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Commentary

State Efforts to Expand Health Coverage: One Bite at a Time

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For more than twenty years, health scholars and advocates have warned us about the lack of adequate health coverage among a growing number of Americans. Health insurance premiums are rising. Many employers, especially small employers who employ over half of the country's workforce, and individuals are seeing premium increases of 30, 40, and even 50 percent. Not surprisingly, America's uninsured population is rising—to more than 41 million people. States are feeling the budget crunch as the economy sags and more and more people turn to state Medicaid and other public health care systems. This all means that state policy makers are looking for solutions. Yet no consensus has emerged on what to do about the uninsurance problem. Conservatives propose encouraging individuals to buy private health insurance and place more reliance on market forces. Liberals continue a struggle initiated during the New Deal to provide publicly financed health coverage.

What can states do to keep health insurance accessible? Are there ways to expand choice and availability of insurance plans? Can states solve the problem of the uninsured? The answer is possibly but not through universal health coverage as the articles in this issue show. The articles in this issue highlight many of the problems confronting the health insurance market and its consumers. They all indicate that states simply cannot create effective universal coverage. The obstacles to universal coverage are incremental policy making, divisive politics, and our intergovernmental system.

While the health policy scholars in this issue complain about the incremental nature of these state reforms and that the state reforms do not go far enough toward national universal coverage, I would argue that state governments prefer to retain complete autonomy over health policy rather than allow it to become a national policy through federal adoption. While states might want federal dollars for a program, they very naturally resent further restrictions on their autonomy. Thus, the states want to retain for themselves policies such as health insurance market reforms, which regulate major economic state industries and are relatively inexpensive for states to implement and run.

While the states in this issue have recently faced the challenge of sustaining gains in health insurance coverage due to budget shortfalls, these articles point out that they have also overcome tremendous barriers and made, in some cases, significant progress in expanding health insurance that can provide lessons for other states.

In his article "Ethnic Politics, Policy Fragmentation, and Dependent Health Care Access in California," Howard Leichter lays out the number of health care programs in California. He focuses on a lack of health care access for the Latino population, women, and children. The implication of his analysis is that this lack of health care access has national implications. One of the main reasons is the fragmentation of the health system. Leichter shows the disproportionate number of children, women, and Latinos uninsured as compared with the overall U.S. population. To deal with this problem, California has a wide range of private and public programs that often overlap and are, according to Leichter, highly inefficient. In addition to the many public/private health care solutions, California has some traditional safety net programs. Medi-Cal is the largest California safety net program. Leichter contends, however, that Medi-Cal reflects the problems facing the health care programs in California. While it is one of the largest programs in the state, Medi-Cal has the lowest amount of Latino and other immigrant groups enrolled in it. Through in-depth interviews, Leichter finds that the reason for the lack of Hispanics and other immigrants participating in Medi-Cal is the cumbersome enrollment and eligibility process, as well as the difficult maintenance routine. For Leichter, Medi-Cal is inherently flawed in the way it treats indigent persons and those lacking English language skills.

Another safety net program in California is the federal Healthy Families program. This program provides coverage to children of families that are not eligible for Medicaid by offering them subsidized premiums and a good selection of benefits. Healthy Families was designed to boost the

number of insured, especially in the immigrant communities. However, this program, as well as an attempt to link this program with Medi-Cal in order to offer coverage to parents of the children, failed according to Leichter. In Leichter's analysis, the reasons for failure are multiple, but two stand out. The most prominent one was the complicated enrollment process similar to that of Medi-Cal. In fact, the enrollment forms for Medi-Cal and Healthy Families were combined. Second, because the program was advertised as an expansion of Medi-Cal a welfare stigma followed the Healthy Families program.

Leichter concludes that cultural problems facing California are acting as a barrier to immigrant access to health care. According to Leichter, the health care problem cannot be solved until the racial problems in California are resolved. The health programs in California are failing because of enrollment barriers, the negative image of the recipients, the negative attitude of bureaucrats, and the negative attitude toward the recipients from California politicians. For Leichter, this all adds up to incremental and incoherent health policy.

Thomas Oliver, in his article on Maryland, deals with health insurance coverage provided by that state. According to Oliver, Maryland has long served as an example of incrementalism and stability. All expansions and changes in the programs have been made gradually over an extended period of time. The long-term goal of insurance coverage in Maryland is universal coverage.

As Oliver points out, Maryland currently has several programs that provide coverage to its citizens. In his article, Oliver describes each of the major health coverage plans. One plan is the Maryland Health Insurance Plan, providing subsidized premiums to all individuals otherwise ineligible for all other types of coverage. Another plan is a required Standard Benefits plan. This plan tries to get all employers to offer insurance to more people through a standardized benefits package. The last major program in Maryland is its Medicaid program.

The Kids Count program was Maryland's attempt at expanding coverage to kids and their families. The expanded program, passed in 1998, was called Maryland Children's Health Program. By Oliver's account, the plan was not perfect since it only covered a limited number of kids and parents. Today, there is a stalled effort for adding a private option to the plan to increase eligibility and coverage.

Oliver concludes that the failure of the programs in Maryland to expand coverage, along with the slow incremental way in which policies are adopted, has prompted the formation of a number of grassroots organi-

zations, seeking either universal coverage or expansions of existing coverage. As Oliver observes, “The Maryland experience reiterates that each step toward greater health security, no matter how small, is a major technical and political challenge. Although they do not require the same convergence of conditions as major innovations, small reforms require almost as much political capital as large ones.” Quoting Odin Anderson, he characterizes Maryland’s experience as “incrementalism with a vengeance” (see Oliver, p. 232).

In his article on Oregon, Leichter discusses that state’s approach to solving the health insurance problem and analyzes the roots of the access problems in Oregon. Leichter contends that Oregon’s approach to the problem has been based on two assumptions. The first is that access to health care is best accomplished through universal access to health care and health insurance. The second assumption is that, given the opportunity, all Oregonians would choose to have health insurance.

As Leichter describes, Oregon offers five major plans that cover most of the population that cannot afford private access to health care. These plans are state, federal, state-federal, premium, and combination funded. Leichter points out that individuals who are eligible but not covered and/or enrolled in any of the five plans tend to be disproportionately among minority groups.

According to Leichter, the barriers to access for minorities in Oregon are seasonal employment, lack of job-offered health benefits, language barriers, and “fear factors.” Administrative barriers can also be one of the toughest barriers to overcome. That is, many complain that there is too much fragmentation in the enrollment process. Also, the eligibility process in Oregon is confusing. The wait time is extremely long. Fragmentation of the five plans often leaves individuals confused as to which plan to apply for.

Leichter offers a number of solutions to the barriers and questions the state’s incremental strategy. One of the solutions is to increase the awareness of programs offered to the communities that are not taking advantage of the services. Another solution is the simplification of the application process. Leichter also advocates making access more affordable. In its present form, Leichter (pp. 264–265) argues that “multiple programs, with multiple eligibility and benefit packages, inherently and unavoidably create confusion and frustration and act as a deterrent to access.” In Leichter’s view (p. 265), “there is a significant portion of the uninsured that cannot or will not move into the health insurance mainstream and whose health care needs remain largely unmet.”

Finally, Michael Sparer's article looks at and tries to help us learn from the health care reforms undertaken in Wisconsin during the economic boom of the 1990s. The question of incrementalism is a key issue considered in Sparer's article. Until the mid-1990s, the health care system in Wisconsin was supported by two socioeconomic factors: a high level of employer-offered insurance coverage and a low level of spending per insured individual by the state, coupled with the highest level of benefits offered.

Then, in 1996, a plan known as W-2 (or Wisconsin Works) was created. W-2 was designed to insure the largest number of uninsured while capping the range of benefits offered. However, federal regulators rejected the plan. The federal government, instead, passed the State Child Health Insurance Program. Wisconsin, led by then governor Tommy Thompson, attempted to piggyback its W-2 program onto the federal program and, according to Sparer, "over the next several years, state and federal officials engaged in an ongoing intergovernmental battle over the shape and structure of the state's publicly funded health insurance programs" (p. 272). The end result of this intergovernmental bargaining was a compromise agreed to in 1999. The compromise was called BadgerCare. BadgerCare offered three-tier coverage to children with families whose incomes are from 100 percent to more than 185 percent below the poverty level. The state also received as a compromise the ability to charge premiums and reduce eligibility. As Sparer reminds us, the program became a model for the rest of the states and made Thompson a nationally known reformer.

Children and their families were not the only group addressed by Wisconsin policy makers. The Community Option Program was an attempt by Wisconsin to deal with long-term health care for the elderly. The Community Option Program limited nursing home construction while increasing funds for noninstitutional, home-based care. In 1997, in addition to BadgerCare, Wisconsin elected to change its state-funded elder care to a health maintenance organization (HMO) model health care system that would afford more opportunities for seniors to stay in the community. As Sparer points out, these programs and approaches placed Wisconsin on the forefront of senior health care reform.

Sparer concludes his article by asserting that Wisconsin should be used as a model and that in a way, its experience has mirrored the development of federal policies while staying one step ahead of them. Although Sparer argues that the results of the state's efforts are "decidedly mixed," Wisconsin no doubt serves as a model for offering the

widest possible coverage to the largest number of people with the minimal financial impact possible.

Discussion

Governors and legislatures alike have bought into the idea that the holy grail of health care is a low number of uninsured. Drive that number down—success! See it rise—failure! And so every policy step focuses on driving down the uninsured rate by expanding health care coverage. As the research here points out, this is certainly easier said than done. There are, among the states, many obstacles to expanding health care coverage. Overall, the analyses reported in this issue tell us that state party politics matters, that powerful interest groups influence policy outcomes, that intergovernmental relations impact state policy, and that incremental policy making dominates states' health efforts to expand health coverage to their citizens.

In the current context of state and national politics, this makes sense. In each milieu, health reform is a politicized issue, with Democrats pursuing broad reform policies and Republicans attacking those proposed reforms as introducing too much government intrusion in health care, as another step toward socialized medical care, and otherwise protecting the status quo. Party positions may be expected to change as Republicans secure increasing numbers of state legislatures and statehouses and begin proposing incremental strategies to expand health insurance coverage. Democrats may become less moderate in their policy positions and place increasingly ambitious reform plans on state policy agendas.

One of the interesting lessons to be gained from observing recent national and state-level debates on health reform is that moderate elements within the parties really are not far apart on the issue, but the posturing that has emerged as the issue becomes increasingly politicized has led party leadership to make great use of differences that are more apparent than real. The galvanization of Republican opposition to government-sponsored universal health care appears to have diffused to the states.

While several of the articles in this issue highlight citizen dissatisfaction with the current state of health care programs, I do not necessarily think that citizen opinion has no significant influence on health policy. Rather than relying on opinion on the specific program or policy as a guide, I would suggest that state legislators appear to be directed by broader understandings of constituents' ideological positions. This is not surprising, particularly given the complexity of health care issues. This, I think,

points to the importance of packaging future health reform proposals. If, as conservative politicians and some polls suggest, there is a shift toward conservatism in American political leanings, reformers would be well advised to portray future policy reforms as being driven by efficiency, cost saving, or some other goal more palatable than redistribution or expansion of rights. While this may be anathema to some progressives, it is sometimes necessary to determine whether being right or winning is a greater goal.

The future of health reform and expansion of insurance in the states is open to question and is now largely off the agenda. The shift of control of state legislatures (Congress and president), the war in Iraq, state budget woes, and national economic troubles have brought with them a shift in policy emphasis. Many state governors agreed to devote a large portion of their state's tobacco settlement money to children's health care. Despite that, the expansion of access to health care quickly gave way to cost control.

While health care dominated much of the states' agendas for the first half of the 1990s, the latter half was directed toward other issues. Health care has been fairly quiet in the states since the mid-1990s as the agenda of states has shifted toward issues such as school choice, tax reform, economic growth, budget shortfalls, and the like. As the articles in this issue point out, the states' brief flirtation with health policy innovation seems to have been the victim of an issue attention cycle. Although some remnants of the reforms remain, they are not well organized, integrated, or fully developed.

The authors in this issue show their frustration with this incremental process of health policy making. I, however, tend to have a different view. In effect, incremental policy making advises us to cool it, mellow out, and hang loose. Instead of trying to reform the world, settle for what you can get at any one time and place. Follow the path of least resistance; compromise; settle for half a loaf, a slice, even a crumb in hopes that next time around you will make more progress. As Charles Lindblom (1968: 25) wrote, "policy making is typically a never-ending process of successive steps in which continual nibbling is a substitute for a good bite."

But even with these political and policy changes and the failure of the states to pass sweeping comprehensive plans, it would be inaccurate to describe health reform in the states as a failure. The actions of the 1990s have resulted in important administrative reforms. The administrative reforms have led to increased regulatory scrutiny of providers and payers in the states, established managed care firmly as the dominant method for

providing care, and opened the health insurance market to individuals and groups for whom access was previously unavailable. Thus access to health care in the states is occurring as it does throughout the nation: great hopes sometimes result in less than was planned, but the outcome still reflects meaningful change.

Reference

Lindblom, Charles. 1968. *The Policy Making Process*. Englewood Cliffs, NJ: Prentice Hall.