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PROMISE AND PERILS OF STATE-BASED ROAD TO UNIVERSAL HEALTH INSURANCE IN THE U.S.

CAROL S. WEISSERT*

I. INTRODUCTION

The states' legacy in provision of health care services is strong. States are responsible for the funding and coordination of public health functions, the financing and delivery of personal health services (including Medicaid, mental health, public hospitals, and health departments), environmental protection, the regulation of medical care providers and the technology that they employ, the regulation of the sale of health insurance, rate setting, licensing, and cost control. In addition, states provide health insurance for their own employees and retirees and play a pivotal role in educating and credentialing health care professionals.¹

Similarly, states are the primary innovators in health policy, serving as what Justice Brandeis is credited as dubbing, "laboratories of democracy."² This role goes back a long way in American history. The 1921 Sheppard-Towner Act, which provided social and medical assistance to pregnant women and babies, was copied from a Connecticut law. States also provided models for the 1935 Social Security Act, the 1973 Supplemental Security Income program, and other health measures. More recently, Medicare's Diagnosis Related Group (DRG) payment system was based on a program in New Jersey, and the 1997 State Children's Health Insurance Program (S-CHIP) was based on programs in Washington and New York.³

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1. See CAROL S. WEISSERT & WILLIAM G. WEISSERT, *GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY 196-97* (2d ed. 2002).

2. While the term "laboratories of democracy" is attributed to Justice Louis Brandeis, the words do not appear directly in his dissent in *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932). Rather, he says, "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *Id.*

3. See WEISSERT & WEISSERT, *supra* note 1, at 226.

Following the failure of comprehensive federal health reform, states have continued to be innovative.⁴ For example, between 1997 and 1999, thirty-five states enacted new restrictions on managed care organizations, usually under the guise of a patients' bill of rights.⁵ States also launched innovative programs to provide coverage for the working poor, to reform small-group health insurance, and establish risk pools for those who found insurance difficult to obtain.⁶ Other programs were developed to mandate community rating, to create new ways of delivering services to Medicaid recipients and state employees, and to hold down the costs of prescription drugs, especially for the elderly.⁷

In spite of these efforts, and an ebullient economy, the number of uninsured has risen and the costs of health care have continued to escalate. Between 1990 and 2000, total health spending in the United States grew, on average, 3.2 percent, while the GDP per capita grew only by an average of 2.3 percent annually.⁸ Over that same decade, the number of uninsured rose from 34.7 million to 38.7 million.⁹ While the State Children's Health Insurance Program,¹⁰ passed in 1997, provided help in covering children and young adults, the overall problem of the uninsured is persistent and pervasive. What can be done, and more specifically, what can states do to solve the problems of the uninsured?

Part II of this article examines the role federalism plays in defining health care policy in the United States, including policy to ensure universal access to health care. Part III explores the reasons states might be the likely initiators of comprehensive public policy reform for the uninsured, and Part IV outlines the constraints on state leadership in this area. Part V posits what a state-based universal health insurance system might look like. Part VI analyzes the likelihood of state action based on the gubernatorial elections of 2002 and state of the state addresses in 2003. Finally, Part VII reflects upon the trends that emerge from this analysis.

4. For more information on the politics of the Clinton Health Plan, see Scott D. Litman, *Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership*, 7 CORNELL J.L. & PUB. POL'Y 871 (1998).

5. Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, 65 LAW & CONTEMP. PROBS. 169, 184 (2002).

6. WEISSERT & WEISSERT, *supra* note 1, at 228-29.

7. *Id.*

8. Gerard F. Anderson et al., *It's the Prices Stupid: Why the United States is So Different from Other Countries*, 22 HEALTH AFF. 89, 91 exhibit 1 (May / June 2003).

9. See ROBERT J. MILLS, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, PUB. NO. P60-215, HEALTH INSURANCE COVERAGE: 2000 13 tbl.A-1, available at <http://www.census.gov/prod/2001pubs/p60-215.pdf> (last visited Jan. 31, 2004).

10. Balanced Budget Act of 1997 § 4901, 42 U.S.C.A. §§ 1397aa – 1397jj (West 2003).

II. FEDERALISM THEORY

To understand states and health policy, one must understand the pivotal role states play in federalism and intergovernmental relations. Federalism can be defined as “a system of rules for the division of public policy responsibilities among a number of autonomous government [entities].”¹¹ In the United States, these entities are the federal and state governments. The autonomous nature of the relationship between these entities is key. States are not simply administrative units of Washington; rather, they have their own responsibilities and duties, many of them overlapping with federal responsibilities.

Federalism was a major component of the 1789 U.S. Constitution and a pivotal element in providing a system of checks and balances to prevent the federal government from becoming a dominant and overweening political institution. Over the centuries, the U.S. Supreme Court has played a significant role in defining the roles of the federal and state governments. In recent years, some argue that the Court has emphasized state autonomy, even expanding state sovereignty at the expense of the federal government’s policymaking and enforcement authority.¹² This has resulted in altering the balance of power between the federal government and the states, particularly by raising the level of state sovereign immunity to new heights.¹³

Clearly checks on state actions remain, including those relating to health policy. For example, until recently the courts had curtailed state regulation of health insurance provided by large companies that self-insure.¹⁴ Currently, state law cannot require these employers to cover certain procedures, insure high-risk groups, or make health coverage available to workers.¹⁵ However, the courts have been more lenient in recent years in allowing states to legislate and regulate in these areas.¹⁶

Politics play an important role in federalism. The U.S. Supreme Court in *Garcia v. San Antonio Metropolitan Transit Authority*¹⁷ suggested that states were adequately represented through the normal political process via their

11. THOMAS ANTON, *AMERICAN FEDERALISM & PUBLIC POLICY* 3 (1989).

12. Susan Gluck Mezey, *The U.S. Supreme Court’s Federalism Jurisprudence: Alden v. Maine and the Enhancement of State Sovereignty*, 30 *PUBLIUS: J. FEDERALISM* 21, 21-39 (2000).

13. *Id.*

14. *See Metropolitan Life Ins. v. Massachusetts*, 471 U.S. 724 (1985) (holding that a state law which mandated that health insurance plans include mental health care coverage was a legitimate state regulation as applied to traditional health insurance products, but that it was pre-empted by ERISA when applied to self-funded health insurance plans).

15. *See, e.g., Id.; Pegram v. Herdrich*, 530 U.S. 211 (2000) (holding that mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA).

16. *See Heather E. Rochet, Note, Trilogy of Cases Narrow Scope of ERISA Preemption: Survival of State Law Claims Regarding Negligent Quality of Care Under ERISA Plans in Light of Travelers, Dukes, and Herdrich*, 40 *BRANDEIS L.J.* 827, 844-47 (2002).

17. 469 U.S. 528 (1985).

representatives in Congress, and thus, absent highly unusual circumstances, it is unnecessary for the Court to intervene to protect their interests.¹⁸ More recently, some members of the Court opined that it is the Court's duty to guard against federal encroachment on the states' policymaking authority.¹⁹

Political scientists also recognize the importance of politics in U.S. federalism. This is particularly evident in Paul Peterson's legislative theory of federalism. Peterson argues that the modern federal system is shaped by the political needs of legislators at various governmental levels who mostly distribute benefits in a self-beneficial manner, by claiming credit for those benefits.²⁰ A second possible model of federalism is what Peterson calls "functional federalism," which predicts that all governmental levels will have their own areas of functional competence.²¹ The governments' various activities will then fall into those areas of functional competence. One such area of functional competence includes programs designed to redistribute societal resources from the "haves" to the "have-nots" by transferring economic resources from the wealthy to the needy.²² Welfare programs are classic redistributive programs, but many feel that health programs are redistributive as well. Alice Rivlin, for example, argues that reform of health financing and control over medical costs will likely not be attained by the states on their own.²³ She believes that the federal government should take firm control over medical costs and provide universal health coverage.²⁴ Federal action can control medical costs by increasing supply, cost-sharing with patients, changing incentives for providers, changing fee systems, setting targets for total health expenditures, or providing a single-payer system where states, or groups of states, could designate financial agents for health care.²⁵ Rivlin argues that only the federal government can provide access to health care for all citizens through universal health insurance.

Rivlin's prescription was written before President Bill Clinton's health care plan was launched—a plan which would have dealt with these issues and more. However, the Clinton proposal was simply not politically tenable. It was defeated

18. *Id.* at 556; Mezey, *supra* note 12, at 27; Geoffrey Moulton, *The Quixotic Search for a Judicially Enforceable Federalism*, 83 MINN. L. REV. 849, 851 (1999).

19. *See* Mezey, *supra* note 12, at 27 (noting Justice Scalia's majority opinion in *Printz v. United States*, 521 U.S. 898 (1997)).

20. PAUL E. PETERSON, *THE PRICE OF FEDERALISM* 39-40 (1995).

21. *Id.* at 16-18 (explaining that the two main purposes of government are developmental and redistributive programs, and that the federal government should assume the primary responsibility for redistribution, while the state and local levels of government assume primary responsibility for development, and further providing examples of developmental and redistributive programs).

22. *Id.* at 17.

23. ALICE M. RIVLIN, *REVIVING THE AMERICAN DREAM: THE ECONOMY, THE STATES & THE FEDERAL GOVERNMENT* 153 (1992).

24. *Id.* at 117.

25. *Id.* at 159-63.

not for one reason, but for many. These included: budgetary constraints; an antigovernment mood; the White House's inability to define the issue, frame the debate, or sustain the effort; the plan's complexity, liberal approach and cost; the inability of experts to agree on the reform; the lack of support from the business community; a deeply divided public; and finally, low levels of support from the elites.²⁶

III. THE PROMISE OF STATE HEALTH POLICY FOR THE UNINSURED

There are a variety of reasons why states are the likely initiators of comprehensive public policy for the uninsured: A) states have the administrative and policy capacity to take leadership in this area; B) states have a record as innovators; C) states have the mechanism of direct democracy; D) preferences lie with the states; and, E) states can serve as the default for creating health policy when Washington fails.

A. States Have the Administrative and Policy Capacity

The term most often used to describe the administrative and policy systems in the states is "resurgence."²⁷ David Hedge argues that there is considerable consensus among scholars and practitioners alike that states have undergone a "dramatic" resurgence in recent decades.²⁸ Hedge also argues that states are more responsive, better able, and more willing to govern now than at any other time in history.²⁹ Furthermore, Hedge argues that citizen participation has increased and states are more successful in achieving diversity than Washington, because there is a higher level of inter-party competition and a growing diversity of interest groups representing public opinion.³⁰ In addition, governors are more powerful; state legislatures are more professional, better staffed, and more assertive; and state courts are more willing to intervene in the decisions and actions of both the legislative and executive branches.³¹ Finally, Hedge argues, that "[most] importantly, the states have taken the lead in addressing a wide range of policy problems," including health care.³²

26. WEISSERT & WEISSERT, *supra* note 1, at 107-08.

27. See DAVID M. HEDGE, GOVERNANCE AND THE CHANGING AMERICAN STATES 3 (1998).

28. *Id.*

29. *Id.*

30. See *id.* at 3.

31. *Id.* at 3-4.

32. *Id.* at 4.

B. States Have a Record as Innovators

In recent years, states have launched innovative programs to improve health care delivery. These programs have attempted to “provide coverage for the working poor, to reform small group health insurance, and establish risk pools for those who find insurance difficult to obtain, to mandate community rating, to develop new ways of delivering services to Medicaid recipients and state employees,” among other issues.³³ Sometimes actions are taken quickly, such as Michigan’s move to statewide Medicaid Managed Care following the governor’s order to “Fire, Ready, Aim.”³⁴ Sometimes they come about more slowly, often in response to external factors.³⁵ In either case, the “risk” to the state is considerably lower than it would be under federal action due to the smaller size and scope of the program for even the largest states. It is also relatively easy for states to “pull back” from their own bad decisions quietly, and with less displacement, than from federal decisions. For example, several states, including Massachusetts, Minnesota, and Vermont, acted prior to the expected adoption of the Clinton Health Care Plan and were forced later to retract or modify their efforts at setting up a “managed competition” system, employer mandates, or universal access.³⁶

Ironically, perhaps, a program that is often politically unpopular in states is, nevertheless, often a source of innovation. In fact, Rachel Block argues that in terms of innovation, Medicaid has a better track record than Medicare, its more widely popular sister program.³⁷

Diffusion of innovation is also important. Political scientists have long charted the mechanisms by which ideas in one state crop up in other states, often

33. See WEISSERT & WEISSERT, *supra* note 1, at 227-29.

34. See Carol S. Weissert & Malcom L. Goggin, *Nonincremental Policy Change: Lessons from Michigan’s Medicaid Managed Care Initiative*, 62 PUB. ADMIN. REV. 206, 207 (2002).

35. See Thomas R. Oliver, *The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland*, 76 MILBANK Q. 59, 60 (1998). The author noted that in Maryland, external events such as political turnover, especially at the office of the Secretary of the Department of Health and Mental Hygiene, combined to trigger three major initiatives in five years. *Id.* at 91-92. He concluded that “[o]ne of the most notable characteristics of the [problem solving] process is that the factors that create opportunities for significant policy change often have little or nothing to do with the substantive problems that concern most policy experts.” *Id.* at 91.

36. See Michael S. Dukakis, *The Governors and Health Policymaking*, in THE NEW POLITICS OF STATE HEALTH POLICY 71 (Robert B. Hackey & David A. Rochefort eds., 2001); Howard M. Leichter, *Health Care Reform in Minnesota: A Journey, Not a Destination*, in HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES 217 (Howard M. Leichter ed., 2d ed. 1997); Howard M. Leichter, *The Little State that Could-Couldn’t: Vermont Stumbles on the Road to Reform*, in HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES 189 (Howard M. Leichter ed., 2d ed. 1997.)

37. Rachel Block, *Navigating Health Care Reform: Why States Should Be Captains of the Ship*, in NATIONAL HEALTH REFORM: WHAT SHOULD THE STATE ROLE BE? 41, 43 (Forrest P. Chisman et al. eds., 1994).

improved, and with that state's preferences and culture in mind.³⁸ Craig Volden finds that states with similar policy goals, similar demographic characteristics, and similar budgetary constraints are more likely to emulate each other.³⁹ Significantly, he also finds that states are imitating the policies that are found to be the most effective in meeting program goals.⁴⁰

C. States have the Mechanism of Direct Democracy

Ideally, health care reform should reflect a broad-based consensus where citizens are actively engaged in the decision-making process.⁴¹ In twenty-four states, citizens do so through an initiative process that offers voters the ability to propose legislation or constitutional amendments.⁴² Nearly half of the states offer citizens the popular voter referendum where citizens can vote to accept or reject legislation already passed.⁴³ The initiative and the referendum processes allow citizens a direct mechanism to enact or reject state laws and constitutional provisions that is not available at the federal level. A number of health initiatives have passed that would likely not have been adopted through the normal legislative channels. For example, between 1996 and 2002, seventeen state-level initiatives passed easing drug laws.⁴⁴ Key among these were medical marijuana laws which have been adopted in ten states.⁴⁵ In addition, Oregon's assisted suicide law, the only one in the country, was enacted by referendum.⁴⁶ Finally, in November 2002,

38. See Frances Stokes Berry & William D. Berry, *State Lottery Adoptions as Policy Innovations: An Event History Analysis*, 84 AM. POL. SCI. REV. 395, 395-96 (1990) ("Regional diffusion models emphasize the influence of nearby states, assuming that states emulate their neighbors when confronted with policy problems. . . . It is unrealistic to assume that a state blindly emulates its neighbors' policies without its public officials being influenced by the political and economic environment of their own state."); Michael Mintrom, *The State-Local Nexus in Policy Innovation Diffusion: The Case of School Choice*, 27 PUBLIUS: J. FEDERALISM 41 (Summer 1997).

39. Craig Volden, *States as Policy Laboratories: Experimenting with the Children's Health Insurance Program 13-16* (April 2003), available at <http://polmeth.wustl.edu/papers/03/volde03.pdf> (last visited Jan. 31, 2004) (unpublished manuscript prepared for the Twentieth Annual Summer Meeting in Political Methodology).

40. *Id.* at 16.

41. Howard M. Leichter, *State Governments and Their Capacity for Health Care Reform*, in HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES 151, 168 (Robert F. Rich & William D. White eds., 1996).

42. WEISSERT & WEISSERT, *supra* note 1, at 210.

43. WEISSERT & WEISSERT, *supra* note 1, at 210.

44. Leila Abboud, *White House Leads Push to Defeat Initiatives for Softer Drug Rules*, WALL ST. J., Nov. 4, 2002, at A4.

45. See Keith Perine, *C-J-S Spending Bill Becomes Venue for Wide Range of Policy Disputes*, 2003 CONG. Q. WKLY. 1906, 1907.

46. Of course, this law has led to some major federalism questions since the U.S. attorney general issued a directive that doctors and pharmacists who knowingly dispense controlled substances to assist patients in committing suicide violate the Controlled Substances Act. A federal district court judge

voters in Oregon defeated a proposal to establish a state-run universal health care system estimated to cost \$19 billion annually.⁴⁷

Even if initiatives fail to collect the majority of votes, they may nevertheless have an effect on state policy. Interest groups can send a message to legislators that the issue is important, and even if the initiative fails, it often lands on the legislative agenda following the election. Elisabeth Gerber found that policies in states with initiatives more closely reflect voter preferences than policies in states without them.⁴⁸

D. Preferences Lie with the States

Americans have dual citizenship: they are citizens of the United States of America and of their own individual states. While states generally contain a diverse swath of people, they are, nonetheless, more homogeneous than the nation as a whole. They can also initiate policy that deals with their citizens' demands, which reflect the citizens' wealth, race, occupation, personal and political philosophy, and health status. Former New Hampshire Governor John Sununu put it this way, "In diversity lies our strength. Our country is strong and prosperous because our state and local governments can address the particular needs of their people and areas by means that are perhaps uniquely appropriate to those involved."⁴⁹ To view it from a political perspective, a uniform federal policy would make a significant number of persons with differing tastes in different states unhappy.⁵⁰

E. State Action Toward Health Policy Can Come by Default.

Martha Derthick described the default issue this way: "Typically, through inaction by Congress, matters are left with the states, which have initial jurisdiction."⁵¹ Thomas Oliver agrees, noting that states become important when

struck down the directive in April 2002. See generally Lindsay F. Wiley, *Assisted Suicide: Court Strikes Down Ashcroft Directive*, 30 J.L. MED. & ETHICS 459 (2002).

47. Jill Wechsler, *Voters Cool to State Health Initiatives*, PHARMACEUTICAL EXECUTIVE, Dec. 1, 2002.

48. ELISABETH R. GERBER, *THE POPULIST PARADOX* 126 (1999).

49. Leichter, *supra* note 41, at 159.

50. See Steven G. Craig, *Should States Be Responsible for New Directions in Health Provision? Lessons from Other Policy Areas*, in *HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES*, 221, 246 (Robert F. Rich & William D. White eds., 1996).

51. Martha Derthick, *American Federalism: Half-Full or Half-Empty?* 18 BROOKINGS REV. 24, 26 (Winter 2000).

there is gridlock on key issues at the federal level.⁵² Examples in health abound, from the tobacco company settlement to prescription drugs, and from malpractice reform to a patients' bill of rights. Most recently, in the area of global warming, certainly an issue that crosses state lines, states have begun to take steps to reduce America's contribution to global warming in the absence of national policy.

IV. PERILS OF STATE-LED UNIVERSAL ACCESS

Apart from the positive indicators of possible state-led universal access just discussed, there are several major constraints that can prevent such leadership. These include: A) the states' limited scope and resources, B) federal constraints, C) possible federal change of heart, D) lack of concurrent voices, and E) term limits in seventeen states.

A. States have Limited Scope and Resources

No matter how wealthy and forward-thinking a state may be, that state's reach is limited by its border. Issues that cross the border are interstate (i.e., interstate commerce) and thus out of the state's reach. For example, telemedicine, corporate ownership of hospitals, and employee insurance from companies that have offices in several states, raise issues that cross state lines.

States are also limited in their available resources. State budgets are smaller than the federal budget, and the range between the smallest and largest states is enormous. California, the largest state, collects nearly \$84 billion in taxes to run state programs.⁵³ At the other end of the spectrum, Alaska, South Dakota, and Wyoming each collect between \$1 and \$1.5 billion in state taxes.⁵⁴ However, all states have a major constraint that Washington does not; states must balance their budgets at the end of their fiscal year. They are usually prohibited from borrowing for non-capital expenses at the end of the year to avoid a deficit. Thus, if states take on major new spending in a comprehensive health program, they must also assume the responsibility for funding that program with actual tax dollars—not

52. Thomas R. Oliver, *State Health Politics and Policy: Rhetoric, Reality and the Challenges Ahead*, in *THE NEW POLITICS OF STATE HEALTH POLICY* 273, 276 (Robert B. Hackey & David A. Rochefort eds. 2001).

53. ROCKEFELLER INST. OF GOV'T, CALIFORNIA FISCAL PROFILE FOR FISCAL YEAR 2000 (2002) available at http://stateandlocalgateway.rockinst.org/fiscal_trends/state_profiles (last visited Jan.31, 2004).

54. ROCKEFELLER INST. OF GOV'T, ALASKA FISCAL PROFILE FOR FISCAL YEAR 2000, ROCKEFELLER INST. OF GOV'T, SOUTH DAKOTA FISCAL PROFILE FOR FISCAL YEAR 2000, ROCKEFELLER INST. OF GOV'T, WYOMING FISCAL PROFILE FOR FISCAL YEAR 2000 (2002) available at http://stateandlocalgateway.rockinst.org/fiscal_trends/state_profiles (last visited Jan. 31, 2004).

monies borrowed or deficit-financed. When the economy is strong, this is no problem; it becomes more difficult in economic downturns when states must scramble to balance the budget.⁵⁵

B. Federal Constraints

One of the most restricting and long-standing federal constraints on state efforts to provide universal access is the Employee Retirement Income Security Act of 1974 (ERISA), which sets administrative and substantive standards for the operation of employee benefit plans.⁵⁶ ERISA contains a preemption clause which for decades was broadly interpreted by courts in a way that posed a substantial challenge to state health reform initiatives.⁵⁷ However, beginning with *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*⁵⁸ in 1995, the Supreme Court indicated a change of course in ERISA cases, finding that ERISA did not preempt New York's hospital rate-setting provisions that imposed a surcharge on Health Maintenance Organizations (HMOs).⁵⁹ In 1997, the Court solidified its reluctance to strictly apply ERISA's preemption clause in two cases.⁶⁰ Finally, in 2003, the Court dismissed the idea that ERISA preempted state "any willing provider" laws.⁶¹ While these cases seem to be narrowing ERISA's preemption, ERISA continues to impede comprehensive state action, particularly since large employers whose workers make up two-thirds of the national work force can opt out of any statewide health care scheme.⁶²

55. See Nicholas W. Jenny & Richard P. Nathan, *Sizing Up the Shortfalls: The States in Straits*, GOV'T FIN. REV. 10, 12-13 (2001).

56. 29 U.S.C.A. §§ 1001-1461 (West 1999 & Supp. 2003).

57. See Deborah S. Davidson, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A "Uniform Patient Protection Act,"* 53 WASH. U. J. URB. & CONTEMP. L., 203, 205 (1998). See generally John W. Schuch, Note, *ERISA Preemption of State Tort Law Claims Against Managed Care Entities*, 67 BROOK. L. REV. 1221 (2002).

58. 514 U.S. 645 (1995).

59. *Id.* at 649 (holding that the provisions did not relate to the employee benefit plans under the meaning of ERISA's preemption provision and therefore, were not preempted). See also Davidson, *supra* note 57, at 222.

60. See *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A., Inc.*, 519 U.S. 316, 334 (1997) (holding that California's prevailing wage law is neither "related to" nor has "connection with" ERISA plans and is therefore not preempted by ERISA); *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 814-16 (1997) (rejecting the theory that any state law that increases the cost of providing benefits to covered employees, and thus has some effect on the administration of ERISA plans, is pre-empted by the ERISA statute).

61. *Ky. Ass'n of Health Plans v. Miller*, 123 S. Ct. 1471, 1479 (2003). Kentucky's "any willing provider" laws prohibits a health insurer from refusing to contract with any qualified health care provider who is willing to abide by the insurer's terms and is within the designated coverage area of the health benefit plan. *Id.* at 1473-74.

62. See Litman, *supra* note 4, at 883.

Congress has not revisited the issue since ERISA was enacted in 1974. While state organizations and others have called for a change in the law, business interests and labor have fought against change, arguing that fifty different sets of state insurance regulations would be inefficient and burdensome.⁶³

C. Potential Federal Change of Heart

One of the strengths of the American political system is its dynamic and flexible nature. Every two years a new Congress convenes in Washington, allowing enactments from a prior Congress to be repealed by any subsequent Congress. While this may work well for federal responsiveness, it creates difficulties for states, which may make decisions based on law adopted in time, only to be changed substantially at a later time. Therefore, while making decisions in part based on federal incentives, states must factor in the possibility that Washington will renege on a promise by changing a law or de-funding a program. This possibility affects the way states respond, either by enacting their own laws or by implementing federal ones. Individual states may not implement a law in the manner intended by Congress, if such action might prove expensive or if there is a subsequent change in federal policy or funding. Recent research has highlighted this response and dubbed it an “irony of delegation.”⁶⁴ States can also enact laws in expectation of federal legislation, as happened in the early 1990s when several states thought national health care reform, especially managed competition, was imminent and enacted state versions.⁶⁵ When the national legislation was not enacted, the state laws were amended or abolished. The expected value of possible change, or inaction, can serve to dampen state enthusiasm and serve as a possible barrier to state health reforms.

D. Lack of Concurrent Voices

Public policy is difficult to enact both in Washington and in state capitals for a myriad of reasons, but key among them in health policy is a failure to have concurrent voices. Consensus on public policy solutions to health-related issues is hard to find. Consumer interest groups seldom agree with provider groups who

63. See Angelo A. Stio III, *State Government: The Laboratory for National Health Care Reform*, 19 SETON HALL LEGIS. J. 322, 373 (1994).

64. See generally Jeffrey S. Hill & Carol S. Weissert, *Implementation and the Irony of Delegation: The Politics of Low-Level Radioactive Waste Disposal*, 57 J. POL. 344 (1995) (discussing the potential problems associated with delegation of authority for low-level radioactive waste disposal from Congress to an administrative agent).

65. See Stio, *supra* note 63, at 323, 347-64.

have different interests than insurers, businesses, and unions.⁶⁶ Partisanship often contributes to the lack of consensus in health issues as well.⁶⁷ Finally, the public sends mixed messages on what they want, and more importantly, what they are willing to pay for.⁶⁸ One could argue that policy consensus is more likely at the state than the federal level since the stakes are lower and interests are likely to be more homogeneous. Indeed, this may be the reason why states have been able to act on a myriad of issues still awaiting federal consensus—issues ranging from malpractice reform to curbing the cost of prescription drugs. However, difficulties in reaching consensus still plague state health policymaking.

E. Term Limits

Seventeen states, including four of the nation's largest (California, Florida, Michigan and Ohio), have enacted legislative term limits which restrict the amount of time state legislators can serve.⁶⁹ In two of these states, California and Michigan, legislators can now only serve three terms (six years) in the lower house and two terms (eight years) in the upper house.⁷⁰ In these states the limits are lifetime; meaning the legislator cannot serve more than the six and eight years, respectively, in his or her lifetime.⁷¹ While the turnover in state legislatures engendered by these provisions might auger for more change as new members come in with new ideas, there is also the argument, supported with some initial research, that new members are more interested in short-term solutions that can be felt quickly in a way that can positively affect a new legislator's career.⁷² Long-term solutions, those with impacts that might be realized after the legislator has left the chamber, are less appealing.⁷³ Not only are long-term solutions not politically advantageous, but they are also more difficult to enact, given the lack of concurrent voices.⁷⁴ Finally, long-term solutions are often more complex, requiring considerable background and expertise to understand the various nuances of both need and potential impact.⁷⁵

66. See WEISSERT & WEISSERT, *supra* note 1, at 3-4.

67. See WEISSERT & WEISSERT, *supra* note 1, at 3-4.

68. See WEISSERT & WEISSERT, *supra* note 1, at 3-4.

69. See NAT'L CONFERENCE OF STATE LEGISLATURES, SUMMARY AND CITATIONS OF STATE TERM LIMIT LAWS, available at <http://www.ncsl.org/programs/legman/about/citations.htm> (last visited Jan. 31, 2004).

70. *Id.*

71. *Id.*

72. See CAREY ET AL., TERM LIMITS IN THE STATE LEGISLATURES 20, 21, 28 (2000).

73. See *id.* at 41-64.

74. See *id.*

75. See *id.* at 45-46.

V. THE LOOK OF STATE-BASED UNIVERSAL HEALTH INSURANCE

If states were able to enact universal state-based health insurance, what would it look like? The state-based road would likely have five elements. It would involve incremental changes, often through the addition of new age groups and/or diseases. It would involve multi-state cooperation, and possible interstate compacts. It would include local and community involvement and participation. It would reflect citizens' preferences, not necessarily national preferences, and it would result in inequities.

A. Incremental Change

Public policy making is largely incremental. Incremental change is often easier to sell to the voting public and fellow legislators because most people are averse to risk. Policymakers are "reluctant to make large and risky changes because the consequences and costs are hard to predict and unintended consequences can be costly."⁷⁶ Incremental changes also build on past programs that have a constituency more willing to readily accept growth than major program revision.⁷⁷

Incremental changes allow policymakers to learn from previous actions and to build on the state's systems in order to carry out policy, as well as maintain political support. Some political scientists argue that political institutions and public policy have a status quo mentality, meaning there is a tendency for the policy to be stable, with only incremental changes feasible.⁷⁸ However, smaller, incremental changes can accumulate over time to produce larger, systemic changes.⁷⁹

As in Washington, incremental change toward universal health insurance coverage in the states means adding groups of people to existing programs and sometimes adding services to cover a specific disease. For example, the State Children's Health Insurance Program (S-CHIP) was a federal-state program that enrolled nearly four million low income children by 2002.⁸⁰ Similarly, federal incentives provided coverage for uninsured women for cervical and breast cancer

76. WEISSERT & WEISSERT, *supra* note 1, at 256-57.

77. WEISSERT & WEISSERT, *supra* note 1, at 254-55.

78. See Paul Pierson, *Increasing Returns, Path Dependence, and the Study of Politics*, 94 AM. POL. SCI. REV. 251, 262 (2000).

79. Leichter, *supra* note 41, at 153.

80. See Embry M. Howell et al., *SCHIP Dodges the First Budget Ax*, in ASSESSING THE NEW FEDERALISM: ISSUES AND OPTIONS FOR STATES 1 (Urb. Inst., Series A, No. A-56, Wash. D.C.), Dec. 2002.

treatment.⁸¹ Also, programs targeted at the elderly and disabled are often popular for federal and state legislators and can serve to incrementally advance coverage of the otherwise uninsured.

B. Multi-state Cooperation and Compacts

In the past decade, the states' Attorneys General have led the way in showing how multi-state cooperation can lead to major change in business behavior and the environment by bringing the tobacco industry to task for costs associated with smoking. Most notable was the "tobacco settlement between attorneys general from 46 states, four territories, and the District of Columbia and the nation's major tobacco companies in November 1998."⁸² The deal provided states with \$206 billion over twenty-five years in exchange for an agreement not to sue the tobacco companies.⁸³ The attorneys general also worked together to get the paint manufacturers and a lead-industry group to pay states for "treating children poisoned by lead paint and for the costs of removing lead paint from buildings."⁸⁴ Governors, some of them former attorneys general, have learned from these experiences and several are attempting to forge multi-state cooperation in the area of prescription drugs where four states from the Northeast, South, and Midwest have formed the nation's first multi-state Medicaid Pharmaceutical Pooling Program.⁸⁵

C. More Local Involvement

Quietly and slowly, over the past decade, local and community-led efforts have been launched across the country to deal with the issue of the uninsured.

81. Breast and Cervical Cancer Prevention and Treatment Act of 2000, 42 U.S.C.A. §§ 1396a, 1396b, 1396d, 1396r-1b (West 2003). In addition to providing screening, the law allowed states to expand Medicaid benefits to uninsured women who are diagnosed with breast or cervical cancer through the federal screening program. *Id.*

82. Sanford F. Schram & Carol S. Weissert, *The State of U.S. Federalism: 1998-1999*, 29 PUBLIUS: J. FEDERALISM 1, 16 (1999).

83. *Id.*

84. Carol S. Weissert & Sanford F. Schram, *The State of U.S. Federalism, 1999-2000*, 30 PUBLIUS: J. FEDERALISM, 1, 12 (2000).

85. Press Release, Office of the Governor, Governor Granholm Gets Results; Moves Michigan Forward in First 100 Days (Apr. 10, 2003), available at http://www.michigan.gov/gov/0,1607,7-168-23442_21974-65835—M_2003_4,00.html (last visited Jan. 31, 2004). The four states are Michigan, Vermont, South Carolina, and Wisconsin.

There are currently hundreds of community efforts underway to deal with the problems of the uninsured.⁸⁶

These efforts are sponsored by coalitions with members representing government, schools, hospitals, health providers, and advocacy groups.⁸⁷ Expanding health care coverage for the uninsured is an important goal for many of these groups. Other goals include increasing access to services by changing policies of providers and improving public health and prevention.⁸⁸ These initiatives are often well organized, providing coordinated delivery of care and oversight by a public-private collaboration.⁸⁹ These efforts were recognized in the campaigns of several gubernatorial candidates, including Jennifer Granholm, the new Democratic governor of Michigan, who has recently sought feedback on implementing such an initiative.⁹⁰

D. Reflect Citizens' Preferences

It is important to remember that state policies are generally non-uniform. While states do learn from and imitate each other to some extent, ultimately their policies reflect the desires of their own citizens. Citizen preferences differ from state to state, and do not necessarily reflect the preferences of the nation as a whole. Thus there is little chance that a state-based system for universal health coverage would be uniform in nature; rather it would vary in coverage, funding, and delivery choices.

E. Inequities

Inevitably, the result of different citizen preferences and policy choices reflecting different citizen preferences is inequity. Citizens of one state will be treated differently than those of another. Some political scientists have argued that this leads to a "race to the bottom," where states will lower their benefits on

86. THE ACCESS PROJECT, ACTION WHERE IT COUNTS: COMMUNITIES RESPONDING TO THE CHALLENGE OF HEALTH CARE FOR THE UNINSURED 1, 2 (June 1999), available at www.accessproject.org/downloads/survey.pdf (last visited Jan. 31, 2004).

87. *Id.*

88. *Id.* at 3.

89. DENNIS ANDRULIS & MICHAEL GUSMANO, THE NEW YORK ACADEMY OF MEDICINE, COMMUNITY INITIATIVES FOR THE UNINSURED: HOW FAR CAN INNOVATIVE PARTNERSHIPS TAKE US? (2000), available at <http://www.rwjf.org/publications/publicationsPdfs/community-init.pdf> (last visited Jan. 31, 2004). The initiative includes efforts to reduce costs, build community relations, and make more efficient use of services. *Id.*

90. See Michigan Rural Health Assoc. News, *Granholm Requests Input on Future of Medicaid*, at <http://www.miruralhealth.org/News/> (last visited Jan. 31, 2004).

redistributive programs such as welfare and Medicaid so they will not become “welfare magnets”—encouraging welfare recipients to leave a state with lesser benefits to come to the state with more generous benefits.⁹¹ Although there is little evidence that welfare recipients do in fact migrate for benefits, apparently public officials believe that they do—and act accordingly.⁹² Thus, under a state-based health insurance system, we would expect to see citizens treated differently depending on where they live (as they do now under Medicaid, a state-defined program, but not Medicare, a federally defined program).

VI. PROMISE CONTINUED: LESSONS FROM THE 2002 ELECTIONS

The 2002 mid-term elections were especially important for the thirty-six states that elected governors. Governors are important bellwethers of state health policy because they generally take the lead in comprehensive health reform—especially those reforms relating to access. The governor may be the only political actor in the state who can build the political coalition necessary to expand access to health care for the uninsured. The governor can garner the media attention needed to attain public support and has resources for policy analytical work essential in building the case for new health programs.⁹³ Once every four years, thirty-six gubernatorial elections are held—including those in the eight largest states of the country. Thus, analysis of the election rhetoric, and initial policy statements outlined in the governors’ state of the state messages, is informative of the promise of universal health care, state style.

A. 2002 Gubernatorial Races

Access to health care was important to many gubernatorial candidates in 2002.⁹⁴ As noted in Figure 1, in nearly 60% of the states with gubernatorial

91. See generally PAUL E. PETERSON & MARK C. ROM, *WELFARE MAGNETS: A NEW CASE FOR A NATIONAL STANDARD* (1990).

92. Scott W. Allard, *Revisiting Shapiro: Welfare Magnets and State Residency Requirements in the 1990s*, 28 *PUBLIUS: J. FEDERALISM* 45 (1998); see also Sanford F. Schram & Joe Soss, *Making Something out of Nothing: Welfare Reform and a New Race to the Bottom*, 28 *PUBLIUS: J. FEDERALISM* 67, 68 (1998).

93. Dukakis, *supra* note 36, at 73-74.

94. In this analysis of the 36 gubernatorial races in 2002, the website for each candidate was surveyed for health care access issues and the candidate’s position on the issue. If the candidate identified public access to health care as a major issue, then the researcher considered that to be a success in the following statistical analysis; if there was no mention of such issues, it was considered a failure. Candidates with no website were not counted for purposes of this analysis. Information from each website was gathered, collected, and compiled by the author and is on file with the Journal of Health Care Law & Policy.

elections, twenty-one states, both Republican and Democratic candidates identified health care as a major issue in the campaign.⁹⁵ In an additional 33%, representing twelve states, one candidate viewed access as a major issue.⁹⁶ In addition, as illustrated in Figure 2, Democratic candidates were more likely to identify access to health care as a major issue in the 2002 campaign: 86% of the Democratic candidates compared to only 64% of Republican candidates.⁹⁷

FIGURE 1

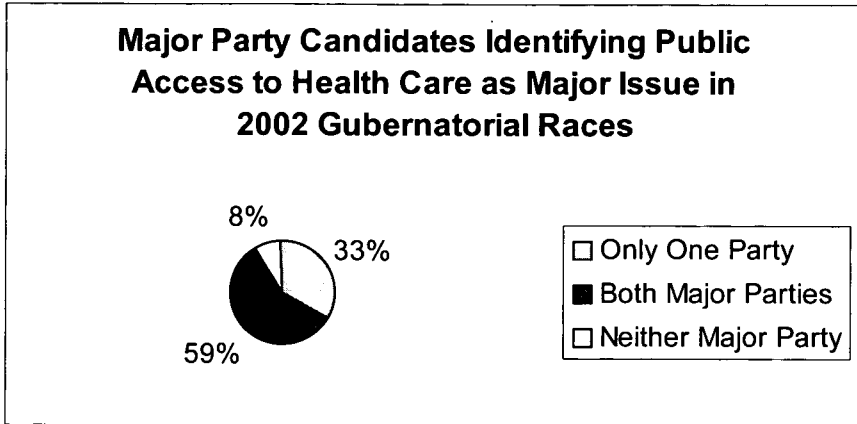
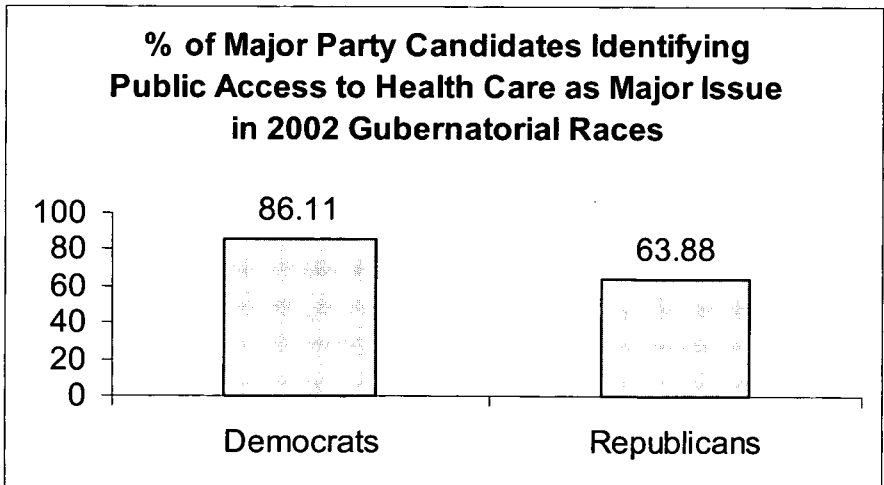


FIGURE 2



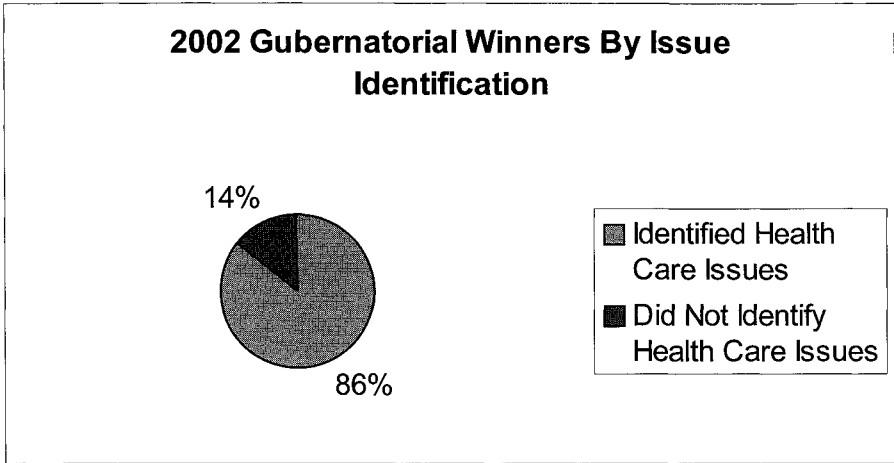
95. Survey data on file with the Journal of Health Care Law & Policy.

96. Survey data on file with the Journal of Health Care Law & Policy.

97. Survey data on file with the Journal of Health Care Law & Policy.

Candidates who viewed access to health care as a major issue seemed more likely to win the election (although clearly other factors played a role as well). While 76% of all candidates identified health access as a major issue in the race, 86 percent of gubernatorial winners did so.⁹⁸

FIGURE 3



The health policy area most often addressed in the gubernatorial campaigns was the cost of prescription drugs. Thirteen candidates included controlling drug costs as an element in their health platform.⁹⁹ This was, of course, often associated with access, especially for the elderly. However, the candidates' approaches to controlling drug costs differed. For example, the Arizona Republican candidate, Matt Salmon, promised to work with pharmaceutical companies to provide discount programs for seniors and to develop programs to help seniors take advantage of these programs.¹⁰⁰ Several gubernatorial candidates (including Democratic candidates in Alabama and Michigan) promised to work with neighboring states to form a regional drug purchasing pool.¹⁰¹ Thirteen candidates

98. Survey data on file with the Journal of Health Care Law & Policy. It is important to note that candidates without websites were not counted for purposes of this analysis.

99. Survey data on file with the Journal of Health Care Law & Policy.

100. *Decision 2002: Ask the Candidates*, ARIZONA DAILY STAR, (Matt Salmon's responses to Arizona Daily Star staff questions), at <http://elections.azstarnet.com/askcan/gov-salmon.php> (last visited Jan. 31, 2004).

101. MIMI MARCHEV & TRISH RILEY, NAT'L ACAD. FOR STATE HEALTH POLICY, ELECTION 2002: WHAT GUBERNATORIAL CANDIDATES SAY ABOUT HEALTH CARE 5 (2002), available at http://www.nashp.org/Files/summary_for_web.pdf (last visited Jan. 31, 2004).

supported a statewide model where the state negotiates with insurers to provide the best buy for drug purchasers.¹⁰²

Both Democratic and Republican gubernatorial candidates talked of lobbying Washington for more money. Some fourteen candidates included this strategy as part of their health policy platform. Alabama's Democratic candidate, Don Siegelman, called for closing federal loopholes to keep more affordable generic drugs off the market; California's Democratic candidate, Gray Davis, called for changes in use of S-CHIP dollars; Nevada's Republican candidate, Kenny C. Guinn, proposed ERISA changes and more money for rural health services; and the Democratic candidate in New York, H. Carl McCall, said he would advocate in Washington for increased federal payment for the uninsured.¹⁰³ The Texas Republican candidate, Rick Perry, promised to seek removal of federal barriers on Medical Savings Accounts; Arizona's Democratic candidate, Janet Napolitano, proposed going to Washington seeking increased funding for a number of health care industry programs; and Kansas' Democratic candidate, Kathleen Sebelius, and Maine's Republican candidate, Peter Cianchette, proposed federal increases in Medicare reimbursement for rural hospitals.¹⁰⁴ Other gubernatorial candidates promised to fight in Washington for Medicare coverage of prescription drugs, including the Democratic candidate in Pennsylvania, Ed Rendell, and Republican candidates in Maine, Massachusetts, and Wyoming.¹⁰⁵

102. *Id.* at 5-6.

103. AM. ASS'N RET. PERSONS, ELECTION 2002 VOTER GUIDE: ALABAMA GOVERNOR (Candidate responses), available at http://www.aarp.org/vg2002/al/al_governor.html (last visited Jan. 31, 2003). See also MIMI MARCHEV & TRISH RILEY, NAT'L ACAD. FOR STATE HEALTH POLICY, GUBERNATORIAL ELECTIONS 2002: HEALTH CARE INITIATIVES TRACKING MATRIX 3 (2002) available at http://www.nashp.org/Files/tracking_matrix_edited_for_web2.pdf (highlighting the proposal by Gray Davis) (last visited Jan. 31, 2004); ON THE ISSUES, KENNY GUINN ON HEALTH CARE, at http://www.issues2002.org/Governor/Kenny_Guinn_Health_Care.htm (last visited Jan. 31, 2004); MCCALL GOVERNOR, ISSUES: HEALTH CARE, at <http://wasearch.loc.gov/e22k/20021002124829/http://www.mccall02.com/html/issues/health.htm> (last visited Jan. 31, 2004) (on file with the Journal of Health Care Law & Policy).

104. See MARCHEV & RILEY, *supra* note 103, at 4, 29 (highlighting the proposals by the candidates from Arizona and Texas); Press Release, Nicole Corcoran-Basso, Sebelius Announces Plan for Health Care and Prescription Drugs (Oct. 11, 2002) [hereinafter Sebelius Press Release]; Press Release, Cianchette for Governor, Cianchette Begins "Road to Growth" Tour Across Maine (Sept. 9, 2002), available at <http://www.cianchetteforgovernor.com/release9-9-02.htm> (last visited Jan. 31, 2004) (on file with the Journal of Health Care Law & Policy).

105. 2002 PA Gubernatorial Candidates: Different Prescriptions for Health Care in Pennsylvania, HEALTH L. PA. NEWS (Newsletter of the Pennsylvania Health Law Project), Oct. 2002 at 7 [hereinafter 2002 PA Gubernatorial Candidates], available at http://www.phlf.org/news/health_law_pa_news_oct_2002.pdf (last visited Jan. 31, 2004); see MARCHEV & RILEY, *supra* note 103, at 14, 16 (highlighting the initiatives by the Maine and Massachusetts candidates); ON THE ISSUES, JIM GERINGER ON HEALTH CARE, at http://www.issues2002.org/Governor/Jim_Geringer_Health_Care.htm (last visited Jan. 31, 2004) (on file with the Journal of Health Care Law & Policy).

Eleven candidates proposed expanded coverage for families with children covered under S-CHIP.¹⁰⁶ Fifteen candidates proposed expansion of health insurance for children, primarily through raising the eligibility ceiling for S-CHIP.¹⁰⁷ The elderly were also a target for candidates, with eleven candidates proposing programs for education on drug management, alternatives to long-term care, and targeted tax cuts.¹⁰⁸ In addition, several governors also proposed expanding Medicaid coverage to the disabled.¹⁰⁹

Several gubernatorial candidates, primarily but not exclusively Republican, called for relief for insurance companies or providers as a way of improving access. The most common proposal along this line, shared by thirteen candidates, was a call for pooling the insurance costs of employers.¹¹⁰ Some candidates (including the Democratic candidates in Arizona, Colorado, and Kansas, and Republican candidates in Arizona and Hawaii) proposed tax incentives for employers providing employees with a basic core of health care coverage.¹¹¹

Two Democratic candidates (Michigan and Pennsylvania) were interested in expanding the number of Federally Qualified Health Centers (FQHCs) in their state.¹¹² This proposal serves to improve access—and leverage federal dollars.

Efforts to persuade health providers to serve in rural areas and to encourage more young people to go into nursing were evidenced in thirteen states. The Massachusetts Democratic candidate, Shannon P. O'Brien, supported expansion in the supply of community health workers throughout the state.¹¹³ Pennsylvania's Democratic candidate, Ed Rendell, called for establishment of a state center for health care careers.¹¹⁴

106. MARCHEV & RILEY, *supra* note 101, at 1, 5.

107. MARCHEV & RILEY, *supra* note 103. The candidates were: Diegelman (D-AL), Napalitano (D-AZ), Davis (D-CA), Heath (D-CO), Bush (R-FL), Brady (D-ID), Blagojevich (D-IL), Sebelius (D-KS), Townsend (D-MD), Granholm (D-MI), Fernald (D-NH), Richardson (D-NM), McCall (D-NY), Rendell (D-PA), and Frreudenthal (D-WY).

108. MARCHEV & RILEY, *supra* note 103. The candidates were: Salmon (R-AZ), Bush (R-FL), Hirono (D-HI), Gross (R-IA), Sebelius (D-KS), O'Brien (D-MS), Moe (D-MN), Penny (I-MN), Taft (R-OH), Fisher (R-PA), and Carcier (R-RI).

109. MARCHEV & RILEY, *supra* note 103. The candidates making these proposals included: Napalaitano (D-AZ), Mahoney (I-IN), Blagojevich (D-IL), Moe (D-MN), Richardson (D-NM), and Pataki (R-NY).

110. MARCHEV & RILEY, *supra* note 101, at 6.

111. MARCHEV & RILEY, *supra* note 103, at 4, 5, 8, 11 (highlighting proposals by candidates in Arizona, Colorado, and Hawaii); Sebelius Press Release, *supra* note 104 (discussing proposal by the democratic candidate from Kansas).

112. MARCHEV & RILEY, *supra* note 103, at 17, 25.

113. MASS. HOSP. ASS'N, CANDIDATES SPEAK OUT: HOSPITALS & HEALTH CARE ESSENTIAL TO OUR QUALITY OF LIFE 8 (2d ed. 2002).

114. THE ARC OF PENNSYLVANIA, QUESTIONS TO 2002 GUBERNATORIAL CANDIDATES 3, available at <http://www.thearca.org/gubernatorial2002.pdf> (last visited Jan. 31, 2004).

While most of the proposals and issues diffused across state lines and have been adopted elsewhere, there were some novel proposals. Particularly noteworthy were proposals on health-related information. For example, Arkansas' Democratic candidate, Jimmie Lou Fisher, called for public disclosure of drug industry marketing and promotional spending.¹¹⁵ Wisconsin's Democratic candidate, Jim Doyle, called for the development of a written report from each insurance company and HMO with the number and percentage of employers whose premiums it has increased by more than 10, 15, and 20 %.¹¹⁶ He then proposed that these results be posted online so employers would know which HMOs and insurers "to avoid."¹¹⁷ The Republican candidate in Texas, Rick Perry, called for the state to publish a small employer rate guide and provide assistance to help small employers find information and understand their options.¹¹⁸

Two other innovative proposals dealt with health professionals and community initiatives. Colorado's Republican candidate, Bill Owens, proposed working to make health insurers offer plans that cross state lines, as well as enabling nurses who live in nearby states to work in Colorado.¹¹⁹ Ohio's Democratic candidate, Tim Hagan, proposed a Community Access Program to provide modest but catalytic grants to local communities to undertake creative public-private partnerships with medical institutions targeted toward reducing racial disparities in health care outcomes.¹²⁰

A few of the candidates promised to expand access for the working poor including the New Hampshire Democratic candidate, Mark Fernald, who pledged to work to create a "Healthy Adults" program to cover the working poor and to create a health insurance program for the uninsured by using the state's tobacco settlement money.¹²¹ New Mexico's Democratic candidate, Bill Richardson, called for building upon SCHIP to create a Medicaid safety net for the elderly and disabled.¹²²

115. Michael R. Wickline, *Governor Touts Rx Discount Fisher Denounces Move as Political*, ARK. DEMOCRAT-GAZETTE, Oct. 4, 2002, at B1, available at 2002 WL 100116206.

116. DOYLE-FOR-GOVERNOR, THE DOYLE HEALTH CARE PLAN, "A HEALTHIER WISCONSIN", available at <http://www.doyle2002.com/issues/health.html> (last visited Jan. 31, 2004).

117. *Id.*

118. GOVERNOR RICK PERRY'S PROPOSALS FOR BUILDING A HEALTHY TEXAS (2002), available at <http://www.rickperry.org/PerryOnInsurance.html> (last visited Jan. 31, 2004).

119. MARCHEV & RILEY, *supra* note 103, at 8.

120. Press Release, Tim Hagen, Policy Statement (copy of original web language on file with the Journal of Health Care Law & Policy).

121. NEW HAMPSHIRE FOR HEALTH CARE, TAKE ACTION! WHERE THE CANDIDATES STAND (response of Mark Fernald) (copy of original web language on file with the Journal of Health Care Law & Policy).

122. *Medicaid Today: The States' Perspective Before the Subcommittee on Health, House Comm. on Energy and Commerce*, 108th Cong. (2003) (Prepared testimony of Gov. Bill Richardson), available at <http://energycommerce.house.gov/108/Hearings/03122003hearing815/Richardson1334.htm> (last visited Jan. 31, 2004).

Other platform issues included malpractice (from the Nevada and the Massachusetts Republican candidates);¹²³ report cards and improved health program dissemination (Democratic candidates in Arizona, Connecticut, and New Mexico);¹²⁴ mental health parity (Democratic candidates in New York and Ohio);¹²⁵ anti-smoking (Democratic candidate in New York);¹²⁶ and MSAs (Republican candidates in Arizona and Minnesota).¹²⁷In several areas, the candidates provided more rhetoric than actual policy solutions. Areas particularly prone to rhetoric without substance were racial inequities (Democratic candidate in Massachusetts), healthy behavior (Democratic candidate in Ohio), public health (Democratic candidates in Wisconsin and Maine), and rural health (Democratic candidates in Arizona and Texas).

While there were some policy areas in which the party candidates clearly differed, far more common was endorsement by both the Democratic and Republican candidates. For example, both the Democratic candidate in Michigan, Jennifer Granholm, and the Republican candidate in Texas, Rick Perry, supported federally qualified health centers, and both the Democratic candidate in Texas, Tony Sanchez, and the Republican candidate in Wisconsin, Scott McCallum, called for incentives for health professionals.¹²⁸

In addition, there were Democratic candidates who called for reducing the health care bureaucracy by streamlining paperwork (Connecticut) and for “market-based” solutions to the problem of escalating prescription drug prices (Ohio).¹²⁹ Tax credits were proposed by Democratic Candidates in Iowa (Tom Vilsack) and Colorado (Rollie Heath), and both Maine’s Republican candidate (Peter Cianchette) and Michigan’s Democratic candidate (Jennifer Granholm) called for more public-private partnerships in solving health care problems.¹³⁰

Overall, what is striking about these proposals is: 1) the importance that access played in the campaigns of most gubernatorial candidates, 2) the common concern for the elderly (particularly prescription drugs) and rising costs, 3) the bi-

123. MARCHEV & RILEY, *supra* note 103, at 16, 19.

124. MARCHEV & RILEY, *supra* note 103, at 4, 8, 21.

125. MARCHEV & RILEY, *supra* note 103, at 22.

126. MARCHEV & RILEY, *supra* note 103, at 22.

127. MARCHEV & RILEY, *supra* note 103, at 5, 18.

128. MARCHEV & RILEY, *supra* note 103, at 17, 29, 31 (detailing proposals for candidates in Michigan, Texas, and Wisconsin, respectively).

129. BILL CURRY FOR GOVERNOR ‘02, QUALITY HEALTH CARE: LOWER COSTS, INCREASED ACCESS, STRONGER PATIENTS’ RIGHTS 7, (Connecticut Democratic candidate for governor) (copy of original web language on file with the Journal of Health Care Law & Policy); MARCHEV & RILEY, *supra* note 103, at 22 (detailing Ohio Democratic candidate’s proposals).

130. ON THE ISSUES, TOM VILSACK ON HEALTH CARE, *available at* http://www.ontheissues.org/Governor/Tom_Vilsack_Health_Care.htm (last visited Jan. 31, 2004); MARCHEV & RILEY, *supra* note 103, at 8, 14, 17 (detailing candidates plans in Colorado, Maine, and Michigan, respectively).

partisan nature of some of the proposals to deal with access (including the proposals for regional drug purchasing efforts, lobbying Congress, and expansion of health insurance for children), 4) the incremental nature of the proposals, 5) the increased concern over interstate cooperation (especially in the drug purchase arena), and 6) the paucity of “crisis” language.

B. 2003 State of the State Messages

Thirty-six governors were elected in November 2002. By January, they were preparing state of the state messages—not as candidates but as governors. What then did they say about access to health care?¹³¹

Nearly half, 47%, of governors giving state of the state messages in 2003 mentioned access to health care in these messages.¹³² Again, the concerns were largely bipartisan. Four governors, two Democrats (Iowa and Oregon) and two Republicans (Alabama and Colorado), highlighted the importance of access.¹³³ Four governors—three Republicans (South Carolina, Vermont, and Ohio) and one Democrat (Virginia) called for changes in Medicaid; five governors (Republicans in Alaska, Minnesota, Montana and Rhode Island, and one Democrat in Wyoming) addressed the costs of medical care as an impediment to access.¹³⁴

131. In the author’s survey of governor-elect speeches, the state was counted only if access to health care was referred to directly.

132. Survey data on file with the Journal of Health Care Law & Policy.

133. Iowa Governor Tom Vilsack, Condition of the State Address (Jan. 14, 2003), *available at* <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech>; Oregon Governor Ted Kulongoski, Inaugural Speech (Jan. 13, 2003), *available at* http://www.governor.oregon.gov/speech_011303.htm (last visited Feb. 3, 2004); Governor Bob Riley, Alabama State of the State Address 2003 (Mar. 4, 2003), *available at* <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (on file with the Journal of Health Care Law & Policy); Governor Bill Owens, Colorado State of the State Address (Jan. 17, 2003), *available at* <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (last visited Jan. 31, 2004).

134. South Carolina Governor Mark Sanford, State of the State Address 2003 (Jan. 22, 2003); Vermont Governor James H. Douglas, State of the Budget Address 2003 (Jan. 23, 2003); Ohio Governor Bob Taft, State of the State Address 2003 (Jan. 21, 2003); Virginia Governor Mark Warner, State of the Commonwealth Address 2003 (Jan. 8, 2003), *available at* <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (discussing the need for Medicaid reforms); Alaska Governor Frank H. Murkowski, 2003 State of the State Address (Jan. 23, 2003), *available at* <http://www.gov.state.ak.us/speeches.php?id=2> (last visited Jan. 31, 2004) (on file with the Journal of Health Care Law & Policy); Minnesota Governor Tim Pawlenty, State of the State Address (Feb. 6, 2003); Montana Governor Judy Martz, State of the State Address (Jan. 21, 2003); Rhode Island Governor Donald L. Carcieri, State of the State Address 2003 (Feb. 4, 2003), *available at* <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (mentioning rising costs as an impediment to access) (last visited Jan. 31, 2004).

Eight governors, including five Democrats and three Republicans, promised to expand or protect S-CHIP.¹³⁵ Six governors called for prescription drug programs—four Democrats and two Republicans.¹³⁶ Malpractice was covered in the addresses of two Republicans and one Democratic governor, and the Democratic governor of Missouri, Bob Holden, suggested increasing the state's cigarette tax to provide health care for the uninsured.¹³⁷ Pooled insurance, which was prominent in the campaign information, appeared only in the state of the state message of one governor, Wisconsin Governor Jim Doyle.¹³⁸ The importance of assuring an adequate number of health providers appeared in only one message.¹³⁹ The new governor of North Carolina, Michael Easley, proposed a new program targeted toward prevention of health problems, and the Democratic governor of New Mexico, Bill Richardson, proposed a new plan to reshape the health care industry in his state to improve access.¹⁴⁰

C. Fiscal Difficulties

As the new governors assumed office, the fiscal difficulties mounted. The decrease in state tax revenues in 2002 was more than twice as steep as declines in previous years when states experienced significant fiscal difficulties (1980-82 and 1990-91).¹⁴¹ New spending became increasingly problematic; legislatures and governors began looking at simply maintaining current programs including those

135. Survey data on file with the Journal of Health Care Law & Policy. The eight governors included Rod Blagojevich (D-IL), Frank O'Bannon (D-IN), Kathleen Sebelius (D-KS), Mike Johanns (R-NE), Kenny Guinn (R-NV), George Pataki (R-NY), Gary Locke (D-WA), and Bob Wise (D-WV).

136. Survey data on file with the Journal of Health Care Law & Policy. The six governors included Janet Napolitano (D-AZ), Gray Davis (D-CA), Linda Lingle (R-HI), Jennifer Granholm (D-MI), Michael Easley (D-NC), and John Hoeven (R-ND).

137. Survey data on file with the Journal of Health Care Law & Policy. The three governors calling for malpractice reform were Governor Jeb Bush (R-FL), Governor Ronnie Musgrove (D-MS), and Governor Rick Perry (R-TX). Missouri Governor Bob Holden, State of the State Address 2003 (Jan. 15, 2003), available at <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (on file with the Journal of Health Care Law & Policy).

138. Wisconsin Governor Jim Doyle, 2003 State of the State Address (Jan. 30, 2003), available at <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (on file with the Journal of Health Care Law & Policy).

139. Survey data on file with the Journal of Health Care Law & Policy. Alaska Governor Frank Murkowski called for ensuring that an adequate number of qualified health professionals stay in the state.

140. North Carolina Governor Michael Easley, 2003 State of the State Address (Mar. 3, 2003), available at <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (on file with the Journal of Health Care Law & Policy); New Mexico Governor Bill Richardson, State of the State Address 2003 (Jan. 21, 2003), available at <http://www.stateline.org/stateline/?pa=state&sa=showStateOfStateSpeech> (last visited Jan. 31, 2004).

141. Donald J. Boyd & Nicholas W. Jenny, *State Fiscal Crisis Far Worse Than Economy Would Suggest*, 3 ROCKEFELLER INST. ST. FISCAL NEWS 1, 1 (2003).

providing health insurance for the working poor and children. As the fiscal situation worsened, not only were new programs put on hold in the first quarter of 2003, but “almost every state [had] made or [was] planning to make cuts in Medicaid benefits, eligibility, or payments to health care providers.”¹⁴²

Indeed, during Fiscal Year 2003, all 50 states and the District of Columbia implemented Medicaid cost containment measures and planned to do more in Fiscal Year 2004.¹⁴³ Between January 2002 and April 2003, five states made major cuts in eligibility for low-income parents, four states lessened the coverage for children, and five states reinstated “at least one procedural barrier that could compromise enrollment or renewal in their health care programs.”¹⁴⁴

VII. TRENDS IN 2002-2003

Three trends emerged from a systematic analysis of gubernatorial candidates' health proposals as portrayed on their campaign websites and state of the state messages: 1) they were a reflection of the public's desire to be lightly governed; 2) decentralization continues to be valued; and, 3) states are important (again) politically.

The issue of the proper governmental role in health care has been an ongoing one for decades. But the bottom line is that Americans have never embraced the idea of strong central governance or provision of a single-payor health care system to the same extent as those provided in Europe and Canada. Rather, there has been a continuing balancing act between providing services for the (truly) needy with the American desire for a market-based health delivery system. Overall there seems to be little interest in heavy-handed governance in health or other areas. The gubernatorial candidates' health pronouncements reflect this preference for lightly governed health.

Decentralization is a second long-standing value in the United States that plays out in health policy preferences. Devolution, the shifting of authority from the federal to state governments, has been a popular source of political rhetoric since President Ronald Reagan in the 1980s, but it has a mixed history of

142. Robin Toner & Robert Pear, *Cutbacks Imperil Health Coverage for States' Poor*, N.Y. TIMES, Apr. 28, 2003, available at 2003 WL 19158015 (referring to Medicaid benefits).

143. VERNON SMITH, PH.D., ET AL., THE HENRY J. KAISER FAMILY FOUNDATION, STATES RESPOND TO FISCAL PRESSURE: STATE MEDICAID SPENDING GROWTH AND COST CONTAINMENT IN FISCAL YEARS 2003 AND 2004: RESULTS FROM A 50-STATE SURVEY 2 (Sept. 2003) available at <http://www.kff.org/medicaid/kcmu4137report.cfm> (last visited Feb. 3, 2004).

144. Press Release, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, New Survey Reports Ten States Moving to Reinstate Barriers to Enrollment or Cut Eligibility for Health Coverage – A Harbinger of Future Problems (July 29, 2003), available at http://www.kaisernetwork.org/health_cast/uploaded_files/july29releasev4.pdf (last visited Jan. 31, 2004).

implementation.¹⁴⁵ The devolution or decentralization of state functions to localities has been less popular. However, there has been a growing interest in “bottom-up” community-based initiatives, often resulting in collaborations between local governmental units and business.¹⁴⁶ In the 2003 gubernatorial races, there was some interest in promoting local solutions to state health problems in gubernatorial candidates especially in Michigan and Ohio.¹⁴⁷

Finally, it appears that the states are politically important (again). As innovators, as implementers, and as an interest group, states are becoming more politically active. President George Bush’s 2000 candidacy got an early and important boost from his fellow Republican governors who hoped to put one of their own in the White House. The National Governors’ Association (NGA) is a visible and often successful lobby group in Washington. Finally, the Supreme Court’s rediscovery of state sovereignty has increased states political legitimacy and stature.¹⁴⁸

VIII. CONCLUSION

Overall, states have both strengths and weaknesses as initiators of universal health insurance. States have long been engaged as providers, shapers, and funders of health programs, and have dominated health policy reform since the 1980’s.¹⁴⁹ Most obviously, state health access programs would likely not be universal. States would adopt and adapt programs to meet the needs of their own citizens. Some advantages could be garnered by interstate cooperation, as the movement toward pooling pharmaceutical programs indicates. But these movements are in their infancy and realistically cannot yet be expected to involve comprehensive programs or policies.

A state-based comprehensive reform would involve different components perhaps building on a framework that is similar. States do clearly learn from other states and innovations diffuse, and change, as they cut across states. Some states would provide more generous and accessible programs; others would not—similar to previous experiences with Medicaid and S-CHIP. Some states can simply afford to do more than others; some states choose not to do so.

145. See generally TIMOTHY CONLAN, FROM NEW FEDERALISM TO DEVOLUTION (1998) (evaluating the federalism reforms that have led to the growing power of the states over the last decade).

146. ANDRULIS & GUSMANO, *supra* note 89.

147. See, e.g., MARCHEV & RILEY, *supra* note 103, at 17, 22 (describing plans to create employer-sponsored insurance programs partially funded at the County level in Michigan, and to develop a system of home and community-based supports for long-term care of the disabled in Ohio).

148. See *supra* notes 56-63 and accompanying text (discussing the Supreme Court’s recent decisions that ERISA does not preempt certain state laws).

149. See Leichter, *supra* note 41, at 171.

A more effective model of universal health insurance might feature states and the federal government working together. After all, as Thomas Oliver reminds us, “[the] states and the federal government share a fairly common [health] agenda, influenced heavily by market dynamics in the health care system and by changing perceptions of social problems, population groups and industries.”¹⁵⁰ A more realistic and prevalent model involves the federal government providing the framework and incentives for states to act, but allowing discretion to the states to put in place a program that best fits the needs and desires of their citizenry. The Medicaid and S-CHIP programs embody this approach although there are some important differences.¹⁵¹ This intergovernmental mechanism—where the federal government provides the parameters and allows states some discretion in policy choices related to both services and beneficiaries—is one that is recommended by legal scholars and political scientists. For example, Scott Litman and James Holloway have argued for cooperative federalism which recognizes that the only way to obtain congressional consensus on health policy is to allow states to implement health care to meet their needs, subject to the general mandate of the federal government.¹⁵² Rather than a mandate, Eleanor Kinney argues that states have traditionally done better in expanding coverage for the uninsured poor when they have joined with the federal government as a partner through the Medicaid program.¹⁵³ Both Litman and Kinney favor reforming ERISA, where states are allowed more leeway to regulate employer-provided health insurance, and urge more flexibility for states in Medicaid.¹⁵⁴

Some political scientists also propose a cooperative federalism approach to health policy, where the federal and state governments are partners, where there is federal funding and standards (along with enforcement, evaluation, and revisions where appropriate), and where states can choose from a menu of policy choices and are encouraged to develop supplemental programs as sources of innovation.¹⁵⁵

150. Oliver, *supra* note 52, at 273.

151. Notably, Medicaid is an entitlement program where any qualifying person must receive services, and S-CHIP is a block grant with a federally determined amount of funding provided to states without any guarantee of coverage for recipients.

152. See generally Litman, *supra* note 4; James E. Holloway, ERISA, *Preemption and Comprehensive Federal Health Care: A Call for “Cooperative Federalism” to Preserve the States’ Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 414 (1995).

153. Eleanor D. Kinney, *Clearing the Way for an Effective Federal-State Partnership in Health Reform*, 32 U. MICH. J.L. REFORM 899, 902 (1999).

154. Litman, *supra* note 4, at 904; Kinney, *supra* note 153, at 924.

155. See, e.g., Robert F. Rich & William D. White, *The American States, Federalism, and the Future of Health Care Policy*, in HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES 293, 298-99 (Robert F. Rich & William D. White eds., 1996); Michael S. Sparer & Lawrence D. Brown, *States and the Health Care Crisis: Limits and Lessons of Laboratory Federalism*, in HEALTH POLICY, FEDERALISM AND THE AMERICAN STATES 181, 195-200. (Robert F. Rich & William D. White eds., 1996).

An important component of cooperative federalism involves accountability, where states are held responsible for implementing policies within the federal parameters and goals. Frank Thompson believes that performance-based accountability is key to what he calls transparent federalism in the health care arena, which can provide insights into what works and what does not and can facilitate the diffusion of innovation.¹⁵⁶

Health access has been on the public agenda in the United States for decades. There is little reason to think that will change in the first decade of the new millenium. In 2003, there seems to be no fiscal resources, no public outcry, and no political will for innovation to actually occur. Thus, the promise of state-based universal health insurance seems extremely limited. On the other hand, states are continuing to deal innovatively with immediate problems and work through possible solutions by both approving and discarding ideas that might later prove to be helpful in fashioning a national system. But that system, should it succeed, will likely be an intergovernmental model rather than a top-down one, and it will be fashioned incrementally, rather than developed all at once. This is the way health care reform has occurred in the past, and there is little reason to expect it to change in the future.

156. Frank J. Thompson, *Federalism and Health Care Policy: Toward Redefinition?* in *THE NEW POLITICS OF STATE HEALTH POLICY*, 41, 63-66 (Robert B. Hackey & David A. Rochefort, eds. 2001).