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Rolanda Moore Haycox

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STUDENT ARTICLE

STRATEGIES TO MEET THE NEEDS OF THE UNINSURED: CAN THE STATES RESPOND TO THE CHALLENGE?

Rolanda Moore Haycox*

I. INTRODUCTION

Health insurance is our health care system's financial lifeblood. Approximately 181 million Americans have private health insurance,¹ yet an additional 37 million Americans are uninsured.² As a result, the uninsured receive fewer health care services³ and tend to be sicker than the insured.⁴ This Article discusses state legislatures' attempts to meet the needs of the uninsured and the challenges inherent in meeting those needs. The uninsured population is described in Part II. The federal Medicare program is described in Part III. State programs designed to cover the uninsured are described in Part IV. These state programs include: (1) Medicaid; (2) state General Assistance-Medical programs; (3)

* J.D. Candidate, 1992, Indiana University School of Law—Indianapolis. M.H.A. Candidate, Graduate Program in Health Administration, Indiana University School of Public and Environmental Affairs—Indianapolis. B.S.N., 1986, Indiana University School of Nursing—Indianapolis. The author would like to thank Professor Eleanor Kinney and Dr. Robert Saywell for their patience and support in the preparation of this Article. My thanks also to Julie Randolph, Tom Gannon, and Phyllis Bonds of the Center for Law and Health at the Indiana University School of Law—Indianapolis for their assistance and encouragement.

1. Office of National Cost Estimates, *National Health Expenditures, 1988*, 11 HEALTH CARE FIN. REV. 1, 17 (1990).

2. PAMELA F. SHORT ET AL., NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT, UNINSURED AMERICANS: A 1987 PROFILE 3 (1988).

3. CHARLES J. DOUGHERTY, AMERICAN HEALTH CARE: REALITIES, RIGHTS, AND REFORMS 12 (1988); Karen Davis & Diane Rowland, *Uninsured & Underserved: Inequities in Health Care in the United States*, 61 MILBANK MEMORIAL FUND Q. 149, 163 (1983).

4. Davis & Rowland, *supra* note 3, at 165.

transitional insurance for former Medicaid and General Assistance-Medical recipients; (4) state risk pools; (5) state catastrophic health plans; and (6) state uncompensated care programs. Part IV also describes the Hawaii Prepaid Health Care Act, which is designed to cover workers, and the Massachusetts Health Security Act, which is designed to cover all state residents. Part V describes state legislation patterned after the Canadian Medicare program, which is designed to cover all state citizens through a single state insurance plan. Finally, Parts VI and VII discuss whether state health insurance programs can survive the friction that arises in administering state insurance programs, the taxation of employers to finance program costs, and the infusion of government control into the health care system.

II. THE UNINSURED POPULATION

Designing a state health insurance program for the uninsured requires an examination of the uninsured population and their health care needs. Over seventy-five percent of the uninsured population under age sixty-five is employed.⁵ Employers with twenty-five or fewer employees are the least likely to provide their workers with health insurance benefits.⁶ Unionization, salary, age, working hours, tenure, residential status, and the kind of work performed may influence an employer's decision to offer health insurance benefits.⁷ Employers are also beginning to shift insurance costs for dependents onto employees.⁸ As a result, the working uninsured often cannot afford private health insurance, yet they are ineligible for public health insurance programs.⁹

In today's American health care system, lack of insurance means lack of health care.¹⁰ The uninsured may receive fewer medical services because they are less likely to seek care, they are referred for fewer specialty services, or they are refused care by providers.¹¹ The uninsured

5. U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, 101ST CONG., 1ST SESS., A CALL FOR ACTION 2, 4 (Comm. Print 1990) [hereinafter A CALL FOR ACTION].

6. *Id.* at 2-3. See also SHORT, *supra* note 2, at 13.

7. SHORT, *supra* note 2, at 5. See also Gail R. Wilensky, *Viable Strategies for Dealing with the Uninsured*, 6 HEALTH AFF. 33, 35 (1987) [hereinafter Wilensky, *Strategies*].

8. Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 862 (1986) (in 1986, approximately three million uninsured children lived in households with an insured adult). See also SHORT, *supra* note 2, at 4.

9. A CALL FOR ACTION, *supra* note 5, at 2.

10. *But cf.* Willard G. Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, 77 AM. ECON. REV. 251, 263 (1987) ("no differential response to health insurance coverage between the healthy and the sickly").

11. Bovbjerg & Kopit, *supra* note 8, at 864.

poor also use fewer than half the medical services consumed by full year Medicaid recipients with comparable levels of illness.¹² Further, the working uninsured make fewer physician visits, use fewer prescription drugs, and have fewer hospital stays than insured workers.¹³ Finding a solution that meets the needs of these persons is today's health policymaker's challenge.

III. MEDICARE: THE FEDERAL GOVERNMENT'S ROLE IN MEETING THE NEEDS OF THE UNINSURED

The federal government plays a significant role in providing health care benefits through the administration of the Medicare program (Title XVIII of the Social Security Act).¹⁴ In 1989, over thirty-three million Americans received health care benefits under the Medicare program.¹⁵ Medicare benefits are divided into two parts: hospital insurance (Part A)¹⁶ and supplemental medical insurance (Part B).¹⁷ Applicants eligible for Part A benefits include persons sixty-five years old and older who are entitled to Social Security Income or railroad retirement benefits and persons with chronic renal disease.¹⁸ Part B benefits are available to Part A recipients and other persons who are sixty-five years old and older who pay a premium.¹⁹ While Part A provides benefits for hospital and post-hospital care,²⁰ Part B provides physician and outpatient services, including durable medical equipment.²¹ The federal Medicare program, however, does not provide older persons with complete health care coverage. For example, Medicare does not cover pharmaceutical, vision, hearing, or preventive services.²² Consequently, state legislatures should include

12. John K. Iglehart, *Medical Care of the Poor—A Growing Problem*, 313 NEW ENG. J. MED. 59, 60 (1985).

13. Alan C. Monheit et al., *The Employed Uninsured and the Role of Public Policy*, 22 INQUIRY 348, 357 (1985) [hereinafter Monheit, *Public Policy*].

14. See 42 U.S.C. §§ 1395-1395ccc (1988 & Supp. I 1989).

15. LINDA DEMKOVICH, NATIONAL HEALTH POLICY FORUM, *THE STATES AND THE UNINSURED: SLOWLY BUT SURELY FILLING THE GAPS 5* (1990) [hereinafter SLOWLY BUT SURELY].

16. 42 U.S.C. § 1395c.

17. *Id.* § 1395j.

18. *Id.* § 1395c. See generally Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1158-61 (1986); H. Bradley Southern, Note, *Medicare's End-Stage Renal Disease Program: Its Development and Implications for Health Care Policy*, 26 HARV. J. ON LEGIS. 225 (1989).

19. 42 U.S.C. §§ 1395o, 1395r.

20. *Id.* § 1395d. See generally Michael Neeley-Kvarme, *Administration and Judicial Review of Medicare Issues: A Guide Through the Maze*, 57 NOTRE DAME LAW. 2 (1981).

21. 42 U.S.C. §§ 1395k, 1395l. See generally Neeley-Kvarme, *supra* note 20, at 4-5.

22. See 42 U.S.C. §§ 1395d, 1395k, 1395y.

older persons when they enact state health insurance programs.

IV. THE ROLE OF STATE LEGISLATURES IN MEETING THE NEEDS OF THE UNINSURED

A. Medicaid

1. State Medicaid Programs

Medicaid (Title XIX of the Social Security Act)²³ is administered jointly by the federal government and the states.²⁴ Persons eligible for state Medicaid programs include the mandatory categorically needy, the optional categorically needy, and the medically needy.²⁵ To qualify for federal funds, state Medicaid programs must provide benefits to the mandatory categorically needy.²⁶ The categorically needy include recipients of Aid to Families with Dependent Children (AFDC); aged, blind, and disabled recipients of Social Security Income; and some low income persons ineligible for AFDC or Social Security Income.²⁷ A state's categorically needy population must also include children under one year old who are at or near the federal poverty level and children under age seven born after 1983 whose family income reached the federal poverty level before 1991.²⁸

A state is able to alter the size of its categorically needy population by altering its AFDC or Social Security eligibility standards. For example, a state legislature may influence Medicaid eligibility by raising the Social Security Income standard through state supplemental payments.²⁹ A state can also establish Medicaid eligibility criteria that are narrower than the federal Social Security Income standards.³⁰ Similarly, because state legislatures have discretion in determining AFDC eligibility and payment levels, they influence Medicaid eligibility for AFDC recipients.³¹

23. *Id.* §§ 1396-1396s (1988 & Supp. I 1989).

24. *Id.* §§ 1396, 1396a.

25. *Id.* § 1396a(a)(10); 42 C.F.R. §§ 435.1-.852 (1990). See also STAFF OF HOUSE COMM. ON ENERGY AND COMMERCE, 100TH CONG., 2D SESS., MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS 52 (Comm. Print 1988) [hereinafter MEDICAID SOURCE BOOK].

26. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. §§ 435.100-.136.

27. *Id.* See generally 3 Medicare & Medicaid Guide (CCH) ¶ 14,311 (1990).

28. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 435.117. See also MEDICAID SOURCE BOOK, *supra* note 25, at 52; Kay Johnson, *Medicaid Coverage for Low Income Children and Pregnant Women: Five Years of Progress*, 9 CHILDREN'S LEGAL RTS. J. 5, 6 (1988).

29. MEDICAID SOURCE BOOK, *supra* note 25, at 52.

30. 42 U.S.C. § 1396a(f); 42 C.F.R. § 435.121. See also MEDICAID SOURCE BOOK, *supra* note 25, at 62.

31. Jerry Cromwell et al., *Defederalizing Medicaid: Fair to the Poor, Fair to Taxpayers?*, 12 J.

A state may also expand its categorically needy population by covering additional persons classified as the optional categorically needy. The optional categorically needy population may include children who are within the AFDC age standards, but whose families' incomes are below the AFDC eligibility requirements,³² and persons in institutions whose incomes are less than 300% of the Social Security payment level.³³ This flexibility allows a state to expand or contract the size of its categorically needy population.

State Medicaid programs may also cover medically needy persons. Programs for the medically needy provide benefits to persons who meet the age and family requirements of the state's categorically needy program, but who, after the payment of medical services, have incomes less than 133 $\frac{1}{3}$ % of the maximum AFDC payment for the same size family.³⁴ These programs may include benefits for pregnant women, children up to one year old, and elderly and disabled persons whose incomes are less than the federal poverty level.³⁵

Medicaid benefits may differ depending on the recipient's eligibility for the state's categorically needy or medically needy program. State Medicaid programs must provide the categorically needy with benefits for hospital, skilled nursing, rural health clinic, laboratory, X-ray, children's health, and family planning services.³⁶ Benefits for the categorically needy must also include outpatient, intermediate care facility, dental, pharmaceutical, vision, and physical therapy services.³⁷

If a state elects to establish a program for the medically needy, that program must provide the mandatory services for the categorically needy to persons twenty-one to sixty-five years old who are in an institution because they have a mental disorder or mental retardation, and must also

HEALTH POL. POL'Y & L. 1, 2 (1987); See Frank J. Thompson, *New Federalism and Health Care Policy: States and the Old Question*, 11 J. HEALTH POL. POL'Y & L. 647, 653 (1986) (those who control eligibility requirements for AFDC and Social Security Income de facto control access to Medicaid).

32. 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. §§ 435.200-233. See also MEDICAID SOURCE BOOK, *supra* note 25, at 52.

33. 42 U.S.C. § 1396a(a)(10)(A)(ii)(IV); 42 C.F.R. § 435.211; 3 Medicare & Medicaid Guide (CCH) ¶ 14,311 (1990).

34. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 435.301. See generally MEDICAID SOURCE BOOK, *supra* note 25, at 53; 3 Medicare & Medicaid Guide (CCH) ¶ 14,311.

35. 42 U.S.C. § 1396a(a)(10)(A)(ii); 42 C.F.R. § 435.301. See generally MEDICAID SOURCE BOOK, *supra* note 25, at 74-76.

36. 42 U.S.C. §§ 1396a(a)(10)(C), 1396d(a); 42 C.F.R. § 440.210. See generally MEDICAID SOURCE BOOK, *supra* note 25, at 93; Cromwell, *supra* note 31, at 7-9.

37. 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 440.210. See generally MEDICAID SOURCE BOOK, *supra* note 25, at 93-96.

include prenatal and delivery services, ambulatory care for persons under eighteen years old and persons entitled to institutional services, and home health services for persons entitled to care in a skilled nursing facility.³⁸ In addition to these benefits, the states may provide the medically needy with a variety of other preventive, diagnostic, and rehabilitative services.³⁹ However, the benefits provided under the state's medically needy program cannot exceed the benefits provided under its categorically needy program.⁴⁰

The federal Medicaid statute gives state legislatures the ability to expand their Medicaid programs to provide health insurance to the poor without forfeiting federal funding. Twenty states have expanded their Medicaid programs.⁴¹ One strategy for providing insurance through Medicaid expansion is to offer Medicaid to otherwise ineligible workers on a sliding scale basis.⁴² For example, Maine is designing a Disabled Buy-In Program that will allow sliding scale Medicaid purchases for disabled persons.⁴³ Minnesota administers a Children's Health Plan that provides outpatient services to children up to age eighteen who are from families with incomes up to 185% of the federal poverty level.⁴⁴ In addition, Massachusetts administers a Medicaid "wrap around" plan for disabled persons ineligible for Medicaid who have incomes up to 185% of the federal poverty level.⁴⁵

Because state legislatures control Medicaid eligibility and benefit requirements, Medicaid coverage provided in states with similar populations in poverty can vary greatly. For example, Wisconsin and Oklahoma each have approximately 395,000 people in poverty, yet in 1985, Wisconsin spent \$942 million and Oklahoma spent \$460 million in Medicaid expenditures.⁴⁶ Similarly, Massachusetts provides Medicaid to

38. 42 U.S.C. § 1396a(a)(10)(C); 42 C.F.R. § 440.220. See also MEDICAID SOURCE BOOK, *supra* note 25, at 93.

39. MEDICAID SOURCE BOOK, *supra* note 25, at 96.

40. *Id.* at 93.

41. Lawrence S. Lewin & Marion E. Lewin, *Financing Charity Care in an Era of Competition*, 6 HEALTH AFF. 47, 50 (1987); Terese Hudson, *State Associations Wary of Universal Health Plans*, HOSPITALS, Nov. 20, 1989, at 46.

42. Lewin & Lewin, *supra* note 41, at 51; Wilensky, *Strategies*, *supra* note 7, at 43. See also 3 Medicare & Medicaid Guide (CCH) ¶ 16,933 (1990).

43. INTERGOVERNMENTAL HEALTH POLICY PROJECT, RECENT STATE INITIATIVES FOR THE UNINSURED 15 (1989) [hereinafter RECENT STATE INITIATIVES].

44. MINN. STAT. ANN. § 256.936 (West Supp. 1991). See also RECENT STATE INITIATIVES, *supra* note 43, at 17; SLOWLY BUT SURELY, *supra* note 15, at 11.

45. MASS. GEN. LAWS ANN. ch. 118E, § 1B (West Supp. 1991). See also RECENT STATE INITIATIVES, *supra* note 43, at 16.

46. Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to*

forty-six percent of its low income residents, but South Dakota provides Medicaid to only fourteen percent of its low income residents.⁴⁷ Thus, the Medicaid program allows state legislatures flexibility in providing insurance for their needy residents.

2. The Arizona Health Care-Cost Containment System

A state can also replace its Medicaid program with an innovative public health insurance plan.⁴⁸ For example, in 1987, Arizona implemented this strategy by contracting with the Health Care Financing Administration (HCFA) to provide the Arizona Health Care-Cost Containment System (AHCCCS).⁴⁹ The Arizona government administers this program by contracting with providers through a bidding process.⁵⁰ Persons eligible for AHCCCS benefits include AFDC and Social Security Income recipients,⁵¹ the indigent,⁵² and the medically needy.⁵³ The program's AFDC and Social Security recipient coverage allows Arizona to receive federal Medicaid funds, and program supporters are working to expand the program to include private health insurance benefits.⁵⁴ AHCCCS provides coverage for hospital, professional, laboratory, children's screening, family planning, outpatient, dental, podiatry, transplant, and transportation services.⁵⁵ It is not known, however, whether AHCCCS costs Arizona less than a Medicaid program.⁵⁶

Federalism, 51 OHIO ST. L.J. 855, 857 (1990); Sandra K. Schneider, *Intergovernmental Influences on Medicaid Program Expenditures*, 48 PUB. ADMIN. REV. 756, 757 (1988).

47. DOUGHERTY, *supra* note 3, at 10. *See also* Cromwell, *supra* note 31, at 1 (states have great flexibility in determining eligibility, coverage, and reimbursement methods).

48. 42 U.S.C. § 1396a(b).

49. ARIZ. REV. STAT. ANN. §§ 36-2901 to -2920 (1986 & Supp. 1990). *See generally* 3 Medicare & Medicaid Guide (CCH) ¶ 15,554 (1990); Nelda McCall et al., *Evaluation of the Arizona Health Care Cost-Containment System*, 7 HEALTH CARE FIN. REV. 77 (1985); Ronald J. Vogel, *AHCCCS: A New Medicare-Medicaid Model in Arizona*, 309 NEW ENG. J. MED. 934 (1983); RANDOLPH A. DESONIA & KATHLEEN M. KING, INTERGOVERNMENTAL HEALTH POLICY PROJECT, STATE PROGRAMS OF ASSISTANCE FOR THE MEDICALLY INDIGENT 79 (1985) [hereinafter STATE PROGRAMS].

50. ARIZ. REV. STAT. ANN. §§ 36-2903, 36-2906. *See also* Vogel, *supra* note 49, at 934.

51. ARIZ. REV. STAT. ANN. § 36-2901.

52. *Id.* §§ 11-297, 36-2901 (Supp. 1990).

53. *Id.* §§ 36-2901, 36-2905. *See also* McCall, *supra* note 49, at 77; Vogel, *supra* note 49, at 935.

54. McCall, *supra* note 49, at 77, 85; Bradford L. Kirkman-Liff et al., *The Evolution of Arizona's Indigent Care System*, 6 HEALTH AFF. 46, 49 (1987).

55. ARIZ. REV. STAT. ANN. § 36-2907. *See also* McCall, *supra* note 49, at 77.

56. *See* Vogel, *supra* note 49, at 934, 936.

B. *State General Assistance-Medical Programs*

State General Assistance-Medical (GA Medical) programs also provide health insurance for the uninsured. GA Medical programs, however, do not qualify a state for federal funds.⁵⁷ Twenty-two states administer GA Medical programs. These states are: Alaska, Connecticut, Hawaii, Illinois, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and Wisconsin.⁵⁸ Persons eligible for GA Medical programs include the poor who do not qualify for AFDC payments or Social Security Income, single persons without children who are unable to work, and families in which both parents do not work.⁵⁹ In general, GA Medical coverage is similar to the benefits provided by the state's Medicaid program.⁶⁰ These programs may include coverage for hospital, professional, laboratory, X-ray, emergency dental, pharmaceutical, vision, and transportation services.⁶¹ By providing GA Medical programs, a state can provide health care coverage to persons who are ineligible for Medicaid. Although the states must fund these programs without federal assistance, they provide an opportunity for decreasing the size of the uninsured population.

C. *Transitional Insurance*

Another approach to meeting the needs of the uninsured is the provision of transitional insurance to the poor who lose their Medicaid or GA Medical benefits when they accept employment.⁶² Maryland, Massachusetts, Michigan, and New Jersey provide transitional insurance programs to their former Medicaid and GA Medical recipients.⁶³ Generally, transitional insurance covers the same health care services provided by public assistance programs.⁶⁴ However, the need for transitional health insurance programs was reduced by the Family Support

57. RECENT STATE INITIATIVES, *supra* note 43, at 8-10.

58. *Id.*

59. *Id.* at 8.

60. *Id.* See MONT. CODE ANN. § 53-3-310 (1991); OHIO REV. CODE ANN. § 5111.02 (Baldwin 1989); 62 PA. CONS. STAT. ANN. §§ 442.1 (Supp. 1991).

61. See CONN. GEN. STAT. ANN. § 17-274 (West Supp. 1990); ME. REV. STAT. ANN. tit. 22, § 3185 (West Supp. 1990); WASH. REV. CODE ANN. § 74.09.700(2)(a) (West Supp. 1991).

62. RECENT STATE INITIATIVES, *supra* note 43, at 8-10.

63. *Id.* at 22-28.

64. See *id.*

Act of 1988⁶⁵ which requires state governments to provide newly employed AFDC recipients with an additional twelve months of Medicaid or private insurance coverage.⁶⁶ Nevertheless, states may provide additional benefits to former Medicaid recipients by furnishing transitional coverage beyond the twelve months required by the Family Support Act.

D. *State Risk Pools*

In addition to public insurance programs, Connecticut, Florida, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oregon, Tennessee, Washington, and Wisconsin administer state risk pool programs.⁶⁷ In these programs, states maintain pooling arrangements with private insurers to provide benefits to medically uninsurable persons.⁶⁸ Persons eligible for participation are those who do not qualify for public insurance, who are rejected by private insurers, or who pay private insurance premiums that exceed risk pool rates.⁶⁹

State risk pools may also include benefits for other uninsured persons. For example, Connecticut's risk pool is available to all residents who are ineligible for Medicare.⁷⁰ In 1987, Oregon enacted a Health Insurance Pool to approve contracts with insurance carriers and to set premium rates for employers and employees.⁷¹ The Oregon Health Insurance Pool, however, does not provide employee dependent coverage.⁷²

State risk pools provide a wide variety of benefits. These programs typically include benefits for hospital, professional, skilled nursing facility, home health, X-ray, laboratory, oral surgery, anesthesia, and transfusion services.⁷³ Risk pool benefits may also include coverage for prescription drugs and contraceptives, oxygen therapy, physical therapy,

65. The Family Support Act of 1988, Pub. L. No. 100-485, 102 Stat. 2343 (codified as amended in scattered sections of 42 U.S.C.).

66. *Id.* § 401, 102 Stat. at 2392-96. See also [1989-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 37,477; RECENT STATE INITIATIVES, *supra* note 43, at 22.

67. RECENT STATE INITIATIVES, *supra* note 43, at 33-37.

68. See generally Susan S. Laudicina, *State Health Risk Pools: Insuring the 'Uninsurable,'* 7 HEALTH AFF. 97 (1988).

69. RECENT STATE INITIATIVES, *supra* note 43, at 33-37.

70. See Monheit, *Public Policy*, *supra* note 13, at 361.

71. OR. REV. STAT. §§ 653.705-785 (1989). See also RECENT STATE INITIATIVES, *supra* note 43, at 50.

72. OR. REV. STAT. § 653.745(4). See also RECENT STATE INITIATIVES, *supra* note 43, at 50.

73. See FLA. STAT. ANN. § 627.6498 (1984 & Supp. 1991); IND. CODE ANN. § 27-8-10-3 (Burns Supp. 1991); IOWA CODE ANN. § 514E.4 (West 1988 & Supp. 1991); MINN. STAT. ANN. § 62E.06 (West Supp. 1991); MONT. CODE ANN. § 33-22-1511 (1991); TENN. CODE ANN. § 56-39-112 (Supp. 1991).

speech therapy, radioactive materials, and prostheses.⁷⁴

Unfortunately, state risk pool premiums are too expensive to provide adequate health insurance benefits for most uninsured persons.⁷⁵ In many states, risk pool premiums may cost up to 150% of average insurance premium rates.⁷⁶ Participating insurance companies pay the difference in premium incomes and program expenses.⁷⁷ Nevertheless, the risk pool concept may provide a viable alternative for state legislatures to consider as they develop programs for the uninsured.

E. *State Catastrophic Health Plans*

State legislatures may also provide the uninsured with health care benefits through catastrophic health insurance programs. New Jersey and New York have adopted this strategy and administer catastrophic health programs.⁷⁸ Generally, private insurance benefits must be exhausted before an individual may receive benefits.⁷⁹ However, disabled persons who do not qualify for Medicaid may be eligible without exhausting their benefits.⁸⁰

State catastrophic health insurance programs provide a broad range of benefits. Standard benefits included under these programs are hospital, professional, skilled nursing facility, clinic, home health, laboratory, X-ray, dental, vision, and rehabilitation services, as well as benefits for medical equipment and supplies, prostheses, drugs, physical therapy, and speech therapy.⁸¹ Catastrophic health plans may be financed by state revenues, deductibles, and copayments.⁸²

State catastrophic health plans may ease the burden of costly illnesses, but they do not provide benefits until a potential recipient depletes all other health insurance resources. As a result, states adopting a

74. See FLA. STAT. ANN. § 627.6498; IND. CODE. ANN. § 27-8-10-3; IOWA CODE ANN. § 514E.4; MINN. STAT. § 62E.06; MONT. CODE. ANN. § 33-22-1511; TENN. CODE ANN. § 56-39-112.

75. STATE PROGRAMS, *supra* note 49, at 34.

76. RECENT STATE INITIATIVES, *supra* note 43, at 38-40.

77. STATE PROGRAMS, *supra* note 49, at 34.

78. RECENT STATE INITIATIVES, *supra* note 43, at 18-19. Rhode Island administered a catastrophic health plan until July 1, 1990 when budget problems forced the state legislature to terminate the program. Alaska, Maine, and Minnesota also terminated their programs. SLOWLY BUT SURELY, *supra* note 15, at 14.

79. RECENT STATE INITIATIVES, *supra* note 43, at 18-19.

80. *Id.* at 14.

81. See N.Y. SOC. SERV. LAW § 369-c (McKinney 1991).

82. RECENT STATE INITIATIVES, *supra* note 43, at 14.

catastrophic health plan must provide additional programs to effectively meet the needs of the uninsured.

F. *State Uncompensated Care Programs*

State uncompensated care programs provide reimbursement to hospitals that provide medical services to the uninsured. Hospitals that treat a high proportion of uninsured persons experience greater financial stress than those hospitals that treat few uninsured persons.⁸³ Consequently, forty-three states ease this burden by reimbursing hospitals for care provided to persons with minimal resources.⁸⁴

A variety of innovative strategies are used to finance state uncompensated care programs. Generally, these reimbursements are provided from state and local revenues.⁸⁵ Other revenue sources are also available. Maryland, Massachusetts, and New Jersey supplement general revenue reimbursements with third party payer assessments.⁸⁶ California and Minnesota use cigarette taxes.⁸⁷ Kentucky, New Jersey, and Pennsylvania use lottery proceeds.⁸⁸ Finally, Alabama, California, Georgia, Montana, North Carolina, Tennessee, and West Virginia solicit donations from hospitals to help reallocate the uncompensated care burden.⁸⁹

A different approach to financing these programs is used in Florida, Maryland, Massachusetts, New Jersey, New York, Ohio, and South Carolina where revenue pools were developed to reimburse hospitals for charity care costs.⁹⁰ Under this approach, hospitals are required to pay a surcharge on total revenues which is redistributed in proportion to each hospital's charity care costs.⁹¹ States implementing uncompensated care programs may be able to contribute to hospitals' financial stability. Yet, because these payments are provided directly to hospitals, they do not decrease the size of the uninsured population.

G. *The Hawaii Prepaid Health Care Act*

Hawaii administers an innovative state health insurance program.

83. Iglehart, *supra* note 12, at 60.

84. RECENT STATE INITIATIVES, *supra* note 43, at 65-66.

85. *Id.*

86. *Id.* at 67, 69-71.

87. *Id.* at 77.

88. *Id.*

89. *Id.* at 78.

90. *Id.* at 65-74.

91. *Id.*

This program, codified in the 1974 Prepaid Health Care Act,⁹² was enacted to provide insurance for the state's gap group individuals.⁹³ Gap group individuals are persons who: (1) have too much income to qualify for Medicaid; (2) are not insured by an employer; (3) choose not to purchase health insurance; or (4) are dependents who are not included in their parents', guardian's, or spouse's health insurance plan.⁹⁴

Hawaii's small population of uninsured persons is the primary reason for the Prepaid Health Care Act's success.⁹⁵ Prior to the Prepaid Health Care Act, ninety percent of Hawaii's population was insured.⁹⁶ The Act maintains Hawaiians' high health insurance level by requiring employers to provide health insurance to employees who work twenty hours per week for four consecutive weeks.⁹⁷ Consequently, the Act does not cover seasonal workers, part-time workers, or public assistance recipients.⁹⁸ Further, employers are not required to provide health insurance benefits for workers who are covered by another insurance plan, a prepaid health care plan, the state's medical assistance plan, or a parents', guardian's, or spouse's health care plan.⁹⁹ Employers are also not required to provide health insurance benefits for their workers' dependents.¹⁰⁰ Despite these exceptions, Hawaii has the smallest uninsured population in the nation.¹⁰¹

Financial support for the the Prepaid Health Care Act is obtained from various sources. Legislative appropriations are an important element in the Act's funding.¹⁰² Employee contributions are restricted to 1.5% of their gross salary.¹⁰³ Employers must pay at least half of their employees' premiums and any difference after the employee's contribution is met.¹⁰⁴ Small business relief is available for businesses with fewer than eight employees if paying health insurance premiums creates a

92. HAW. REV. STAT. §§ 393-1 to -51 (1985 & Supp. 1990)

93. *Id.* § 431N-3 (Supp. 1990).

94. *Id.*

95. *ERISA: Exemption from Preemption for Hawaii Prepaid Health Care Act: Hearings on H.R. 4046 Before the Subcomm. on Labor-Management Relations of the Comm. on Education and Labor, 97th Cong., 2d Sess. 34 (1982)* [hereinafter *Hearings*] (testimony of Betty Hirozawa, Government Affairs Committee, Hawaii Chamber of Commerce).

96. *Id.*

97. HAW. REV. STAT. § 393-14.

98. *See id.*

99. *Id.* § 393-17.

100. *Id.* § 393-21. RECENT STATE INITIATIVES, *supra* note 43, at 43.

101. SLOWLY BUT SURELY, *supra* note 15, at 6.

102. HAW. REV. STAT. § 431N-3.

103. *Id.* § 393-13.

104. *Id.* *See also* RECENT STATE INITIATIVES, *supra* note 43, at 43.

hardship.¹⁰⁵

The Prepaid Health Care Act provides a broad range of coverage and allows some flexibility for employers to tailor their plans to the needs of their business and their employees. The Act mandates insurance coverage for hospital, physician, surgical, maternity, substance abuse, and preventive services.¹⁰⁶ Employers may choose the insurance plan they will offer their workers, or they may self-fund by paying directly for their employees' health services.¹⁰⁷ The Prepaid Health Care Act Advisory Counsel also has the authority to approve plans providing services varying from the statutory requirements.¹⁰⁸

Despite the broad range of services provided under the Prepaid Health Care Act and the numerous employees who enjoy these services, businesses were reluctant to support it. In *Standard Oil Company v. Agsalud*,¹⁰⁹ the Standard Oil Company challenged the Act's validity. Standard Oil resisted expanding its multistate employee benefit plan to meet the Act's requirements, and argued that the 1974 Employee Retirement Income Security Act (ERISA)¹¹⁰ preempted the Prepaid Health Care Act.¹¹¹

These arguments proved to be successful when the Ninth Circuit Court of Appeals held that ERISA preempts the Hawaii Prepaid Health Care Act.¹¹² ERISA regulates private employee benefit and pension plans.¹¹³ Under ERISA, an employee benefit plan is any plan maintained by an employer to provide benefits for medical, surgical, or hospital

105. HAW. REV. STAT. § 393-45.

106. *Id.* § 393-7. RECENT STATE INITIATIVES, *supra* note 43, at 43.

107. HAW. REV. STAT. § 393-12.

108. *Id.* § 393-7(b).

109. 442 F. Supp. 695, 697 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

110. See 29 U.S.C. §§ 1001-1461 (1988 & Supp. I 1989).

111. *Standard Oil*, 442 F. Supp. 695, 697. See generally Michael G. Pfefferkorn, Comment, *Federal Preemption of State Mandated Health Insurance Programs Under ERISA—The Hawaii Prepaid Health Care Act in Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339 (1989).

112. *Standard Oil*, 633 F.2d at 766.

113. See 29 U.S.C. §§ 1001-1461.

care.¹¹⁴ If a state law "relate[s] to employee benefit plans," it is preempted;¹¹⁵ however, laws that "regulate insurance" are not preempted.¹¹⁶ The court reasoned that the Prepaid Health Care Act "must 'relate to' employee benefit plans within the meaning of ERISA's broad preemption provision."¹¹⁷ Yet, even after *Standard Oil*, employers in Hawaii continued to provide workers with insurance benefits that met the Act's requirements.¹¹⁸

In 1983, the Hawaii government successfully petitioned Congress to exempt the Act from ERISA regulation.¹¹⁹ Whether Congress will exempt other employer-based programs from ERISA regulation is unclear. As a result, because Hawaii had a high percentage of insured citizens before the Prepaid Health Care Act was passed, and because the state legislature obtained an exemption from ERISA regulation for the Act, its duplication is unlikely.¹²⁰

114. *Id.* § 1002(1).

115. *Id.* § 1144(a). See *General Elec. Co. v. New York State Dep't of Labor*, 891 F.2d 25, 29 (2d Cir. 1989), *cert. denied*, 110 S. Ct. 2603 (1990) (A state law is "related to" employee benefit plans when it has a "connection with or reference to" such plans, "it purports to regulate . . . the terms and conditions" of such plans, or "it proscribes the type and amount of an employer's contribution."); *Insurance Bd. v. Muir*, 819 F.2d 408, 410-11 (3rd Cir. 1987) (ERISA preempts Pennsylvania mandated benefits law); *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502, 504 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978) (ERISA preempts the 1975 Knox-Keene Health Care Service Plan Act).

116. 29 U.S.C. § 1144(b)(2). See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1984) (Massachusetts mandated benefits law requiring coverage for hospital and surgical expenses in employee health care plans is the regulation of insurance reserved to the states by the McCarren-Ferguson Act and is therefore not preempted); *Blue Cross & Blue Shield v. Bell*, 798 F.2d 1331, 1334 (10th Cir. 1986) (Kansas mandated benefits law requiring coverage for newborn infants is the regulation of insurance reserved to the states by the McCarren-Ferguson Act); *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308, 312-13 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986) (Michigan mandated benefits law requiring coverage for substance abuse is the regulation of insurance within the savings clause and is therefore not preempted); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (New Hampshire mandated benefits law requiring coverage for mental health services is the regulation of insurance reserved to the states by the McCarren-Ferguson Act and is therefore not preempted). See generally Michael S. Ackerman, Note, *ERISA: Preemption of State Health Plan Laws and Worker Well-Being*, 1981 ILL. L. REV. 825 (1981); Lawrence A. Vranka, Jr., Note, *Defining the Contours of ERISA Preemption of State Insurance Regulation: Making Employee Benefit Plan Regulation an Exclusively Federal Concern*, 42 VAND. L. REV. 607 (1989).

117. *Standard Oil Co. v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

118. *Hearings, supra* note 95, at 27 (statement of Albert H. Yuen, President, Hawaii Medical Services Association).

119. See 29 U.S.C. § 1144(b)(5).

120. See *Hearings, supra* note 95, at 121 (testimony of Honorable Spark M. Matsunaga, U.S. Senator, Hawaii).

H. *The Massachusetts Health Security Act*

The Massachusetts government implemented a progressive approach to meeting its uninsured residents' needs by enacting the Health Security Act. The Health Security Act resulted from tensions created by the implementation of a hospital revenue pool designed to compensate hospitals for care provided to the medically indigent. In 1985, the Massachusetts legislature implemented the hospital revenue pool and financed it through a surcharge on hospital bills.¹²¹ In return for these uncompensated care payments, hospitals were required to provide free care to the medically indigent.¹²² By 1987, the surcharge grew to 13.25% of hospital revenues, and hospitals complained that inflation costs and shortfalls from Medicare payments exceeded their reimbursements.¹²³

In 1987, Massachusetts Governor Michael Dukakis introduced the Massachusetts Health Partnership (Partnership).¹²⁴ The Partnership was designed to provide health insurance benefits to high risk individuals, Medicare recipients, public employees, unemployment compensation recipients, and uninsured workers.¹²⁵ The Massachusetts legislature, however, did not pass the Partnership.¹²⁶

Later in 1987, Senator Pat McGovern proposed the Health Security Act which was passed on April 21, 1988.¹²⁷ An alliance of Massachusetts universities, hospitals, state agencies, and insurance carriers supported the Health Security Act's implementation.¹²⁸ To gain support for the Act, the state pledged \$200,000,000 to compensate hospitals for expenses exceeding their Medicare payments.¹²⁹ Yet, because of increasing budget demands, Governor Dukakis refused to release much of the

121. MASS. GEN. LAWS ANN. ch. 118F, § 15 (West Supp. 1991). See generally, Greg Scandlen, *Massachusetts Universal Health Insurance Law: A Blueprint for the States?*, 17 TAX MGMT. COMPENSATION J. 3 (1989); RECENT STATE INITIATIVES, *supra* note 43, at 70.

122. MASS. GEN. LAWS ANN. ch. 118F, § 15. See Scandlen, *supra* note 121, at 3.

123. Alan Sager, *Prices of Equitable Access: The New Massachusetts Health Insurance Law*, 18 HASTINGS CENTER REP. 21, 22 (1988); Scandlen, *supra* note 121, at 3.

124. Linda A. Bergthold, *Purchasing Power: Business and Health Policy Change in Massachusetts*, 14 J. HEALTH POL. POL'Y & L. 435, 441 (1989); Scandlen, *supra* note 121, at 3.

125. Scandlen, *supra* note 121, at 3.

126. *Id.* at 4.

127. MASS. GEN. LAWS ANN. ch. 118F, §§ 1-20 (West Supp. 1991); Alan Sagar, *Making Universal Health Insurance Work in Massachusetts*, 17 LAW MED. & HEALTH CARE 269, 275 (1989) [hereinafter Sagar, *Universal Health*].

128. Scandlen, *supra* note 121, at 3.

129. Sager, *Universal Health*, *supra* note 127, at 276.

money appropriated for the Act's implementation.¹³⁰ In addition, because the Massachusetts legislature had difficulty balancing its budget, it paid the first two years of Medicare shortfall payments only after the Massachusetts Hospital Association sued the state government for the money.¹³¹ The state has now capped the amount of debt hospitals can charge to the hospital revenue pool, and the Massachusetts Hospital Association has again filed suit.¹³²

Despite these difficulties, the Massachusetts government continues to administer the Health Security Act. The Act continues, however, to strain the Massachusetts budget as well as the budgets of employers and employees. The Health Security Act only requires that employers provide health insurance benefits which typically are included in employer and employee sponsored health benefit plans,¹³³ and only employers who do not provide health insurance for their employees are taxed.¹³⁴ Employers with more than five employees who do not provide employee health insurance benefits are assessed two surcharges.¹³⁵ The first surcharge is the medical security surcharge which is assessed at \$1,680 per employee.¹³⁶ The second surcharge is assessed at \$16.80 per employee and is used to provide health benefits for unemployment compensation recipients.¹³⁷ In addition, a sliding scale based on family income is used to determine employees' contributions.¹³⁸ Because surcharges are imposed when employers fail to provide employee health insurance benefits, the Health Security Act is described as a "pay or play" system.¹³⁹

To alleviate the financial strain resulting from the payment of health insurance premiums, the Health Security Act provides relief for small businesses. The Act established a small business pool to help businesses

130. *Id.*

131. *Id.*; Karen Pallarito, *Problems Prompt Thoughts About Massachusetts Universal Health Plan*, MODERN HEALTHCARE, Sept. 24, 1990, at 34, 35.

132. SLOWLY BUT SURELY, *supra* note 15, at 8.

133. MASS. GEN. LAWS ANN. ch. 118F, § 6(i) (West Supp. 1991).

134. *Id.*, ch. 151A, § 14G (West Supp. 1991).

135. *Id.* See also Scandlen, *supra* note 121, at 5.

136. MASS. GEN. LAWS ANN. ch. 151A, § 14G(c) (the \$1,680 surcharge is calculated as 12% of the first \$14,000 of wages per employee).

137. *Id.* § 14G(a) (the \$16.80 surcharge is calculated as .12% of the first \$14,000 of wages per employee). In 1990, the Massachusetts legislature postponed the implementation of these surcharges. The legislative changes moved the start of the first surcharge to 1994 and moved the start of the second surcharge to 1992. These changes, however, were vetoed by Governor Dukakis later that year. SLOWLY BUT SURELY, *supra* note 15, at 7.

138. MASS. GEN. LAWS ANN. ch. 118F, § 11(4) (West Supp. 1991). See also RECENT STATE INITIATIVES, *supra* note 43, at 45.

139. Sager, *Universal Health*, *supra* note 127, at 270.

with up to six full-time employees.¹⁴⁰ In addition, a health insurance hardship trust fund provides assistance for any business whose insurance payments are equal to five percent of its gross revenues.¹⁴¹ A two year tax credit is also available to employers who have up to fifty-one employees, are providing employee health insurance benefits for the first time, and pay up to fifty percent of their employees' premiums.¹⁴² Consequently, large businesses may try to benefit from these provisions by reorganizing into smaller units to receive small business assistance.¹⁴³

The Health Security Act also established the Department of Medical Security to arrange insurance for persons who are not eligible for a health insurance plan, medical assistance program, or third party payment for health services.¹⁴⁴ Despite its broad scope, the Act leaves some Massachusetts residents uninsured. For example, the elderly who require coverage beyond their Medicare benefits remain underinsured and part-time and seasonal workers are excluded from the statute's requirements.¹⁴⁵

The considerable monetary support needed to insure Massachusetts residents through the Health Security Act is reflected in the financial projections for its implementation. The Dukakis administration estimated that it needed \$600,000,000 to finance the Act's five year phase-in period.¹⁴⁶ The Massachusetts House of Representatives, however, estimated that the phase-in period would cost \$1,000,000,000.¹⁴⁷ Similar cost estimates ranged up to \$2,000,000,000.¹⁴⁸ The current Massachusetts budget provides \$34,000,000 to fund the Act, and income-based premiums may be imposed to maintain its financial stability.¹⁴⁹ Given these projections, it is not surprising that the Act was once described as a "leaking, heavily laden boat asked to take on more passengers in worsening weather."¹⁵⁰

140. MASS. GEN. LAWS ANN. ch. 118F, § 11(4). See also Scandlen, *supra* note 121, at 5.

141. MASS. GEN. LAWS ANN. ch. 118F, §§ 11(6), 13 (West Supp. 1991). See also Scandlen, *supra* note 121, at 5.

142. MASS. GEN. LAWS ANN. ch. 151A, § 14G(f). See also Scandlen, *supra* note 121, at 5.

143. Scandlen, *supra* note 121, at 7.

144. MASS. GEN. LAWS ANN. ch. 118F, §§ 3, 5, 8 (West Supp. 1991). See also Scandlen, *supra* note 121, at 4.

145. *Mandated Coverage: Massachusetts' Ordeal*, HOSPITALS, July 20, 1988, at 66, 70 (interview with Stephen Hegarty, President, Massachusetts Hospital Association and David Kinzer, President 1973-85, Massachusetts Hospital Association).

146. Scandlen, *supra* note 121, at 6.

147. *Id.*

148. William A. Leitner, *Massachusetts: Omen or Anomaly?*, 58 ALA. MED. 7, 13 (1988).

149. SLOWLY BUT SURELY, *supra* note 15, at 8.

150. Sager, *Universal Health*, *supra* note 127, at 279.

Further complications increase the likelihood that the Health Security Act will be discontinued. Because the Act is costly and a new Massachusetts governor has replaced Mr. Dukakis, the Massachusetts legislature may repeal the Act before the phase-in period is completed.¹⁵¹ Massachusetts business owners argue that the Health Security Act is preempted by ERISA, but they have not yet challenged the statute's validity in court.¹⁵² ERISA may not preempt the Health Security Act because the statute does not directly require employers to provide health insurance coverage to their employees.¹⁵³ If challenged, the Massachusetts government may argue that the Health Security Act is a legitimate exercise of the state's taxing power that assesses all employers equally.¹⁵⁴ This argument is weakened as more exceptions are created for part-time and seasonal workers.¹⁵⁵ With these exceptions, the Act appears to use a backdoor approach to employee benefit regulation leaving uncertain whether the Health Security Act is preempted by ERISA. Although other state legislatures may consider patterning a program after the Health Security Act, the Act's uncertain future and Massachusetts' unique political environment make its duplication unlikely.¹⁵⁶

V. THE CANADIAN MEDICARE PROGRAM: A MODEL FOR THE STATES

The Canadian national health insurance program (Medicare)¹⁵⁷ provides a viable alternative for states to consider as they develop programs for the uninsured. The Canadian Medicare statute requires that the provinces provide health insurance for their entire population.¹⁵⁸ Before Medicare, one in five Canadian residents did not have health insurance benefits.¹⁵⁹ As a result of this statute, approximately ninety-eight percent

151. See Pallarito, *supra* note 131, at 36; SLOWLY BUT SURELY, *supra* note 15, at 7, 9.

152. Sager, *Universal Health*, *supra* note 127, at 276.

153. Scandlen, *supra* note 121, at 6.

154. *But see* Standard Oil Co. v. Agsalud, 442 F. Supp. 695, 710 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981) (concluding that the Hawaii Prepaid Health Care Act is not an exercise of the state's taxing power because it does not require payment to the state as a state).

155. Telephone Interview with Susan Sherry, Consumer Representative, Massachusetts Study Commission on Financing and Delivery Reform (Feb. 22, 1990).

156. See SLOWLY BUT SURELY, *supra* note 15, at 7-9.

157. Canada Health Act, ch. 6, §§ 1-23, 1984 S.C. 273 (Can.).

158. *Id.* § 10. See also WILLIAM S. COMANOR, NATIONAL HEALTH INSURANCE IN ONTARIO: THE EFFECTS OF A POLICY OF COST CONTROL 2 (1980).

159. Maurice Leclair, *The Canadian Health Care System, in NATIONAL HEALTH INSURANCE: CAN WE LEARN FROM CANADA?* 11, 15 (Spyros Andreopoulos ed., 1975).

of Canadian residents are insured.¹⁶⁰

The Medicare program is an umbrella for the ten provincial health insurance programs.¹⁶¹ Because each province administers an independent insurance program within federal guidelines, the states can effectively pattern programs after the provincial programs without the implementation of an American national health insurance plan. The provincial governments administer their programs through a single public authority.¹⁶² Each province is required to make insurance benefits available to its residents on "uniform terms and conditions."¹⁶³ A resident is defined as a person "lawfully entitled to be or to remain in Canada who makes his home in Canada and is ordinarily present in the province, but does not include a tourist, a transient, or a visitor in the province."¹⁶⁴

The Canadian government requires that all provincial insurance programs include benefits for accommodations, meals, nursing services, laboratory services, diagnostic services, drugs, surgical services, and physical therapy.¹⁶⁵ Some provinces provide additional services such as mental health, emergency, and outpatient services.¹⁶⁶ Other optional services include family planning, plastic surgery, and surgical dental services.¹⁶⁷ Residents may also obtain additional health insurance benefits through nonprofit insurance companies.¹⁶⁸ The provinces fund their programs through general revenues, premiums, taxes, and copayments,¹⁶⁹ and continue to provide benefits when a Canadian citizen leaves a province or loses a job.¹⁷⁰

Whether ERISA will preempt a health insurance plan patterned after the Canadian Medicare statute is uncertain. State health insurance program advocates argue that ERISA will not preempt programs

160. *Id.*

161. See Canada Health Act, ch. 6, §§ 1-23. See generally Robert G. Evans, *Beyond the Medical Marketplace: Expenditure, Utilization, and Pricing of the Insured in Canada*, in NATIONAL HEALTH INSURANCE: CAN WE LEARN FROM CANADA? 129, 129 (Spyros Andreopoulos ed., 1975).

162. Canada Health Act, ch. 6, § 8. See also Evans, *supra* note 161, at 129-130.

163. Canada Health Act, ch. 6, § 12.

164. *Id.* § 2. See also Evans, *supra* note 161, at 129; Leclair, *supra* note 159, at 28.

165. Canada Health Act, ch. 6, § 2. See also Leclair, *supra* note 159, at 30.

166. STAFF OF HOUSE SUBCOMM. OF THE COMM. ON WAYS AND MEANS, 94TH CONG., 2D SESS., NATIONAL HEALTH INSURANCE RESOURCE BOOK 297 (Comm. Print 1976) [hereinafter NATIONAL HEALTH INSURANCE RESOURCE BOOK].

167. *Id.*; Leclair, *supra* note 159, at 36.

168. NATIONAL HEALTH INSURANCE RESOURCE BOOK, *supra* note 166, at 297-307.

169. *Id.* at 301; Evans, *supra* note 161, at 131.

170. NATIONAL HEALTH INSURANCE RESOURCE BOOK, *supra* note 166, at 305; Evans, *supra* note 161, at 130.

modeled after the Canadian statute.¹⁷¹ A state advocating such a program could argue that mandated insurance is not an employee benefit, but an equal benefit to all persons in the state.¹⁷² Furthermore, a state could argue that ERISA may not prohibit the use of its taxing power to levy a payroll tax on all employers to fund coverage for the uninsured.¹⁷³ The Connecticut, Florida, Illinois, Indiana, Maine, Michigan, Minnesota, Missouri, Ohio, and Washington state legislatures have considered bills for the implementation of a state insurance program patterned after the Canadian Medicare program, however, similar legislation has not yet been enacted.¹⁷⁴

VI. CHALLENGES FACING STATE LEGISLATURES IN MEETING THE NEEDS OF THE UNINSURED

State legislatures implementing programs for the uninsured must overcome the challenges associated with program administration, increased cost, and government control of the health care system. Despite the numerous strategies designed by state governments to meet the needs of the uninsured, no state has successfully overcome these problems. Although Americans are demanding a greater number and higher quality of health care services, these challenges frequently cause state legislatures to refuse to enact state insurance programs. While the nation debates the implementation of a national health insurance program, the states may successfully decrease the size of the uninsured population. In order to implement successful programs, however, state legislators and their constituents must have a thorough understanding of the challenges they face.

A. *Administering a State Health Insurance Program: Cost, Eligibility, and Benefits*

A successful state insurance program will contain costs, increase access to health care, provide a power balance between the government and health care providers, and maintain competition in the health care market. In order to meet these goals, state legislatures must decide who is

171. Telephone Interview with Susan Sherry, Consumer Representative, Massachusetts Study Commission on Financing and Delivery Reform (Feb. 22, 1990).

172. Telephone Interview with Julie K. Koegel, Coordinator, Indiana Health Care Campaign (Feb. 18, 1990).

173. See Bovbjerg & Kopit, *supra* note 8, at 907-08.

174. Indiana Health Care Campaign, *Citizens Action Leadership in State Health Campaigns* (Indiana Health Care Campaign, Indianapolis, IN) (Jan. 1990) (on file with author).

entitled to health care benefits under the program.¹⁷⁵ For example, a state legislature must decide whether the program will provide health care services for a child in a neighboring state who has a parent who is a state resident.¹⁷⁶ A state legislature must also decide whether to require coverage for an insured's dependent parents and whether to grant reciprocity for other states' insurance plans. The work needed to identify employees' dependents and transient residents will increase program costs.

Once program recipients are identified, providers must have the resources to provide services to eligible persons.¹⁷⁷ Thus, a state must balance its providers' economic problems against its residents' needs.¹⁷⁸ By attempting to provide equal health care access to all state residents, state health insurance programs encourage the rationing of health care resources.¹⁷⁹ Rationing assumes a governmental duty to establish criteria for allocating resources.¹⁸⁰ When rationing occurs, residents may complain that physicians are overworked, long lines exist for care, and examinations are rushed.¹⁸¹ State health insurance programs may provide the uninsured with the opportunity to receive care, but that care may seem inadequate compared to the services received by those fortunate enough to have private insurance.¹⁸² The goal of any health insurance program, however, is to increase access to care. Consequently, consumers may be required to trade efficiency for increased access.¹⁸³

B. *Taxing Employers to Finance State Health Insurance Costs*

The primary issue in program implementation is cost. Programs financed by taxing employers create unique problems. A state legislature implementing an employer-financed program must consider: (1) changes in employee compensation; (2) efficiency in health services; (3) the effects

175. Telephone Interview with Julie K. Koegel, Coordinator, Indiana Health Care Campaign (Feb. 18, 1990).

176. *Id.*

177. See Hudson, *supra* note 41, at 46.

178. See James F. Blumstein, *Financing Uncompensated Care: An Approach to the Issues*, 38 J. LEGAL EDUC. 511, 514-17 (1988).

179. Wendy K. Mariner, *Prospective Payment for Hospital Services: Social Responsibility and the Limits of Legal Standards*, 17 CUMB. L. REV. 379, 413 (1987).

180. Blumstein, *supra* note 178, at 513.

181. See Tom Dennis, *Canadians Flock to Costly U.S. Health Care*, INDIANAPOLIS STAR, March 4, 1990, at A7.

182. *Id.*

183. But see Aaron Wildavsky, *Doing Better and Feeling Worse: The Political Pathology of Health Policy*, in *DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES* 105, 106 (John H. Knowles ed., 1977) (better access is not the same as better health).

on multistate firms; and (4) the program's goals. Unless a state legislature considers each of these factors, an employer-financed health insurance program may fail.

First, increased worker compensation through mandatory state health insurance benefits may cause a decrease in wages.¹⁸⁴ Employees may prefer increased wages to expanded health insurance coverage or any health insurance coverage at all.¹⁸⁵ For example, under traditional health insurance plans, most workers do not apply for dental, vision, or hearing benefits,¹⁸⁶ yet these benefits may be included in state health insurance plans. Employees reject these benefits because they need monetary compensation and they do not expect to benefit from additional coverage.¹⁸⁷ However, people have different needs and under state insurance programs, employees may receive benefits they do not want and do not expect to use.¹⁸⁸

The second consideration for implementing employer-financed programs is efficiency in health services delivery. State legislators should remember that inefficient services will lead to consumer dissatisfaction and increased program costs. Taxing employers to finance state health insurance programs does not encourage the efficient use of health care services. Once employees are forced to accept additional health insurance benefits, they are more likely to demand unnecessary health care services.¹⁸⁹ Thus, extensive health insurance coverage gives neither patients nor providers an incentive to use the health care system efficiently.¹⁹⁰ Under employer-financed programs, the working population will enjoy insurance coverage, but persons who are too sick to work will remain unemployed and uninsured.¹⁹¹

The national scope of many businesses presents a third obstacle to employer-financed health insurance. As the lawyers representing Standard Oil argued, multistate firms incur financial problems when state legislatures attempt to meet uninsured residents' needs by taxing employers.

184. Uwe E. Reinhardt, *Health Insurance for the Nation's Poor*, 6 HEALTH AFF. 101, 107 (1987).

185. See COMANOR, *supra* note 158, at 6.

186. Gail R. Wilensky et al., *Variations in Health Insurance Coverage: Benefits vs. Premiums*, 62 MILBANK MEMORIAL FUND Q. 53, 56-57 (1984) [hereinafter Wilensky, *Variations*].

187. See *id.*

188. See DOUGHERTY, *supra* note 3, at 55.

189. Victor R. Fuchs, *The "Competition Revolution" in Health Care*, 7 HEALTH AFF. 5, 21 (1988); Wilensky, *Variations*, *supra* note 186, at 75.

190. Marc L. Berk et al., *How the U.S. Spent Its Health Care Dollar: 1929-1980*, 7 HEALTH AFF. 46, 47 (1988).

191. Davis & Rowland, *supra* note 3, at 165.

Multistate firms may have health insurance programs that provide workers in different states with comparable benefit packages. When a state health insurance statute requires employers to provide health insurance in any benefit arrangement, multistate firms will incur increased expenses, but the statute will not disrupt their benefit programs. On the other hand, when a state health insurance statute requires employers to provide specific health insurance benefits, it will disrupt the company's benefit programs.¹⁹² In states where specific health insurance benefits are not required, company employees may receive more wages and fewer insurance benefits. In states where specific insurance benefits are required, however, employees may receive more insurance and fewer wages. This compensation disparity may hurt large businesses' ability to compete for valuable human resources.¹⁹³

Finally, a state legislature considering an employer-financed health insurance program must clearly define the program's goals. The program's secondary effect on employment levels and the program's ability to provide adequate benefits must be monitored and evaluated. Funding state programs by taxing employers may lead to a declining employment level.¹⁹⁴ An increase in labor costs may lead to a decline in employment.¹⁹⁵ A state's labor force will experience this decline when higher compensation levels increase labor costs. Furthermore, when part-time and seasonal workers are excepted from health insurance requirements, employers may lie about a worker's status, hire more part-time workers, or discharge workers before they become eligible for insurance.¹⁹⁶

An employer's selection of benefits may result in further complications. Employers may attempt to meet program requirements by providing health insurance that covers only nominal health care services. If a

192. *But see Hearings, supra* note 95, at 94 (statement of Honorable Spark M. Matsunaga, U.S. Senator, Hawaii) (multistate companies' benefit packages will not be disrupted by the Hawaii Prepaid Health Care Act because the Act's requirements are lower than the benefits these companies extend).

193. David M. Kinzer, *Why the Conservatives Gave Us Universal Health Care: A Parable*, 34 HOSP. & HEALTH SERVICES ADMIN. 299, 308 (1989). See MASS. GEN. LAWS ANN. ch. 118F, § 1 (West Supp. 1991) ("It is hereby found and declared: . . . That, the inability of certain businesses to offer health insurance benefits to their employees is a hindrance to their ability to compete for capable employees in the labor market and therefore has a negative economic impact on the commonwealth.").

194. Monheit, *Public Policy, supra* note 13, at 360-61.

195. There is evidence that a 10% increase in labor costs may lead to a 0.5-1.0% decline in employment. Michele L. Robinson, *Mandatory Insurance: Tough Choices Ahead*, HOSPITALS, Nov. 20, 1988, at 40.

196. Sager, *Universal Health, supra* note 127, at 277. See Scandlen, *supra* note 121, at 7.

state plan requires coverage for services typically included in an employer-sponsored health benefit plan, workers may not receive the benefits they want or need and may be unable to purchase these services themselves. According to economists, consumers express their preferences through economic votes cast when they use health care services.¹⁹⁷ Therefore, the test to evaluate a program's performance is whether "it give[s] reasonable individuals what they want *and only what they want*, in the sense that, understanding the alternatives, they would purchase it for themselves assuming their income [is] not below a certain level."¹⁹⁸ A state insurance plan fails this test when workers must purchase insurance with resources apart from those appropriated by the state government for health insurance.

C. *Government Intervention in the Health Care System*

Individuals who oppose state health insurance programs argue that they give state governments too much control over medical resource allocation. The rebuttal to this argument is that cost control is waste control and therefore, state insurance programs must support cost control.¹⁹⁹ Consequently, state legislatures will determine who will receive health insurance benefits and what resources will be used to provide those benefits. A state government should not fulfill the provider role by redistributing income to provide purchasing power for the poor.²⁰⁰ Nonetheless, when a government allocates available medical resources and defines individual insurance coverage, it is acting as a health care provider.

When state insurance programs dictate physician payment and resource utilization, medical innovation may decline. Physicians who fear that the government will not reimburse them for new procedures may become reluctant to try new treatment protocols.²⁰¹ Similarly, shortages of health care professionals will worsen if resources are not allocated to areas suffering shortages. State legislatures must balance these considerations because "however much [they] wish to reduce costs and increase

197. Blumstein, *supra* note 178, at 513.

198. Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 Nw. U. L. REV. 6, 15 (1975).

199. See Blumstein, *supra* note 178, at 511. See also COMANOR, *supra* note 158, at 48.

200. Rand E. Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1109 (1981).

201. Compare Mariner, *supra* note 179, at 395 (government control causing restraint of physician behavior examined within the Medicare prospective payment system) with Sager, *Universal Health*, *supra* note 127, at 269 (concluding that the Health Security Act does not involve physicians or their patterns of practice).

efficiency, [they] must not reduce the financial carrot below what providers actually need to survive."²⁰²

In contrast to a government insurance program, a market approach promotes economic creativity in the generation of new services.²⁰³ When a market approach is used, legislators will focus on efficiency rather than equity²⁰⁴ and will promote competitive markets before they redistribute purchasing power.²⁰⁵ Competition promotes efficient health care utilization and delivery.²⁰⁶ In a competitive model, consumers make voluntary transactions in which they balance marginal economic costs against marginal health benefits.²⁰⁷ Yet, consumers cannot express their needs through purchase selections when the services available to them are limited. Although removing new and costly services from state health insurance programs will conserve resources, the public must decide that it is willing to increase access to health care by sacrificing individual choice and medical innovation.

VII. IMPLICATIONS FOR THE FUTURE

State legislatures are beginning to meet the needs of the uninsured by implementing legislation to provide insurance for their state's residents.²⁰⁸ Traditionally, state governments, through their general police power, have the authority to provide and finance health care.²⁰⁹ Some scholars deny that state legislatures can produce policies that will resolve health care problems,²¹⁰ and maintain that direct federal involvement is needed to finance American health care.²¹¹

Advocates of state health insurance programs see state programs as a step toward national health insurance.²¹² These advocates doubt that state legislatures will succeed in administering health insurance programs

202. Mariner, *supra* note 179, at 387.

203. DOUGHERTY, *supra* note 3, at 136.

204. Blumstein, *supra* note 178, at 517.

205. See Rosenblatt, *supra* note 200, at 1109.

206. See *id.*

207. *Id.* at 1070, 1088. See also DOUGHERTY, *supra* note 3, at 137.

208. For a discussion of the most recent and innovative state programs, see SLOWLY BUT SURELY, *supra* note 15, at 16-29.

209. O'Connor v. Donaldson, 422 U.S. 563, 583 (1975) (Burger J., concurring); Jacobson v. Massachusetts, 197 U.S. 11, 24 (1905).

210. See Thompson, *supra* note 31, at 654-55.

211. See Reinhardt, *supra* note 184, at 108.

212. Telephone Interview with Julie K. Koegel, Coordinator, Indiana Health Care Campaign (Feb. 18, 1990); Telephone Interview with Susan Sherry, Consumer Representative, Massachusetts Study Commission on Financing and Delivery Reform (Feb. 22, 1990).

without federal support.²¹³ As the states enact differing programs, these advocates hope that national health insurance will become a reality.²¹⁴ Yet, a single level of medical care may not meet every person's needs. Consequently state legislatures may be in a better position than the federal government to identify state residents' health care needs.²¹⁵

State programs for the uninsured are costly. Because state governments will control program funding, they will have a greater influence on private medical practice. Increased government control provokes arguments that state health insurance programs promote health care rationing without allowing natural market forces to work. In addition, when state health insurance programs are implemented, consumers must change their expectations of resource allocation and the efficiency of health care services.

State residents must decide whether they are willing to alter their expectations to facilitate successful state programs for the uninsured. State programs for the uninsured have disadvantages, but with the cooperation of state residents and health care professionals, they can curb the growth of the uninsured population. Justice Brandeis once expressed his support for state innovation by writing:

Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.²¹⁶

If cost, access, and competition are considered in the planning of state programs, our states may become the pioneers in slowing the growth of our nation's uninsured population.

213. See Fitzhugh Mullan, *Poor People, Poor Policy: Government Programs for the Disadvantaged*, 6 HEALTH AFF. 113, 116 (1987).

214. U.S. BIPARTISAN COMM'N ON COMPREHENSIVE HEALTH CARE, 101ST CONG., 2D SESS., ACCESS TO HEALTH CARE AND LONG-TERM CARE FOR ALL AMERICANS (March 2, 1990).

215. See Blumstein, *supra* note 178, at 523; Hudson, *supra* note 41, at 46.

216. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).