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Healthcare Reform in the United States: The Role of the States

Arthur Birmingham LaFrance[1]

INTRODUCTION

Although national efforts at healthcare reform in the United States have largely stalled, reform efforts at the state level have enjoyed surprising success[2]—either independently of federal programs or within the latitude allowed by federal funding for the states.[3] These state efforts hold great promise of extending access and healthcare coverage to uninsured Americans, improving quality of care, containing costs, and raising new revenues. These efforts are of great importance not only to other states, but also to other nations that already have universal healthcare and are now struggling with issues of coverage, cost, and quality.[4]

It is commonly understood that reform of the United States healthcare system is greatly needed. Total national healthcare expenditures exceed $1 trillion annually and, at the present rate of increase, will surpass $2 trillion within the present decade. This burden is unacceptable, whether viewed as a percentage of domestic national product, exceeding 18 percent, or as a per capita expenditure, exceeding by nearly a factor of two to three times expenditures by other industrialized nations.[5] The burden on individuals is onerous, unequal, and increasing.

At the same time, there are major deficiencies in coverage and quality. As to coverage, the U.S. Census Bureau reports that over 47 million Americans are uninsured.[6] As to quality, the Institute of Medicine estimates tens of thousands Americans die from negligence in hospitals annually.[7] By most quality measures, American outcomes fall far short of international standards, whether the criteria are simple mortality or more complex quality-of-life measures.[8]

There is consensus that the United States cannot continue on the present path. A recent analysis by the Center on Budget and Policy Priorities concluded that if present budget policies are continued, by 2050, the national debt will increase from 37 percent of the national economy to 231 percent.[9] In 2050, the debt would be twice the size of the national economy.[10] The Center determined that stabilizing national finances would require an immediate tax revenue increase of 18 percent or a 15 percent cut across the board of all federal programs, and not just those relating to healthcare.[11] The task, the Center concluded, was to deal with challenges created by expansion of healthcare services, of demographic trends, and of costs in healthcare.

National-level reform has been proposed regularly since the presidential incumbencies of Presidents Roosevelt, Truman, and Clinton.[12] These proposals have failed, and the present administration, with even more modest goals, is not likely to have greater success. Yet, the various presidential aspirants in 2007–2008 emphasize healthcare, in unduly divergent ways, as central issues in their campaigns.

This article focuses on the promising state level activity to reform the healthcare system. State healthcare reform has, in the main, escaped attention despite our federal union's framework and invitation for state solutions to national problems. Indeed, the very first national health program—for pregnant women—as reflected in *Massachusetts v. Mellon*, was specifically founded on a structure of cooperative federalism.[13] Similarly, programs to alleviate poverty and to provide healthcare for the aged and the poor have been constructed to assure state administration since their inception. Over the past two decades, state innovation has expressly been a part of creativity and exploration through the system of Section 1115 waivers, relieving states of Medicaid requirements.[14]

As we shall see, states have been creative and, often times, successful in addressing the most pressing needs of our healthcare system.[15] The states, of course, have a powerful incentive for innovation—healthcare comprises

32 percent of all state spending, and state Medicaid spending is projected to grow 5.8 percent in 2008.[16] States have successfully addressed the inadequacy of covered services, healthcare coverage for the poor and uninsured, joint buying of drugs, preventative healthcare, children's health, and public health needs.[17] Many of these initiatives rely on federal funding, but many do not.

The present-day efforts of the various states provide useful models as to the variety of approaches, especially those moving towards universal healthcare in Massachusetts, California, New York, and Vermont, or towards improving quality and benefits and holding down costs. A brief summary of state approaches includes: requiring employers to provide insurance ("play" or "pay"); requiring employees to purchase insurance; developing a pool for employees to purchase insurance; developing a "high risk" pool to compel insurers to provide coverage; expanding ages and income eligibility standards for Medicaid and the State Children's Health Insurance Program (SCHIP); purchasing insurance or drug benefits for citizens at reduced rates; providing preventative health programs; and establishing multi-state consortia for all of these purposes. The objective is universal healthcare, but not necessarily through a single-payer system. Inevitably, state reforms rely on a continued—indeed, an increased—context of federal funding.

We will turn first to the national level of healthcare in the United States to briefly review efforts at reform and to set the context within which states work. The remainder of the article will explore state efforts, attempt to assess their value and probable success, and develop an agenda for state action.

I. HEALTHCARE REFORM AT THE NATIONAL LEVEL

The American healthcare system depends heavily on locally delivered services through privately retained physicians, hospitals, and nursing homes. Over half of hospitals are religiously or governmentally operated.

The patient must pay for all of these services, either through insurance or through entitlement programs such as Medicare (if retired from employment), Medicaid (if poor), or SCHIP (if children). Those without such coverage either go without healthcare or appear at hospitals for emergency care, for which they are personally liable for payment, which leads to poor care and overburdened resources. The confusing mix of state/federal, public/private, and employee/employer players satisfies no one, especially the 47 million Americans who do not have insurance (private or governmental) that would provide them with access to physicians, hospitals, and pharmaceuticals.[18]

A. Federal Proposals for 2007–2008

The Bush administration proposed a sweeping array of initiatives concerning healthcare for 2007 and 2008 in the budget announced early in 2007.[19] At a time when costs for medical services are rising and the aging population is increasing, Medicare and Medicaid funding would have been cut by more than $100 billion over a period of five years. For Americans covered by Medicare, the budget proposed increasing the patient's share of premiums paid for drugs, as well as other services. The budget also proposed a hard trigger in which Medicare spending would be capped if general revenue funding exceeded 45 percent of Medicare financing.[20]

Two proposals warrant particular attention: (1) a tax deduction would have been allowed for families paying insurance premiums up to $15,000 while making employer-provided insurance taxable; and (2) increased funding would have been directed towards community health centers and counties in which there was a high presence of poverty.[21] Somewhat offsetting these measures was a proposal that reimbursement be reduced for physicians and for disproportionate share hospitals (those hospitals receiving higher Medicare payments because they treat a disproportionately higher number of Medicaid patients than other hospitals). With reference to Medicaid, there would be reductions in hospital and nursing home

payments, and the biggest Medicaid cuts would come from a drop in the administrative match rate paid to states.

Not surprisingly, the proposals were met with substantial criticism. On February 9, 2007, a panel discussion at the Brookings Institution took the tax proposal to task as favoring the wealthy because poor families have little tax liability.[22] Critics also charged that the proposals would cause employers to drop coverage. Members of Congress, including Representative Stark and Senator Rockefeller, particularly focused on inadequate funding for SCHIP, which would have been extended with only $5 billion over five years, an amount estimated to cover only one-third of SCHIP's needs.[23] A Congressional Joint Committee on Taxation report concluded that the Bush plan would raise taxes $333.6 billion from 2009 to 2017, with an average increase of $2,200 in taxes for 58 million Americans, and would replace the present system of incentives for employer-based insurance with an ineffectual system of tax deductions.[24]

The budgetary proposals were particularly disappointing in light of the December report by the Medicaid Commission, which called for substantial reform of Medicaid.[25] Among the Commission recommendations were improving long-term care, addressing institutional bias, improving healthcare records, dealing with the dually eligible Medicare/Medicaid population, and expanding state innovation. The Bush proposals did little to address these problems.

The Bush proposals are summarized briefly here to demonstrate their sweeping ineffectiveness. The crucial need is to extend financing—and access—to 47 million Americans who cannot afford healthcare. Not only are the Bush proposals inadequate to accomplish this goal, but also most recently are self-contradictory. In August 2007, the Centers for Medicaid & Medicare Services (CMS), the central federal financing and regulatory health agency, sent a letter to all of the states to bar expansion of SCHIP for fear that private insurance companies would lose customers.[26]

The Bush proposals' shortcomings were highlighted by their contrast to the proposals considered by Congress.[27] Max Baucus, the chairman of the Senate Committee on Finance, provided an overview of proposals and put forward five principles for healthcare reform: universal coverage, a shared burden among employers and individuals, cost control, expansion of preventive services, and shared responsibility.[28] Baucus noted, in particular, the failure of Medicare-managed care, in which it is estimated that Medicare Advantage plans are paid on average 12 percent more than fee-for-service care. Another senator, Ronald Wyden, proposed what is perhaps the most comprehensive effort at reform, the Healthy Americans Act. The Healthy Americans Act is essentially a program of universal healthcare which keeps in place the role of employers, but extends to the poor and uninsured the same coverage provided to members of Congress.[29]

The Commonwealth Fund, a private foundation that aims to improve healthcare in the United States and other industrialized countries, reviewed ten bills from the last two Congresses and concluded that most would reduce or eliminate the role of employer-based insurance and tax treatment, would mandate that coverage be available, would provide subsidies to low-income people, and would create coverage pools for high risk individuals.[30] As we shall see, many of the state efforts at reform and expanding access are built around the continued (and expanded) role of employers in providing health insurance to employees presently lacking coverage.[31] Thus, national and state reform efforts seem to be on a collision course, at least in respect to this one central feature of the American healthcare system.

By the autumn of 2007, the various candidates for the office of president—Republican and Democrat—had all addressed the issue of healthcare reform. Only the Democrat candidates proposed sweeping reform, and of them, the most extensive proposal was that of Senator Clinton. She would create a mixed public/private system, funded by rejecting Bush-era tax policies. Others would eliminate employer-based

insurance. It is unclear which candidate holds the advantage. What seems clear is that national efforts are largely directed at funding for healthcare and, possibly, thereby extending the number of people covered.[32] Yet, rarely does anyone seriously propose the simple solution of universal healthcare on a national scale; only the states of Massachusetts, California, and Vermont (and possibly New York) have addressed the possibility. Nor is anyone tackling the difficult problems of quality, cost control, and effectiveness of the healthcare system.[33] Again, these have been addressed chiefly at the state level. Thus, the real lessons in healthcare reform, whether for domestic reformers or those in other nations, are to be learned at the state level.

It may be worth pausing to ask why reform has been stuck at the national level and why the states have seemed to be able to move on a subject of national urgency when the federal government, despite providing the major source of funding, has been paralyzed. For this, it is worthwhile to examine the structure and context of American healthcare.

B. Setting the Context for the States

The failure of reform at the national level has been partly due to the politics of the moment. Currently, a weakened Republican presidency faces a strengthened Democratic majority in Congress. The varying candidates for the presidency are maneuvering for position.[34] The usual lobbying interests—the insurance industry, the pharmaceutical industry, and the medical/hospital industrial complex—have no role in universal healthcare. Furthermore, all of this is true at a time when a trillion-dollar war is being fought in Iraq and Afghanistan—all off budget.

However, the last major healthcare reforms took place during similar times in 1965, during the Vietnam War and the Civil Rights era, with the creation of Medicare for retired workers and Medicaid for the poor and generally young families. Those programs are now funded by nearly $800 billion annually by Congress, which demonstrates that Congress can make a

difference in improving healthcare. Additionally, Congress gives billions of dollars in funding to veterans programs, with nearly 130 hospitals around the nation, and Congress adopted SCHIP in 1996, which further demonstrates congressional support for healthcare.[35]

What cripples Congress, however, is reflected in the very nature of these programs. First, Congress responds to specific populations or needs, such as children, women, and elderly workers. These are the "worthy poor."[36] Implicitly, such an approach denies the legitimacy of universal healthcare as a strategy, and certainly as a right. It also pits disadvantaged groups against each other, as illustrated by the present congressional debate over whether to increase funding for children's health insurance programs by reducing funding for Medicare. It is doubtful, given American tradition, that Congress will ever change its fundamental assumptions.[37]

Separately, most social welfare content—if not funding—is delivered at the state level. This is constitutionally grounded and is of the essence to the American federal system. Thus, Medicaid and SCHIP are federally funded, but state administered. The early efforts of Medicaid to mandate nationally the scope of services had floundered by the 1980s on a vast system of waivers, allowing states to go their separate ways. In 1995, the creation of SCHIP extended the trend by leaving the states free to spend block grants as they chose. While Medicare is nationally funded and administered, most of the funds go to hospitals and doctors who are state regulated.

Finally, employers and insurers are in the central place in American healthcare, which is radically different from the healthcare systems in countries such as Canada, Australia, New Zealand, Britain, Germany, and Japan. It is through employment that health insurance is obtained, with the employer buying the insurance and receiving a tax deduction, and the employee obtaining coverage as a benefit, untaxed as "income." This means that no one is in a position to insist on cost effectiveness or quality because the consumer (the patient) does not pay the bill. This is also the model for government programs such as Medicaid and Medicare. As a

result, some 47 million Americans simply fall between the pools of Medicaid, Medicare, and employment-based insurance coverage and have no healthcare benefits, although half are employed.[38]

All of this is in contrast to healthcare systems in other countries.[39] There, national systems of healthcare long ago affirmed the universality of healthcare as a benefit, if not a right. Some countries, such as Germany and Japan, use employers as vectors for delivery or finance of healthcare. However, these nations assure coverage for all. While these countries have solved the basic problem of access to healthcare, they are increasingly finding quality difficult to assure and the cost difficult to bear. And so these countries are seeking means of controlling cost, assuring quality, and maintaining universality of healthcare. These are among the issues now present at the state level in the United States, and it is to the efforts to address these issues that we now turn.

II. An Agenda for Action

In looking at what states are doing, it may be best to pause briefly and ask, what is it that they should be doing? What are the areas of greatest urgency? There are three: services provided, access to healthcare funding and services, and quality. In the background for each, of course, is the problem of cost. It would seem inevitable that cost would increase as services, access, and quality increase. But this is not necessarily the case—improvements in each of these areas may lead to better health, and better health, in turn, may lead to less use of healthcare services and less expense.

States must necessarily emphasize those approaches used to increase access to healthcare. Programs that have surplus funding, such as Medicaid and SCHIP, are broadening their eligibility requirements to cover more uninsured individuals. Another way that states have increased access to healthcare is to tap funding sources uniquely available to the states, such as requiring employers to provide healthcare insurance or pay taxes (so-called "play or pay") or requiring employees to purchase minimum healthcare

insurance whose content is state determined.[40] Yet another approach to expand access to healthcare is for states to address the specific needs of their residents, as with pharmaceutical programs and multi-state consortia, which have produced dramatic results. Finally, efforts are best directed at problems or populations with the greatest potential for maximum impact, clearly the case with expanding healthcare to children and preventive services to adults.

We will next discuss how states might set an agenda to improve availability of pharmaceuticals; how states may assure enrollment of the uninsured, the mentally ill, and children; and how states may improve quality of care. Significantly, this agenda is *not* limited simply to expanding funding because states have not so limited themselves.[41]

A. Services: Pharmaceuticals

In a system of universal healthcare, as in Britain, Canada, and New Zealand, there is no problem with scope and availability of services. All are provided; all are covered. However, the United States healthcare systems of Medicare, Medicaid, Veterans Health Administration, and SCHIP are limited to defined services and targeted populations: the retired elderly, the poor, veterans, and children. Until recently, Medicare only provided drugs incident to hospitalization; Medicaid drug coverage for the poor varied from state to state. And, of course, private insurance had limits as well, in co-pays, formularies, and exclusion of coverage where not "necessary" or "experimental." Only the United States Department of Veterans Affairs (VA) system provided pharmaceuticals bought inexpensively through direct negotiations.

The recent enactment of Part D Coverage under Medicare has gone a long way toward addressing the deficiency in drug coverage for the elderly. The literature on Part D is extensive, and its shortcomings are obvious, particularly as to the so-called "doughnut hole" (lack of coverage between $2,000 and $5,000, requiring out-of-pocket expenditures by patients).[42]

There remain some three to four million eligible individuals who have not received help under Part D.[43] Also, it appears that the Part D program is paying higher prices for prescription drugs than all other government programs.[44]

Still, the cost of pharmaceuticals under Part D will be significantly less than projected because of the expanded use of generic drugs and the lower than projected cost of bids by private drug plans. Indeed, the Congressional Budget Office projects that the prescription drug benefits will cost 26 percent less from 2007 to 2013 because of that factor alone.[45] Coupled with this lower cost is a dramatic decline in the growth of prescription drug spending overall in U.S. healthcare.[46]

Problems remain, however. For example, Medicare Part D drug prices for the top drugs prescribed to seniors are nearly 60 percent higher than prices paid for the same drugs by the VA.[47] For some drugs, prices in the top five Part D plans were more than 1,000 percent higher than VA prices.[48] The Centers for Medicare & Medicaid services claim that the comparison to the VA is not valid because the VA offers a narrower formulary, has a different benefit structure, and engages in negotiating prices.[49] However, these arguments simply highlight the reforms needed for Medicare. A proposal has been submitted by House Democrats to permit the United States Department of Health and Human Services (DHHS) to negotiate lower drug prices.[50] While some critics say this would not succeed, it is clear that the experience of the VA is to the contrary.

This detailed review of recent developments in the national program of Medicare is necessary because Part D impacts states. Many Medicare recipients are poor and receive drugs through state Medicaid programs. Pharmaceuticals have been available through Medicaid in virtually every state since Medicaid's inception. People who are dually eligible for Medicare and Medicaid can now obtain their drugs through the federal Medicare Part D program, relieving the states of a preexisting burden, but

subjecting states to new attempts by the federal government to reclaim the savings.[51]

This leaves a number of unresolved problems for the states with respect to pharmacuetical benefits. For example, states must provide funding (part of it federal) for the poor through their Medicaid and SCHIP programs. However, the rate of prescription drug usage varies greatly from state to state, with the lowest prescription drug usage in Alaska and the highest prescription drug usage in West Virginia, Kentucky, and Alabama.[52] The national average is 11.3 prescriptions per person.[53] Further, the amount spent on prescriptions varies enormously from state to state. There is no relationship between the health—or wealth—of a state and the amount spent on pharmaceuticals. Cost of pharmaceuticals is, thus, an urgent issue facing states, whether their citizens have public or private insurance.

The cost of pharmaceuticals remains, if not uniquely a state problem, then certainly and particularly important under Medicaid. States must move from simply paying the prices set by pharmaceutical companies to negotiating with companies for lower prices, much as the VA does.[54] As we shall see, a number of states have focused on solving this problem, particularly by interstate consortia or in-state purchasing options.

The states must also determine which pharmaceuticals are effective and which are cost effective. The states must also develop alternative approaches to medication to relieve conditions, which may be resolved by public health measures and rehabilitation or prophylactic measures, for such conditions as obesity, tobacco-related diseases,[55] or alcohol-related diseases. In the main, they have chosen formularies, pharmacy benefit managers, and managed care as stratagems for approaching these concerns.

B. Access: The Uninsured, the Mentally Ill, and Children

The term *access* has come to have a special meaning in healthcare. It could, quite literally, refer to physical access, as in getting to a hospital. Instead, it usually refers to the ability of a person to obtain healthcare

insurance—whether private or public. Insurance, thus, finances access to care and, in this sense, the problem of access is perhaps the most urgent one facing United States healthcare. It is particularly a state problem because services, such as hospitals and doctors, are either state funded or regulated.

1. The Uninsured

Over 47 million Americans lack healthcare insurance, whether private or public.[56] Nearly half of the uninsured work, and one would expect would qualify for insurance through their employment and employer. But the percentage of employers providing insurance has dropped from the previous high of 70 percent to below 60 percent in the last decade because the smallest and biggest employers are opting out of providing health insurance.[57] Indeed Wal-Mart, the nation's largest employer with over one million employees, provides little or no healthcare insurance to less than half of its employees.[58]

This deficiency is of such enormous proportions that it has generated responses from a number of sources. President Bush's State of the Union address on January 23, 2007, proposed a new federal grant program using existing healthcare funds to help states provide health insurance coverage to their citizens.[59] But some of the money would certainly have come from reducing payments to disproportionate share hospitals, which are an important part of the safety net that helps the poor and uninsured, and it is unclear where the rest of the funding would come from. Needless to say, the Democrats were unsupportive, as reflected in comments by Senator Edward Kennedy, the chairman of the U.S. Senate Committee on Health, Education, Labor, and Pensions.[60]

A large number of private groups have made proposals to address the lack of coverage for 47 million Americans. The Health Coverage Coalition for the Uninsured developed a six-point proposal, emphasizing coverage for children first and longer-term public and private sector proposals later.[61] The largest medical benefits provider in the country, WellPoint, has

undertaken to expand enrollment in existing programs and to expand those programs to provide coverage for parents and families earning up to 200 percent of the federal poverty level (FPL).[62]

The principal response has come from states, rather than from the federal government or private sources. Medicare, Medicaid, and SCHIP are, by definition, limited programs; those who fall outside of their limits fall into the safety net of the states, if one exists. Moreover, administration of Medicaid is left to the states, and much of the administration of Medicare is undertaken by fiscal intermediaries such as insurance companies like Blue Cross, who are themselves regulated by the states. Both Medicare and Medicaid deliver services through hospitals and other providers licensed by the states.

Because most hospitals are chartered under state law and enjoy charitable status under state law, expanding their services to the poor is uniquely a state opportunity. Expanded funding under Medicaid and SCHIP is the clearest response. In addition, state attorney generals can assure that hospitals provide significant care to the poor or uninsured as a condition for keeping their tax exempt status. Helping in this effort are the new federal Internal Revenue good governance practices for 501(c)(3) organizations, released in 2007.[63] While the Internal Revenue Service (IRS) lacks authority to impose governance standards for exempt organizations, it does have authority to impose guidelines. Among the proposed guidelines are ethics codes, board due diligence, transparency, controls on compensation decisions, and modern information systems.[64] IRS oversight of not-for-profit organizations has the potential to lend impetus to vigorous state prohibition on discriminatory activities.[65]

Similarly, insurance companies are chartered and regulated by the states. Some insurance companies such as Blue Cross and Blue Shield enjoy not-for-profit status. It is possible for the states to mandate rates, coverage provisions, high risk pools, and non-discriminatory policies—all of which would go a long way toward expanding financing and healthcare access for

the uninsured. Such mandates are especially crucial and contentious for the mentally ill, the subject of the next section.

2. The Mentally Ill

As with the uninsured, the mentally ill are uniquely a concern for the states. Traditionally, states have provided care through institutions, but the move toward community-based mental health treatment has left support chiefly to Medicare disability programs or Medicaid. For the past two decades, reform efforts have been directed at extending employer-based private insurance coverage and benefits to the mentally ill. In February 2007, the proposed Mental Health Parity Act of 2007 was offered in Congress to remedy this deficiency, and it required businesses with more than fifty workers to provide mental health coverage.[66] Even if successful, the act would not reach those who are unemployed, and it contains a cost exemption for businesses if they are projected to have increased healthcare costs exceeding 2 percent of total plan costs.[67]

The extension of benefits to the mentally ill is, constitutionally, a state matter. A number of states have mandated parity for mental health benefits, when compared to physical health benefits. Such a bill was signed by Ohio Governor Robert Taft on December 29, 2006.[68] The bill requires insurance companies to offer mental health benefits comparable to those of the benefits offered for physical disease.[69] But as with bills elsewhere, there are opt out and hardship exceptions.[70] Once again, as with the unemployed and uninsured, private insurance reaches only a limited number of those in need.

A point of special importance to the mentally ill is the availability of medication. Elsewhere, this article discusses the availability and inadequacy of pharmaceutical benefits through public and private healthcare coverage. Drug benefits are of crucial importance to the mentally ill because, over the past two decades, treatment of mental illness has shifted from institutions to pharmaceutically based care. The cost, as a result, has

been shifted from the state to the individual, and the cost of psychotropic or antidepressant drugs is prohibitively expensive.

3. Children

Finally, expanding healthcare for children is an important agenda item for states. Children have been covered by Medicaid since its inception. In 1996, as a part of the Clinton welfare reform, a new program was added: the State Children's Health Insurance Program. States have been enthusiastic participants in SCHIP, reaching children who would otherwise have gone without coverage because their parents did not meet income eligibility for Medicaid. States continue to add funding and children to SCHIP, most recently with the budget adopted in New York, which would give coverage to an additional 400,000 children.[71]

Funding remains a problem at a national level, however. A coalition of national advocacy groups sent a letter to Congress on February 12, 2007, calling for $60 billion in new funding for SCHIP.[72] Among the members were the Georgetown University Center for Children and Human Development, the American Academy of Pediatrics, and the March of Dimes. In September, the House and Senate approved $35 billion.[73] The debate between Congress and the White House continued with Congress approving a SCHIP expansion based on increased taxes on tobacco and reduced funding of Medicare Advantage (managed care). President Bush vetoed the bill on October 4, 2007. No one expected an override to be possible, and both sides anticipated continuation of SCHIP into the presidential campaign.[74]

A further problem for individual states with SCHIP is unpredictability due to the national cap on federal funding. States cannot tell whether they will be fully funded, while funds for other states may lie unused at the end of the year. The problem is highlighted by the experience in Georgia in 2007. In that case, the program was expected to be bankrupt by March due to a funding shortfall of $131 million in the federal share, which could have

led to the closing of many children's programs.[75] Georgia's experience is typical of another funding difficulty with SCHIP, which tends to award more money to states that insure fewer children. Under this approach, in 2004, more than $1 billion of unused funds was returned to the federal treasury, at a time when seventeen states are now projected to have shortfalls in fiscal year 2007.[76] On January 15, 2007, President Bush signed a law temporarily solving some of the expected funding shortfalls by redirecting $271 million from states with unspent funds in 2004 and 2005.[77]

The challenge for the states lies in the simple membership of SCHIP. SCHIP reaches only about 70 percent of its target population.[78] Nearly 20 percent of children are excluded because of their immigration status.[79] Some 4 million uninsured children appear to be eligible for Medicaid but remain uninsured.[80] The majority of current enrollees are not eligible for coverage through parents because their parents lack employer-sponsored coverage.[81] In addition, the number of children eligible for employer-sponsored coverage through their parents and the number of enrollees with uninsured parents also impacts the number of children eligible for coverage under Medicaid."[82]

Despite these shortfalls, or perhaps because of them, SCHIP offers an important opportunity for the states. The states have the option of expanding coverage in important ways, not only for children, but also for adults who would be uninsured otherwise—a major underserved population. Fourteen states now cover adults under their SCHIP programs and nine of those expect a funding shortfall in fiscal year 2008.[83] Coverage of adults under the SCHIP program exceeded the number of children covered in Arizona, Michigan, Minnesota, and Wisconsin in fiscal year 2005.[84] An important question is, thus, whether covering adults is necessary in order to reach children or whether covering adults under SCHIP deprives children of valuable health insurance coverage. One aspect of this debate has been whether, with limited funds, states should limit coverage, thereby posing a

risk that parents would not take children for medical care if they were responsible for deductibles or copays of substantial size.[85]

Paradoxically, perhaps predictably, SCHIP has become a major ideological battleground between state reformers and national-level conservatives. The latter group views expansion of coverage through SCHIP as a creeping process toward universal coverage. State efforts to raise the eligibility of individuals covered under SCHIP by raising the age levels of children who can be covered by SCHIP; raising the income of homes to two, three, and four times the FPL; and by adding parents have been met by furious opposition. The ideology is apparent in the concern of national conservatives that such efforts will "crowd out" private insurance companies because customers will cancel their policies and use public insurance instead.[86]

C. The Quality Chasm[87]

The national debate over healthcare reform has focused largely on funding and access. But in the end, as in the beginning, what people are looking for is quality. Certainly, that is true of patients and parents. It is also true, upon reflection, of administrators and providers. The measure of whether costs are justified remains quality—that is, necessity and effectiveness of care. Medicare has tried, through managed care approaches, to control quality by prior authorizations, concurrent review, chronic case management, and drug formularies. While managed care has largely receded in the private sector, it continues to receive emphasis on the national level through the Medicare Advantage programs and, on the state level, through managed Medicaid, which now is the dominant pattern for state healthcare. This adds to cost but does have an impact on quality. While studies indicate that Medicare Advantage is more expensive than Medicare fee-for-service programs, both in administration and expenditure, it remains a potential force for quality in healthcare delivery.[88]

Still, it seems clear that Medicare and Medicaid have failed to assure even basic safety in healthcare, and the need and opportunities for improvement through state initiatives are substantial. Avoidable medical errors in American hospitals annually run about 3 percent of Medicare admissions—an incidence rate that is rising, leading to 250,000 Medicare patient deaths over the last three years.[89] The excess cost was $8.6 billion.[90] The causes of error include failures in traditional patient care, such as foreign bodies left in patients post-surgery, bedsores, sepsis, and respiratory failure after surgery.[91] These errors occurred in state-regulated hospitals, and it may be assumed that experiences for Medicaid patients are similarly defective.[92] Safety then, is high on the state agenda for healthcare reform.

We will look below at three areas of state initiative: pay for performance, evidence-based medicine, and transparency. Several important points need to be noted. First, these approaches have been principally developed by private players, insurers, or nonprofits. Second, there are related initiatives—for example, in-store limited service clinics or mail order pharmaceuticals services—which increase ease or access to healthcare and thereby improve quality. But, most importantly, quality for all is compromised where coverage—as is now the case—is denied to many, and so the discussion in section II(b) above directly bears on the quality chasm.[93]

1. Pay for Performance

Both public and private insurers emphasize three areas with respect to quality and safety. First, is the pay for performance movement. Third-party payers may set quality standards and then provide incentive payments to hospitals, physicians, or other providers to induce them to meet performance standards.[94] In 2007, several bills in Congress held promise of raising quality and safety, and lowering costs by paying hospitals for improved performance.[95] Physicians reporting quality information will receive about $300 million in Medicare bonus payments under a new law

signed in December 2006 by President Bush.[96] The doctors who report quality data, known as quality measures, will receive a 1.5 percent bonus payment.[97]

The American College of Physicians advocates a variant of this program to expand and enhance the role of primary care physicians in a coordinate care medical home. This program was the subject of an eight state medical home demonstration in 2006 and 2007. As with Medicare, a number of states are attempting pay for performance with their Medicaid programs, with over half of the states now doing so.[98] The Congressional Research Service has concluded there is little evidence that pay for performance programs save money in the long run. To the contrary are the views of Peter Orszag, director of the Congressional Budget Office, who concludes that encouraging "best practices" could save one-third of America's $2.1 trillion annual healthcare expenditures.[99]

Common sense suggests good care leads to good health and less cost—a double priority for the states. The Institute for Healthcare Improvement estimates there are 15 million healthcare harms annually. Some 85,000 patients die annually from hospital-based infections. These infections cost the health care industry an additional $5 billion each year. These cost hospitals $13,000 each, and third-party payers nearly $10 billion annually.[100]

2. Evidence-Based Medicine

To assure good quality prospectively, practitioners seek to practice sound medicine, as proven by evidence. The term *evidence-based medicine* has repackaged an old concept: use only proven methods. The new emphasis, however, employs new demographic and epidemiologic and computer-driven capabilities. And so, cost can be driven down, quality can be improved, and health enhanced.

Perhaps the most active proponent of evidence-based medicine has been in the private sector by the Institute for Healthcare Improvement (IHI). Its

approach is to identify and encourage basic best practices, resulting in what it believes will be 100,000 lives saved annually using this approach.[101] As mentioned earlier, preventable deaths in hospitals are a major concern for the quality of medicine. The Institute of Medicine studies have established that approximately 100,000 lives are lost in hospitals through negligence each year,[102] and Center for Disease Control studies have estimated that 2 million patients are needlessly infected annually in hospitals.[103]

IHI launched two campaigns—100,000 Lives Campaign and 5 Million Lives Campaign—to encourage hospitals to adopt best practices based on evidence-based medicine.[104] For the 100,000 Lives Campaign, hospitals were encouraged to take steps that included forming rapid response teams, reducing heart attacks, reducing adverse drug events, preventing central line infections, preventing surgical site infections, and preventing ventilator-associated pneumonia.[105] The 5 Million Lives Campaign addressed new concerns: high alert medications, surgical complications, pressure ulcers, staph infections, congestive heart failure, and hospital Board of Trustee involvement.[106]

The IHI efforts have produced demonstrably favorable results. Having done so, the opportunity is presented for states to capitalize on the experience generated. To repeat the point made several times earlier, hospitals and physicians are licensed and regulated by the states, who also pay some 40 percent to 60 percent of their bills—providing powerful tools for effecting quality.

3. Transparency

Transparency, like pay for performance and evidence-based medicine, is a market-driven approach to quality. One example of transparency took place in Oregon, where a Web site was recently created that lists the actual charges of a dozen hospitals for approximately twenty procedures, giving consumers data essential to effective decision making.[107] This enables consumers to shop for the price factor in healthcare. Consumers can also

consider the quality factor by learning of the experience and error rates of providers. By making such information available, the states can capitalize on an aspect of the pay for performance movement that involves value-driven healthcare coupled with transparency.[108] Transparency means maximum disclosure of performance and price data, which facilitates choice by consumers.

The National Committee for Quality Assurance (NCQA) has taken steps to require that providers report quality of care data under requirements issued on February 15, 2007.[109] NCQA uses the same standards, clinical measures, and patient experiences to evaluate health maintenance organizations, preferred provider organizations, and point of service plans. The result is a consistent spectrum of public disclosures designed to help people make informed choices. In doing this, NCQA uses the Health Plan Employer Data and Information Set criteria, which states can incorporate in their reform efforts.[110]

Transparency is also a value that has gained currency in legislation. Georgia's governor signed an executive order encouraging businesses to share healthcare quality and cost information with beneficiaries.[111] This will also encourage health insurance providers and third-party administrators to share pricing information. Similar steps have been taken in Tennessee, pursuant to federal initiatives calling for reporting quality of care data and public reporting of price of care.[112]

Transparency has become a tool for the Centers for Medicare & Medicaid Services to improve quality and safety for Medicare beneficiaries.[113] One result is the Better Quality Information project, which is an effort to aggregate Medicare claims data and make the resulting information available to Medicare beneficiaries so that they may make informed choices among providers.[114] Another result is the Performance Measurement and Reporting System, which collects performance data on hospitals and physicians from insurers for a public database. Obviously, privacy and accuracy issues are involved in such a process.[115] Yet transparency, in

affording comparative insurance coverage data or practitioner performance data, can be uniquely subject to state legislation and administrative purview. Because much of the "shopping" for healthcare is actually done by third-party payers, they—along with the states—are in the best position to report on and rate providers such as hospitals and physicians.[116]

In closing, an agenda for action by the states includes three areas for concern: services, access, and quality. The preceding analysis makes clear that much remains to be done in these areas. It is clear that these are not areas that are of exclusively federal concern because they are of equal importance to states, private providers, and consumers. Many of the state initiatives respond to opportunities presented by federal funding, but many are directly based on state constitutional powers over taxation and health and welfare. In the discussion which follows on state initiatives, therefore, it is important to consider in what ways states may act more broadly and powerfully than the national government in dealing with common, shared problems.

III. STATE INITIATIVES

As the preceding discussion makes clear, in any agenda for action, states are already extensively engaged in incremental reforms. In this section, we consider more fundamental, systematic reform. Without exception, states are concerned about the range of healthcare services, the access of citizens to obtain these services, and the quality of the services.

The preceding discussion sets the context within which states can act, either with federal funding and federally granted latitude or independently, by generating state funding using taxes or by mandating private funding. The latter is perhaps the most significant. Several states such as Massachusetts and California have taken major steps towards universal healthcare by mandating that citizens purchase insurance, that employers either provide insurance for employees or be taxed if they do not, and that insurers make available affordable policies for people of limited means.

Mandates have also been directed at insurance companies to create high risk pools for those who cannot purchase health insurance. Thus, the most dramatic reforms have been made either by tapping local and state funds held by citizens or by tapping the treasuries of employers, many of whom have previously opted out of the system of privately provided health insurance coverage for employees.

A. Universal Coverage

1. The Central Place of Employers

In approaching health reform, each state must deal with a central problem: determining the place of employers in providing healthcare insurance, not only to their employees, but also to the uninsured within a state. One crucial aspect of the American healthcare system is the central place of employers.[117] In the 1930s, with the advent of healthcare insurance, it became possible to provide stable income to doctors and hospitals and to provide assurance of healthcare to the insured. The mechanism for doing so was through the employer. An employer would purchase health insurance as a benefit to the employee, which provided the employer with a tax deduction and the employee with tax-free benefits.

In this decade, the wisdom of this arrangement has come under serious question. The cost of healthcare has driven up the cost of healthcare insurance, causing many employers to question whether they can provide healthcare coverage to their employees. The average annual premium for a family increased from $6,722 in 2000 to $10,728 in 2005, and premiums increased 60 percent for employers.[118] The percentage of employers providing insurance to their employees has dropped from nearly 70 percent to 60 percent.[119] More troubling, the percentage of employees without employer-based insurance increases as income decreases.[120] Ninety percent of those earning more than three times the minimum wage had access to

job-based coverage; only 42 percent of employees earning minimum wage had access to employer-based coverage.[121]

A pattern is emerging where employers provide large wage increases and large benefit decreases.[122] Employers may also increase contributions required of an employee toward healthcare benefits. As a consequence, a recent Kaiser Family Foundation study established that many employees opt out of healthcare coverage.[123] There is a differential that disfavors employees in smaller companies and lower income categories.

As noted above, many proposals in Congress would abolish or severely restrict the role of employers in providing healthcare coverage on the ground that the mechanism is failing. But a contrary approach would be to make the system work. In fact, all states keep employers in the mix. The employer may be viewed as an important administrative unit, an advocate for good healthcare, or a source of valuable funding.[124] Otherwise, a state would need to expand its bureaucracy and public funding to undertake the role played by employers. Even if all employees are afforded healthcare, and the state expands its Medicaid and SCHIP coverage, the state remains a long way from providing universal healthcare, at least within its borders.

The central role of employers in state reform efforts is validated by a Robert Wood Johnson Foundation report, "State of the States 2007: Building Hope, Raising Expectations."[125] The report extensively summarizes the innovative policies of a dozen states. Among these are comprehensive healthcare reform in Massachusetts, Vermont, and Maine; public-private partnerships in Arkansas, Montana, New Mexico, Oklahoma, Rhode Island, Tennessee, and Utah; and children's initiatives in Illinois and Pennsylvania.

A number of states have undertaken public-private partnerships.[126] These partnerships are significant because they keep employers in a central position to purchase insurance, provide insurance to employees, and expand the numbers of individuals covered.[127] Essentially, each state attempts to make existing health insurance cost less and be available to more low-

income citizens. State attempts include subsidizing private insurers, creating a pool of coverage available to low-income workers, and creating high-risk pools or new premium assistance programs. As noted earlier, this evidence demonstrates the state commitment to keep employers and insurers as mainstays of expanded coverage, going a long way toward universal coverage.

In addition to partnerships, states have attempted to mandate that employers, particularly large employers, provide coverage for employees or be taxed. This is the "play or pay" approach. The largest national employer is Wal-Mart, and the most dramatic instance of a mandate has been that of the so-called Wal-Mart bill in Maryland. There, Maryland's requirement that employers with more than 10,000 employees spend at least 8 percent of their payroll on healthcare was invalidated by a federal court of appeals on the grounds that the bill violated federal strictures under the Employee Retirement Income Security Act.[128] The Wal-Mart decision raises doubts about mandates and the effort to compel employers to purchase insurance for employees. But, as discussed below, giving an employer the option to purchase or to pay a tax as part of a comprehensive scheme is a sound strategy to expand the scope of healthcare coverage.

At the opposite end of the spectrum from the mandates is the effort to create purchasing pools, which would enable states to buy healthcare products, chiefly pharmaceuticals, at a low price, and then make the products available to their citizens. Voluntary purchasing pools as a stand-alone strategy are unlikely to be sufficient to expand coverage,[129] but voluntary purchasing pools are likely to make pharmaceuticals more affordable. However, the Robert Wood Johnson Foundation report summarizing the healthcare program in Massachusetts and the purchasing pools in California and Florida provides evidence to the contrary.[130]

While some states concluded that pool buying might not improve the quality of healthcare, other states have purchased pharmaceuticals similar to the approach taken by the VA. While the experience has been mixed,

Maine, New Hampshire, and other states provide some hope for the public through state purchasing pools. State purchasing pools may succeed where employer mandates fail because funding for the pools, although limited, is secure, whereas funding of mandates imposed on insurance companies or employers must be generated by insurance premiums.

2. Comprehensive Reform: California

Although Massachusetts has received the most national attention, the state effort that warrants most scrutiny is that of California. Size matters. Both states' efforts are attempts to provide private health insurance coverage for all citizens, which—coupled with Medicaid, Medicare, and SCHIP—would go a long way toward the national health coverage of countries of comparable size. Governor Schwarzenegger's plan would require every one of California's 6.5 million uninsured residents to have health insurance by using a combination of funds from individuals, employers, providers, hospitals, and state and federal sources.[131] The estimated cost of this plan is $12 billion.[132] The complex plan would require employers to provide insurance to workers or pay into a state purchasing pool. In addition, California plans to insure illegal immigrants.

The California proposal would require all individuals to secure insurance at least at the level protecting against catastrophic costs.[133] The poorest citizens would receive coverage through Medicaid and SCHIP. One million residents with incomes above the FPL but below 250 percent of the poverty level, would be eligible for coverage through a state purchasing pool and would make premium contributions toward Medi-Cal coverage of between 3 percent and 6 percent of their gross income.[134] Employers with ten or more workers would either provide coverage or pay 4 percent of their payroll into the state's purchasing pool.[135]

Governor Schwarzenegger's proposal has a number of other features, including cafeteria-style plans, health savings accounts, and increased reimbursement for healthcare providers. From their increased

reimbursement funds, physicians and hospitals would pay a dividend to help fund the state-run purchasing pool.[136] Future reimbursement rates would be tied to specific performance measures, much like those initiated at the federal level.

The $12 billion cost of the California plan is to be covered by $5 billion in new federal funds, $3.5 billion from providers in hospital dividends, $2 billion in shifting funds now used to pay disproportionate share hospitals, $1 billion in employer fees, and $203 million in other funding.[137] The expanded federal funding would come from Medi-Cal and SCHIP.

Not surprisingly, criticisms have been directed at the imposition of dividends on providers; the shifting of funds from disproportionate share hospitals (which are part of the safety net for the poor); and dependence upon increased federal funding at a time when that funding is being cut dramatically. A Republican proposal seeks to redirect money from tobacco taxes to help fund an expansion of clinics and would not require employers to provide coverage or mandate that all state residents obtain insurance.[138] Insurers have particularly opposed Governor Schwarzenegger's plan because it bars them from spending less than 85 percent of premium revenues on direct patient care.[139] Others have raised questions about whether an existing waiver for hospital care under Medicaid can be expanded or continued, without which much of Schwarzenegger's plan would collapse.

A particularly problematic aspect of Schwarzenegger's proposal is that it requires one million uninsured adults without legal residency to have insurance. These individuals would not be eligible to purchase insurance in the state purchasing pool. Approximately 40,000 undocumented individuals would obtain employer-sponsored coverage; 160,000 would buy individual coverage; and the remaining 750,000 under 250 percent of the FPL would be the responsibility of the counties.[140] They would retain $1 billion in disproportionate share hospitals funds, and the University of California hospitals would retain another $1 billion.

Another problematic aspect of the California proposal is selecting ten counties to receive $540 million over the period from 2008 to 2011 as part of the "coverage initiative." The coverage initiative is tied to a Medicaid waiver, which is also tied to hospitals' "financing waivers." The aim is to extend hospital coverage to 180,000 uninsured individuals. But, the hospital "waiver" impacts already depressed hospital revenues and, thus, the financial capability created is dubious.

One difficulty with ambitious efforts, such as those of Governor Schwarzenegger, is that building on private insurance leaves the insurers free to set premiums, set rates, and to drive up costs. On June 7, 2007, the California Assembly passed legislation (A.B. 1554) that would impose a prior approved rate regulation scheme similar to the property/casualty insurance scheme.[141] As of mid-October 2007, when this article was being finalized, Governor Schwarzenegger had called a special session of the legislature to consider a revised bill which would lead to a constitutional amendment. The new bill removes some of the earlier funding burdens, such as the 2 percent fee on doctors and fees on individuals. It also provides lottery funding and expands individual healthcare insurance.[142]

While California's effort is ambitious in scope and monumental in its numbers, only Massachusetts has moved well into the implementation phase. We will now turn to that state's reforms.

3. Comprehensive Reform: New York and Massachusetts

Three other states have undertaken approaches that may lead to universal healthcare: New York, Vermont, and Massachusetts.[143] In New York, Governor Spitzer has proposed a budget guaranteeing access to health insurance for an additional 400,000 uninsured children and streamlining an enrollment process for Medicaid that would add 90,000 adults over the next four years.[144] Spitzer also proposes bargaining to reduce prescription drug prices and shifting care from nursing homes toward community alternatives. Funding, in part, will come from reducing Medicaid spending on medical

education and freezing Medicaid reimbursement rates for hospitals and nursing homes.[145]

All of the steps are part of a pathway towards universal health coverage, developed in a report released December 19, 2006, by the United Hospital Fund and the Commonwealth Fund called "A Blueprint for Universal Health Care Coverage in New York."[146] The report estimated that universal coverage would cost an additional $4 billion a year.[147] The authors concluded that the task in New York was more difficult than that in Massachusetts because New York has less employer coverage than Massacusetts and has more people who are currently uninsured.[148] The proposal in New York, as in Massachusetts, would require all individuals to have or obtain health insurance. Assessments on employers would provide incentives to offer coverage directly and raise some of the revenue needed to finance other expansions.

It is not a surprise that there has been resistance to the Spitzer proposal. In February 2007, the Healthcare Association of New York State declared that the proposed federal budget would reduce Medicare payments to New York hospitals by $2.8 billion over five years and would similarly lower Medicaid funding. Medicare and Medicaid are major sources of hospital funding, and such reductions in funding would cripple any effort to add to hospital burdens; however, such reductions seem highly unlikely.

The New York and California proposals for healthcare reform must be compared with the successful efforts in Massachusetts, which have received extensive national attention. Put simply, Massachusetts will require every citizen to have health insurance. Much of that coverage will come through Medicare, Medicaid, or employer-based insurance. For those who are left uninsured, a state pool will be created.[149] Implementation has not been easy. However, reviewing those difficulties is instructive, and the lesson to be learned is that the Massachusetts approach will succeed and can be emulated elsewhere.

The chief difficulty with healthcare reform has not been with respect to structure but rather to content. Massachusetts was to have a panel set minimum standards for insurance, but on January 22, 2007, a panel decided to delay issuing final recommendations after learning that prices for premiums could average $380 per month. That fee would be assessed on those earning 300 percent of the FPL. Those earning less than 100 percent of the FPL would receive free health insurance, while those between 100 percent and 300 percent of the FPL would receive subsidized coverage.[150]

The Massachusetts board decided to postpone a vote on "minimum creditable coverage." Minimum creditable coverage would provide protection only against catastrophic costs with some provision for preventive care. Out-of-pocket maximum payments would be $5,000 for individuals and $10,000 for families with maximum deductibles of $2,000 for individuals and $4,000 for families. There would be deductible coverage for three routine doctor visits for individuals and six for families. The president of the Massachusetts Association of Health Plans expressed concern that the recommended minimum standards might impede the ability of Massachusetts to make affordable coverage available.[151]

On February 8, 2007, the Massachusetts panel decided to consider allowing carriers to offer plans that do not carry coverage for prescription drugs. The panel requested bids for plans with and without prescription drug coverage. The decision provoked controversy, as did issues concerning part-time and seasonal employees and whether companies may terminate plans if and when the payroll drops below ten workers. In March, the Commonwealth Health Insurance Connector Authority recommended that nearly all plans be required to offer drug coverage, with minimum standards phased in during 2007, and that all residents be required to purchase a plan by September 2008.[152] Two plans would be offered: one with a $250 dollar deductible for individuals or $500 per family, and one with first dollar coverage for chronic conditions. Eighty-six thousand

residents had insurance with no drug benefits, and this would cost about an additional 10 percent in premiums.[153]

This brief, and yet complicated, account of the Massachusetts process illustrates the difficulties in moving toward universal healthcare by using employer or privately purchased health insurance. The responsible agency must determine minimum coverage, estimate costs from private insurance carriers, determine what people can afford, and then revise the process. Yet, keeping employers in the mix seems essential to states such as California and Massachusetts because employers provide a source of funding and of administration. They can also shop for good insurance products for their employees, thus, becoming surrogates in the marketplace for both the patients and the government.

Perhaps the most unpredictable, yet crucial, aspect of the Massachusetts plan is assuring that residents will, indeed, obtain insurance, either through employment or direct purchase. This means keeping cost down while expanding coverage. Most recently, the Commonwealth Health Insurance Connector Authority postponed the minimum standards for acceptable coverage until 2009, and will allow residents to be in compliance if residents obtain coverage under any existing insurance plan during 2007.[154]

Massachusetts is farthest along the path to providing universal healthcare and is confronting issues inherent in an effort to create universal healthcare with limited funds and limited funding.[155] Although it seems like a series of false starts, the Commonwealth is making progress: by February 2007, 100,000 of the 370,000 Massachusetts residents who lacked health insurance had obtained coverage since the law took effect in July 2006. About 55,000 individuals were covered by expanded Medicaid, and another 45,000 became enrolled in the state subsidized Commonwealth care plan, most transferring from the state free pool. The uncompensated care pool or Medicaid provided coverage for 166,000 workers employed by employers with fifty or more employees during 2006.[156] That was a 4 percent rise.

Under the new law, employers with eleven or more workers are now required to pay a fee of $295 per employee if they fail to insure 25 percent of their workforce. For two years in a row, Stop & Shop Supermarkets and Wal-Mart headed the list of employers with more than 3,000 uninsured employees. As noted above, a recent decision, *Retail Industry Leaders Association v. Fielder*,[157] raises questions that may have relevance to Massachusetts. Essentially, the Maryland act had provided that any employer with more than 10,000 employees must spend at least 8 percent of its total payrolls on employee health insurance costs.[158] The act was crafted to cover Wal-Mart, which had employed over 16,000 Maryland residents.[159] The court of appeals concluded that the Maryland act was preempted by the Employee Retirement Income Security Act and was, therefore, not enforceable.[160] Not surprisingly, Wal-Mart has joined a healthcare reform initiative committed to the proposition that the employer-based healthcare system is dead.

The Massachusetts approach seems headed for success and is being closely watched elsewhere.[161] It provides a model for universal healthcare that keeps private players in place by using state initiatives complemented by federal programs. Its continued success could be jeopardized, paradoxically, by those who propose national reforms abolishing the role of employers and insurance companies. They are, however, unlikely to succeed.

B. Children

The state efforts detailed above seek broadly to emulate the universal healthcare coverage of many nations such as Britain, Canada, Australia, and New Zealand. Those nations achieve coverage through direct government provision of services with a parallel private system available if citizens so choose. California, New York, and Massachusetts instead match government programs with private insurance, requiring provision by employers and purchase by citizens.

A number of states have undertaken more focused reforms, targeting disease agents such as tobacco, or vulnerable populations such as children. Most notably, some states, like Minnesota, Washington, and Tennessee, have expanded enrollment, funding, and eligibility under federally funded programs such as Medicaid and SCHIP. The Minnesota governor proposed expanding eligibility to cover children and families earning 300 percent or less of the FPL and reducing premiums by about 50 percent for children. The governor also proposed rolling in a private sector option for families earning at least 200 percent of the FPL. A family of four earning 225 percent of the FPL would save nearly $2,000 in premiums annually.[162] The governor of Washington requested an additional $31 million to expand healthcare to reach 32,000 children who are currently without insurance coverage.[163] In addition, the Washington Blue Ribbon Commission on Health Care Costs and Access proposed that the state pay for care that provides the most appropriate, highest quality treatment in the most cost effective way.[164] Similarly, Tennessee expanded its SCHIP to reach families with incomes up to 250 percent of the FPL, which is currently about $50,000 per year for a family of four. The benefits would be modeled after the state employee health plan,[165] and there would be no premium costs to the insured individuals.

Importantly, some states have also imposed mandates on private insurance carriers, as in the universal healthcare states discussed above. In May 2007, Maryland mandated that health insurance carriers provide family insurance coverage to child dependents until age twenty-five, including dependents of a domestic partner. Other states have expanded benefits by expanding incentives to private carriers for coverage of children.

It seems clear that a focus on children is a compassionate, efficient use of limited funds. Healthy children make healthy students, who make successful citizens. Expanding care for the young is the most cost-effective investment available in healthcare. This is one of the many instances where expanding healthcare has the potential for reducing costs.

Nevertheless, state efforts to expand SCHIP enrollment have been met with increasing national opposition. This is true even though many states have simply tried to enroll eligible children—about 5.5 million of whom are not receiving SCHIP benefits.[166] About one-third of these children live below the poverty line, and the majority of these children are minorities. Congress is contemplating reauthorization of SCHIP at $35 billion. This would keep coverage for 6.6 million children, plus add coverage for 3.2 million children,[167] which would effectively be a *reduction* in the present, fully eligible pool. Thus, Congress is failing to capitalize on the potential for improving children's healthcare.

More troubling than funding for SCHIP is the political opposition to states that exercise their autonomy by enlarging access to healthcare by expanding eligibility criteria for children or by adding parental coverage. According to a recent report by The Commonwealth Fund, there are 13 million people age nineteen to twenty-nine without insurance living 200 percent below the FPL. The Commonwealth Fund report recommended that age nineteen no longer be the pivotal age when healthcare benefits—public or private—are lost.[168] Nearly twenty states now mandate higher ages. A number of states have also added SCHIP coverage of parents to eliminate the anomaly of a home where children have access to healthcare but parents do not.

All of this has provoked substantial backlash, although these methods are clearly contemplated by the federal, block grant nature of SCHIP. The ranking member of the Senate Finance Committee, Senator Chuck Grassley, a Republican from Iowa, asked the Bush administration to reject New York's request to increase SCHIP eligibility to four times the FPL, which would have extended benefits to a family earning $80,000 per year.[169] Similarly, on August 17, 2007, the Centers for Medicare & Medicaid Services sent a letter to state administrators insisting that states take steps to limit enrollments and not "crowd out" private insurers.[170] Among these suggestions were to have states institute year-long waiting periods, limit

financial eligibility to 250 percent of the FPL, impose cost sharing, prevent employers from changing dependent coverage, and assure that the percentage of employer-covered children does not decline by more than 2 percent.

The critics of SCHIP expansion see expansion as an incremental move towards universal healthcare. If the age of participants increases and financial eligibility expands, the increases in enrollment may link up with other innovations to lower the age of eligibility for the elderly under Medicare.[171] This, they complain, would eliminate—or "crowd out"—private insurers. But even if this is true, it is far from clear that this is a bad thing. Private insurers are so enmeshed in the American healthcare system that it seems likely that they would continue to participate—and profit.

The wisest strategy for the states would be to continue to prod Congress to reauthorize SCHIP, which is due for final review in September 2007, at as high a level as possible, and then augment that finding with ample state funds. Everyone agrees that the 1996 creation of SCHIP was one of the best developments in American healthcare since Medicaid. And if it grows as the children grow, then indeed universal healthcare, or something close, will result.

C. Drugs

The earlier discussion analyzed, in some detail, the recent expansion of Medicare through Part D drug coverage. Medicare is a federal program that covers chiefly retired workers. That leaves 250 million other Americans to obtain healthcare coverage through other methods such as through the VA, through private insurance, through state-based programs, or through private payment. Even Medicare recipients pay, on average, over $2,000 per year for medications. Clearly, the provision and cost of pharmaceuticals are important aspects of access to healthcare.

States have authority to expand coverage through programs such as Medicaid, to drive down costs through bulk buying and consortia with other

states, and to negotiate prices for formularies on behalf of its citizens. Washington and Oregon have formed a consortium for joint purchasing of pharmaceuticals in order to reduce price and cost.[172] The new Northwest Prescription Drug Consortium signed a contract with ODS Corporation pursuant to which the states can negotiate with drug companies for the lowest possible drug prices. Employers and uninsured individuals are eligible.[173]

In February 2007, Colorado's Governor Ritter signed a bill enabling uninsured Coloradans who do not qualify for Medicaid or for the basic children's plan and who earned less than 300 percent of the FPL to buy drugs at state negotiated lower prices.[174] The state will negotiate lower drug prices with manufacturers of generic medications. Pharmacies can then voluntarily sign up to participate in the program and sell the medications to Coloradans who enroll. Up to 10,000 types of prescription drugs could become available.[175] A similar effort has been in play in New England for nearly three years with significant success.[176]

These are quite diverse approaches. Obviously, any effort directed at reducing the cost of pharmaceuticals is worthwhile. That sector of the healthcare budget is the one which, over the past decade, has experienced the greatest inflation. As the population ages, demand for multiple pharmaceuticals will only increase. In addition, increased demand is driven by the development of new pharmaceuticals that make surgical interventions unnecessary. As with innovations concerning children, discussed above, healthcare dollars invested in driving down the cost of pharmaceuticals often generates a genuine impact on the health and well being of an important segment of the public.

The model for the states is the VA, which for years has negotiated reduced rates and bulk purchases for its facilities and clientele. The result has been a substantial cost savings. The same is possible at the state level, as a number of states have demonstrated.

This summary of state activity, beginning with universal healthcare and ending with pharmaceutical benefits, is necessarily selective because there is varied and intense activity in virtually every state. Moreover, the discussion above is focused principally upon the ferment and movement over the past few years and includes many executive and legislative proposals which may not be adopted. Nevertheless, this picture presents a useful portrayal of what concerned policymakers and stakeholders have viewed as both important and possible. And, of course, much of what has been sketched here has, in fact, been adopted and implemented by at least a few states. And they, in turn, provide a roadmap and hope for the others.

IV. CONCLUSION

This picture is one of promising activity, of attention to expanding financing, and provision of services[177] to vulnerable populations. At the beginning of this article, the crisis in quality was highlighted as an urgent problem facing healthcare in the United States. States can do much to solve that problem by employing techniques of managed care, which is used by Medicare and private insurance,[178] and by employing techniques of improving best practices, through private initiatives, which will hopefully influence public agencies and programs. The most important initiatives by the states have been to expand access and coverage in ways that add little to the national expenditures and will go a long way toward reaching the single most chronic problem in American healthcare: reaching the uninsured and providing them with with access to healthcare by expanding mandates on employers and insurance companies. States have also shown initiative in funding programs for children by expanding funding under SCHIP and maneuvering through that program's pitfalls.

What can be said of what has been accomplished at the state level? The discussion above compels the conclusion that there are a number of positive and significant developments.

Because state resources are limited, states have begun to require more efficient and equitable uses of existing resources. Mandates for insurance companies and for employers are an example. Those who criticize employer-based insurance ignore the important role employers play as sources of funding, as sources of administration, and as advocates for better healthcare. Those states which seek to enhance the role of employers are on the right course.

With limited financial resources, paradoxically, the states developing universal healthcare are on the right course. This seems counterintuitive because expanded healthcare would seemingly cost more, thus colliding with the limited nature of financial resources. But, in fact, expanding access and coverage is a relatively inexpensive process and can be decoupled from the separate question of the content of such coverage. States like Massachusetts are thus headed in the right direction by attempting to cover every citizen, subsequently working out the content of that coverage within the constraints of limited resources.

A number of states have undertaken a more measured approach by identifying specific populations such as children for enhanced treatment. As discussed above, several states have expanded Medicaid coverage of children, while a number of others have raised the FPL levels of eligibility to extend SCHIP to more children. Because the latter program is in addition to Medicaid, it can include entire families. Thus, it can reach not only the poor but also working families, thereby increasing access and eligibility.

The same may be said of those states which have identified access to affordable pharmaceuticals as a primary concern. Several states are engaged in bulk buying, while others are engaged in negotiating prices that then become available to citizens. Either approach is valuable. The emphasis may seem less necessary with the advent of Part D of Medicare, but the limits of that coverage in scope and population remain problematic. Pharmaceuticals are necessary for many outside the Medicare population

and are increasingly used as alternatives to surgery or institutionalization for the mentally ill. In a sense, then, a focus on pharmaceuticals not only addresses a major cost factor in healthcare, but also addresses significant segments of the healthcare constituency.

Yet the full role and potential of the states remain undeveloped. Chief among the undeveloped areas is use of the states' taxing power to advance public health by raising revenues and discouraging bad health practices. State taxes can certainly be increased to expand healthcare. But more importantly, they can be used to drive down factors of ill health, chief among which are alcohol consumption, obesity, and tobacco-related disease. Success in these areas would save lives, save resources, and expand healthcare in other directions.

Some states have attempted to use the taxing power to drive down tobacco use and to raise money for healthcare. In 2007, Oregon sought (and failed) to increase its taxes on cigarettes by nearly 50 percent.[179] In January 2007, a special panel in Maine recommended raising taxes from $2.00 to $2.50 a pack, which would have generated an additional $37.9 million.[180] The panel also recommended increasing taxes on snacks, beer, and wine. In terms of efficiency, a better approach could hardly be conceived—such taxing policy not only raises the needed revenues, but deters conduct which itself generates health problems and consumes healthcare services.[181] Yet, little is being done with taxes to advance the public health.

The same comments may be made of the state police power. In our federal union, roads and highways are largely entrusted to the states. Injuries and fatalities on the highways are a major contributor to healthcare costs and could be substantially reduced by decreasing permissible speeds. Similarly, automobile emissions are a major contributor to healthcare problems, as well as to global warming. Yet, only California seems to be developing a policy in this area with a direct view towards improving healthcare.

Many in this country believe that obesity has become a national epidemic with major implications for healthcare. A principal arena for addressing the problem would be in the schools, where nearly 25 percent of our population obtains a major portion of its dietary needs. There is little evidence that states are using the schools as a tool to address obesity by expanding exercise programs or controlling dietary plans.

The segment of the healthcare constituency that remains most at risk is the mentally ill. Medicare and Medicaid coverage are limited, and the need for pharmaceuticals is great for this segment of the population. Indeed, in the uninsured population, the mentally ill remain at great risk because of the absence of parity between physical ailments and mental illness in employer-based, privately purchased insurance. While a number of states have mandated parity legislation,[182] much remains to be done, and most of it is critically important to the mentally ill.

Perhaps the most promising area of state activity is safety.[183] Improving safety can reduce costs by reducing medical error, reducing healthcare complications, and reducing resulting costs. Quality improvement is the most promising area of state activity, partly because of the directions and models developed by private players such as the Institute for Healthcare Improvement, the Kaiser Family Foundation, and NCQA. These entities develop studies for evidence-based medicine and best practices, they involve providers in adopting practices that improve healthcare, and they use the results as criteria for accreditation purposes. Not surprisingly, Medicare, Medicaid, National Institutes of Health, and CMS all favor quality improvement. States can and should do the same. The experience of the VA hospitals, in driving up quality while driving down costs, confirms the value of emphasizing quality improvement and safety in delivering healthcare at the state level.

Finally, what can be said of the essential role of the states? The answer must be what it has been since the inception of the federal union: the states are closest to the population they serve and, since the beginning, have been

entrusted with caring for the health, welfare, and safety of the citizenry. By the 1930s, with Social Security, and certainly by the 1960s, with Medicare and Medicaid, it was clear that the power of the federal purse was necessary to assure adequacy and uniformity of welfare and healthcare across the nation. However, federal legislation has supported and assured a cooperative federalism with the states. Lest this seem naïve, it should be added that the role of the national government remains not only to assure financial adequacy but also to guarantee uniform equity. As the Supreme Court held in *Edwards v. California*,[184] it remains essential to assure that a person's health and well being should not turn upon the accidents of birth, race, or residence. That national mission and obligation remain no less compelling today than they were then.

This leaves to the states the opportunity to expand scope of coverage and quality in ways they deem best and most feasible within the federal context or independently of it. Universal healthcare, state-by-state, is now a reality. Beyond that, basic policy development in health improvement and quality of services represent the next frontiers for state innovation and responsibility. These have been proper state provinces since the writing of the Constitution.

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[1] Professor of Law, Lewis & Clark Law School, Portland, Oregon. My thanks go to Bernadette Nunley and Amy Heverly, my fine research assistants; to Barbara Homzuik, my wonderfully competent and patient administrative assistant; and to Dean James Huffman, for his continuing support in arranging the research funding for this article. My thanks go as well to the faculty and bioethics students at the University of Houston Law School and the Law Department at the University of Canterbury, Christchurch, New Zealand, who provided many of the insights for comparative healthcare systems reflected in this article. This article is also forthcoming in (2007) 14 Canterbury Law Review.

[2] *See* U. S. Senate Budget Committee: Hearing Schedule, http://budget.senate.gov/democratic/hearingstate.html (last visited Dec. 2, 2007). The American Medical Association and the AARP in late summer 2007 launched a $1,000,000 television campaign to force even a limited reform bill out of Congress, expanding children's health and altering Medicare policy. *See* AMA Medicare Physician Payment Action Kit, http://www.ama-assn.org/ama/pub/category/14332.html (last visited Dec. 2, 2007). It is expected that healthcare reform will be a major issue in the 2008 presidential elections.

See Presidential Candidates Begin to Unveil Health Care Proposals, 13 Health Plan & Provider Rep. (BNA) 847 (Aug. 8, 2007) [hereinafter *Candidates*].

[3] *See* NAT'L GOVERNOR'S ASS'N, LEADING THE WAY: STATE HEALTH REFORM INITIATIVES 3–4 (2007), *available at* http://www.nga.org/Files/pdf/0707HEALTHREFORM.pdf.

[4] This article is being published jointly in the United States and New Zealand (where the author has just concluded teaching at the University of Canterbury), a nation of five million citizens with a population and healthcare needs quite similar to a number of the American states whose reform efforts are discussed in this article. That discussion may be of interest as well to reformers in other nations, such as Australia, Britain, and Canada, where healthcare systems are facing problems of cost, quality, and coverage.

[5] *See* Jessica S. Banthen & Didem M. Barnard, *Changes in Financial Burdens for Health Care: National Estimates for the Population Younger than 65 Years, 1996–2003*, 296 J. AM. MED. ASS'N 2712 (2006). In 2003, more than 48 million Americans spent over 10 percent of their total income on healthcare, and nearly 19 million of those individuals spent over 20 percent; they are disproportionately poor, elderly, and minorities. *Id.* at 2712, 2716–17.

[6] CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006 18 (2007), *available at* http://www.census.gov/prod/2007pubs/p60-233.pdf. The percentage of people covered by employer insurance dropped to below 60 percent in 2006. FAMILIES USA, WRONG DIRECTION: ONE OUT OF THREE AMERICANS ARE UNINSURED 13–14 (2007), *available at* http://www.familiesusa.org/assets/wrong-direction-one-out-of.pdf. Some 71 million working Americans had no health insurance during 2006–2007. Significantly, during this two year period, the total of uninsured under age sixty-five was 89.6 million. *Id.* at 1–2. Nearly 80 percent are in working families; almost 64 percent lacked insurance for six months; more than 50 percent for nine months. *Id.* at 4, 7.

[7] COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 2 (2001).

[8] In this introduction, as well as in Part I, I will make a number of general observations about the structure and scope of American healthcare without the usual detailed footnote references simply because the focus of the paper is on reform efforts at the state level. This assumes the reader has familiarity with the overall healthcare system in the United States. As to that, there are many good books, chief among them is KENNETH WING, THE NATION'S HEALTH (2004). Excellent explanatory material on Medicare, Medicaid, and the State Children's Health Program (SCHIP) may be found on the Web site of the U. S. Department of Health and Human Services at the relevant programmatic tabs and on the Web site of the Bureau of Census where one may consult exhaustive tables of statistics. Finally, at the risk of committing scholarly suicide, the online encyclopaedia, Wikipedia, http://www.wikipedia.org/, has excellent articles on the United States healthcare system, its programs, and its constituent parts. These Internet sources are particularly significant for this article, which is aimed both at domestic U. S. audiences and at audiences abroad who are interested in models of reform for their healthcare systems.

[9] RICHARD KOGAN ET AL., CTR. ON BUDGET & POLICY PRIORITIES, THE LONG-TERM FISCAL OUTLOOK IS BLEAK: RESTORING FISCAL SUSTAINABILITY WILL REQUIRE MAJOR CHANGES TO PROGRAMS, REVENUES, AND THE NATION'S HEALTH CARE SYSTEM 2 (2007), *available at* http://www.cbpp.org/1-29-07bud.pdf.
[10] *Id.*
[11] *Id.* at 3.
[12] *See Candidates*, *supra* note 2 (discussing the positions of the various presidential candidates).
[13] Massachusetts v. Mellon, 262 U.S. 447 (1923).
[14] *See* Lucy A. Williams, *The Abuse of Section 1115 Waivers: Welfare Reform in Search of a Standard*, 12 YALE L. & POL'Y REV. 8 (1994).
[15] There has been little written on this subject, other than episodic accounts relating to specific efforts. But one continuing set of reports is helpful—the *State of the States*—by State Coverage Initiatives, a national program of the Robert Wood Johnson Foundation, administered by AcademyHealth. *See* State Coverage Initiatives, State of the States, http://statecoverage.net/stateofstates.htm (last visited Dec. 2, 2007). The content of the 2007 report is more recent than the last report, for 2006, and more analytical. *See id.* Other references, now nearly ten years old, are Eleanor D. Kinney, *Clearing the Way for an Effective Federal–State Partnership in Health Reform*, 32 U. MICH. J.L. REFORM 899 (1999); MICHAEL S. SPARER, MEDICAID AND THE LIMITS OF STATE HEALTH REFORM (1996); and MAKING HEALTH REFORM WORK: THE VIEW FROM THE STATES (John J. DiIulio, Jr. & Richard R. Nathan eds., 1994). Most recently, see NAT'L GOVERNOR'S ASS'N, *supra* note 3.
[16] NAT'L ASS'N OF STATE BUDGET OFFICES & NAT'L GOVERNORS ASS'N, THE FISCAL SURVEY OF STATES 5 (2007), *available at* http://www.nasbo.org (follow "Publications" hyperlink; then follow "Fiscal Survey of States, Spring 2007" hyperlink). As state revenues increase, they project increased Medicaid spending over the next few years. *See* VERNON SMITH ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, AS TOUGH TIMES WANE, STATES ACT TO IMPROVE MEDICAID COVERAGE AND QUALITY: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2007 AND 2008 22 (2007), *available at* http:/www.kff.org/Medicaid/upload/7699.pdf.
[17] *See* Alliance for Health Reform, http://www.allhealth.org (last visited Dec. 2, 2007).
[18] To get a sense of the variety of state models, a useful reference is the recent report by the Colorado Blue Ribbon Commission on the five proposals it has developed—from thirty-one submitted—for that state alone to consider. *See* BLUE RIBBON COMM'N FOR HEALTH CARE REFORM, REVIEW OF THE FIVE NARROW PROPOSALS SUBMITTED TO THE BLUE RIBBON COMMISSION FOR HEALTH CARE REFORM (2007), *available at* http://www.colorado.gov/208commission/ (follow "Proposals" hyperlink, then follow "Technical Advisor's Review of Submitted Proposals" hyperlink, then download the document).
[19] OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 2008, DEP'T OF HEALTH & HUMAN SERVS. 63 (2007), *available at* http://www.gpoaccess.gov/usbudget/fy08/pdf/budget/hhs.pdf.
[20] *Id.* at 67–68.

[21] *Id.* at 69–70.
[22] New Directions in Health Policy: A Discussion of the President's Tax-Based Health Insurance Proposals, A Series of Panels Hosted by The Brookings Institution (Feb. 9, 2007) (transcript available at http://www.brookings.edu/comm/events/20070209.pdf).
[23] Linda M. Richmond, *U.S. Budget: Bush Proposal Cuts Medicaid $25.7 Million; Fund One Third of Projected SCHIP Shortfall*, 15 Health Care Pol'y Rep. (BNA) 194 (Feb. 12, 2007).
[24] *Reform Proposals: Taxes would Rise $334 Billion Under Bush Health Plan, JCT Report Says*, 15 Health Care Pol'y Rep. (BNA) 400 (Mar. 26, 2007).
[25] *See* MEDICAID COMM'N, FINAL REPORT AND RECOMMENDATIONS (2006), *available at* http://aspe.hhs.gov/medicaid/122906rpt.pdf.
[26] CMS required that states impose waiting periods, impose cost sharing, verify insurance status, prevent employers from changing dependent policies to shift dependents toward public coverage, and assure there is no more than 2 percent decline in employer-insurance coverage. *See* Letter from Center for Medicaid and State Operations to State Medicaid Director (Aug. 17, 2007). This was to prevent the so-called crowd out of private insurers by public programs. *See* Jonathan Gruber & Kosali Simon, *Crowd Out Ten Years Later* (Nat'l Bureau of Econ. Research, Working Paper No. 12858, 2007), *available at* http://papers.nber.org/papers/w12858. The governors of New York and California called for withdrawal of the regulations. *See Governors, Health Officials Seek Withdrawal of CMS Rules Targeting 'Crowd-Out' by SCHIP*, 12 Health Care Daily Rep. (BNA) (Aug. 31, 2007), *available at* Westlaw, 08/31/2007 HCD d1.
[27] *See Candidates*, *supra* note 2.
[28] *Charting a Course for Health Care Reform: Moving Toward Universal Coverage, Hearing Before the S. Comm. on Finance*, 110th Cong. (2007), *available at* www.senate.gov/~finance/hearings/statements/031407mb.pdf (statement of Max Baucus, Chairman, S. Comm. on Finance).
[29] Healthy Americans Act, S. 334, 110th Cong. (2007), *available at* http://www.theorator.com/bills110/text/s334.html The bill was read twice and referred to the Committee on Finance. *Id.*
[30] SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2005–2007: PART I, INSURANCE COVERAGE (2007), *available at* http://www.commonwealthfund.org/usr_doc/Collins_conghltcarebillsinscoverage_1010.pdf?section=4039.
[31] *See* Patrick Healy & Robin Toner, *Wary of Past, Clinton Unveils a Health Plan*, N.Y. TIMES, Sept. 18, 2007, at A24.
[32] *See id.* at A1.
[33] *See* Editorial, *HillaryCare's New Clothes*, WALL STREET. J., Sept. 19, 2007, at A20; Paul Krugman, *A Test for Democrats*, N.Y. TIMES, Aug. 3, 2007, at A19; Paul Krugman, *Health Care Hopes,* N.Y. TIMES, Sept. 21, 2007, at A19; Laura Meckler, *Politics & Economics: Why Clinton Embraced Employer-Based Insurance; Candidate Discovers Workers and Bosses Attached to Status Quo*, WALL STREET. J., Sept. 19, 2007, at A12; and Karl Rove, *Republicans Can Win on Health Care,* WALL STREET. J., Sept. 18, 2007, at A15.
[34] *See Candidates, supra* note 2.

[35] *See supra* note 8.
[36] *See* ARTHUR B. LAFRANCE ET AL., THE LAW OF THE POOR (1973); ARTHUR B. LAFRANCE, WELFARE IN A NUTSHELL (1978).
[37] *See generally* Symposium, *National Health Reform and America's Uninsured*, 32 J.L. MED. & ETHICS 386 (2004). *See also* Timothy S. Jost, *Why Can't We Do What They Do? National Heath Reform Abroad*, 32 J.L. MED. & ETHICS 433 (2004).
[38] *See* DENAVAS-WALT ET AL., *supra* note 6, at 18.
[39] A powerful, if uncritical, portrayal of the contrasts between American healthcare and that of foreign nations is provided by Michael Moore's 2007 film *Sicko*. SICKO (Dog Eat Dog Films 2007).
[40] This is the approach in Massachusetts, which has gotten the most attention with its reform efforts. *See infra* Part III.
[41] An obvious constraint on state efforts are the limitations by Medicaid. See *supra* note 14 as to the recent expansion due to expanding state revenues. For the past two decades, 1115 waivers have commonly relieved states of these constraints, as with the Oregon Plan of prioritizing healthcare. Less obvious, and more troublesome, are the constraints imposed by the Employee Retirement Income Security Act (ERISA), which prevents states from changing or challenging health insurance companies providing employer-employee benefits. Mercifully, this subject is beyond the scope of this article. *But see* Health Partnership Through Creative Federalism Act, H.R. 506, 110th Cong. (2007), introduced by Representative Tammy Baldwin (D-WI), providing exemptions from ERISA. *Highlights*, 12 Health Care Daily Rep. (BNA) 99 (May 23, 2007).
[42] Press Release, U. S. Senate Special Comm. on Aging, Kohl: Medicare Part D's Low-Income Subsidy May Not Be Reaching Our Neediest Seniors (Jan. 31, 2007), *available at* http://aging.senate.gov/record.cfm?id=268323.
[43] *Id.*
[44] FAMILIES USA, NO BARGAIN: MEDICARE DRUG PLANS DELIVER HIGH PRICES (2007), *available at* http://www.familiesusa.org/assets/pdfs/no-bargain-medicare-drug.pdf.
[45] CONGRESSIONAL BUDGET OFFICE, U.S. CONGRESS, THE BUDGET AND ECONOMIC OUTLOOK: FISCAL YEARS 2008 TO 2017 59 (2007), *available at* http://www.cbo.gov/ftpdocs/77xx/doc7731/01-24-BudgetOutlook.pdf.
[46] *See* THE SEGAL COMPANY, 2008 SEGAL HEALTH PLAN COST TREND SURVEY (2007), *available at* http://www.segalco.com/publications/surveysandstudies/2008trend survey.pdf. As to generics, a concern that brand name drug companies will pay generic companies not to market generics, defeating cost reduction and national policy, caused the Senate Judiciary Committee to approve the Preserve Access to Affordable Generics Act in February 2007. Preserve Access to Affordable Generics Act S. 3582, 109th Cong. (2006).
[47] FAMILIES USA, *supra* note 44.
[48] *See id.*
[49] *Medicare Says Drug Plans Are Negotiating 'Large Discounts' for Seniors*, SENIORJOURNAL.COM, July 3, 2006, http://www.seniorjournal.com/NEWS/ MedicareDrugCards/6-07-03-MedicareSaysDrug.htm.

[50] Medicare Prescription Drug Price Negotiation Act of 2007, H.R. 4, 110th Cong. (2007).
[51] These are the so-called clawback provisions. Any foreign reader of this article, or student generally of the American healthcare system, can only be appalled at the complexity and stupidity of these provisions.
[52] BLUECROSS BLUESHIELD OF TENN., INSIDE TENNESSEE'S MEDICINE CABINET: HOW MUCH IS ENOUGH 2 (2007).
[53] *Id.*
[54] *Part D Drug Benefit: Report Says HHS Negotiation of Rx Prices for Medicare Benefit Could Save $30 Billion*, Health Care Daily Rep. (BNA) (Apr. 5, 2007), *available at* Westlaw, 4/5/2007 HCD d4. Congress has consistently failed to authorize DHHS to buy in bulk, at lower costs, as does the Department of Veteran Affairs.
[55] As we shall see, it is possible to combine solutions. For example, prohibitive taxes on tobacco drives down usage while raising revenue for healthcare. *See infra* Part III. Also, the current debate in Congress to expand SCHIP, in part by taxing tobacco, illustrates the interrelationship of public health and health benefit programs. *See* Kendra Casey Plank & Steve Teske, *SCHIP: House to Consider SCHIP Bill Without Commerce Committee Approval*, 12 Health Care Daily Rep. (BNA) (July 30, 2007), *available at* Westlaw, 7/30/2007 HCD d2.
[56] U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, HEALTH INSURANCE COVERAGE: 2005, HIGHLIGHTS (2006) (the health insurance data has been revised since the 2006 publication), *available at* http://www.census.gov/hhes/www/hlthins/hlthin05/hlth05asc.html.
[57] *See* Steve Greenhouse & Michael Barbaro, *Wal-Mart Memo Suggests Ways to Cut Employee Benefit Costs*, N.Y. TIMES, Oct. 26, 2005, at C1; *see also* Reed Abelson, *States Are Battling Against Wal-Mart over Health Care*, N.Y. TIMES, Nov. 1, 2004, at A1.
[58] *See* Greenhouse & Barbaro, *supra* note 57.
[59] President George W. Bush, State of the Union Address (Jan. 23, 2007) (transcript available at http://www.whitehouse.gov/news/releases/2007/01/20070123-2.html).
[60] Press Release, Senator Edward M. Kennedy, Statement on President Bush's Health Care Remarks Today (Jan. 25, 2007), *available at* http://kennedy.senate.gov/newsroom (follow "statements" hyperlink, then click on "Statement by Senator Edward M. Kennedy on President Bush's Health Care Remarks Today" hyperlink).
[61] HEALTH COVERAGE COALITION FOR THE UNINSURED, EXPANDING HEALTH CARE COVERAGE IN THE UNITED STATES: A HISTORIC AGREEMENT (2007), *available at* http://www.coalitionfortheuninsured.org/pdfs/agreement.pdf.
[62] Press Release, BlueCross BlueShield Ass'n, WellPoint Unveils Plan for Covering America's Uninsured: Nation's Largest Health Benefits Provider Calls for Universal Coverage of Children, Pledges to Reach Out to the Uninsured with New Products and Charitable Donations (Jan. 8, 2007), *available at* http://www.bcbs.com/news/plans/wellpoint-unveils-plan-for.html.
[63] *See* INTERNAL REVENUE SERV., GOOD GOVERNANCE PRACTICES FOR 501(C)(3) ORGANIZATIONS, *available at* http://www.irs.gov/pub/irs-tege/good_governance_practices.pdf (last visited Dec. 2, 2007).
[64] *Id.* at para. 4.

[65] *See* LEIGH WACHENHEIM & HANS LEIDA, THE IMPACT OF GUARANTEED ISSUE AND COMMUNITY RATING REFORMS ON INDIVIDUAL INSURANCE MARKETS (2007), http://www.ahip.org/content/default.aspx?docid=20736. Most recently, the California Health Facilities Financing Authority required Sutter Health to make an $8 million contribution as a condition of getting $910 million in bonding authorization. This means that Sutter will pass along part of its savings from tax-exempt bonds. The CHFFA is drafting rules for charitable service as a condition of receiving its funding. *See California: Tax-Exempt Bonds for Sutter Health Tied to Charitable Donations for First Time,* 15 Health Care Pol'y Rep. (BNA) 480 (Apr. 9, 2007).

[66] Mental Health Parity Act of 2007, S. 558, 110th Cong. (2007).

[67] *Id.*

[68] Press Release, Office of the Governor of Ohio, Governor Signs Senate Bill 116 (Dec. 29, 2006), *available at* http://governor.oh.gov/releases/122906SenateBill116.htm.

[69] Press Release, Ohio Psychiatric Ass'n, Governor Taft Signs Ohio Parity Bill! (Dec. 29, 2006), *available at* http://www.ohiopsych.org/alerts/122906_gov.htm.

[70] Most recently, legislation extending coverage to the mentally ill as an insurance mandate is under consideration in Texas and adopted in Washington state for Medicaid. *See Washington: Governor Signs Legislation to Improve Mental Health Care for Children, Other Bills*, 15 Health Care Pol'y Rep. (BNA) 682 (May 21, 2007). *See also Texas: Senate Approves Legislation to Require Mental Health Parity in Group Plans*, 15 Health Care Pol'y Rep. (BNA) 684 (May 21, 2007).

[71] *New York: Legislators' Budget Includes Child Health Coverage Increase, Medicaid Growth Limit*, 15 Health Care Pol'y Rep. (BNA) 477 (Apr. 9, 2007). However, the New York expansion of SCHIP has been rejected by HHS because it would increase eligibility to 400 percent of the FPL and did not require a year long waiting period. The CMS administrator concluded private insurers might lose business. *See* Steve Teske, *SCHIP: CMS Denies New York Waiver to Cover Higher Income Children*, 12 Health Care Daily Rep. (BNA) (Sept. 10, 2007), *available at* Westlaw, 9/10/2007 HCD d2. The state has sixty days to appeal. Other states will be watching this closely.

[72] Letter from the AIDS Alliance for Children, Youth & Families et. al to the U.S. Congress (Feb. 12, 2007), *available at* http://www.ambpeds.org/Site/pub_policy/PDF/SCHIPReauthorization21207.pdf.

[73] The difference is significant, of course, but it does seem as though the continuation of SCHIP is secure. Notably, an increase in taxation of tobacco to help pay for SCHIP was left out. *See Congressional Roundup: House, Senate Pass Budget Pact; Tobacco Tax Increase for SCHIP Left Out*, 16 Health Law Rep. (BNA) 651 (May 24, 2007).

[74] *See Medicare: House, Senate Face Difficult Task in Merging Their Separate Bills, Analysts Say*, 13 Health Plan & Provider Rep. (BNA) 831 (Aug. 8, 2007); *SCHIP: Bush Vetoes Children's Health Bill; House Override Vote Set for Oct. 18,* 12 Health Care Daily Rep. (BNA) (Oct. 4, 2007), *available at* Westlaw, 10/4/2007 HCD d2.

[75] Press Release, Ga. Dep't of Cmty Health, PeachCare for Kids Enrollment Closes to New Members; Children Currently Enrolled Continue to Receive Care (Feb. 8, 2007), *available at* http://dch.georgia.gov/vgn/images/portal/cit_1210/40/4/75255708Press_Release-PeachCare_Cap.pdf.

[76] Press Release, MoALPHA Legislative Updates, SCHIP Will Face Future Budget Shortfalls Unless Legislators Act (July 20, 2005), *available at* http://www.moalpha.org/docs/news/leg_news/ 072005.html.
[77] National Institutes of Health Reform Act of 2006, Pub. L. No. 109-482, 120 Stat. 3675 (2007).
[78] Genevieve Kenney & Allison Cook, *Coverage Patterns Among SCHIP-Eligible Children and Their Parents*, URBAN INST. HEALTH POL'Y ONLINE, Feb. 2007, at 1, 4.
[79] *See id.*
[80] *Id.* at 4.
[81] *Id.* at 5.
[82] *Id.* at 3.
[83] Keep Children Covered Act of 2007, S. 401, 110th Congress (2007). *See also* Linda M. Richmond, *SCHIP: CMS Defends Lower Funding for Adults in SCHIP, Says States Did Deal on That Basis*, 12 Health Care Daily Rep. (BNA) (Mar. 23, 2007), *available at* Westlaw, 3/23/2007 HCD d6.
[84] Christopher Lee, *Children's Health Care on Agenda: Divisions Surface as Congress Works to Renew Program*, WASH. POST, Mar. 4, 2007, at A8.
[85] *Highlights, Various Groups Seek SCHIP Changes, as Finance Committee Prepares for Markup*, 12 Health Care Daily Rep. (BNA) 100 (May 24, 2007), *available at* Westlaw, 5/24/2007 HCD d1.
[86] *See infra* Part III.C. Most recently, the Centers for Medicare and Medicaid Services sent a letter on August 17, 2007, to the states, the National Governors Association, and the National Conference of State Legislators requiring states to adopt five strategies to prevent "crowd out" of private insurers by SCHIP expansion. Letter from Dennis G. Smith, Director, Ctrs. for Medicare and Medicaid Servs. to State Medicaid Director (Aug. 17, 2007), *available at* http://www.cms.hhs.gov/SMDL/downloads/SMD081707.pdf; *see also* John K. Iglehart, *The Battle over SCHIP,* 357 NEW ENGL. J. MED. 957 (2007).
[87] The title of this section of the article is taken from the name of one of the leading works on the subject of quality in healthcare, published by the Institute of Medicine, in 2001. INST. OF MED., *supra* note 7.
[88] JIM HAHN, LIBRARY OF CONGRESS, PAY-FOR-PERFORMANCE IN HEALTH CARE (2006), *available at* http://www.vascularweb.org/_CONTRIBUTION_PAGES/Government_Relations/PDF_Doc/CRS%20report%20on%20P4P.pdf. Recent reports establish that Medicare Advantage services cost the government 10 to 15 percent more than fee-for-service Medicare. Medicaid, on the other hand, seems efficiently served by managed care approaches.
[89] HEALTHGRADES, HEALTHGRADES QUALITY STUDY: FOURTH ANNUAL PATIENT SAFETY IN AMERICAN HOSPITALS 5 (2007), *available at* http://www.healthgrades.com/media/dms/pdf/PatientSafetyInAmericanHospitalsStudy2007.pdf.
[90] *Id.* at 2.
[91] *See id.* at 3. *But see* EUGENE A. KROCH ET AL., THE COMMONWEALTH FUND, HOSPITAL PERFORMANCE IMPROVEMENT: TRENDS IN QUALITY AND EFFICIENCY (2007), *available at* http://www.commonwealthfund.org/usr_doc/Kroch_hosp_performance_improve_1008.pdf?section=4039 (noting trends in improvement).

[92] As to state-based clinics, see Federal Trade Commission Staff Letter, 16 Health Law Rep. (BNA) 1201 (Oct. 11, 2007). As to the impact of large numbers of uninsured on health care for those with insurance, see Mark V. Pauly & José A. Pagán, *Spillover and Vulnerability: The Case of Community Uninsurance*, HEALTH AFFAIRS, Sept.–Oct. 2007, at 1304.

[93] *See* Cecilia M. Assam & Peyton M. Sturges, *Provider Regulation: FTC Sees Benefits to Massachusetts Rules for Store-Based Clinics; Ad Screening Nixed*, 16 Health Law Rep. (BNA) 1201 (Oct. 11, 2007); *see also* Pauly & Pagán, *supra* note 92 (regarding the impact of large numbers of uninsured on healthcare for those with insurance).

[94] *See generally* HAHN, *supra* note 88.

[95] *See* KAREN DAVIS ET AL., THE COMMONWEALTH FUND, AN ANALYSIS OF LEADING CONGRESSIONAL HEALTH CARE BILLS, 2005–2007: PART II, QUALITY AND EFFICIENCY 64 (2007), *available at* http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=511249

[96] *See Top 10 Medicare Issues in 2007*, 18 Medicare Report (BNA) 41 (Jan. 12, 2007).

[97] Hospitals received 3.3 percent rate increases for fiscal year 2008 for meeting reporting and quality standards under Medicare's Inpatient Prospective Payment System (IPPS) and Reporting Hospital Quality Data for Annual Payment Update Program (RHQDAPU). Press Release, Ctrs. For Medicare & Medicaid Servs., CMS Announces Payment Reforms for Inpatient Hospital Services in 2008 (Aug. 1, 2007), *available at* http://www.cms.hhs.gov (follow "Newsroom Center" hyperlink; then "Press Releases" hyperlink; then "Aug. 1, 2007" hyperlink).

[98] *See* KATHRYN KUHMERKER ET AL., PAY-FOR-PERFORMANCE IN STATE MEDICAID PROGRAMS, A SURVEY OF STATE MEDICAID DIRECTORS AND PROGRAMS (2007).

[99] *Costs: Widespread Use of Best Medical Practices Could Slash Health Costs, CBO Official Says*, 12 Health Care Daily Rep. (BNA) (June 22, 2007), *available at* Westlaw, 6/11/2007 HCD d2.

[100] Press Release, Ctr. for Disease Control, Hospital Infections Cost U.S. Billions of Dollars Annually (Mar. 6, 2000), *available at* http://www.cdc.gov/od/oc/media/pressrel/r2k0306b.htm [hereinafter CDC Press Release].

[101] Institute for Healthcare Improvement, Overview of the 100,000 Lives Campaign, http://www.ihi.org/IHI/Programs/Campaign/100kCampaignOverviewArchive.htm (last visited Nov. 3, 2007) [hereinafter 100,000 Lives Campaign].

[102] INST. OF MED., *supra* note 7.

[103] CDC Press Release, *supra* note 100.

[104] *See* 100,000 Lives Campaign, *supra* note 101; Institute for Healthcare Improvement, 5 Million Lives Campaign Overview, http://www.ihi.org/IHI/Programs/Campaign/Campaign.htm (last visited Mar. 25, 2007) [hereinafter 5 Million Lives Campaign].

[105] ANDREW HACKBARTH ET. AL, INST. FOR HEALTHCARE IMPROVEMENT, THE HARD COUNT: CALCULATING LIVES SAVED IN THE 100,000 LIVES CAMPAIGN (2006), *available at* http://www.ihi.org/NR/rdonlyres/AA1B05AD-5DFF-45D6-8A2F-05C69C9C2860/0/ihiarticle.pdf.

[106] 5 Million Lives Campaign, *supra* note 104.

[107] *See* Oregon Health Policy and Research – Policy and Analysis Unit, Compare Hospital Costs, http://www.oregon.gov/OHPPR/RSCH/comparehospitalcosts.shtml (last visited

Dec. 4, 2007). Regence Blue Cross provided similar data on physicians, but was recently forced to withdraw its rankings in Washington state. The common theme is to provide, in healthcare, the kind of data available, say, with automobiles. Other states and the federal government provide similar data on physicians and hospitals, generating a number of court challenges.

[108] U.S. Department of Health & Human Services, Value-Driven Health Care Home, http://www.hhs.gov/transparency (last visited Dec. 4, 2007).

[109] Press Release, Nat'l Comm. for Quality Assurance, NCQA to Require Quality Measurement, Improvement of All Health Plans (Feb. 15, 2007), *available at* http://web.ncqa.org/tabid/188/Default.aspx.

[110] *See id.*

[111] Press Release, U.S. Dep't of Health & Human Servs., Governor Perdue Issues Executive Order on Health Care Transparency, (Feb. 12, 2007), *available at* http://www.hhs.gov/news/press/2007pres/20070212ga.html.

[112] U.S. Dep't of Health and Human Servs., http://www.hhs.gov/transparency/goverment/index.html (last visited Dec. 23, 2007).

[113] *Boomers and the Budget: What Does It Mean for America's Seniors: Hearing Before the Spec. S. Comm. on Aging and the Dep't of Health & Human Servs.*, 110th Cong. (2007) [hereinafter *Boomers and the Budget*], *available at* http://www.hhs.gov/asl/testify/2007/02/t20070215a.html (statement of Leslie V. Norwalk, Acting Administrator, Ctrs. for Medicare & Medicaid Servs.). Significantly, CMS has come in for heavy criticism from provider groups for failure to adopt regulations establishing Provider Safety Organizations under Public Law 109-41.

[114] Press Release, U.S. Dep't of Health & Human Servs., Medicare to Provide Beneficiaries with Information on Physician Performance as Part of Value-Driven Health Care Initiative (Feb. 15, 2007), *available at* http://wchq.org/pdf/news_releases/CMS_BQIFinal_Press_Release.pdf; *see also* U.S. Department of Health & Human Services, Pilot Programs, http://www.hhs.gov/transparency/pilot/index.html (last visited Dec. 5, 2007). Eight regional collaboratives now participate in the BQI Project: California, Arizona, Delaware, Maryland, Virginia, Massachusetts, Minnesota, and Wisconsin. *See CMS BQI Project Expands*, HEALTH MGMT TECH., May 2007, *available at* http://findarticles.com/p/articles/mi_m0DUD/is_5_28/ai_n19311335.

[115] The PMRS proposal can be found at 72 Fed. Reg. 52,133 (Sept. 12, 2007). As to controversy, the New York Attorney General has threatened to sue United Healthcare to prevent a physician ranking system because of feared inaccuracies. *Physicians: Properly Planned Physician Ranking Systems Withstand Legal Scrutiny, Analysts Conclude*, 12 Health Care Daily Rep. (BNA) (Oct. 11, 2007), *available at* Westlaw, 10/11/2007 HCD d6. Privacy issues also abound in public access to physician Medicare billing/payment records with CMS. *See* Judith A.Thorn, *Physicians: Reaction Split on Court Decision to Allow Medicare Data Release to Consumer Group*, 12 Health Care Daily Rep. (BNA) (Sept. 14, 2007), *available at* Westlaw 9/14/2007 HCD d3.

[116] See, most recently, Texas Blue Cross' Web-based rating system. Susanne Pagano, *Quality: Blue Cross Begins Web-Based Physician Rating System Amid Concerns,* 13 Health Plan and Provider Rep. (BNA) 619 (June 6, 2007).

[117] Employers also play an important role in the national health systems of other nations, such as Germany and Japan.
[118] *See* U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, http://www.ahrq.gov/data/mepsix.htm; KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2007 ANNUAL SURVEY (2007), *available at* http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf; Vanessa Fuhrmans, *Health-Care Premiums Climbing Faster Than Inflation, Studies Say*, WALL STREET. J., Sept. 12, 2007, at D9.
[119] KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, *supra* note 118, at 31.
[120] *Id.* at 47–48, 51–53.
[121] *See* E. RICHARD BROWN ET AL., UCLA CTR. FOR HEALTH POLICY RESEARCH, JOB-BASED INSURANCE DECLINES FOR MODERATE- AND LOW-INCOME WORKERS (2007), *available at* http://www.healthpolicy.ucla.edu/pubs/files/empbased_ins_PB_jul07.pdf.
[122] Press Release, Wash. Employment Sec. Dep't, Fewer Washington Employers Offering Health Insurance (Feb. 12, 2007), *available at* http://fortress.wa.gov/esd/portal/info/newsreleases/healthinsurance; RICK LOCKHART, WASH. EMPLOYMENT SEC. DEP'T, WASHINGTON STATE EMPLOYEE BENEFITS REPORT (2007), *available at* http://www.workforceexplorer.com/admin/uploadedPublications/7794_EB_2006_Report.pdf.
[123] KAISER FAMILY FOUNDATION, INSURANCE PREMIUM COST-SHARING AND COVERAGE TAKE-UP, (2007), http://www.kff.org/insurance/snapshot/chcm020707oth.cfm.
[124] That is very much the case in the major reform efforts in California, as we shall see infra. *See* Stephen Siciliano, *Access: New California System to Keep Key Role for Employer Coverage, Governor's Aide Says,* 12 Health Care Daily Rep. (BNA) (Aug. 8, 2007), *available at* Westlaw, 8/8/2007 HCD d11. Among the presidential candidates, the most experienced in healthcare reform, Senator Clinton, would retain a place for insurers and employers, as a political reality.
[125] AMANDA BRODT ET AL., STATE COVERAGE INITIATIVES, STATE OF THE STATES: BUILDING HOPE, RAISING EXPECTATIONS (Isabel Friedenzohn et al. eds, 2007), *available at* http://statecoverage.net/pdf/StateofStates2007.pdf.
[126] *Id.* at 13–21; *see also Boomers and the Budget*, *supra* note 113 (discussing provider safety organizations).
[127] This is emphatically true of California, as developed in the next section of this article. *See California: Governor's Aide Says State's New System Will Retain Key Role for Employer Coverage,* 13 Health Plan & Provider Rep. (BNA) 870 (Aug. 15, 2005).
[128] Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007). *But see* PATRICIA BUTLER, STATE COVERAGE INITIATIVES & NAT'L ACAD. FOR STATE HEALTH POLICY, ERISA IMPLICATIONS FOR STATE HEALTH-CARE ACCESS INITIATIVES: IMPACT OF THE MARYLAND "FAIR SHARE ACT" COURT DECISION (2006), *available at* http://www.statecoverage.net/SCINASHP.pdf.
[129] BRODT ET AL., *supra* note 125, at 36–37.
[130] *Id.*

[131] Office of California Governor Arnold Schwarenegger, Health Care Reform Fact Sheet, http://gov.ca.gov/index.php?/fact-sheet/5190/ (last visited Mar. 28, 2007). See Julie Appleby, *Q&A with Governor Arnold Schwarzenegger*, USA TODAY, Aug. 30, 2007, at B2, for a useful summary.
[132] Julie Appleby, *California Muscles Its Way Through Health Reforms*, USA TODAY, Aug. 30, 2007, at B1.
[133] Office of California Governor Arnold Schwarzenegger, *supra* note 131.
[134] *Id.*
[135] *Id.*
[136] *Id.*
[137] M. RENEE ZEREHI, AM. COLL. OF PHYSICIANS, STATE EXPERIMENTATIONS WITH REFORMS TO EXPAND ACCESS TO HEALTH CARE 14 (2007), *available at* http://www.acponline.org/hpp/state_exp.pdf.
[138] Press Release, Cal. State Senate Republican Caucus, A Comprehensive and Cost Effective Solution Proposed by Senate Republicans (Jan. 30, 2007), *available at* http://republican.sen.ca.gov/news/99/pressrelease4440.asp.
[139] Press Release, HealthLeaders-InterStudy, Proposal to Cover California Uninsured Spreads the Pain (Jan. 10, 2007), *available at* http://home.healthleaders-interstudy.com (follow "Press Releases" hyperlink under "Press & Events"; then follow "01-10-2007" hyperlink).
[140] GOVERNOR OF CALIFORNIA, GOVERNOR'S HEALTH CARE PROPOSAL 5 (Jan. 8, 2007), *available at* http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.
[141] A.B. 1554 is available at http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_1551-1600/ab_1554_bill_20070425_amended_asm_v97.html. More recently, the California legislature considered A.B. 8, requiring employers to play or pay by January 1, 2009, and requiring insurers to offer 5 basic plans. A.B. 8 was proposed on September 10, 2007, but was vetoed in October. Health Access Weblog, Expected But Disappointing, http://www.health-access.org/2007/10/expected-but-disappointing.htm.
[142] Frederick L. Pilot, *California: Schwarzenegger to Call Special Session to Forge Compromise on Health Care Reform*, 13 Health Plan and Provider Rep. (BNA) 982 (Sept. 19, 2007).
[143] For a general review of state activity, see NAT'L GOVERNORS ASS'N CTR. FOR BEST PRACTICES, LEADING THE WAY: STATE HEALTH REFORM INITIATIVES (2007), http://www.nga.org/Files/pdf/0707HEALTHREFORM.PDF.
[144] Press Release, Office of N.Y. Governor Eliot Spitzer, Governor Spitzer Delivers First State of the State Address (Jan. 3, 2007), *available at* http://www.ny.gov/governor/press/0103073.html.
[145] Governor Eliot Spitzer, An Agenda to Fundamentally Reform New York's Health Care System, Address at the Nelson A. Rockefeller Institute (Jan. 26, 2007) (transcript available at http://www.ny.gov/governor/keydocs/0126071_speech.html).
[146] Press Release, United Hosp. Fund, Report Outlines Long-term Blueprint to Approach Universal Health Insurance Coverage in New York State (Dec. 19, 2006), *available at* http://www.uhfnyc.org/press_release3159/press_release_show.htm?doc_id=434796. HHS, through a CMS letter, has refused approval for New York's expansion of SCHIP. *See* Teske, *supra* note 71.

[147] DANIELLE HOLAHAN ET AL., UNITED HOSP. FUND, A BLUEPRINT FOR UNIVERSAL HEALTH INSURANCE COVERAGE IN NEW YORK 31 (2007), *available at* http://www.uhfnyc.org/usr_doc/Blueprint_for_Universal_Coverage.pdf.

[148] This is a crucial point. Any incremental change is affected by the existing base. If it is already demographically high, the chances of success are enhanced.

[149] ALAN G. RAYMOND, BLUE CROSS BLUE SHIELD OF MASS. FOUND. ET AL., THE 2006 MASSACHUSETTS HEALTH CARE REFORM LAW: PROGRESS AND CHALLENGES AFTER ONE YEAR OF IMPLEMENTATION 4 (2007), *available at* http://masshealthpolicyforum.brandeis.edu/publications/pdfs/31-May07/MassHealthCare ReformProgess%20Report.pdf. People who pose "high risks" of healthcare needs are often unable to get insurance. Several states have created high risk pools, requiring insurers to provide coverage, albeit at higher rates. One such state is Colorado. *See Colorado: Governor Signs Bill on Health Insurance Underwriting, Other Health Care Measures,* 13 Health Plan & Provider Rep. (BNA) 642 (June 13, 2007). Another is North Carolina. *See* Act to Establish the North Carolina Health Insurance Risk Pool, H.B. 265, 2007-2008 Gen. Assem., Reg. Sess. (N.C. 2007), *available at* http://www.ncga.state.nc.us/gascripts/BillLookUp/BillLookUp.pl?Session=2007&BillID =H265. The federal government has funding for such pools. *See* Act to Amend the Public Health Service Act to Extend Funding for the Operation of State High Risk Health Insurance Pools, 45 C.F.R. 148 (2007), *available at* http://www.cms.hhs.gov/ MedicaidGenInfo/ Downloads/CMS2260IFC.pdf.

[150] Act of Apr. 12, 2006, ch. 58, 2006 Mass. Laws, *available at* http://www.mass.gov/legis/laws/seslaw06/sl060058.htm.

[151] COMMONWEALTH HEALTH INS. CONNECTOR AUTH., COMMONWEALTH OF MASSACHUSETTS POLICY COMMITTEE AGENDA (Jan. 19, 2007), *available at* http://www.mass.gov (search "Policy Committee Agenda," then follow "The Commonwealth of Massachusetts" hyperlink with the Jan. 19, 2007 date).

[152] *Massachusetts: Massachusetts Panel to Vote on Requirement That All Health Insurers Offer Drug Coverage,* 13 Health Plan & Provider Rep. (BNA) 316 (Mar. 21, 2007).

[153] *Id.*

[154] *Massachusetts: Health Panel Approves Delay Until 2009 for Minimum Coverage Standard Compliance,* 15 Health Care Pol'y Rep. (BNA) 412 (Mar. 26, 2007).

[155] Pam Belluck et al., *Massachusetts Sets Benefits in Universal Health Care Plan*, N.Y. TIMES, Mar. 21, 2007, at A18.

[156] EXECUTIVE OFFICE OF HEALTH & HUMAN SERVS., DIV. OF HEALTH CARE FIN. & POLICY, THE USE OF PUBLIC HEALTH ASSISTANCE IN MASSACHUSETTS IN FY06: EMPLOYERS WHO HAVE FIFTY OR MORE EMPLOYEES USING MASSHEALTH OR THE UNCOMPENSATED CARE POOL (2007), *available at* http://www.mass.gov/ Eeohhs2/docs/dhcfp/r/pubs/07/50+_ee_2007_report.pdf.

[157] Retail Indus. Leaders Ass'n v. Fielder, 475 F.3d 180 (4th Cir. 2007). The *Fielder* case poses a threat, not only to Massachusetts, but also California and its reform efforts. *See* Frederick L. Pilot, *ERISA: Reform Proposals by California Governor, Top Lawmakers Face Likely ERISA Challenge,* 12 Health Care Daily Rep. (BNA) 166 (Aug. 28, 2007). *But see* BUTLER, *supra* note 128. Essentially, it is arguable that allowing companies to choose whether or not to offer health care, under a play or pay broad-based tax system, is

not a mandate prohibited by ERISA. *See* N.Y. Conference of BlueCross & BlueShield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

[158] *Fielder*, 475 F.3d at 183.

[159] *Id.*

[160] *Id.* at 198.

[161] Most recently, Massachusetts has tackled a chronic problem—free use of emergency departments of hospitals—by imposing fees on those with incomes above 200 percent of the FPL. *Access: New Regulation Imposes Cost Sharing on Residents Seeking Free Medical Care*, 12 Health Care Daily Rep. (BNA) (Oct. 1, 2007), *available at* Westlaw, 10/1/2007 HCD d13.

[162] Press Release, Office of Minn. Governor Tim Pawlenty, Healthy Connections: Health Care Reform to Lower Costs, Improve Quality, and Increase Access to Coverage (Jan. 11, 2007), *available at* http://www.governor.state.mn.us/mediacenter/pressreleases/PROD007915.html; Press Release, Senator Linda Berglin, Senate Aims to Insure More People, Save Taxpayers Money (Jan. 10, 2007), *available at* http://www.senate.mn/members/member_pr_display.php?ls=&id=510.

[163] Press Release, Office of Wash. Governor Christine Gregoire, Governor Gregoire Unveils Plan to Expand Children's Health Coverage (Jan. 11, 2007), *available at* http://www.governor.wa.gov/news/news-view.asp?pressRelease=435&newsType=1.

[164] BLUE RIBBON COMM'N ON HEALTH CARE COSTS AND ACCESS, FINAL REPORT 8 (2007), *available at* http://www.governor.wa.gov/priorities/healthcare/BlueRibbon_FinalReport.pdf.

[165] Press Release, Office of Tenn. Governor Phil Bredesen, Governor Bredesen's CoverKids Program Gets Federal Approval (Jan. 19, 2007), *available at* http://www.tennesseeanytime.org/governor/viewArticleContent.do?id=954.

[166] *See* Julie L. Hudson & Thomas M. Selden, *Children's Eligibility and Coverage: Recent Trends and a Look Ahead*, 26 HEALTH AFFAIRS 618 (2007).

[167] *SCHIP: 5.5 Million Children Eligible for SCHIP, Medicaid, but Not Enrolled, Study Finds,* 12 Health Care Daily Rep. (BNA) (Aug. 16, 2007), *available at* Westlaw, 8/16/2007 HCD d2.

[168] SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, RIGHT OF PASSAGE? WHY ADULTS BECOME UNINSURED AND HOW NEW POLICIES CAN HELP (2007), *available at* http://www.commonwealthfund.org/usr_doc/Collins_riteofpassage2007_1049_ib.pdf?section=4039.

[169] *Highlights,* 12 Health Care Daily Rep. (BNA) (Aug. 17, 2007), *available at* Westlaw, 8/17/2007 HCD d1.

[170] *See* Letter from Dennis G. Smith to State Medicaid Director, *supra* note 86. For a state's reaction, see also Steve Teske, *SCHIP: States to Seek Help from Congress in Cancelling Federal Child Health Rules,* 12 Health Care Daily Rep. (BNA) 163 (Aug. 23, 2007).

[171] *See* Kimberly A. Strassel, Editorial, *Socialized Medicine Showdown*, WALL STREET. J., June 29, 2007, at A14.

[172] *Oregon Prescription Drug Program Enrollment Begins Thursday*, SALEM-NEWS.COM Dec. 6, 2006, http://www.salem-news.com/articles/december062006/opdp_120606.php.

[173] Prescription discount cards are now available to underinsured or uninsured Washington residents to obtain deeply discounted drugs. *Washington: Discounts on Prescription Drugs Available to State's Uninsured Residents*, 15 Health Care Pol'y Rep. (BNA) 414 (Mar. 26, 2007).
[174] Press Release, Office of Colo. Governor Bill Ritter, Jr., Gov. Ritter Signs First Bill, Creates Prescription Drug Plan (Feb. 5, 2007), *available at* http://www.colorado.gov/governor/ (follow "Press Office" hyperlink; then follow "View 2006-2007 Press Releases Here" hyperlink; then scroll down to February 5 and follow "Gov. Ritter Signs First Bill, Creates Prescription Drug Plan" hyperlink).
[175] *Id.*
[176] Press Release, Office of Me. Governor John E. Baldacci, Governor Receives Blue Ribbon Commission on Dirigo Health Reform (Jan. 29, 2007), *available at* http://www.maine.gov/tools/whatsnew/index.php?topic=Gov+News&id=29304&v=Article-2006.
[177] The knowledgeable reader will recognize that two trends towards restricting coverage are not discussed here: state reductions in Medicaid pursuant to the Deficit Reduction Act of 2004 and employer reductions through so-called consumer-driven health plans (CDHP). Neither is a state initiative, and each simply shifts to patients costs the consumer cannot afford with no improvement in quality or health.
[178] In addition, many states use the techniques of managed care within Medicaid. Among these techniques are formularies restricting authorized drugs, prior authorizations of procedures and tests, concurrent review of in-hospital patients, management of chronic patient care, and the use of physician gatekeepers. These techniques slowed the growth in the costs of healthcare in the 1990s. They are not treated here since they are initiatives of the managed care movement of the 1980s in Medicare at the national level. However, they offer hope for other nations looking to slow growth in costs or to improve efficiencies in quality of care today.
[179] Medical News Today, Oregon Governor Proposes Cigarette Tax Increase to Fund Children's Health Care Coverage (Oct. 2, 2006), http://www.medicalnewstoday.com/articles/52946.php
[180] MUSKIE SCHOOL OF PUB. SERV., INST. FOR HEALTH POLICY, FINANCING MECHANISMS FOR STATE HEALTH INSURANCE COVERAGE INITIATIVES: A REVIEW OF EXISTING STATE PROGRAMS 13 (2006), *available at* http://www.muskie.usm.maine.edu/Publications/ihp/FinancingState HealthCoverageInitiatives.pdf (summarizing how other states have used raising tobacco prices to pay for health insurance plans).
[181] Similar efforts failed at the national level and elsewhere on the state level. *See Maryland: House, Senate Divided over Proposal to Expand Medicaid Using Tobacco Taxes*, 15 Health Care Pol'y Rep. (BNA) 412 (Mar. 26, 2007). The states seem largely hamstrung by their adoption of the 2000 Multi-State Tobacco Settlement. *See* Arthur B. LaFrance, *Tobacco Litigation: Smoke, Mirrors and the Public Health*, 26 AM J.L. & MED. 187 (2000).
[182] *See* INST. OF MED., *supra* note 7.
[183] *See* BRODT ET AL., *supra* note 125 (discussing techniques of managed care designed to assure cost control but equally well adapted to quality assurance).
[184] *See* Edwards v. California, 314 U.S. 160 (1941).