Window Shopping: State Health Reform Politics In The 1990s

The dynamics of “catalytic federalism” could lead to new opportunities to attack the problem of the uninsured.

by Lawrence D. Brown and Michael S. Sparer

ABSTRACT: Throughout the 1990s states sought politically acceptable policies to reduce the ranks of the uninsured. Visions of comprehensive health reform and universal coverage yielded by mid-decade to more modest measures to repair private health insurance markets, and to these enactments were added several new public programs (state and federal) to expand coverage for lower-income children and, in some cases, adults. Because governments remain ill equipped to counter the power of business, insurers, and providers in conflicts fought on private turf, reform agendas have been more readily set, moved, and cleared in public-sector arenas. Although the number of uninsured rose steadily until 1999, “catalytic federalism”—the accelerating interplay between state and federal reform forces and funds—may be putting the programmatic foundations for broader coverage incrementally into place.

As the 1980s closed, windows of opportunity opened for health reform (defined here as measures to expand health insurance coverage) with increasing frequency across the fifty states. By 1993 those subnational windows had widened into a national reform opportunity the Clinton administration could neither refuse nor (seemingly) lose. National reform of course quickly collapsed, and in the latter half of the decade chastened states shopped within their strategic arsenals for incremental reforms that might reduce their growing numbers of uninsured residents.

The verdict on the fruits of their labors would seem to be conveyed by a simple melancholy fact: In 1998 the number of people without health insurance stood higher than the figure for 1990–1992 in forty-two of fifty states. (Among the happy eight, four—Alabama, Florida, Louisiana, and Oklahoma—registered small drops in high rates of uninsurance, and four—Kansas, Ohio, Rhode Island, and Tennessee—saw tiny drops in rates that were already relatively low.)

Those inclined to let the data speak for themselves might infer

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from these numbers that at least for this salient problem, state health policy is much ado about little or nothing. The states seem to be as fated to fumble health reform as are the feds. A lingering look at political process, however, not only challenges the “dynamics without change” interpretation but also suggests a more nuanced reading of state health policy outcomes themselves. Here we try to distill patterns and lessons mainly, although not exclusively, from five states—California, Colorado, Florida, Kentucky, and Washington—in which we conducted interviews between 1995 and early 2000 as part of a study, funded by the Robert Wood Johnson Foundation (RWJF), on the capacity of states to achieve health reform. (Unless otherwise noted, quotations in the text come from state officials or stakeholders interviewed on promise of anonymity.) We argue that the heart of the policy exercise is to craft politically acceptable cross-subsidies for the uninsured and that the capacities of states to set, move, and clear health reform agendas differ with the political challenges that accompany proposed subsidies for the uninsured in distinct strategic arenas. We start with a quick sketch of the three main phases of state health reform in the past decade and then draw implications about the roles and limits of states as health reform leaders.

The Learning Curve

Phase 1: states that had to wait. By 1990 several developments converged to compel second thoughts about the conventional wisdom that affordable universal coverage lay beyond states’ capacity to achieve and awaited a national solution devised by the federal government. Slow economic growth coupled with intense media coverage of the rising number of uninsured (thirty-four million in 1990) reminded Americans that loss of a job could mean loss of health coverage, too. Meanwhile, rising Medicaid spending (triggered in part by states’ growing adeptness at drawing federal matching monies) bedeviled budgets in many states and forced political leaders to sift options for reform of Medicaid and of “the system” itself.

As the 1990s began, states seemingly set the pace, albeit an uneven one, for national health reform. As the issue heated up, few governors or legislative leaders could afford to sit and do nothing. Most states sustained reform “dialogue” among political leaders, interest groups, and the media. Many appointed commissions or task forces to explore reform options in some detail. Some saw commission reports worked into proposed legislation, introduced with prominent political backing. A few watched these bills come close to enactment. A handful passed legislation moving toward universal coverage.
Under Gov. Michael Dukakis, Massachusetts enacted a play-or-pay law that aimed to phase in universal coverage. In 1989 Oregon passed not only its famous “rationing” plan, which linked expanded eligibility for Medicaid to curtailment of coverage for certain medical services, but also an employer mandate to be implemented in stages. In Washington State commissions working under Democratic governors Booth Gardner and Michael Lowry weighed myriad reform strategies. Florida governor Lawton Chiles declared that the states should boldly lead where the feds evidently feared to tread and pushed a “health security” plan in which the state would seek a federal waiver to use savings in Medicaid managed care to subsidize health coverage for lower-income families. Gov. Brereton Jones (Kentucky) and Gov. Roy Romer (Colorado) promoted universal coverage proposals. California governors George Deukmejian and Pete Wilson declined to follow suit, but legislative stirrings, in addition to the prospect that universal coverage might become a ballot initiative and pass, put reform prominently on the state’s health policy agenda. Strong forward motion within and across “laboratories of democracy” in these and other states both reflected and reinforced political signals that also prompted Bill Clinton’s proposals of 1993–1994 for comprehensive national health reform.

At both the state and national levels of the federal system, however, it soon grew clear that in the politics of health reform, those who would serve could only stand and wait. The crucial question—who would pay for new coverage for the uninsured?—proved to be intractable everywhere. Play-or-pay in Massachusetts and the employer mandate in Oregon lapsed, unimplemented. As early as 1989 the California Assembly, led by Speaker Willie Brown, had cleared a bill roughly modeled on Hawaii’s employer mandate of 1974. When the Senate balked, a task force sifted the options and returned an endorsement of the mandate. Although sympathetic to its objectives (a participant quoted him as remarking with feeling, that “if a man’s got a job you just can’t understand why he hasn’t got health insurance”), Governor Deukmejian was dissuaded by business opposition and declined to push the recommendation. As an initiative on the ballot in 1992, the mandate lost by a two-to-one margin after proponents were heavily outspent.4

Governors Jones of Kentucky and Chiles of Florida fought long and hard for their proposals, but neither the Kentucky legislature (controlled by Democrats) nor Florida’s (Democratic House majority, even party split in the Senate) would comply. Meanwhile, the more Colorado stakeholders contemplated Colorado Care, which would expand coverage by means of increased income and payroll taxes and a state-run purchasing cooperative, the less they liked it.
One of its prime movers remembered:

January 1993—our kickoff for Colorado Care. 150 people, six task forces, all meeting in a church. Romer gives a little “sermon” and we’re off and running. Great! Clinton was in, health reform would be on the table in 100 days. Then summer 1993. Our report was written, and the governor says “What’s going on? The president’s getting creamed, I’m losing support. Do I want to lose my career over health reforms that Colorado isn’t ready for?” Republicans were attacking nationally, there were Harry and Louise, business was ganging up. Colorado Republicans were peeling off—“What?! A tax is gonna pay for this?! I didn’t know that!” It speaks for itself. They thought it was free! It ended up looking big and ugly and Clintonesque and socialistic, and the governor tap-danced away from it.

Perhaps the most poignant reform case was Washington State, which enacted its version of affordable universal coverage in its Health Services Act of 1993, combining an employer mandate with managed competition. Several propitious and mutually supportive political advantages—years of steady deliberation on the issues by groups of public and private leaders, strong support by Governor Lowry and key legislative leaders, the courageous endorsement by the head of the Washington State Hospital Association of a hospital tax to help fill funding gaps and thus win crucial legislative votes, and the relatively detached posture of big business—enabled supporters to defeat opponents from small business and insurance.

The reform coalition’s triumph lasted barely a year. By fall 1994 national controversy over the Clinton plan had registered in Washington State, which, conservatives noted acridly, had contrived to pass a state facsimile of a national reform model the rest of the nation had sent packing. Moved partly by recriminations over health reform, state and national, the state’s electorate in 1994 installed a legislature markedly more conservative and Republican than the one that had recently passed the reform bill. Small business and insurers flexed their political muscles before an admiring legislative audience, which noted that the state could not in any case implement an employer mandate without a waiver of provisions of the federal Employee Retirement Income Security Act (ERISA) (which precludes states from enacting laws that relate to employee benefits programs except when the law is part of traditional state regulation of insurance)—a waiver most unlikely to be granted now that Republicans controlled Congress and the waiver’s last best hope, Rep. Thomas Foley of Spokane, had lost not only the House speakership but also his House seat. In 1995 the legislature repealed the mandate and other (but not all) provisions of the 1993 law.

Phase 2: insurance reform as Plan B. Pondering the collapse of grand plans for system reform, state leaders focused on what seemed, in retrospect, to have been all along the heart of popular concern: namely, malfunctions in the private health insurance mar-
ket that made coverage unavailable or precarious for vulnerable portions of the population. These groups included those who lost a job and therewith employer-based insurance, suffered “job lock” to preserve health insurance benefits, or sought coverage in the individual or small-group (fewer than fifty workers) markets, in which underwriting was common and premiums relatively high. In 1994 and thereafter many states passed, extended, or refined laws that aimed to improve the availability and affordability of coverage. Most prominent among measures promoting access to coverage were portability (required continuity of coverage for workers who changed employers), guaranteed issue (carriers selling group coverage could not exclude poorer risks within them), and guaranteed renewal (“which prevents dropping any subscriber except for fraud or nonpayment”).\footnote{Chief among reforms to make coverage more affordable was community rating, generally modified by the addition of “rate bands” that allowed carriers some freedom to vary premiums up or down depending on age and perhaps even health status. Some states created statewide or regional purchasing alliances to concert the buying power of eligible firms (usually smaller ones) shopping for health coverage.\footnote{Some also adopted measures (including public subsidies) intended to make health coverage newly affordable for, and presumably more attractive to, small firms and their workers. Policymakers hoped that these interventions would correct the most glaring inequities in the workings of the U.S. health insurance industry. Meanwhile, the federal government had embarked on its own version of insurance reform, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which “nationalized” and in turn compelled modification of some state-based provisions.}}

Considerations of power as well as purpose lent insurance reform its broad political appeal. The approach avoided battling with business over employer mandates. It triggered conflict with health insurance plans—especially those heavily invested in the small-group and individual markets and intent upon aggressive underwriting and cherry picking among risks. Political leaders generally assumed, however, that the protests of “the insurance industry” against bans on exclusionary practices lacked the legitimacy of employers’ assaults on mandates that would put them out of business.

Implementation of the reforms soon proved, however, that, as usual, things were less simple than they seemed. Money with which to cross-subsidize newly available, affordable, and secure coverage for the actuarially challenged had to come from somewhere. In some states—California, for example—these cross-subsidies played out unproblematically across the insured population. In others—Washington, for instance—small-group reforms moved smoothly along,
but those aimed at the individual market stirred intense conflict. And in yet others—Kentucky is a leading and much noticed case—the whole exercise fell into turmoil that came to dominate the state’s health policy agenda.\textsuperscript{8} There, healthy younger workers, hit by the sticker shock that employers began to see in their premiums, complained that the subsidies were unfairly coming from them. State leaders blasted insurance companies for cynically raising premiums to fortify their political case against the reforms. The industry in turn attacked the states for promising free lunches to credulous voters and threatened to cease writing policies for small groups and individuals within states that did not recant.

Few elected state officials had the expertise to judge the merits of these matters (a leading Kentucky legislator was quoted as having remarked: “We passed a dramatic bill in 1994 because no one read it and understood what was in it”). State insurance commissioners, aided by imported consultants, labored to gauge the empirical consequences of the reforms and modeled the likely impact of proposed modifications on the distribution of coverage and cost. Policymakers worried that if insurers did indeed pull out, the fallout in abandoned markets might not only thrust thousands of citizens back into the ranks of the “uninsurables” but also obligate the public sector to shoulder the costs of swelling high-risk pools.

By the end of the decade many states were treated to annual debates over such scintillating issues as whether (in the words of a business representative in Florida) “to add rate deviations for health status and claims experience limited to 10 percent per year and 15 percent over the life of the contract, and drop groups of one or keep them but limit their open enrollment to once per year.” Amid a debate whose technocratic cast in no way softened its acrimony, state policymakers tended to conclude that the reforms had stabilized health insurance for a small but not insignificant number of citizens but had not stemmed the rise in the number of uninsured.

Purchasing alliances, too, looked like a modest drop in a huge bucket. At the end of the decade, for example, California’s alliance had signed up about 140,000 members, but roughly 80 percent of these were people who already had coverage and switched to the alliance to get a better deal, and only 2 percent of eligible firms were participating.\textsuperscript{9} This is of course no indictment of a strategy that secured coverage for people who might otherwise have been dumped into the ranks of the uninsured. That granted, however, few close observers of insurance market and purchasing reforms in the states contended that they offered anything remotely resembling a solution to the problems of the U.S. health insurance system. An alliance official in California summed it up succinctly: “We can
knock 10 to 15 percent off the premium, but to most small employers going from $100 premium to $85 means nothing. In fact, going to $50 means nothing. The alliance offers a better deal for small firms that are buying health insurance already. It’s not going to reduce six or seven million uninsured appreciably.” Other voluntary strategies to entice small employers into the health insurance market were likewise largely a reprise of familiar falterings.\(^\text{10}\)

**Phase 3: Pressing the home-court advantage.** Having lost bitter battles with business and having then fought to a kind of draw in protracted skirmishes with insurers, state policymakers came to value more highly the advantages of reform strategies plotted and pursued on their own turf—that is, within the public sector itself. Notwithstanding the deep-seated privatism of U.S. health coverage, the public sector offers impressive—and growing—scope for action. Medicare and Medicaid, for instance, cover only about one-quarter of the population, but they supply roughly half the dollars in the health care system, equipping policymakers with formidable leverage that both federal and state governments have been using quietly but steadily for more than a decade to extend coverage. Indeed, federal and state leaders have come to play off one another’s progress in a pattern that might be termed “catalytic” federalism.

Beginning in the late-1980s, in a series of provisions within annual budget acts, the federal government expanded Medicaid coverage for children and pregnant women and severed their Medicaid eligibility from categorical constraints. The states protested these less than fully funded federal mandates but also began innovating around their own growing commitment to introduce managed care into Medicaid. In Section 1115 waiver applications to the feds, states proposed that savings won by Medicaid managed care be used to fund expansions of eligibility not only for lower-income women and children but also for uninsured adults. (Tennessee’s TennCare program and Oregon’s rationing plan are leading examples.)

**Covering children.** Enticed by matching federal monies but averse to the fiscal entrapments of “entitlements,” states meanwhile launched and enlarged child coverage increments of their own, a strategy that often appealed to fiscal conservatives as well as to liberals. In 1995, for example, a Medicaid official in California explained that Governor Wilson, who deplored the budget-busting tendencies of health care as much as anyone, was nonetheless resolved to “fill in the cracks for kids—more benefits, larger numbers, higher income thresholds—and to do it with targeted, incremental programs.” Thence the Access for Infants and Mothers (AIM) program, the Child Health and Disability Prevention (CHDP) program, and Calreach in California—and such analogues as Child Health Plus (New York), Child Health Plan (Colo-
rado), and Healthy Kids and MediKids (Florida), among many more.

Inspired both by its own success in expanding Medicaid (about thirteen million new beneficiaries had joined the program between the late-1980s and late-1990s) and by state innovations, the federal government added another big piece to the coverage puzzle in 1997—the State Children’s Health Insurance Program (SCHIP)—which gave to the states federal funds expected to cover as many as half of the nation’s uninsured children. While pondering how to use their substantial discretion in implementing their programs, states also debated how much money from tobacco settlements and taxes should be committed to filling further gaps in health coverage. By the end of the 1990s several states, contemplating Medicaid, SCHIP, and myriad programs of their own design, concluded that some public program was or could soon be available for all—or almost all—children whose families could not afford or otherwise get health insurance, a remarkable testimony to public-sector health reform capacity.

**Eligibility versus enrollment.** This happy prospect was not undimmed, however. States differed markedly in their largesse, and even in the more generous states each new increment of public coverage dramatized the difference between universal eligibility and universal enrollment. Millions of children (and adults) entitled to public coverage did not know about it, did not know how to apply for it, did not bother to avail themselves of it, did not choose to pay the “nominal” premiums attached to higher-income options, feared the stigma of “public assistance,” or stayed uninsured for other reasons, poorly understood. This “take-up” problem, difficult enough with less well educated populations not always fluent in English, was sharply aggravated by the effects of the federal welfare reform law enacted the year before SCHIP. Having cut the ties that bound medical coverage to welfare status for part of the Medicaid population in the 1980s, federal policymakers reminded the world ten years later that Medicaid remained “welfare medicine” after all.11

Before the welfare reform law of 1996, beneficiaries enrolled in Aid to Families with Dependent Children (AFDC) were automatically signed on to Medicaid. Now states can oblige those who qualify for Temporary Assistance for Needy Families (TANF) (AFDC’s replacement) to make a separate inquiry about their eligibility for Medicaid and then tackle a distinct enrollment process that states, counties, and cities can, according to their fiscal and ideological inclinations, make easier or harder. Medicaid enrollment grew from 28.9 million beneficiaries in 1990 to 41.7 million in 1995 but then fell 5.5 percent for adults and 1.4 percent for children between 1995 and 1997, and national welfare changes appear to be a prime source of the decline.12 A survey of women and children who left welfare between
1995 and 1997 found that only 36 percent of women and 50 percent of children were on Medicaid, leaving 41 percent of the former and 25 percent of the latter uninsured.\textsuperscript{13}

Moreover, increased eligibility for public-sector programs has been offset by erosions in private-sector coverage. Between 1977 and 1996 the civilian population under age sixty-five with employer-based coverage fell from 67 percent to 60 percent. Between 1987 and 1996 the news bifurcated into good and bad: The number of employers offering coverage rose slightly (3 percent), but the number of workers accepting the offer fell by 8 percent.\textsuperscript{14} Declining take-up rates presumably reflected an unacceptable gap between the growth of insurance premiums and that of workers’ wages, so moderation in the former might be expected to slow or cancel the erosion. Steve Long and Susan Marquis indeed found that both employers’ offers and workers’ take-up rates stabilized between 1993 and 1997, when increases in health costs leveled off.\textsuperscript{15} In 1999 the number of uninsured persons fell for the first time in eleven years—a decline of 1.7 million left a total estimate of 42.6 million.\textsuperscript{16} Whether these hopeful trends signal a decisive break with past patterns remains to be seen, however. Between 1996 and 1999 private coverage for children in families with incomes below 200 percent of the federal poverty level declined from 47 percent to 42 percent, while public coverage increased from 29 percent to 33 percent, leaving the number of uninsured children roughly constant. Low-income adults with children saw a decline from 51 percent to 46 percent in private coverage, while public coverage held steady.\textsuperscript{17}

\textit{Fiscal constraints}. Seekers of the silver lining hope that the cumulative frustrations of this pattern—one step forward (mainly public), one back (partly public, partly private)—will spur state leaders to accelerate their steps toward universal coverage. Programs like TennCare and New York’s new Family Health Plus, not to mention Hawaii’s employer mandate in force since 1974, show that the prospect of continual public chipping away at the number of uninsured adults is not utopian. The obstacles are high, however. State leaders look out at frighteningly large numbers of uninsured citizens—a whopping seven million people, 22 percent of the population, in California, for example. “The problem is so huge it’s overwhelming,” a legislative staffer in that state remarked warily. “You can spend and spend and not make a dent.” Insurance and immigration issues intertwine uncomfortably, especially in such border states as Arizona, California, and Texas, which together contained 30 percent (13 million) of the nation’s forty-four million uninsured in 1998.

The budget costs of universal coverage secured by public programs are huge, and the trade-offs they enforce in states such as
California and Colorado, which labor under formal public budget caps, are acutely painful. (Among fourteen states that recently used “unexpectedly large increases” in tax revenues to fund “significant” tax reductions, Colorado’s cut was largest as a percentage of revenue.) Policy priorities that for years took a back seat to health care—roads, education, corrections, and more—clamor for fiscal recognition. Within the health sphere itself, long-term care, drug coverage for the elderly, special programs for the developmentally disabled, and other needs exert mighty moral and political claims that compete with broader insurance coverage. Policymakers recall the sad fortunes of state finances in the recession of the early 1990s, know that ideal economic circumstances—strong growth, low unemployment, and shrunken rates of increase in health spending in the late 1990s—took years to produce a small downturn in the growth of the uninsured, and tremble to think what generous public entitlements adopted today might mean for state budgets when the good times end. Incrementalism is alive, well, and working in the states, but such outcome measures as raw numbers of uninsured citizens are not a proper gauge of its achievements.

**Health Reform Capacity: Subsidies, Agendas, Coalitions**

The continuing presence of uninsured Americans reflects above all the nation’s cultural hesitation over whether government should secure coverage for all citizens or merely fill gaps for those whom the private sector cannot adequately insure. Other nations, of course, show no such hesitation: To them, health care is a right of citizenship, one made meaningless unless government secures it—a mission that includes crafting the cross-subsidies required to give everyone reasonable access to decent care on affordable terms. Although Americans may flirt with the notion of a right to health care when pollsters come calling, they regularly reject the corollary that government has a duty to enforce that right and so seem to prefer to view health care as a “good” that should be supplied privately as much as possible, leaving government a residual role on behalf of those whom private coverage demonstrably cannot accommodate. (Who these people are, and what constitutes “demonstrable” failure of private coverage, are constant sources of policy conflict.)

These cultural proclivities discourage “society” and that facet of it called the polity from grappling effectively with the tough redistributive essence of universal coverage: the design of workable, acceptable cross-subsidies among citizens. This issue, moreover, is as basic to the politics as it is to the theory of coverage expansion. The three phases of state health reform in the 1990s exhibit distinct
subsidy strategies, policy agendas, and political coalitions.

**Comprehensive reform.** The comprehensive reform phase envisioned cross-subsidies among employers and workers. (Who would pay how much for what was, and remains, a thorny and unresolved question.) No compelling policy logic anointed an employer mandate as the chosen strategy for funding new coverage, but several political considerations made it attractive *prima facie.* First, although the main alternative, a single-payer system (“like Canada’s”) had ardent proponents, that approach was too redolent of “big government” (and big taxing, regulating, and perhaps rationing) to stand much chance of prevailing. Second, as both the Clinton administration and several state counterparts hopefully concluded, a mandate could be billed as an “employer premium,” thus averting dreaded talk of taxes, which a single-payer system and social insurance (for instance, Medicare for all) inescapably entailed. Third, the mandate had a comforting air of incrementalism about it: The U.S. system was, after all, employer-based at its core, and most firms voluntarily offered health coverage. Obliging most of the rest to do likewise seemed to be simple fairness all around. Fourth, subsidies could doubtless be designed to win over small-business opposition. Finally, the benign workings of managed care (and perhaps managed competition) on which most reform plans intended to rely would brake health costs, thus answering the objection that firms could not afford coverage for their workers.

It is a telling commentary on the political mysteries and disjunctions surrounding health reform that so few supporters of the mandate strategy in the early 1990s foresaw the vehemence with which the business community—and especially its ideologically severe and politically adroit small-business leadership in the National Federation of Independent Business (NFIB)—rejected mandates and the arguments on which they would supposedly ride in. Business opponents charged that the costs of the mandate would drive many of them into failure, leaving workers with neither jobs nor (*a fortiori*) health coverage. They argued further that this “incremental” approach was in fact a radical violation by the public sector of time-honored rights of private firms to pay workers what they are worth in the marketplace. This contention struck a chord not only with the small firms that would face new obligations under a mandate but also with many large firms, which offered to their workers health insurance whose costs were increased in some measure by cross-subsidies to employers that declined to offer coverage but found a public mandate too much to swallow ideologically. (Large firms doing business in several states also found individual state mandates too much to swallow administratively.) Moreover, the
widespread presence of small business within and among legislative districts and the ardent and skill of the business organizations fighting the mandate ensured a respectful hearing for these attacks, gave policymakers long (and, as it turned out, indefinite) pause before enacting so controversial a measure, and helped persuade them to try to persuade the public that although health reform surely remained imperative, there must be a better way to do it. Indeed, so powerful was employers’ opposition that what some analysts viewed as the normative heart of the policy matter—that mandates are a regressive approach to redistributive cross-subsidies because employers would tend to fund them by trading off workers’ wage increases for new spending on health insurance premiums—largely vanished from the political radar screen.

The collapse of state (and of course national) grand illusions about health reform highlighted disturbing limitations in the capacity of states to steer a health reform agenda that treads upon private prerogatives. In the early 1990s setting the reform agenda was, if anything, too easy. Policymakers declared that they “could not wait” to fix a system that everyone knew was broken; polls documented the public’s seemingly enthusiastic assent; reform models flew about everywhere; foundation grants hired the expertise with which to sort out ideas and work them into concrete proposals; and small-business opponents, politically isolated, would be compelled to get with the program. Nor was it difficult, at least before 1994, to move the agenda thus set. In many states, single-payer sentiment, although limited, seemed to be growing, which prompted providers and insurers to negotiate the details of reform legislation. Also, single-payer aside, “special interests” feared voter backlash should they be branded as obstructors of overdue change.

What remained beyond reach, however, was construction of coalitions that could clear the agenda. Providers sometimes backed employer mandates, but their resistance to the accompanying cost controls damaged their credibility and clout. Small business was (or looked) very close to being unanimous in opposition to mandates and made very clear the deep intensity of its preferences on the matter. Big business rarely lifted a finger to advance the mandate strategy. Whenever reformers coupled mandates with proposals for new competitive processes managed by an array of firm governmental rules, insurers joined the attack. Opponents badly outmatched supporters of mandates in number, unity, and financial might; coalitions collapsed in state after state, usually nowhere near the finish line. Washington State, where a coalition of public leaders, providers, and consumers faced down small business and insurers in 1993, became in 1995 the exception that proved the rule.
“For all of its turmoil and limits, the state insurance reform phase was a modest victory for political realism.”

- **Insurance reform.** Chastened by the political pitfalls of making employers the key private-sector vehicle of cross-subsidies, policymakers shopped for a different approach and settled on insurance reform. Cross-subsidies would be crafted not within and among firms and workers but rather among pools of “insured lives,” and new public rules would fall on insurers, not employers. The strategy had clear appeals: Protecting or creating coverage for people who lost jobs, got sick, or had been denied coverage tapped images of basic fairness and did not threaten to destroy firms and jobs.

This mechanism for subsidizing the uninsured had its own political liabilities, however. One image of simple justice favored public protections that prevented “greedy insurance companies,” whose profits were already “too high,” from abusing the sick and poor. But another potent and competing image of fairness, long on display in the tenacious hold of experience rating in the U.S. health insurance system, insisted that better risks deserve better rates. Why should healthy families watch premiums rise for the sake of new coverage for the disadvantaged? The obvious riposte—that such intergroup subsidies are the solidaristic essence of universal coverage itself—was far from obvious in the American cultural context, and reforms that mainly worked within small-group and individual markets lacked sufficient scope for cross-subsidies to carry the system far toward universal coverage anyway. Policymakers who began by emitting populistic blasts against rapacious insurers soon settled down to bargain over the benefits and costs of (say) creating separate rating categories for groups of two to five persons instead of retaining them in larger pools of two to fifty, what (if any) percentage increase to allow for health status in upward adjustments to rate bands, and how much new authority to grant purchasing alliances in negotiating premium rates for their members. Insurers meanwhile marshaled sticks (threats to leave markets in which they could not register “fair” profits) and carrots (campaign contributions and appeals from omnipresent networks of insurance agents and brokers).

For all of its turmoil and limits, the insurance reform phase was a modest victory for political realism. New state regulations have been much modified but rarely repealed, thus securing coverage for a limited number of people hitherto highly vulnerable to the tribulations of the individual and small-group health insurance markets, and HIPAA, federal icing on the state’s cake, has finally thrust the
national government firmly into regulation of private health insurance. The strategic agenda was set with relative ease. After the collapse of comprehensive reform, political leaders feared to face voters and pro-reform groups with nothing to show for all the fanfare. Insurance reform seemed to be safely anchored in popular notions of fairness; moreover, long debates about broader reforms, by enlightening business and provider groups about the identity and travails of the uninsured, had piqued their interest in plausible reforms that played out on another stakeholder’s turf. Moreover, the coalition politics that finally cleared that agenda differed markedly from those that motivated employer groups to wage war against mandates. Insurance reforms applied mainly to individuals and small employer groups, leaving big business largely on the sidelines. Within the small-business community, some firms feared that they would be net losers from new subsidies to aid the vulnerable, but many others (including mom-and-pop operations and single-person “firms”) expected to come out ahead, leaving small business divided but (as a rule) officially favorable to the reforms.

The insurance industry itself split in patterns particular to the market structure in each state. In general, carriers that sold heavily in the affected markets cared deeply; those less heavily invested cared less. “Foreign” (multistate) plans often felt more threatened than did those headquartered in or limited to a particular state. Commercial plans worried more than nonprofits, indemnity carriers more than health maintenance organizations (HMOs). Given strong support from consumer groups and the determination of political leaders to deliver at last on long-pending reform promises, fragmentation among business and insurance groups created a dependable window for the enactment and refinement of new (albeit modest) public interventions into health insurance markets.

**Catalytic federalism.** By acknowledging that state governments are not well equipped to fashion new health coverage by means of cross-subsidies imposed on powerful business and insurance interests, the third reform phase—planned and funded largely within the public sector itself—carried policy evolution and learning a step farther still. Over the past decade and a half policymakers (state and federal) have refined an “introverted” legislative style that uses public monies (general revenues, tobacco tax and settlement funds, and federal matching sums) for cross-subsidies devised in relatively peaceful detachment from the interest-group struggles that have slowed or stymied reforms elsewhere.

As in the preceding reform phases, state developments track (and in this case follow) national innovations. Starting in the 1980s, Medicaid expansions—some mandatory, some optional for the
states—and later SCHIP were inserted into the federal government’s annual omnibus budget acts by credible coalitions of liberal and conservative leaders, largely unsathed by unfriendly political fire that accompanies election campaigns, 100-day pledges, the discharging of popular mandates, the nightly news, and other cacophonous concomitants of “mass” politics. This protective cover derived from two features of what Samuel Beer called “public sector politics.” First, procedural features of the congressional budget process gave activists room to maneuver, and second, new coverage drew on public funds that entailed no mandates and prescriptions deemed offensive to private interests. These funds included general revenues (formally justified by offsetting economies in other parts of the budget and by savings imputed to earlier primary and preventive health interventions), but also such additions as sin (tobacco) taxes and windfalls expected from legal settlements of suits filed against the tobacco industry. (In principle, of course, tobacco-related funds could be spent on any public purpose, but the widely recognized link among smoking, illness, and health care costs gave health policy a powerful claim and an inside track.)

These federal innovations both set the stage for state implementation of new national mandates and encouraged states to add new increments of coverage. The feds moved the upper limit for Medicaid coverage of children and pregnant women to a higher percentage of poverty, which enticed expansion-minded states to raise it higher still. Federal SCHIP monies sufficient to supply new coverage for x percent of uninsured children tempted states to design provisions to cover y percent more. And, as a veteran participant in California remarked, each new federal and state program comes equipped with an enlarged or newly energized cadre of public managers with ideas of their own on how their program(s) might be made bigger and better and how another level of government might help to make that happen. The incrementalist genius of the American federal system has produced in the health arena the newest continuous floating poker game: See your bet, raise, and call (for more money). As this catalytic federalism chugged on, universal child health insurance eligibility was coming within reach of some states by the end of the 1990s, and some were debating the feasibility of new increments of coverage for adults.

There is of course no small irony in a political evolution that sets off from plans to rationalize both public and private sectors of the health system into affordable universal coverage without the merest mention of the “t” word (taxes) and ends up with incremental additions to public coverage that are politically possible and passable only because they leave the private sector alone and use public funds
for cross-subsidies. Ironic, but not surprising, this policy approach to redistribution faithfully mirrored the distribution of political power in the health sphere. Federal and state policymakers could set their incremental agenda because they had a solid (albeit controversial) programmatic base on which to build: Medicaid. They could move that agenda because their designs posed no direct threat to private power centers, whose general ideological distaste for bigger government was insufficient to trigger the investment of much political capital to block new public coverage. (In James Q. Wilson’s terms, these public programs combined new “distributed” insurance benefits with costs diffused among taxpayers and a range of groups, not concentrated on the business and insurance sectors that worked to kill or hobble reform.)

The leaders could clear their agenda because the coalitions that counted centered on key legislative leaders (for instance, Henry Waxman and Henry Hyde in the Medicaid expansions, Ted Kennedy and Orrin Hatch in SCHIP), the White House (or state house), and a small cadre of supportive groups, working together within the protective framework of the federal budget process or comparably low-key state arenas.

This public-sector progress is not unmixed, to be sure. In particular, the right hand of government, welfare reform, has hampered efforts of the left hand, Medicaid expansion and SCHIP, to extend public coverage, and the accumulating complexities of federal and state programs create a disjunction between eligibility and enrollment both because eligibles may not understand which program(s) their children may enter and how and because the demands of marketing, counseling, enrollment, and recertification strain state managerial capacities. Nonetheless, it is fair to say that at the end of the 1990s one and only one reform strategy—public-centered incrementalism spurred by “catalytic federalism”—is in decent political health and possibly capable of further policy growth and refinement.

**Other Windows?**

A study focused on five states is an imperfect basis for generalization about “the system,” but we suspect that the tale told here captures important features of the health reform struggles of the 1990s. As the decade progressed, the private sector proved capable of installing dramatic cost-cutting measures under the banner of managed care, but in the search for new coverage, and the cross-subsidies it requires, for the uninsured, private interests produced more problems than solutions. As the decade ended, lofty talk of a coherent system in which all citizens would enjoy equitable coverage, the affordability of which would be secured by competitive processes managed by benign national rules, collapsed into a growing sectoral
separation and segmentation in which the private sector took one road (lower premiums for employers, higher profits through managed care for insurers and investors), while the public sector took another (use of new revenues from taxes and settlements to fund new coverage for specific categories of the uninsured).

Until a modest reversal in 1999, the number of uninsured kept rising in the 1990s, despite hopes that a strong economy would combine with low increases in health care costs to generate new private-sector coverage. The continuing presence of more than forty-two million uninsured people suggests that future demands on the public sector to secure and supply coverage will grow—steadily and, should the economy sour and health costs soar, perhaps dramatically. Unless leaders within the private sector—notably in the business and insurance communities—show new readiness to discuss cross-subsidies within their precincts as a question of deep public interest, the public sector will become an ever more prominent picker-upper of pieces, and public monies will become an ever-larger source of cross-subsidies. Nor need insurance be “the” answer. For decades policymakers have crafted a variety of implicit subsidies for safety-net providers—hospitals, community health centers, and public health clinics—while focusing explicit attention on expanding coverage. Some would rebalance the strategies by awarding much enlarged sums to safety-net providers to supply ready access to disadvantaged populations—“undocumented aliens,” for instance—who may not be insured any time soon.

Those who celebrate the turn to market forces in the 1990s as a reprieve from statism and a belated shift to “normal” economic behavior in the health system touch but one small piece of a much larger elephant. The capacity of the public sector—federal and state governments in intricate catalytic combination—to fashion socially indispensable redistribution has grown impressively, but from the small and narrow categorical base of a Medicaid program that covers only about half of the American poor. More capacious health reforms demand broader redistribution across larger populations (state, federal, or both), a solidaristic exercise for which the United States has so far shown decidedly limited cultural taste. Culture is multifaceted, not linear, however—a set of predispositions, not determinants. Should favorable political circumstances and wise policy leadership somehow converge, the surprising dynamics of catalytic federalism might yield yet another round of windows and opportunities.

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