The States That Could Not Wait

Lessons for Health Reform from Florida, Hawaii, Minnesota, Oregon, and Vermont

Milbank Memorial Fund

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PREFACE

The Milbank Memorial Fund, now in its ninth decade, defines its mission as informing influential senior public and private decision makers about data and ways of thinking that can improve health policy. This report distills the experience and advice of leaders from five states that have led the nation in health care reform in recent years. These leaders are listed on the next page.

The Fund arranged for these leaders to meet for three days in November 1992, and it commissioned Harry Nelson, who served for many years as a medical writer for the *Los Angeles Times*, to report on the meeting. The participants in the meeting reviewed Nelson's report.

The Fund traditionally takes no position on the merits of particular solutions to America's health problems. We call attention, however, to the report's revelation of extraordinary agreement among people of very different partisan loyalties from diverse states. These leaders agree that the political will to reform can be mobilized and that the reason for their success to date, relative to other states and indeed to the nation, is their success in creating and maintaining broad coalitions.

The title of this report expresses the urgency and pride felt by the leaders of the five states. It was adapted from a statement about health reform by Governor Lawton Chiles of Florida, quoted in the *New York Times* (January 5, 1993, p. A10): "We just can't wait, given what the costs are."

The Fund has also commissioned histories of the process of health reform in each of the five states. The authors of these histories, each a political scientist, received tremendous cooperation from leaders within the states. The histories will be published later this spring. Additional copies of this report and information about the histories are available from the Fund.

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INTRODUCTION

A week before Thanksgiving in 1992 an exceptional three-day meeting took place on the slopes of Mount Hood in Oregon. It was attended by legislators, officials, and civic leaders from five states, who had the gumption to tackle what might be called "the 800-pound gorilla" of health care reform. The five states are Hawaii, Oregon, Minnesota, Vermont, and Florida.

Against sometimes stiff opposition, these lawmakers initiated and fought for the passage of bills aimed at making the health systems in their states more financially manageable and user friendly. They are the first to admit that these steps are only the beginning of a continuing, arduous task. They know from hard experience how difficult it is to change health care delivery and methods of payment. Gaps still exist. None of the five states has yet achieved full universal coverage or proven cost containment. But, as political realists, these lawmakers and their colleagues of both parties know that, short of state bankruptcy, there is no recourse other than to continue the reforms now underway.

Why were these five states selected to serve as examples? Nearly twenty years ago Hawaii was first in the nation to enact legislation requiring small businesses to provide health insurance to their employees, a course now being discussed nationwide. The other four states illustrate a variety of approaches toward solving the access-versus-cost problem. Oregon created a priority list for its Medicaid services; Vermont and Florida established single state agencies with great powers to achieve health care reform; Minnesota exemplifies how people with strikingly different philosophic and political perspectives can achieve a common goal.

Perhaps as many as thirty states today express an interest in health system reform without waiting to see what the Clinton administration will do. Many people in these states believe that effective national reform will require partnership with the states. The purpose of this pamphlet is to provide state executives and legislators with information that may assist them in taking on their own 800-pound gorillas.

Here is an outline of what leaders of state health reform in the five states believe needs to be done:

Devise ways to achieve universal access to health care for the currently uninsured and uninsurable.

Take steps to control costs by:

- reforming the health insurance industry
- moving toward community rating
- cutting administrative costs by integrating state agencies that deal with health care and developing common billing requirements across all payers, public and private
- implementing controls to regulate high-cost technology
- changing the behaviors of providers and patients
- increasing the ratio of primary care physicians to specialists
- undertaking and applying research on the outcomes of particular treatments in order to use resources more efficiently
- encouraging preventive health services and managed care
- instituting practice guidelines for physicians.
- reforming the tort system

Decide on the method of paying for universal access.

This glance at what the five states have accomplished to date will first describe what is unique for each state and then briefly list the highlights. For a more detailed outline, see Summary of Legislation, page 15.

HAWAII

As the only state that has actual experience with mandated, employment-based health insurance, Hawaii can show others how to make this approach work, describe its limits, and delineate the kinds of additional programs that are needed to extend services to everyone.

→Employers are required to provide insurance for all workers spending more than twenty hours per week on the job.

→Low-cost insurance is offered to persons with incomes below 300 percent of the poverty level through the State Health Insurance Program (SHIP), which subsidizes premiums on a sliding scale and strongly emphasizes illness prevention.

→Together with Medicaid, SHIP covers about 93 percent of persons under age sixty-five.

OREGON

Oregon is the only state to build its approach on the notion that a priority list of health services could be used to define the basic package of guaranteed services.

→Tax incentives have been created for small employers to help cover employees on a voluntary basis. If there are not enough

enrollees by 1995, employers will be required to provide coverage to employees and their dependents or face being taxed and having their employees entered in a public plan.

→All persons up to the poverty level will be covered by Medicaid.

→All health care services for Medicaid, and eventually those contracted for by employers, will be ranked according to their effectiveness and other criteria, and the number of covered services will be determined by the legislature at least every two years based on available funding.

→The Medicaid waiver needed for implementation of the plan was approved by the federal government in March 1993, with constraints the state can accept.

MINNESOTA

Minnesota is the state most dedicated to using practice guidelines and instituting a total expenditure cap to contain costs and to pay for universality through cost savings plus new taxes designated for health care.

→The newly created MinnesotaCare Plan will be a major source of insurance coverage for low-income families and individuals. Eventually it will incorporate Medicaid and other indigent programs.

→Insurance reform has been instituted as a step toward community rating. The law requires insurers to offer plans with minimum benefits and cost-sharing provisions to small employers, guarantee the issuance and renewability of coverage, and extend most of these provisions to the individual insurance market.

→A commission has been created to develop a plan to reduce health care inflation by 10 percent per year for five years, beginning in 1993. The commission's first report, issued on schedule in January 1993, is now before the legislature for enactment of cost control under "competitive managed care."

→The state has begun initiatives to increase the education and retention of primary care providers.

VERMONT

Vermont is unique in creating a clear, centralized body and process for defining the public choice between a single-payer system and a multipayer system. Its commitment to community rating makes Vermont an important state laboratory with which other states can compare their plans and results.

→The Vermont Health Care Authority was created to design two alternative health care systems—a single-payer and a multipayer system—by November 1993. Both plans should offer universal coverage by October 1994, including provisions for global budgeting, uniform health benefits for all residents, centralized planning, incentives to contain costs, reimbursement mechanisms for providers, and recommendations for incorporating

long-term care. This decision-making body has also been instructed to consider insurance reform and provisions for increasing the number of primary care physicians.

FLORIDA

Florida is unique in its commitment to a play-or-pay approach to universal access and to the formation of a state health services corps for improving geographic access.

→A law has been enacted that guarantees access to health care for every resident by December 1994; the law also created the Agency for Health Care Administration, which, by December 1994, will consolidate health care financing, purchasing, and planning, and which will regulate health facilities and professionals as well as cost-containment functions. This agency will also be responsible for developing a Florida Health Plan, designed to provide private or public health insurance for all Floridians.

Here are some essential steps to success, say the leaders of the five states:

- Build on the strengths of existing programs because they can act as the foundation for further reform.
- Design a road map for where you want to go.
- Knowledgeable and dynamic leaders are a key to the success of health reforms.
- Develop the best cost-effective health care database.
- Examine carefully the single-payer system versus the multipayer system in your state—and do not call it a Canadian system, even if you want one.
- Work with community groups in order to organize a large base of public support.
- Work with the news media.
- Remember that opposition groups are not monolithic. Exploit the splinter groups among the providers and within the insurance industry.
- Capitalize on disappointments.
- Build in a system to evaluate your progress so that you do not advance too far down the road to make corrections.
- Be sure that your legislation offers enough flexibility for the executive branch to maneuver to bring people together.
- Give your legislation firm implementation dates.

Here are illustrations from the five states of the most important of these steps.

Build on the strengths of existing programs because they can act as the foundation for further reform. 1

Insurance reform:

Legislation for insurance market reform has been introduced for several years in most of the fifty states.

Programs for children:

In *Vermont*, a 1988 expansion of coverage for poor children demonstrated that some opponents of universal care were beginning to accept the concept.

The passage of *Minnesota*'s plan is credited largely to a popular program for high-risk children that had been in place since 1976 and to a risk pool for "uninsurable" persons passed in 1988. The 1976 program is partly subsidized by a tax on insurance companies, thus providing a precedent.

Health Maintenance Organizations (HMOs):

Minnesota's reform efforts benefited from the state's twenty-year history with managed care. Since 1973 Minnesota has mandated all employers of fifty or more workers that provide health insurance to offer an HMO as an option to their employees. Minnesota is now in the process of encouraging managed care

in rural areas, where HMOs are weak, by forming networks of providers unaffiliated with HMOs.

A secondary benefit of HMOs in Minnesota emerged when the HMO lobby favored community rating and recommended that a provider tax be a source of financing of the reform bill.

Prenatal care:

In *Oregon*, the priority-setting process developed from budget decisions made after the legislature expanded prenatal care and other services for poor women and infants who previously had none, and discontinued funding for the most expensive organ transplants.

Employer mandates:

In *Hawaii*, the entire reform was built on the 1974 law that mandated all employers not covered by collective bargaining to provide health insurance for employees. Until the law was implemented, most legislators were unable to see existing gaps and therefore to propose ways to fill them.

Public input:

The formation in 1983 of a civic organization, *Oregon* Health Decisions, to solicit public input on health matters heralded an early rumbling of discontent with the system. Six years later, the organization became a vehicle for holding community meetings at which members of the public guided the setting of priorities for health services.

Medicaid:

Some of the strategies used to accomplish *Florida*'s 1992 reform package had their basis in a 1984 state law that made Florida the first state to impose a tax on net hospital operating revenues. The state used the money to create a trust fund to finance the expansion of the state's Medicaid and primary care services. During the 1992 session, legislators threatened to use the provider tax in order to win acceptance of its measures. The legislature also continued an earlier practice of appointing task forces to look into various health service problems and used their recommendations to strengthen support for reforms.

Design a road map to where you want to go. 2

One reason for reluctance to take on health reform is the magnitude of the required overhaul. Here is what happened in the five states:

Leaders in each state developed a big picture of the goals and elements of a mature, reformed system.

They identified the existing elements of their system that could be enhanced while moving toward reform.

They mapped out reforms step by step, building incrementally on each achievement in

legislative content and political mobilization.

Initial success was possible in several of the states because interest groups did not perceive the approach of a major reform. For example, in *Hawaii*, few appreciated the implications of the prepaid health care act when it passed. Instead, most viewed it as a logical expansion of a set of benefits tailored to labor union pressures. Prepaid health care is now more than a labor issue.

Similarly, in *Oregon*, the list of health service priorities for Medicaid patients was not initially viewed as a way to define adequate care for everybody.

3 *Knowledgeable and dynamic leaders are a key to the success of health reforms.*

Each of the five states can point to leaders who played a crucial role in their reform process.

In *Minnesota*, a group of seven legislators worked with the governor, setting aside partisan differences and dedicating themselves to the cause of health care reform. All seven legislators were experienced. Each held a key position in the house or senate. Four were Democrats, three were Republicans. Each was committed to accommodation rather than partisan politics, even in the face of the Republican governor's earlier veto of a health reform bill. The group's shared dedication to reform and its skillful leadership combined with the governor's subsequent support to defeat a barrage of opposition by medical organizations and hospitals.

In *Oregon*, the senate president led a coalition of key legislators from both houses, joined by the leadership of various interest groups. The senate president, a physician, was the dominant force in formulating the new health policy, partly because the governor had other priorities.

In *Hawaii*, the governor, who was interested in health, worked with legislative health committees chaired by individuals who were committed to health care improvements (but not tied to provider or payer interest groups). Their cooperation accounted for reform changes.

In *Vermont*, the governor, a physician, asserted leadership and was supported by key legislators in both houses.

In *Florida*, the governor, a former U.S. senator who was keenly interested in maternal and child care issues, propelled the drive for health care reform. He appointed a task force to integrate the work of two earlier groups that had focused separately on private and public health responsibilities.

4 *Develop the best cost-effective health care database.*

Accurate data are an important aid to achieving universal access and cost containment. There is no shortage of data, but reliable data are hard to obtain. Insurance carriers, for example, can supply lots of statistics that do not add up to the whole story.

Minnesota used an actuary's information, but found it imprecise. Legislators had to make adjustments to the actuary's information, using data from HMOs.

In *Oregon*, data convinced legislators of the need for reform by defining the gaps in the system and revealing what kinds of care were unavailable to the uninsured.

People who do not want reform may use lack of data as an excuse to stall reform. The five states learned to use what they had. Each state then took steps to create a cost-effective data-gathering system that could collect relevant data from the private sector.

5 *Examine carefully the single-payer system versus the multipayer system in your state—and do not call it a Canadian system, even if you want one.*

Support for a Canadian type single-payer plan existed in most of the five states. However, single-payer supporters failed to command a strong role in influencing the legislation passed by any state. Yet the Vermont and Florida laws expressly state that a single-payer plan can be an option in the future; switching to a single payer is a possibility for any of the states if the first approach fails.

There are formidable barriers to state enactment of single-payer plans. For example, it may not be practical to abolish insurance companies, one aim of some single-payer plans. Moreover, if states did so, current federal law preempts their authority to reform the self-insured portion of the market, which accounts for about half of all insured workers. A single-payer system would have to be national, or at least it would require the lifting of federal constraints from the states.

In *Oregon*, the single-payer plan failed primarily because its promoters realized their bill would never pass the house, although it possibly could have passed the senate. Although unions supported the legislature's multipayer approach, they cautiously joined the multipayer coalition, believing such reform to be in the right direction and wishing to add their voices to single-payer arguments as the Oregon plan progressed.

Oregon legislators believe the first critical step is to make a statutory commitment to universal access. This commitment, they say, is essential to creating a comprehensive policy and building a structure within which a policy can operate

effectively. Establishing that commitment was the primary goal of their health care reform.

They see the decision about how to pay for universal access as being secondary. The money collection methodology, the legislators say, can be determined on the basis of political feasibility. The legislators believed that consumers who prefer a single-payer approach would not argue against universal access merely because they dislike how it is paid for.

In *Vermont* in the early 1990s, antipoverty groups and unions were pressuring for coverage of the uninsured. Business was disturbed by increases in the cost of health insurance premiums. Everybody wanted reform. The issue was whether reform should be radical or mainstream. Unions, advocates for the poor, and the American Association of Retired Persons (AARP) pushed for a Canadian-style system. Just about everybody else wanted a multipayer plan.

Strong support for the single-payer bill bound together the diverse opposing forces and increased their willingness to support a multipayer bill. There was vocal support for a single-payer plan among the public, but hardly any in the legislature. The governor's view was that the single-payer bill offered no mechanism to pay for increased access. Legislators looked with disfavor upon single-payer advocates out of fear that the government would be the single payer, placing lawmakers in an uncomfortable position when money is scarce. A clause in the new law postpones until 1994 the legislature's decision to fund the program with a single- or multipayer system—or with a mix of both.

In *Minnesota*, a single-payer bill was blocked by the powerful state senate health committee, which declined to go any further than a commission's recommendation to retain mainstream payment methods.

Florida's experience with a single payer also was short lived. The introduction of a single-payer bill in 1988 aroused alarm in the state's business community and sparked the creation of two task forces that recommended spearheading the multipayer plan, which was passed and signed into law by the governor in 1992.

Work with community groups in order to organize a large base of public support. 6

State officials reported that they increased public support for their initiatives by taking the following actions:

They gained commitments from persons and groups for more than a short-term effort. They defined "success" in terms of years, not months.

They recruited unions early and especially tried to minimize threats to civil service workers.

They sought out elements of political parties and factions that had some interest in reform.

They contracted with a nonprofit organization to hold meetings for the purpose of informing the public of the intent of health reform and explaining its necessity.

7 *Work with the news media.*

The public does not respond well to statistics, but it does to stories. *Minnesota* provides an example.

In 1991, when reform-minded legislators in Minnesota began building their case, they were aided by the Children's Defense Fund (CDF), which found patients with serious untreated health problems. CDF prepared press releases describing these cases and sent one each day to legislators and to the press. The stories appeared daily during the crucial period when legislators were negotiating their health reform bills and helped to create public support. Earlier, when a cost commission was working on recommendations that were to form the backbone of the legislation, heavy news coverage helped build public support (60 percent, said the polls) for a tax increase to cover the uninsured.

In *Oregon*, the publicity resulting from the death of a seven-year-old boy set the stage for discussion of health care rationing. The legislature shifted funding for organ transplants from the regular Medicaid budget to an optional list, which meant that requests for transplants had to compete with mental health and other social programs. Funding for transplants was not included in the final budget. The case of the seven-year-old boy, whose only insurance was Medicaid, received national attention when the state refused to pay for his transplant. Private contributions were insufficient to pay for the surgery and the boy died.

Remember that opposition groups are not monolithic. Exploit the splinter groups among the providers and within the insurance industry. 8

The degree of opposition to proposed legislation by organized medicine, hospitals, and insurers varied from state to state. The *Oregon* and *Vermont* medical and hospital associations, unlike those in Minnesota and Florida, supported reforms early in the political process.

Physicians played important roles as legislators or officials in Oregon and in Vermont. In Oregon, the legislative sponsor of the reform package was an emergency room physician, who dominated the reform. Medical societies did not speak for all the physicians. Many primary care providers, especially those who worked in clinics and health centers, differed with official medical opinion.

Here are some examples. First, providers:

When *Vermont*'s governor died in 1991, the new governor, a physician, announced his support for the reform bill. He is credited with providing level-headed guidance, which helped to deflect the opposition of organized medicine without seriously damaging the bill's intent.

Vermont doctors wanted change. But they believed that everybody, including the public, must share the burden of cost containment. They wanted to participate actively on the legislation's proposed boards, which would decide on prices and budgets. They were concerned about limitations on clinical freedom. They also wanted quicker resolution of malpractice claims. Given these demands, they supported the bill.

The Vermont Hospital Association supported the general direction of the multi-payer bill and worked closely with the legislators to ensure that cost containment did not fall too heavily on hospitals.

In *Florida*, the chief opponent of reform was the state medical association. Florida physicians have substantial stakes in expensively equipped diagnostic centers and other businesses to which they make referrals. The state is well stocked with for-profit hospitals and, in some counties, with excessive amounts of high-tech equipment.

Organized medicine failed in its efforts to kill reform because it had exhausted its energies in an unsuccessful fight to defeat legislation (unrelated to the reform bills) that barred physicians from making referrals to facilities in which they had financial interest.

The *Minnesota* Medical Association (MMA) worked hard to arouse the public against reform. It was especially disturbed by the 2 percent provider tax. The Mayo Clinic and other high-visibility institutions joined forces against it. Since passage of the bill, both the MMA and Mayo have supported the changes and are cooperating with the commission.

Not all provider groups opposed reform. Support came from family practitioners, HMOs, and the state's nurses, psychologists, chiropractors, public health workers, mental health professionals, and community health clinics.

The seven key legislators and the governor, who set aside partisan differences to achieve reform, agreed to adopt a policy that would prevent lobbyists from using a "divide and conquer" strategy.

For four months the seven legislators held secret meetings at which no formal votes were taken. All seven had to agree on every decision made. The group identified what were to be the essential elements of their bill.

When the first bill was drafted in Minnesota, the hospitals and organized medicine were surprised by the fact that the two parties

had secretly worked out these compromises. Instead of suggesting constructive changes, organized medicine, hospitals, and high-tech medical equipment firms launched an aggressive opposition campaign.

A critical difference involved the choice between a provider tax or an income-tax surcharge to pay for the new insurance coverage. The provider tax won out. The bill passed despite powerful opposition because the tactics used by opponents of the bill antagonized legislators and solidified their resolve to institute reforms.

And some examples about insurers:

In *Vermont*, the bitterest opponent of reform legislation was the insurance industry—but not all insurers. Blue Cross/Blue Shield was losing money and was eager for reform. Some large commercial companies did not entirely agree with their smaller allies.

The scene had been set in 1991 when the state's eighty insurance companies suffered a sharp defeat because they were forced to offer community rates for the small group market. In 1992 they faced the prospect of having to extend community rating to the nongroup market, which the Blues were already doing.

Some of the insurance companies threatened to quit the state if the bill passed, while predicting that premium rates for the young would more than double and that the ranks of the uninsured would soar.

The new bill provided a safety net in case some carriers left the state. It also limited any premium rate increase to 20 percent per year, provided the company had a loss ratio (how much paid out in claims relative to premiums) of at least 70 percent. The loss rate for the Blues was high, but it was relatively low for the ten carriers writing nongroup policies.

The legislators did not compromise with the insurers. The bill passed and was signed by the governor.

Several carriers did leave the state and others have stopped taking new subscribers. The governor said he was disappointed that more did not leave.

In the beginning, the only opponents to the *Oregon* plan were small businesses. By 1991, however, a section of the insurance industry actively opposed certain elements of small group insurance reform proposals.

Small business in Oregon, as in most other states, objected that expanding coverage to 280,000 workers and dependents would cause many smaller concerns to fail. Legislators responded by enacting target voluntary subscription rates for working individuals who were currently uncovered and by continuing low-cost insurance coupled with income tax credits. They agreed to cancel the mandate if virtually all small

business employees and their dependents were covered on a voluntary basis.

During the 1991 session, a segment of the insurance industry that serves small groups in Oregon became alarmed when legislators began reforms requiring insurers to grant coverage to all small groups. Their opposition centered on the community rating aspects of insurance reform. They were isolated politically, especially after the major insurance companies sided with the legislature because they saw an opportunity to level the marketplace.

In *Minnesota,* Democrats wanted to move to community rating and to apply controls on insurers that would prevent them from either denying coverage to persons with prior health conditions or reissuing policies.

The Republicans wanted to soften these goals by setting age brackets to lessen the premium increases that community rating would exact from young, healthy individuals.

The Blues and HMOs in general supported the Democrats' goals.

A chief concern of the Republicans was that the conditions created by insurance reform would cause the young and healthy to opt out of the health system. They also feared that the provider tax and other reforms opposed by organized medicine would cause physicians to leave the state.

With the controls now in effect, it should be possible to tell within a year whether the Republicans were correct.

Capitalize on disappointments. 9

In 1991, *Minnesota*'s governor vetoed a reform bill that would have restructured the health insurance system. However, less than a year later, HealthRight, an even broader reform, was enacted with the governor's blessing. The public wanted it, the governor apparently needed a political boost, and in 1992 the entire legislature was up for election.

The earlier experience hardened resolve and sharpened legislative talents, familiarized everybody with the problems, and gave proponents a better understanding of what they had to do to win.

When *Oregon*'s request for a federal waiver was turned down in August 1992, state officials responded with renewed vigor by submitting a revised request that was approved in March 1993.

The difficulties of the legislative process and the complexities of health care reform might make the task seem impossible to many policy makers. However, leaders in the reforming states agree that the future for health reform is bright.

This brief outline of the experiences of five states demonstrates that significant health care reform can occur in this country and that the states have a central role in defining what is possible and practical. It shows also that health reform is an issue that now transcends the usual political dynamic and produces bipartisan leadership and a partnership between the executive and legislative branches of government.

Much tough work is ahead. Universal coverage and cost containment have not yet been realized in any state. Obstacles like federal preemption of state regulation of employee benefit plans must still be faced. Coalitions could dissolve. Key leaders and committee chairmen could be replaced. Future implementation dates could be bypassed.

But the people whose experiences are summarized in this report believe that the goals will be achieved if vision, leadership, and coalition building make it happen. Each state offers instructive experiences and potential resources. State action on health care reform can address fundamental concerns of Americans. It can also serve as a catalyst or a model for change at the federal level.

Following are profiles of steps toward health reform legislated by the five states. Each state built on earlier efforts and in every one the multiple barriers of partisan disagreement, interest group pressures, public skepticism, and exhausting meetings were faced and overcome. There were compromises. No victory was total. Gaps still exist. All five states are considering actions in the next legislative session to fill the gaps.

HAWAII

1974. The Prepaid Health Care Act, which covers all full-time employees, was passed. Half of the coverage is funded by the employer and half by the employee, except that the employee's share cannot exceed 1.5 percent of his or her total wages. A federal Medicaid waiver was successfully obtained.

→A generous Medicaid program has been built in over the years since 1966.

→*1989.* A State Health Insurance Program (SHIP) was created for groups not covered either by Medicaid or by prepaid health care. The state subsidized the program with sliding fees for the insured. For persons under 100 percent of poverty level, the plan is free.

→*1991.* A Primary Care Network Bill was passed to develop primary health care centers throughout the state. A related bill offered incentives for medical schools to turn out more primary care doctors.

→*1991.* Blue Ribbon Panel recommendations focused on administrative procedures, which included electronic claims processing, automated record keeping, a universal claims form, and improved data collection.

→State subsidies were given to nonprofit agencies in areas such as mental health, preventive services, primary care, AIDS, teen health, and sex abuse counseling.

→*1992.* A proposal to finance long-term-care insurance (requires a waiver from federal government).

Remaining gaps: Hawaii does not regulate health insurance, hospitals, doctors, or pharmacies. The health system has not yet "captured" the hardest-to-reach uninsured like the homeless, the mentally ill, immigrants, and native Hawaiians. The mortality rate of the latter group is double that of the rest of the population.

OREGON

1983. Oregon Health Decisions (OHD), a nonprofit educational organization, was formed and proceeded to hold community meetings and to issue recommendations on plans for the uninsured. OHD also increased public acceptance of the necessity for reform.

→*1987.* The Oregon Department of Human Resources requested $2.2 million from the legislature to cover thirty-four organ transplants, a $1 million increase over the previous two years. State house and senate

committees instead shifted transplants out of the regular budget and onto an optional priority list, where requests competed with mental health programs and head injury patients for funding.

→*1988.* A proposal to appropriate $220,000 to fund five Medicaid transplants was defeated on grounds of "inequity" because 400,000 working Oregonians had no health insurance and were not eligible for Medicaid.

→*1989.* Three new laws took effect over various time periods that made everyone below the federal poverty level eligible for Medicaid, eventually eliminating the uninsured status of 120,000 persons; providers were to be paid according to fees established by an independent actuary; access for 2,800 uninsurables was expanded by creating high-risk insurance pool coverage to an additional 260,000 employed persons. The level of care was to match Medicaid, which included high-cost procedures like transplants. Tax credits encouraged employers to cover employees. Some facets depended on federal waiver approval.

→*1990.* The Health Services Commission and Oregon Health Decisions held fifty-eight public meetings and conducted a telephone survey to study citizens' values and preferences for medical/health situations and treatments.

→*1991.* The Health Services Commission publicized a list of 709 health services and treatments arranged in order of priority for Medicaid funding. Available funding each year will determine how far down the list services will extend.

→*1991.* The legislature reformed small group health insurance to require that all sales to small group insurers include the offer of a policy substantially similar to the Medicaid prioritized list.

→*1991.* The Health Resources Commission was created to grapple with cost containment.

→*August 1992.* The federal waiver required for Oregon to make changes in Medicaid was denied by the U.S. Secretary of Health and Human Services on the grounds that the plan was in conflict with the Americans with Disabilities Act.

→*November 1992.* Oregon resubmitted a modified request for a waiver with a revised list of 688 condition/treatment pairs.

→*December 1992.* The legislative committee determined that the Medicaid budget for 1993–95 will cut off services after number 568 out of 688 health services/treatments on the priority list.

→*March 1993.* The federal waiver was approved for the revised plan.

Remaining gaps: It has not yet been determined either how the plan will contain costs or how expanded access will be funded. The governor has recommended a 1 percent tax on provider income.

MINNESOTA

1972. The state received a head start in managed care by mandating all employers of fifty or more insured workers to offer HMOs as an option.

→*1988.* The Children's Health Plan was created for non-Medicaid, low-income pregnant women and children under six years of age. Funded by a minimum annual fee and a one-cent cigarette tax, it was expanded in 1991 to include all children through age eighteen.

→*1989–91.* The Health Care Access Commission was formed and issued a report that contained far-reaching recommendations for reform, identified the uninsured, and suggested a twenty-five dollar annual fee per child. Its report provided the basis for the Minnesota Health Care Plan that the legislature passed by a comfortable margin in May 1991. The governor vetoed that bill.

→*1992.* The Minnesota Health Care Plan was the basis for the HealthRight Law (now called Minnesota Care), which was passed and signed in April.

The law took a regulatory approach to containing costs, expanding access, reforming health insurance, dealing with rural health problems, collecting health care data, and finding ways to fund expanded access to health services. Funding will be achieved by a five-cent increase in the cigarette tax; a 2 percent hospital tax on gross patient revenues beginning in January 1993; a 2 percent tax on provider gross revenues beginning in January 1994; and a 1 percent tax beginning in 1996 on gross premiums for nonprofit health service plans and HMOs.

A Health Care Cost Containment Commission was created to set a target for slowing health cost inflation by 10 percent per year beginning in 1993; to establish statewide and regional goals on total spending; to foster regional health care planning; to restrain providers by retroactive monitoring of expenditures for high-tech items costing more than $500,000; to review the effects of treatment methods; to encourage health promotion; and to prohibit insurance companies from denying coverage to small businesses or refusing group policy renewals.

A Rural Health Advisory Council will be created to provide state aid to rural hospitals in trouble and loan forgiveness to rural doctors. The University of Minnesota will take steps to increase the number of primary care doctors and to reduce the number of specialists.

Gaps: The plan will cover only about 40 percent of the uninsured by 1997. Health insurance underwriting practices are not strictly regulated. Control over high technology may not be effective.

VERMONT

1987. The Vermont Health Insurance Plan was enacted to find ways to extend coverage to the uninsured. However, the governor and the assembly were unwilling to produce the $32 million required to provide comprehensive benefits to the state's 32,000 uninsured. Although it did not become law, the plan alerted the public, providers, business, and insurance companies to the need for universal coverage.

→ *1992.* The Vermont Health Care Reform Act became law. Its timetable extends through 1994 and it expands access for all children, institutes community rating for individual insurance policies, establishes a system of global budgeting, creates a Vermont Health Care Authority that is mandated to control costs and expand access, and sets a plan for the University of Vermont to train more primary care doctors.

→ In November *1993* the new three-member Health Care Authority Board must submit two universal access plans: one of these is to be a single payer and the second, a multi-payer plan.

→ In January *1994* the General Assembly will meet to consider the Health Care Authority Board's proposals. If the legislature adopts a plan for universal access, a medical malpractice reform will begin. Regardless of whether a universal access plan is adopted, the board will establish annual unified health care budgets (global budgets) that set total spending levels on health care. Spending caps will be applied to hospitals only.

FLORIDA

1988. A single-payer plan bill was introduced with the backing of a national physicians' organization and senior citizens.

→ *1990.* The legislature and the governor created two task forces to survey the private and public health sectors and to make recommendations for change.

→ *1991.* The task forces decided on a "play or pay" type plan.

→ *1992.* The governor signed the Health Care Reform Act, which integrates the regulation and administration of the health industry and guarantees access to health care for every resident by December 31, 1994.

The act created the Agency for Health Care Administration (AHCA), which will consolidate health care financing, purchasing, and planning over a two-year period. It will also regulate health facilities and health professionals and oversee cost containment functions. The agency will include an eleven-member health care board, appointed by the governor, consisting of four providers, three representatives of businesses, one insurer, and three consumers.

AHCA will assume responsibility for issuing certificates of need, licensure, and

certification, for overseeing health policy, and for regulating health facility costs.
→ By December 1994 the agency will be responsible for Medicaid and for developing the Florida Health Plan, which will provide private or public health insurance for all Floridians.

The agency also will be charged with reforming health insurance, limiting health care cost increases to manageable levels, restructuring health regulation, and establishing a health care database.

The guidelines for the Florida Health Plan include:
→ Ensuring access to affordable basic benefits for all residents, regardless of health condition or employment status.
→ Instituting cost containment by promoting preventive care and controlling proliferation of tertiary care; establishing practice guidelines and utilization systems; consolidating state health insurance programs; simplifying billing and administrative overhead; improving the system for handling medical negligence disputes.
→ Instituting health insurance reforms.
→ Establishing a comprehensive health data system for providers, facilities, and insurers.

The act creates a Florida Health Services Corps to encourage medical professionals to practice in underserved areas.

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