $40 in tax and the federal government provides $60 in matching funds, the State of Oregon would spend $100 split between expanding coverage and increasing Oregon Health Plan payments. The hospital in question could receive its tax money back by serving Oregon Health Plan patients and receiving increased payments for those services.

will now be uniform across the state. Hospitals estimate that the Oregon Health Plan pays around 60% of cost; the new policy will increase payments to around 80% of cost, as Medicare payments in Oregon are much lower than the national average. It also includes Medicaid Managed Care Organizations in the plan to reimburse hospitals. Because the vast majority of Oregon Health Plan beneficiaries are enrolled in managed care, the state is not directly paying the hospitals for their usage of services. The state will instead increase capitation payments to the MCOs, trusting that these increases will be passed on to hospitals. This arrangement is the cause of some nervousness in the hospital community, as the MCOs are independent organizations. It is essentially a handshake deal that the increased payments will find their way to hospitals and reimburse them for the tax.

The details of the reimbursement increases should not obscure the fact that there was tremendous incentive for all parties to reach a deal. Hospitals are important players whose interests are respected by legislators. The expiration of the existing provider tax system with no replacement was unacceptable as a policy option to participants, as that would have left more Oregonians without insurance than before, let alone failing to expand coverage, which was a primary goal of the governing coalition. It would have left around $1 billion in federal funds on the table for lack of a means to provide a match. And without a deal, Medicaid payments to hospitals were potentially more vulnerable to cuts to balance the budget in a very difficult fiscal environment. Ultimately, the two sides met in the middle, expanding coverage, increasing payment rates and eliminating the guarantee from the state that each individual hospital would be held harmless, to comply with new federal rules. As part of the deal, hospitals agreed to lobby for the passage of HB 2116 and were critical to ensuring that the necessary votes were secure. A member of the governor's staff indicated that the final deal was superior from their viewpoint than the initial proposal offered by the hospitals before the session, and viewed the negotiating process as a success.

The insurance tax portion of HB 2116 was less contentious than the hospital tax, but was still the result of extensive negotiations. Proponents of the tax intentionally tied the insurance premium tax to funding the expansion of health insurance coverage for children, and desired that the tax be absorbed by

insurers rather than passed on to customers. Insurance companies, most of which are not-for-profit in Oregon, countered that their margins were too thin to pay the tax without passing it on. Regulators at the Oregon Insurance Division helped convince some legislators that it was unlikely that a premium tax could be imposed on insurance companies without being passed on to customers. The surprise twist to the negotiations over the insurance tax was that insurers came with a strong counterproposal: a paid claims tax. Instead of being levied on commercial insurance premiums, this tax would be levied on insurance claims as they are processed by Third Party Administrators (TPA). This might sound like a distinction without a difference, but the incidence of each tax is not the same. The premium tax would only fall on individual and small group insurance premiums, a minority of the insurance market, as ERISA prohibits states from directly taxing large, self-insured plans. Applying a tax to paid claims through the TPAs would hit a much broader base and would discourage companies from becoming self-insured to avoid the tax. This approach was appealing to some legislators, but two problems stood in the way. First, there was legal uncertainty about the paid claims tax. While there were a variety of legal and policy experts who thought that it would comply with ERISA and be accepted by the federal government for matching funds, it had never been tested in court, and courts have sometimes used ERISA to strike down laws that affect self-insured plans in even modest respects. Second, there were political problems with the paid claims tax. It was opposed by self-insured businesses, such as Intel and Nike, which did not want to pay the tax. More importantly, it was also opposed by labor unions, whose Taft-Hartley trusts would have escaped the premium tax but not the paid claims tax. While the opposition of large, self-insured businesses was probably not influential with majority Democrats, labor union opposition was.[12] When it became clear that there would not be support in the legislature for a paid claims tax, that was discarded and an agreement was made with the insurers. The major compromise was that the bill was amended to specifically allow insurers to pass on the premium tax to customers and include a line on their bills itemizing the tax. Additionally, HB 2009 left out some of

[12] Since the legislative session ended, Maine has started collecting a paid claims tax to fund its health plan, and other states are considering doing so. If these taxes avoid or survive legal challenges, it is possible that the paid claims tax could be a future option for Oregon, should the political problems be addressed.

the more stringent proposals of the Fund Board to regulate insurance rates, such as by setting hard limits on administrative expenses or premium growth rates, although it was not clear that these proposals had enough support to pass anyway. What the agreement didn't include was the support of business groups. Ultimately, this is not a tax on insurers, but on policyholders. Associated Oregon Industries and the National Federation of Independent Businesses opposed the tax because it would hit their members. The Oregon Business Association, considered to be more moderate than the other business groups, supported the taxes, although their members are typically large, self-insured companies that would not be affected. The opposition of AOI and NFIB was not influential with Democrats in the legislature, who carried HB 2116 on their own in the House and with two Republican votes in the Senate.

There is no question that provider taxes were selected to fund the coverage expansions in large part for political expediency; there was no chance of passing a payroll tax or other broad-based tax increase during a legislative session amidst a major economic downturn. However, there were also substantive policy advantages to taxes on health care services and insurance other than securing a federal match that would otherwise be lost. Provider taxes have an advantage in that receipts increase with the cost of health care. It is unlikely that a payroll tax would continually generate revenue commensurate with increases in health care costs, and would be less sustainable in that respect.

While hospitals and insurers were key players in this most recent health reform policymaking process, multiple participants were surprised at the lack of involvement of physicians as a group. The AMA has been and is a major player in national health reform issues, but the Oregon Medical Association had a minimal role in the most recent legislative process.

Compared to the tax proposals, the structural reforms, quality and cost control measures contained in HB 2009 were much less controversial. They are, however, also more challenging from a policy perspective. Both legislators and stakeholders indicated that the Fund Board's report was better at outlining where we need to go than how we get there, especially as it pertains to legislation. As one interviewee put it, many of the reforms necessary to improve the health care delivery system need to take

place at higher or lower levels in the system: at the federal level for Medicare payment reform and at the local level for delivery system reform. The state is in a difficult position, trying to cajole improvements to the delivery system, such as the establishment of Integrated Health Homes, through regulatory and payment reforms. By the end of the session, HB 2009 had grown quite large, incorporating a set of transparency, quality and cost control bills that had already been passed by the Senate. Large bills can be challenging to pass, as there is more that can cause disagreement. It is possible that all of the attention on the taxes in HB 2116 may have actually made it easier to pass HB 2009; one of the reasons for removing the taxes and placing them into a different bill was to try to get a bipartisan vote for the reforms in 2009. Moving the health functions of state government into a new agency, the Oregon Health Authority, increased support for the bill, as there was widespread agreement that the Department of Human Services was too big and unwieldy. Mostly small changes were made to secure support for HB 2009. For example, some legislators disliked the original name for the commission that would replace two existing boards and oversee the authority, the Oregon Health Authority Board, so it was renamed the Oregon Health Policy Board.

Most of the participants viewed the recent health reforms as a relatively successful policy process. Legislation was passed, coverage was expanded, which was an important goal for many participants, and more fundamental reforms were put into motion. However, there was also acknowledgement that the funding mechanism for coverage expansion is not a long-term solution, as it expires in four years and there is uncertainty about the continued federal role. One of the participants described Greenlick-Bates as the best next step possible toward longer-term goals of universal coverage, quality improvement and cost control. One stakeholder who participated on one of the Health Fund Board's committees suggested that what is missing from efforts to achieve universal coverage is a political strategy. What public processes have not been able to resolve is how much Oregonians are willing to pay, or give up, for what kind of increase in coverage and lower costs.

Discussion

The experience of Oregon's political process of health reform can be compared to the theoretical expectations of the Advocacy Coalition Framework. Additionally, that framework provides a basis to compare Oregon's policy process and results with those of other states that have attempted to expand coverage and reform health care systems. First, it is useful to place the Oregon reforms within the context of the history of health reform efforts nationwide.

Health Reform in the United States

Since the middle of the twentieth century, the primary focus of health reform advocates has been increased coverage. After the failure of Truman-era efforts to create a national, universal system of social insurance for medical care, reformers adopted a more focused approach with the strategy of targeting coverage expansions to sympathetic groups, beginning with the aged and the destitute (Marmor, 2000). With the 1965 passage of Medicare, elderly Americans obtained government medical insurance financed mostly by taxes, and the federal-state Medicaid program was created to fund insurance for the poor. Ever since, reformers have attempted to expand coverage to more and more people, focusing on groups that are seen as deserving of help by the public. As a result, Medicare was expanded to include people with disabilities and, in the 1990s, Congress created the State Children's Health Insurance Program (SCHIP), a federal-state partnership to increase coverage of children. Recent political battles on the federal level have involved SCHIP, as Congress passed and President Bush vetoed an expansion of the program in 2007, followed by the passage and ultimate signing of an SCHIP expansion in 2009 (CHIP, 2010). This strategy to cover more sympathetic groups has been operative in Oregon as well. The initial coverage reforms in Greenlick-Bates are incremental expansions that focus primarily on children but also low-income adults. The Oregon Health Authority, however, is charged with planning reforms to achieve universal coverage, which if legislatively adopted would be a sea-change from the typical piece-meal pattern of health coverage expansion throughout recent American political history.

Oregon and the ACF

The recent health reform process in Oregon has been compatible with the predictions of the Advocacy Coalition Framework. In the state of Oregon, the political fight during 2009 was mostly over the secondary aspects of health coverage reform, as those in power generally agreed that increasing coverage and ultimately achieving universal coverage was a core belief. The Universal Coverage coalition in Oregon includes the Oregon Health Fund Board, majority Democrats in the legislature, the Governor, unions, moderate business groups and much of the medical establishment (insurers, hospitals and doctors). The Free Market coalition includes minority Republicans in the legislature, anti-tax activists and conservative business groups. The voters are also an important player in Oregon politics beyond their role in electing legislators, as they have the ability to reverse legislation passed by the legislature through the referendum process, or refuse to approve a referral, as in the case with the 2007 proposed tobacco tax increase that would have expanded coverage to most Oregon children. Greenlick-Bates was made possible by the 2006 and 2008 elections which gave Democrats control of both legislative bodies and supermajorities, respectively, strengthening the universal coverage coalition. A system wide governing coalition that was supportive of these policies was spurred by the policy-oriented learning of the Oregon Health Fund Board and one very important external force: the pending expiration of the existing provider tax and changes in federal rules that made straightforward extension impossible. This left the fight over the secondary aspects of how exactly to pay for reform and what it should look like. A deal was struck that was acceptable to the key players and it became law. The potential threat hanging over the process was that of a voter referendum. With narrowly-targeted taxes and the support of the participants who could have funded a signature-gathering effort, this threat was stymied by lack of financial and organizational support, but it could be a serious challenge to a future phase of reform. For instance, if the Oregon Health Authority were to pursue a universal coverage plan with an exchange, guaranteed issue, an individual mandate and subsidies, and a future legislature were to attempt to fund those subsidies with a pay-or-play payroll tax, or some other broad-based funding source, the chances of a referendum succeeding are more likely.

Table 6 – Members of Universal Coverage and Free Market coalitions in Oregon

Universal Coverage coalition	Free Market coalition

▪ Majority Democrats in the legislature
▪ Governor Kulongoski
▪ The Oregon Health Fund Board
▪ Labor unions
▪ Moderate business groups
  o Oregon Business Association
▪ The Oregonian Editorial Board
▪ Hospitals
▪ Health Insurers
▪ Physicians
	▪ Minority Republicans in the legislature
	▪ Conservative business groups
	  o Associated Oregon Industries
	  o National Federation of Independent Businesses
	▪ Anti-tax groups
	  o Freedomworks

Oregon and ITA

Ruger predicts that health reform policies will usually be incremental because it is easier to find agreement on low level policies (specific solutions, such as a small expansion of coverage) than on both a middle level goal (universal coverage) and a low level policy that would achieve that goal. In this respect, Oregon is typical because the Greenlick-Bates legislation initially establishes incremental increases in coverage. However, combined with the structural reforms, the law does set in motion reforms and processes that could lead to major expansions of coverage in the future. Unlike Ruger's example of SCHIP on the federal level, Greenlick-Bates in Oregon appears to be part of a coherent strategy to achieve comprehensive health care reform, and lawmakers seem to have enacted as much of it as was politically possible in 2009. Supporters of Greenlick-Bates were aligned on the middle level goal (comprehensive reform with the ultimate goal of universal coverage) and enacted the most aggressive policy to pursue that goal that could engender political support.

The Oregon Health Fund Board as a Policymaking Tool

It is not realistic to expect a commission report, even with an extensive, public process, to convince everyone on an issue with as strong opinions as health care reform. There are also definite weaknesses to asking any group of non-experts, no matter how committed and well-intentioned, to make policy recommendations on such a complex issue. For instance, the Oregon Health Fund Board recommended establishment of an insurance exchange without any other market reforms, such as guaranteed issue, an

individual mandate and subsidies. There are enormous problems with such an approach, which no health policy expert would endorse. However, as policymakers involved with health reform in Oregon stated, the actual recommendations of the Fund Board were not nearly as important as having a large and open public process to get all of the issues on the table, which it did accomplish successfully, and which seemed to provide momentum and political cover for legislative action. Particularly in a state like Oregon where public processes are highly valued, having this commission was probably a necessary precursor to any significant health reform effort.

Comparison of Oregon with Other States

The differences among the six states that have pursued significant reform efforts are remarkable. They range from large in population to tiny, rich to poor, with high levels of insurance and high levels of uninsurance. Vermont followed the process most similar to Oregon, with a commission (led by legislators, not private citizens) followed by legislation including an incremental coverage expansion and some structural efforts to improve the health care delivery system. In both cases, the efforts were smaller in scope than Oregon's, although Vermont is a very small, homogenous state with a low uninsured population.

Massachusetts' reform efforts have interesting similarities, but striking differences. Like Oregon, reform in Massachusetts was in part driven by a powerful external force: the threat of loss of federal Medicaid waiver funds, which gave policymakers strong incentive to strike a deal, much like the expiration of Oregon's existing provider tax was an important factor. Massachusetts also benefited from policy-oriented learning, but from technical work coordinated by private parties, not a public commission. With a system wide governing coalition that was in support of universal coverage, the Massachusetts example also appears to confirm the predictions of the ACF. The state's rapid and comprehensive reforms have been very successful at expanding coverage, as Massachusetts is now the national leader in reducing uninsurance. However, they started from a much better position, with a low uninsurance rate to begin with, a unique source of funds, a relatively wealthy population and a well-funded health care system including Medicare

reimbursements much higher than Oregon (Dartmouth Atlas Project, 2009). And even Massachusetts, with all of its success, did not attempt to establish a broad-based funding source, such as a payroll tax, to fund coverage expansion, instead choosing to exempt some residents from the individual mandate due to a lack of funds for subsidies and the related affordability concerns. While Massachusetts has been widely praised for its health reforms, if a state as wealthy and well-positioned as Massachusetts cannot achieve universal health coverage on its own, it is doubtful whether any state could do so. Oregon's reforms in HB 2009 create the foundation for more comprehensive health insurance coverage expansion, but that will be dependent on future legislative support and a larger, broad-based funding mechanism, such as a pay-or-play payroll tax, which would be susceptible to legal (ERISA) and political (referendum) challenges. On the other hand, Oregon arguably surpassed the Massachusetts reforms in beginning efforts to improve cost control and quality, such as aligning public employee health care to drive system change, the electronic POLST registry, Integrated Health Homes and other reforms.

California is very much the cautionary tale of health reform, with an ambitious plan to dramatically expand coverage that collapsed in the face of the state's enormous budget problems. Even without the fiscal meltdown, lack of agreement among the key players in California health policy was probably enough to prevent success. If anything, California's overreaching attempt at reform demonstrates to health reform advocates that a successful, incremental effort is preferable to a comprehensive effort that fails.

Hawaii is the special case of health reform policy. The only state with an employer mandate, and a special exemption in the federal ERISA law to protect it from court challenges, Hawaii's economy is well-positioned for such a mandate due to their large base of tourism jobs that cannot be outsourced. In earlier attempts at health reform both Oregon and Massachusetts enacted employer mandates into law, but repealed them before they could be implemented. While some sort of employer mandate, such as a pay-or-play payroll tax, could be a viable part of a more comprehensive reform, by itself it has the weakness of discouraging full-time employment.

Maine's experience shows that it is possible to enact incremental health reform that doesn't accomplish much, and may even make the situation worse. By creating a guaranteed-issue, highly regulated insurance market without an individual mandate or sufficient subsidies, the market for individual insurance has become high cost and dysfunctional, suffering from adverse selection. Maine voters, like Oregonians, rejected sin taxes at the ballot box, eliminating a key funding source for the subsidies.

Oregon's health reform policymaking process resulted in changes that became law, with provisions to increase coverage and address cost and quality, that were more significant than in any other state that has attempted reform, with the possible exception of Massachusetts. No state has found the political will to enact major broad-based taxes or strict cost control measures to facilitate dramatic changes in coverage levels. Given Oregon's resources and large uninsured population, health reform advocates probably accomplished as much as was politically possible with the Greenlick-Bates legislation in 2009. However, the long term prognosis for the reforms is uncertain. The coverage expansions are funded by taxes that expire in four years. This is a temporary solution that will eventually have to be addressed with a more sustainable funding source if it is to be continued. And at least 500,000 Oregonians will remain uninsured, probably more due to employment losses and dropping of insurance coverage associated with the recession. The results of the structural reforms will take much longer to evaluate. An ambitious Oregon Health Policy Board and a supportive legislature could result in fundamental reforms that expand coverage, control costs and improve quality. For instance, an ambitious board that takes the charge of aligning public employee health plans seriously could use the opportunity to instigate change in the payment and delivery systems, which could have a significant impact on costs in the long run. It is just as easy to imagine a situation where the Oregon Health Authority is less successful at these goals. There is a gubernatorial election in 2010, along with normal legislative elections, and the system wide governing majority could change in ways that alter the course of the Oregon Health Authority. And Oregon's system of direct democracy hangs over all major policy efforts by legislators; a funding mechanism for a large coverage expansion could easily be sent to the voters, who might reject it. With the passage of Greenlick-Bates, Oregon appears to be well-

positioned for potential health reform at the federal level. If the federal government regulates the insurance market, establishes an individual mandate, provides subsidies and requires states to establish exchanges, the Oregon Health Authority seems to be situated to assume those responsibilities with minimal changes.

Evaluation of Theories (ACF and ITA)

Both Sabatier's Advocacy Coalition Framework and Ruger's application of Incompletely Theorized Agreements to health reform policy are useful and applicable to these cases, but could also benefit from some extension and revision. From the perspective of the ACF, there are two clear advocacy coalitions, the Universal Coverage coalition and the Free Market coalition, that are active on the state and federal levels. The political strength of these coalitions is affected by external events, elections and policy-oriented learning (commissions, research). The ACF does not predict when change will occur in health reform policy, but it does correctly predict the necessary preconditions for action. The framework could be improved by distinguishing ideological groups from self-interested participants in the policy process. These self-interested parties are far more likely to move between coalitions depending on how secondary disagreements are resolved. In many respects, they are key to any successful health reform policy. When the Free Market coalition is large and united, it is very powerful and can block health care reform easily, as was seen in Congress in 1994 and California in 2007. When it is divided and the Universal Coverage coalition has attracted as many non-ideological interests as possible through compromise on secondary issues and accommodation of the self-interest of key participants, the Universal Coverage coalition can prevail, as it did in Massachusetts in 2006 and Oregon in 2009.

Ruger's application of Incompletely Theorized Agreements is an apt description of many of the incremental reforms Congress has enacted, such as SCHIP, which combine low level agreement on a particular policy with often strong middle level disagreement about what the ultimate goal of health reform should be. It seems applicable to California, where there was no agreement on middle or lower levels, and Massachusetts, where there was agreement on both levels. It is harder to apply to Oregon, which did not

enact a complete universal coverage policy in 2009, but did take important steps as part of a coherent plan to expand coverage and reform the system. While the middle level goal in Oregon clearly includes eventual establishment of universal coverage and Greenlick-Bates does not, by itself, make the same amount of progress toward that goal as the Massachusetts reforms, in this case the middle and low level goals are not incongruent. The ITA theory could be extended to consider that the middle and low levels may actually be aligned, but specific policy action must be limited by the constraints of political viability. The limitation on reform in this case is not conflict about the goals or policies, but a search to find the most effective policy to advance these goals that can find political support.

Practical Political Implications

The experience of Oregon and other states with attempts at health reform provides a variety of practical lessons for health care reform advocates: (1) the political environment must be right for reform, (2) external events that require change are an opportunity for reform, (3) small successes are preferable to big failures and (4) compromise on secondary issues is key to political viability. Given that health care policy impacts everyone, often in profound ways, and a formidable constellation of interest groups is involved, it will always be difficult to achieve any change. Therefore, having allies of the Universal Coverage coalition in power in the legislature and executive is a prerequisite for reform. And because health care reform is so difficult that many policymakers may want to avoid it, external events that require action, such as the expiration of Oregon's provider tax and Massachusetts' Medicaid waiver, are key opportunities for reform that can be utilized to achieve larger goals. If comprehensive reform is not politically viable, incremental reform should be embraced by members of the Universal Coverage coalition if they want to be effective. Accomplishing nothing is not only failure, it can delay future successes. Failed, unrealistic efforts such as the California plan for reform needlessly occupy the valuable time of policymakers and provide them with many reasons not to work on reform in the future. Finally, it is clear that the Universal Coverage and Free Market coalitions are not immutable; attracting members who are ideologically flexible is key to the passage

of any reform, and this is best done by protecting the self-interest of organizations that are significantly affected by changes to health care policy. Compromise on the secondary issues to attract as many supporters to the Universal Coverage coalition is difficult and aggravates the true believers in particular policy approaches, but it is the only way to achieve comprehensive reform within our pluralistic political system.

Conclusion

Oregon's recent experience shows that a commission-led policy development process with significant public involvement can be an effective political tool to facilitate passage of health reform legislation. It, along with the experience of other states, shows that most successful reforms at the state level will be more incremental than comprehensive, with policies that are innovative, but inexpensive. Seeking coverage expansion in tandem with structural reforms can be a viable political strategy and may be good public policy. There is evidence that some form of policy-oriented learning is useful for advocates of health reform in states. Whether this learning should take the form of a public, citizen-led commission, like in Oregon, a legislative commission, like in Vermont, or work of private foundations and interest groups, like in Massachusetts, may be dependent on the political culture of the state in question.

It is difficult to evaluate structural reforms as enacted in Oregon and Vermont, as their effects are necessarily long-term. The experience of state attempts to reform health care provides considerable evidence that states are not well-positioned to establish universal coverage or reform the health delivery system to control costs and increase quality on their own; Congressional action will be necessary to achieve these goals. The combination of states' lack of regulatory control over Medicare, ERISA and the apparent lack of support among legislators and voters for broad-based taxes to fund coverage expansions all combine to limit the ability of states to make dramatic change. However, these initial, incremental efforts at the state level contribute to our understanding of the effectiveness of various approaches to health care reform. They

also could position these states to more effectively implement and take advantage of potential reform at the federal level, and serve as models for states that have been less active in health reform policy.

List of Works Cited

Aaron, H. J., & Butler, S. M. (2008). A Federalist Approach to Health Reform: The Worst Way, Except For All The Others. *Health Affairs*, 725-735.

Antos, J. (2008). Lessons From The Clinton Plan: Incremental Market Reform, Not Sweeping Government Control. *Health Affairs*, 705-710.

Baicker, K., & Chandra, A. (2008). Myths And Misconceptions About U.S. Health Insurance. *Health Affairs*, w533-w543.

Barrilleaux, C., & Brace, P. (2007). Notes from the Laboratories of Democracy: State Government Enactments of Market- and State-Based Health Insurance Reforms in the 1990s. *Journal of Health Politics, Policy and Law*, 655-683.

Belluck, P. (2007, April 23). As Health Plan Falters, Maine Explores Changes. *The New York Times*.

Bend Bulletin. (2008, December 14). Oregon's health reform pathology. *The Bend Bulletin*.

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The Triple Aim: Care, Health, And Cost. *Health Affairs*, 759-769.

Blendon, R. J., Buhr, T., Sussman, T., & Benson, J. M. (2008). Massachusetts Health Reform: A Public Perspective From Debate Through Implementation. *Health Affairs*, w556-w565.

Blumberg, L. J., & Davidoff, A. J. (2003). *Exploring State Variation in Uninsurance Rates among Low-Income Workers.* Washington: The Urban Institute.

Bodaken, B. G. (2008). Where Does The Insurance Industry Stand On Health Reform Today? *Health Affairs*, 667-674.

Buchmueller, T., DiNardo, J., & Valletta, R. (2009). *Employer Health Benefits and Insurance Expansions: Hawaii's Experience.* San Francisco: Federal Reserve Bank of San Francisco.

Children's Health Insurance Program. (2010). Retrieved January 2010, from National Conference of State Legislatures: http://www.ncsl.org/?tabid=14510

Cogan, J. F., Hubbard, R. G., & Kessler, D. P. (2005). Making Markets Work: Five Steps To A Better Health Care System. *Health Affairs*, 1447-1457.

Curtis, R., & Neuschler, E. (2009). Affording Shared Responsibility For Universal Coverage: Insights From California. *Health Affairs*, w417-w430.

Dartmouth Atlas Project. (n.d.). *Medicare Reimbursements per Enrollee*. Retrieved December 18, 2009, from The Dartmouth Atlas of Health Care: http://www.dartmouthatlas.org/interactive_map.shtm

Feder, J. (2004). Crowd-out and the politics of health reform. *The Journal of Law, Medicine & Ethics*, 461-464.

Feldstein, M. (2006). Balancing The Goals of Health Care Provision And Financing. *Health Affairs*, 1603-1611.

Ferguson, C. C., Fowler, E. J., & Nichols, L. M. (2008). The Long Road To Health Reform Requires Bipartisan Leadership. *Health Affairs*, 711-717.

Fuchs, V. R., & Emanuel, E. J. (2005). Health Care Reform: Why? What? When? *Health Affairs*, 1399-1414.

Furman, J. (2008). Health Reform Through Tax Reform: A Primer. *Health Affairs*, 622-632.

Gabel, J. R., Whitmore, H., Pickreign, J., Sellheim, W., KC, S., & Bassett, V. (2008). After The Mandates: Massachusetts Employers Continue To Support Health Reform As More Firms Offer Coverage. *Health Affairs*, w566-w575.

Gawande, A. (2009, June 1). The Cost Conundrum. *The New Yorker*.

General Election Tabulations. (2008, November 4). Retrieved December 15, 2009, from Maine.gov: http://www.maine.gov/sos/cec/elec/2008/tabs-ref-cnty-11-08.html

Ginsburg, P. B. (2008). Employment-Based Health Benefits Under Universal Coverage. *Health Affairs*, 675-685.

Graves, B., & Cole, M. (2009, January 6). Health care: Who gets left out? *The Oregonian* , p. A1.

Gruber, J. (2006). The Massachusetts Health Care Revolution: A Local Start for Universal Access. *Hasting Center Report*, 14-19.

Hacker, J. S. (2008). Putting Politics First. *Health Affairs*, 718-723.

Haislmaier, E. F., & Owcharenko, N. (2006). The Massachusetts Approach: A New WAy To Restructure State Health Insurance Markets and Public Programs. *Health Affairs*, 1580-1590.

Harris, G. (2009, November 11). Maine Finds a Health Care Fix Elusive. *The New York Times*.

Herzlingler, R. E., & Parsa-Parsi, R. (2004). Consumer-Driven Health Care: Lessons From Switzerland. *JAMA*, 1213-1220.

Heysell, R. R., & Mackin, D. (2009, April 12). Hospitals support real reform. *Medford Mail Tribune*.

Holahan, J., & Blumberg, L. (2006). Massachusetts Health Care Reform: A Look At The Issues. *Health Affairs*, w432-w443.

House Bill 2009. (2009). Retrieved August 2009, from http://www.leg.state.or.us/09reg/measpdf/hb2000.dir/hb2009.en.pdf

House Bill 2116. (2009). Retrieved August 2009, from http://www.leg.state.or.us/09reg/measpdf/hb2100.dir/hb2116.en.pdf

House Revenue Committee Hearing and Work Session on HB 2116. (2009, May 28).

Interim Senate Commission on Health Care Access and Affordability. (2006). *Draft: Comprehensive Health Care Reform.*

Joint Ways and Means Subcommittee on Human Services Work Session HB 2009. (2009, May 28).

Jost, T. S. (2004). Why Can't We Do What They Do? National Health Reform Abroad. *The Journal of Law, Medicine & Ethics*, 433-441.

Kilbreth, E., & Fox, K. (2008). *The Dirigo Health Reform Act: A Case Study of Small Group Market Reform in Maine.* Albany, NY: The Nelson A. Rockefeller Institute of Government Health Policy Research Center.

Lunch, W. (2005). Health Policy. In R. A. Clucas, M. Henkels, & B. S. Steel (Eds.), *Oregon Politics and Government* (pp. 242-255). Lincoln: University of Nebraska.

Marmor, T. R. (2000). *The Politics of Medicare, Second Edition.* New York: Aldine De Gruyter.

McDonough, J. E., Miller, M., & Barber, C. (2008). A Progress Report on State Health Access Reform. *Health Affairs*, w105-w115.

McDonough, J. E., Rosman, B., Phelps, F., & Shannon, M. (2006). The Third Wave Of Massachusetts Health Care Reform. *Health Affairs*, w420-w431.

McGlynn, E. A., & Wasserman, J. (2006). Massachusetts Health Reform: Beauty Is In The Eye Of The Beholder. *Health Affairs*, w447-w449.

Miller, T. (2006). Massachusetts: More Mirage Than Miracle. *Health Affairs*, w450-w452.

Mulkey, M. R., & Smith, M. D. (2009). The Long And Winding Road: Reflections On California's 'Year Of Health Reform'. *Health Affairs*, w446-w456.

Oberlander, J. B., & Lyons, B. (2009). Beyond Incrementalism? SCHIP And The Politics Of Health Reform. *Health Affairs*, w399-w410.

Oberlander, J. (2008). The Politics Of Paying For Health Reform: Zombies, Payroll Taxes, And The Holy Grail. *Health Affiars*, w544-w555.

Ruger, J. P. (2007). Health, Health Care, and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision Making. *Journal of Health Politics, Policy and Law*, 51-87.

Sabatier, P. A. (1993). Policy Change over a Decade or More. In P. A. Sabatier, & H. C. Jenkins-Smith, *Policy Change and Learning: An Advocacy Coalition Approach* (pp. 13-39). Boulder: Westview Press.

Secretary of State. (2002). *November 5, 2002 General Election Abstract of Votes*. Retrieved October 30, 2009, from http://www.sos.state.or.us/elections/nov52002/abstract/m23.pdf

Secretary of State. (2007). *November 6, 2007 Special Election Abstract of Votes*. Retrieved October 30, 2009, from http://www.sos.state.or.us/elections/nov62007/abstract/results.pdf

Secretary of State. (2002). *Official 2002 General Election Online Voter's Guide*. Retrieved October 30, 2009, from http://www.sos.state.or.us/elections/nov52002/guide/measures/m23.htm

Senate Bill 27. (2007). Retrieved October 30, 2009, from http://www.leg.state.or.us/07reg/measpdf/sb0001.dir/sb0027.intro.pdf

Senate Bill 329. (2007). Retrieved 20 2009, October, from http://www.leg.state.or.us/07reg/measpdf/sb0300.dir/sb0329.en.pdf

Skocpol, T. (1996). *Boomerang: Clinton's Health Security Effort and the Turn against Government in U.S. Politics.* New York: W.W. Norton & Company.

Southby, R. F. (2004). Where Do We Go From Here: Is There Any Hope For Real Health Care Reform? *The Journal of Law, Medicine, & Ethics*, 442-445.

Statesman Journal. (2009, March 1). Raising hospital tax may be unhealthful. *Statesman Journal.*

Steinbrook, R. (2008). Health Care Reform in Massachusetts - Expanding Coverage, Escalating Costs. *The New England Journal of Medicine*, 2757-2760.

The Oregonian. (2009, April 23). A reasonable approach to health care reform. *The Oregonian* , p. C4.

The Oregonian. (2009). *HB 2009*. Retrieved December 13, 2009, from Oregon Legislature Bill Tracker: http://gov.oregonlive.com/bill/HB2009/

The Oregonian. (2009). *HB 2116*. Retrieved December 13, 2009, from Oregon Legislature Bill Tracker: http://gov.oregonlive.com/bill/HB2116/

van de Ven, W. P., & Schut, F. T. (2008). Universal Mandatory Health Insurance In The Netherlands: A Model For The United States? *Health Affairs*, 771-781.

Various Oregon Policymakers and Stakeholders. (2009, October-December). (B. Collins, Interviewer)

Vesely, R. (2009, June 15). Maine revamps funding formula. *Modern Healthcare*, p. 2009.

Weil, A. (2008). How Far Can States Take Health Reform? *Health Affairs*, 736-747.

Willamette Week. (2009, September 16). *Murmurs (News in Brief).* Retrieved December 19, 2009, from Willamette Week: http://wweek.com/editorial/3545/13067/

Wilson, J. F. (2008, May 20). Vermont Health Care Reform Aims for More Coverage, Less Expense, and Better Care. *Annals of Internal Medicine*, pp. 797-800.

Wyden, R., & Bennett, B. (2008). Finally, Fixing Health Care: What's Different Now. *Health Affairs*, 689-692.

Appendix: Interviews

Questions

1. What goals were important to achieve by health care reform in Oregon?

2. What is your evaluation of the work of and report produced by the Oregon Health Fund Board? In what ways was it successful/did it achieve its goals? In what ways was it not successful/did not achieve its goals?

   a) Was having an independent board an effective policy development process?

3. What is your evaluation of the work of the Oregon Legislature on health reform during the 2009 session? In what ways was it successful/did it achieve its goals? In what ways was it not successful/did not achieve its goals?

   a) How were HB 2009 and 2116 influenced by the work of the Oregon Health Fund Board?

4. Who were the key players in developing and passing a plan to expand health coverage in Oregon? Which players were most influential? Which were least influential? Why? Who wasn't involved, but should have been?

5. What were the most important compromises made in order to pass HB 2009 and 2116? What were their effects? (Where was disagreement - among Democrats? Between Democrats and Republicans? Between the legislature and the executive? Among interest groups? With the recommendations presented by the Health Fund Board?)

Participants

Three Oregon legislators (including at least one from each chamber and political party)
One member of the Governor's staff
Two insurance executives, both of whom participated on subcommittees of the Oregon Health Fund Board
One representative of Oregon hospitals

Appendix: Definitions of Terms

Adverse selection: In health insurance, adverse selection is when people with medical needs purchase insurance and make claims, causing premiums to rise and healthy people to cancel their coverage, which continues to place upward pressure on premiums as there are fewer healthy people in the risk pool to cover the costs of claims. Insurance companies avoid adverse selection by engaging in medical underwriting, which is the process of only selling insurance to people who are currently healthy and charging higher premiums for certain risk factors, such as tobacco use and age.

Community rating: Pure community rating means that insurance companies are required to charge all customers the same premium for a given policy. It is common for states to require community rating in general but allow certain exceptions, such as for tobacco use, and to allow for limited variation of premiums among different age groups.

Employer mandate: A requirement that employers provide a minimal level of health insurance to employees directly or contribute financially to the health benefits in some way. See: Pay-or-play payroll tax.

ERISA: The Employee Retirement Income Security Act is a federal statute that governs private pension plans and the health benefit plans of large companies that self-insure and often operate in multiple states. The law exempts these self-insured plans from the regulatory control of state governments. ERISA greatly complicates the efforts of states to enact health care reform policies, as attempts to establish employer mandates are vulnerable to charges that they violate the law.

Guaranteed issue: Under a guaranteed issue insurance market, insurance companies are required to sell (issue) insurance policies to anyone, regardless of their medical history or demographics, and cannot deny coverage for a preexisting condition.

Individual mandate: A requirement that individuals obtain a minimal level of health insurance. The mandate can be enforced by a tax penalty on individuals who do not purchase coverage (as in Massachusetts) or through automatic enrollment (as in The Netherlands).

Insurance exchange: A government regulated marketplace in which all citizens can easily compare available insurance plans and purchase coverage. The exchange serves as a gateway between people and insurers as well as a mechanism to distribute subsidies to help low and middle income families obtain insurance. The Massachusetts Connector (www.mahealthconnector.org) is an example of an insurance exchange.

Oregon Health Fund Board (OHFB): An independent commission created by the Oregon Legislature and appointed by the Governor in 2007 to develop a plan to reform health care in Oregon to expand coverage, control costs and improve quality of care.

Oregon Health Plan (OHP): Oregon's version of Medicaid, which operates under a federal demonstration waiver allowing the state to offer a smaller benefits package than traditional Medicaid and use the savings to cover more people.

Paid claims tax: A tax on insurance claims that is collected from Third Party Administrators who are hired to handle claims for insurance companies and self-insured plans. This is considered to be a way to get around ERISA, which would prohibit states from levying a tax on large group, self-insured plans. The paid claims tax, currently the major source of funding for Maine's health coverage subsidy program, has not yet been tested in court.

Pay-or-play payroll tax: A form of an employer mandate, whereby employers offering health insurance to employees pay a lower tax rate (or receive a credit on their taxes) and employers not offering health benefits pay a higher tax rate.