Chapter 7

Health Care—Afflicted Budgets

While Congress and the Clinton administration spent much of 1994 debating and ultimately failing to enact health-care reform, several state legislatures succeeded in enacting health-care reforms. In other states, the results were similar to those at the federal level—the legislature failed to effect changes despite considerable efforts (Pear 1994a). I examine health-care reform efforts in 1994–95 in Oregon, Vermont, Tennessee, Florida, Washington, and Colorado. Tennessee, Oregon, and Washington revised their states' Medicaid programs or offered health-insurance subsidies to low-income individuals. In Colorado, legislators and the governor retreated from a plan to replace Medicaid with an expanded managed-care program. Florida and Vermont representatives failed to enact health-care reforms designed to control Medicaid costs and expand insurance coverage.

With Medicaid, legislators found themselves facing high political costs for a particular-benefits program. Because of continual cost increases, state representatives faced either raising taxes or cutting services to continue providing benefits and attracting federal matching grants. This problem was compounded because Medicaid benefits for those under age sixty-five were often conditioned on the household head being unemployed, a situation many legislators found inequitable and perceived created resentment for public-health programs among constituents.

This chapter makes three contributions to the understanding of legislators' efforts to maximize benefit/tax ratios and how governing principles shape these efforts. First, legislators began to transform Medicaid from a redistributive program, offering particular benefits, to a program more closely resembling a public good, offering subsidized benefits to a broader group of citizens. Lawmakers did so not because they preferred public goods to particular benefits but because of the inequities created by Medicaid and the concentration of benefits to unemployed low-income families

while the working poor were typically ineligible. Legislators referred to their concerns about citizens' abilities to pay for health care and about whether citizens deserved to pay for and benefit from public-health programs. After thirty years of rising costs, state officials favored changes because Medicaid created constant financial stress and because it had lost political support. In terms of governing principles, legislators could not ask citizens for annual tax increases for Medicaid because the program lacked policy accountability. This lack of policy accountability forced legislators to cut spending in other areas, which in turn threatened state governments' overall political accountability.

Representatives supported incorporating managed care into Medicaid because doing so created alternatives to address the inequities created by offering Medicaid to the unemployed but not to low-income workers and their families. Managed-care alternatives offered a means to apply both the ability-to-pay and deserves-to-pay principles. With the introduction of co-payments, beneficiaries would to some extent pay when they used health services and thus deserved to pay. Proposals for sliding-scale premium subsidies in Tennessee, Oregon, Vermont, and Florida reflect an application of the ability-to-pay principle.

Health politics' second contribution to the understanding of subnational politics and changes in benefit/tax ratios is that federal policies and politics influenced the parameters of state policies and politics. When introduced in 1965, Medicaid created state matching grants to establish programs and provide benefits. Forty-nine states accepted the federal government's bargain in 1965, and Arizona later enacted a modified program. At the outset, program costs were relatively modest. The replacement of the federal-state Kerr-Mills medical assistance program with Medicare for the elderly had left states with slack resources with which to fund Medicaid (Pauly and Granneman 1983). But by accepting this federal matching-grant program, the states unwittingly set the stage for their own health-reform politics in the 1990s.

The grant structure of Medicaid and waivers from the Health Care Financing Administration influenced the shape and success of state reforms. For example, concerns about vertical transferability emerged as legislators tried to retool Medicaid while retaining federal matching grants. Consequently, state representatives designed reforms and negotiated federal waivers in which they would be "held harmless" should they succeed in generating Medicaid savings. Representatives worked to ensure

that savings from reform would flow to newly insured citizens and to state general-revenue funds.

National politics flowed into health-reform efforts in Colorado, Washington, and Florida. As with income tax politics, federal politics directly and indirectly influenced state health-care politics. In every case-study state, legislators related how the Clinton administration's proposals and reactions from nationally prominent Republicans shaped specific proposals and the political climate for health-care reform.

The third contribution to the understanding of benefit/tax ratio changes is that tax options available to legislators shaped both stopgap Medicaid changes and long-term reform efforts. Obscurability and equity considerations led legislators to promote sin taxes as the primary means of financing reform.[1] Subsequently, these very narrow tax bases restricted the expansion of Medicaid/managed-care coverage. Constituents' willingness to accept and legislators' willingness to vote for such taxes were components in reform measures in all the case-study states. For legislators, sin taxes presented justifiable funding because representatives could explain to constituents that citizens who put their health at risk by smoking or drinking alcohol deserved to pay for public-health programs. Lawmakers also believed that their constituents would be less likely to revolt against sin taxes than against sales or income tax increases. These financing strategies provide evidence that representatives explicitly link taxes to the services they provide.

Representatives sought benefits for a variety of constituencies. All legislators sought to control rising Medicaid costs, achieve greater health-insurance coverage, and subsequently offer tax cuts or spending increases in education, anticrime, and transportation programs. Yet the initial focus was on Medicaid funding crises. Legislators sought to alter the Medicaid program because it offered particular benefits with alarming cost increases to people whom many citizens and legislators viewed as undeserving or no more deserving than low-income workers. As outlined in chapter 2, if costs are visible and burdensome and representatives perceive a program to be politically unpopular, then a program may be unsustainable. This was the situation with Medicaid. In response, legislators sought to transform a particular-benefits program into broader managed-care programs.

Liberal legislators emphasized increasing both the economic and physical well-being of Medicaid beneficiaries and the working poor who lacked health insurance. Representatives promoted ongoing doctor-

patient relationships and incentives for preventive care. For Medicaid beneficiaries, legislators sought increased health benefits and an end to the "welfare stigma" associated with Medicaid. For the working poor, representatives wanted to eliminate the inequity of entitling unemployed single parents to Medicaid but denying benefits to working individuals and their families.

Moderate and conservative legislators emphasized the fiscal benefits of controlling Medicaid costs. These representatives argued that taxpayers would benefit if more persons enrolled in health-insurance plans and thus decreased the amount of uncompensated care provided. With the decrease in uncompensated care, legislators forecast decreases in the practice of shifting the costs of uncompensated care onto private, insured (and therefore paying) patients. The fiscal slack resulting from decreases in Medicaid appropriations could in turn finance tax reductions or increased spending.[2] These legislators stressed correcting the inequities of Medicaid and offering health insurance to the working poor, explaining that such individuals and families deserved to benefit from public-health programs as much as the unemployed did.

Table 15 outlines potential costs and benefits from Medicaid reform. These changes had both political and economic components. By introducing co-payments or sliding-scale premiums, legislators sought to provide additional revenue for subsidized health insurance not only out of economic necessity but also because beneficiary contributions could increase political support for programs within legislative chambers and among citizens. Legislators in Colorado, Tennessee, and Florida suggested that Medicaid failed politically because beneficiaries remained disengaged from using health services prudently and the program had no mechanisms to hold either providers or beneficiaries accountable for inefficient service utilization.

Background

Medicaid presented the mirror image of the problems legislators associated with undependable revenues discussed in chapter 3. Exorbitant annual increases in Medicaid appropriations created repeated fiscal crises in which representatives cut nonhealth spending or raised taxes. Between 1987 and 1993, Medicaid spending rose from less than 10 percent of all state government spending to nearly 18 percent (Council of State Governments 1994). In Tennessee, Medicaid expenditures doubled from $820 mil-

lion in 1987 to $1.6 billion in 1991, and these increases nearly bankrupted the state general fund (Tennessee 1994–95). Legislators in other states faced less severe crises, but cost increases nonetheless motivated efforts to change the Medicaid program.

Along with rising costs, Medicaid has suffered from other unintended, related problems. Foremost among these is that general-practice physicians have declined to accept Medicaid patients as reimbursement fees provided by the program have fallen below those paid by private, paying patients. Consequently, an increasing proportion of beneficiaries have sought health services in hospital emergency rooms, thereby requiring Medicaid to pay higher reimbursements to hospitals than would have been

TABLE 15. Costs and Benefits of Medicaid Reform

Constituency	Benefits	Costs
Current medicaid beneficiaries	Doctor–patient relationship	Co-pays
	Preventive services	Sliding-scale premiums
Working uninsured	Insurance coverage	Co-pays
	Doctor–patient relationship	Sliding-scale premiums
Insured citizens	Preventive services	Higher sin taxes
	Reduced cost shifting from uncompensated and partially compensated care	
		Possible increase in cost shifting from utilization of health services by formerly uninsured
	Fewer reductions in and more dependable nonhealth government services	
	Lower taxes conditioned on Medicaid savings	

paid to physicians. Legislators recognized that because federal Medicaid guidelines prohibited co-payments from beneficiaries, families had no incentive to seek physician care prior to seeking emergency-room care. This dilemma further compounded Medicaid cost increases.

Representatives identified Medicaid as the federal-state programs in which they had lost the greatest policy latitude and in which federal mandates imposed the highest costs. Twenty-seven percent of the legislators interviewed cited Medicaid as the most costly intergovernmental program and as a program in which mandates drove costs.[3] A Colorado legislator summarized the overall effects of Medicaid mandates:

> *Representative:* Government mandating has really had an adverse effect on the Colorado state government—particularly . . . in health care. Really, Medicaid has been driving the state budget for the last seven or eight years. In 1986, we spent $364 million on Medicaid. Now that figure is $1.3 billion. Now, that's a lot of money that could be going to education. . . . The penny on the sales tax was for what? $300 million?
>
> *GB:* $364 million.
>
> *Representative:* Right, $364 million. Even after inflation, the increase in Medicaid is probably at most $600 million but not $900 million over eight years. So all that money could have gone to education, and we wouldn't have gone to the voters only to get turned down anyway on the sales tax.

From 1966 through 1985, relatively high medical inflation created three-quarters of Medicaid costs increases. By the mid-1980s, an increasing percentage of cost increases resulted from federal requirements that states enroll more beneficiaries based on particular categories of need (U.S. Advisory Commission 1992, 12). These enrollment increases became acute during the 1990 recession and began to place tremendous pressure on state budgets at a time when many states faced declining revenues. At the same time, the federal government did not identify Medicaid mandates as unfunded mandates in the same way as environmental regulations. Medicaid regulations were categorized as conditions for aid.

Legislators found skyrocketing expenditures forcing them to reshape health-care policies. These costs impinged on their ability to provide other goods and services, including education and training, anticrime measures, and tax reductions. Faced with the prospect of providing ever-more-

expensive benefits to a group of people many voters viewed as undeserving, legislators moved to control the costs of the program lest all citizens find their benefit/tax ratios continually declining. Seventy percent of legislators discussed how accelerating Medicaid expenditure increases influenced their support for health-care reform. Half of the legislators identified specific non–health related spending cuts and tax increases that had been enacted because of Medicaid costs.

Thirty-three of seventy-six legislators who discussed health reforms indicated that they supported transforming health benefits because they did not believe that Medicaid delivered benefits to those who deserved them. Beyond the issue of cost savings was the issue of offering government goods and services that accord with legislators' principles about who should benefit from government spending.

Although concerns about rising Medicaid appropriations provided the primary motivation for reform efforts, two other factors encouraged representatives. First, problems in private insurance markets prodded Republicans to support changes in health-care and insurance packages. Legislatures in Colorado, Florida, Washington, Oregon, and New York have all addressed issues such as preexisting conditions, insurance portability, and insurance rating systems. Second, a lack of political support for Medicaid encouraged some Republicans and many Democrats to promote Medicaid changes to generate greater support for broad health-care reforms.

Legislators developed reform packages based on legislative political dynamics, governors' leadership, available financial resources, and extent of the Medicaid crisis in their states. Legislators referred frequently to equity issues and invoked the ability-to-pay and deserves-to-pay principles. A third variation of the equity principles was that certain citizens deserved to benefit from state public-health programs. Legislators suggested that children and the working poor deserved as much assistance in obtaining health insurance as did current Medicaid beneficiaries. Legislators addressed concerns about vertical transferability, dependability, and, to a lesser extent, obscurability.

Strategies for Health-Care Reform

State reforms shared a common denominator in their efforts to transform Medicaid from a particular-benefits program into a program more closely resembling a public good. Medicaid offered particular benefits by paying on a fee-for-service basis. Consequently, the distribution of benefits

depended first on eligibility for Medicaid and then on an individual's utilization of health services. In contrast, most of the state reform plans abandoned individual services and moved to subsidies for insurance policies or membership in health maintenance organizations (HMOs), with the ultimate goal of insuring the entire state population. By 1993, sixteen states used managed-care programs for basic Medicaid services to the nonelderly (U.S. Advisory Commission 1993).

In the managed-care programs, insurance policies became the benefits for citizens. Individual policy premiums and coverage determined benefits and costs for enrollees. The extent of coverage and subsidy rates among Medicaid and uninsured populations determined the cost to the state and federal governments. These new programs more closely resembled a public good in that eligibility was no longer restricted by employment but was instead determined by income or ability to pay. Although no state offered universal coverage, the states' new roles as the insurers of last resort meant that citizens who lost private insurance could turn to the state program. Legislators sought to make health insurance a public good through which everyone would have an insurance policy for which they would pay according to a combination of their ability and their utilization of health services (i.e., a combination of the ability-to-pay and deserves-to-pay principles). In contrast to other public goods such as national defense, insurance coverage would be produced both publicly via state subsidies and privately via HMOs and private insurers. The transformed Medicaid program became analogous to public goods, such as education, that are produced via both private and public means but are nonetheless available to and consumed by all citizens.

A few basic ingredients were more or less present in state reform strategies. Legislators fostered bipartisan support for reform by offering Republicans and Democrats means to improve the well-being of disparate groups of citizens with a single reform package. Legislators recognized the incremental nature of policy change and pursued modest progress toward cost containment and increased coverage over and above their goals for either universal coverage (favored by Democrats) or a more privately based, free-enterprise health system (favored by Republicans). Incremental policy change also offered an avenue by which legislators could rebuild support for public-health programs, which had eroded. A third component emerged when state officials negotiated federal waivers in which they could generate efficiencies in Medicaid and retain any savings.

Other strategic considerations emerged. Politically, legislators consid-

ered the willingness of the governor to invest political capital in health-care reform, the prospects for federal health-care reform, and the necessity and probability of attracting bipartisan support. From a policy perspective, reform architects contemplated how far they could expand insurance coverage and the necessity of reform itself, a consideration driven by the extent of the state's Medicaid crisis.[4] With these concerns in mind, legislators in six states made serious efforts to alter their Medicaid programs and health-care systems.

The legislative proposals in Colorado, Florida, Tennessee, Oregon, Vermont, and Washington illustrate how health-care reform was an effort to transform a particular-benefits program into a public good and was shaped by federal policies and politics and how the tax alternatives available to legislators set parameters for their proposals.

Medicaid: Managed Reform

The efforts to transform Medicaid from a fee-for-service program to a subsidized managed-care program represent a shift from a particular-benefits program to a program more closely resembling a public good. With managed-care proposals, the benefits become either a state-subsidized insurance policy or membership in an HMO. Whereas beneficiaries' utilization of health services represented the value of benefits under Medicaid, the cost of an insurance policy or HMO membership represents the value of benefits with the managed-care programs.

The assertion that health-care reforms changed Medicaid from a particular-benefits program to one more closely resembling a public good deserves further explanation. Only in Washington and Oregon did legislators enact programs designed to provide universal coverage in a comprehensive legislative package. In the other states, a considerable portion of a state's uninsured population would remain uninsured. Nonetheless, every reform package moved away from Medicaid, which strictly limited health services to specific groups, such as the indigent elderly and single, unemployed parents and their children. In its place, subsidized managed care broadened the population served and moved toward a situation in which health insurance, not health services, would become a nonexclusionary public good.

Tennessee. The movement to managed care received considerable bipartisan support among legislators. Representatives offered bipartisan sup-

port for the movement because of its potential cost savings. Democrats stressed that the shift enabled them to offer health insurance to a greater number of individuals than Medicaid could. Republicans supported expanded coverage and the opportunity to decrease cost shifting by health-care providers.[5]

Among the case-study states, only Tennessee authorized wholesale reform in a single legislative session. The legislature effectively exempted itself from the reform process when it enacted the hospital tax in 1992 and required that the tax expire in 1994. At that time, the Medicaid replacement program was to be enacted or the state would revert to using sales tax revenues for Medicaid appropriations. Despite the lack of a formal legislative role, several legislators involved themselves in the development of Tenncare, the state's managed-care replacement for Medicaid. Although the governor could enact Tenncare without further legislation, he needed some level of legislative acceptance because legislators would appropriate funds for Tenncare and thus play a role in its administration and political viability.

Tennessee representatives commented that both the financial and political problems with Medicaid motivated them to demand its replacement. Legislators believed that increasing taxes to continually fuel Medicaid spending was not sustainable because the program had lost too much political support. In other words, Medicaid had lost both the political and policy accountability necessary for legislators to fund it. One Republican summarized the situation as follows:

> When we hit our crisis two years ago, I called the commissioner and asked him what we should do. He told me point blank, "This Medicaid is broken, and if I were you, I wouldn't dump any more money into it—not even what you have now, because you'll cut benefits every year. . . . So we had to do something to save money and to get the benefits out there more fairly.

The Tennessee legislature's response to the Medicaid funding crisis in 1992 illustrates federalism's creative politics. Initially Tennessee attempted to address its Medicaid funding crisis by taxing hospitals for Medicaid services and other indigent care. The legislature dedicated these revenues as the state source for Medicaid funding. This created a situation in which the state generated revenues from its own spending. The hospital tax enabled the state to attract federal matching grants for its Medicaid dol-

lars by cycling the same state dollars through the program. For example, the federal government offers Tennessee approximately two dollars for every dollar it spends on Medicaid. If a service costs one hundred dollars and Tennessee taxes it at 50 percent, the price of the service rises to $150, of which Tennessee must pay $50 and the federal government $100. However, of the $150 spent, $100 went to cover the actual cost of the service, and $50 was remitted to the state government for the hospital tax. Table 16 depicts how Tennessee effectively recycled the same state dollars through its Medicaid program and essentially shifted the entire service cost of Medicaid to the federal government.

TABLE 16. The Tennessee Indigent Services Tax

1	2	3	4
	A: No Services Tax		
Patient • cost: 0 • benefit: $100	*Hospital* • cost: $100 • Revenue: $100 from Tennessee government	*Tennessee* • cost: $100 paid to hospital • Revenue: $67 from federal government; $33 from Tennessee taxpayers	*Federal government* • $67 to Tennessee *Tennessee taxpayers* • $33 to Medicaid
	B: Indigent Services Tax		
Patient • cost: 0 • benefit: $100	*Hospital* • cost: $150 ($100 for service; $50 tax remitted to state government)	*Tennessee* • cost: $150 remitted to hospital • Revenue: $100 from federal government (67% of $150); $50 from hospital; nothing from taxpayers	*Federal government* • cost: $100 remitted to Tennessee (67% of $150) *Tennessee taxpayers* • cost: 0

This policy design enabled Tennessee to develop a system in which the federal government bore nearly 100 percent of Medicaid costs. When I asked why they abandoned this tax for the broader hospital tax, one legislator summarized his colleagues' responses:

> We moved from what we called Scam 1 to . . . Son of Scam, only because the feds came down on us for it. They didn't mind us doing it, but other states started to copy it. Hey, they were ready to go with it in Arkansas, so we had to have the broader hospital tax.

The legislature replaced the indigent-care tax with a broader 6.75 percent tax on all hospital services. Legislators supported the hospital tax because they perceived they could not raise the state's 8 percent sales tax or expand its base without dire political consequences. Five of the representatives interviewed related that many legislators would have preferred a broad-based tax instead of the hospital tax. Because the hospital tax fell on those who used health services, several representatives felt its incidence was inequitable. Nonetheless, the relatively high sales tax and constitutional prohibition against an income tax left the legislature with few options for broad-based taxes. Moreover, six legislators suggested that raising another tax would have only been the first in a never-ending series of tax increases if the state government did not address the underlying problem of increasing Medicaid costs. The obscurability and dependability of the hospital tax, coupled with its expiration, engendered sufficient support from both Republicans and Democrats.[6]

Although federal Medicaid mandates were conditions for aid rather than unfunded mandates, Tennessee's state government estimated the marginal cost to its treasury from changes in federal program requirements and funding. For its 1994 budget, Tennessee estimated that $206 million of $263 million in federally mandated expenditures occurred in Medicaid. However, $72 million of the $206 million were costs generated by decreases in the federal matching rate for Tennessee resulting from the state's economic growth.

Only in Tennessee did legislators never mention increasing tobacco and alcohol taxes. Not a single legislator indicated support for changing tobacco or liquor taxes, which may not be surprising given that Tennesseeans produce both products. Legislators either supported the hospital tax or stated that it was the least objectionable funding mechanism available in 1992 immediately following the voters' rejection of Governor

Ned McWherter's income tax proposal. Representatives rejected other tax increases because of low-tax philosophies or because such increases would have been the first in a series necessary to continue funding Medicaid in the absence of reform.

Despite the hospital tax's shortcomings, legislators saw advantages to it. The tax indirectly addressed cost shifting in health-care services. Federally determined reimbursement rates often fall below the actual cost of a service. As a result, service providers shifted the Medicaid costs onto private, paying patients. Thus, if Medicaid pays $50 for a service that costs $100, the hospital will charge a privately insured patient $150 for the same service. The hospital tax offered a limited response to cost shifting. By generating Medicaid dollars by taxing health services, legislators created a system in which greater cost shifting generated greater state Medicaid revenues, which were then matched two to one by the federal government. Greater Medicaid funding implied that the state could offer greater reimbursements for health services, thus decreasing the amount of uncompensated care.

Tennessee legislators enjoyed considerable success in setting the stage on which their state's Medicaid program was transformed into from a particular-benefits program to one more closely resembling a public good. After the program's enactment in March 1994, one-quarter of the state's uninsured and all of its Medicaid beneficiaries enrolled in Tenncare (Tennessee 1994–95).

In Tennessee, the legislature's actions in 1992 effectively exempted it from a formal role in reforming Medicaid. Several legislators commented that they took this step to ensure that the reform process did not unravel as lobbyists and legislators manipulated various components of reform packages. The Tennesseeans felt that the critical nature of their Medicaid crisis necessitated the relatively quick enactment of wholesale reform. The strategy succeeded to the extent that Tennessee abandoned Medicaid for Tenncare. The Tennessee strategy proved prudent, in contrast to events in Florida, where a last-minute Republican-led filibuster in the state senate derailed health-care reform.

Florida. The Florida House of Representatives passed the Florida Health Reform Act of 1994 by an overwhelming vote of 117 to 3. Two months later, Senate Democrats were unable to block a Republican-led filibuster, and the act failed to become law. The strategies behind the bipartisan support in the House were similar to those in other states. Rep-

resentatives built on the Basic Health Act of 1993, and Democratic committee chairpersons coupled insurance reform with a managed-care Medicaid alternative and offered cost savings. Additionally, the Committee on Health specifically addressed Republican concerns about physician choice by including an "any willing provider" clause that stipulated that managed-care enrollees could go to the physician of their choice but would bear any costs above a state-determined reimbursement level. As one influential Democrat with health-care expertise outlined,

> We've had to go back and forth, but basically we couldn't impose a tax to do it. We went to the hospitals, and they said they couldn't be pushed any further. But we knew that if you can get the working poor to contribute to something plus some share of a state subsidy, which we could afford by getting Medicaid recipients out of the [emergency rooms] and to the [general practitioners], then the state would be able to draw down the federal dollars to get the program going from the former Medicaid match.
>
> The next thing we offered them was Medicaid savings, and then we had the support for the plan, which passed through the House 117 to 3. Now I'm a little worried because Bob Dole is starting to send signals to scuttle this in the [state] Senate.

Lobbyists and staffers confirmed that Senator Dole was involved in the Florida legislation and speculated that he did not want states passing efforts similar to President Clinton's national proposal. Activists from both parties stated flatly that the Health Care Reform Act would have given Governor Lawton Chiles a large boost in his tight reelection race.

As with the national debate on health reform, critics charged that state efforts could lead to a decrease in choices among health services for people enrolling in state-subsidized health-care plans. Republicans and Democrats countered this charge with several arguments. Because the state was paying most of the bill for those who relied on the state for insurance subsidies, it could justify limiting their choice of physicians. Most legislators intended for state-subsidized managed care programs to designate "gatekeeper" general practitioners whom beneficiaries would visit prior to receiving further services. Democrats responded that those on Medicaid and those without health insurance relied too heavily on emergency-room visits. Moving such persons from emergency rooms to physicians' offices

implied no decrease in choice. Third, supporters argued that the national politicians opposing reform because of decreasing choices were wrong.

A Florida Democrat noted that both Democratic and Republican opponents of the Florida Health Plan raised the issue of physician choice. In contrast to other states, where legislators attempted to counter the validity of the choice argument, Democrats on the health committee in the Florida House worked to accommodate the opposition's views.

> We have a certain section [of the legislature], mainly the Republicans, who would oppose everything and anything we would put on the table, so we said, "Why are you against this?" and they said, "It destroys choice." So we began from there and offered the "any willing provider" clause as a compromise on choice that enrollees could go to a [preferred-provider-organization] system if they pay for it, which puts them in a more traditional full-indemnity plan.

In Florida, a House Republican with a professional background in health care enlisted the support of the governor and his colleagues for a twenty-five-cents-per-pack cigarette tax to finance expanded coverage and offer new community health programs focusing on prevention. The tax climates in most states left legislators with few, if any, options for financing reform other than sin taxes. One Florida legislator offered his own assessment while enjoying a series of cigarettes:

> As much as we'd like to move on health reform, we really have no options to get the money for it. We can't raise taxes, and we only have the sales tax. The one exception is that we might get a cigarette tax. Hell, I just might be smoking the state to health right now. I've never thought of this habit as a public service before.

In most states, health-care reform proceeded incrementally. The Florida Health Security Act of 1994 followed on the heels of the Basic Health Act in 1993, although the former failed to become law. In Oregon, the legislature enacted the comprehensive Oregon Health Plan in 1989 but allowed itself opportunities to modify the plan over time by phasing in different elements. This incremental approach also afforded the state critical time to negotiate various waivers from federal laws. This federal role eventually placed a constraint on further implementation of the plan in 1995.

Oregon. Oregon's recent experience with health reform indicates the limits the federal government can place on reform. Having gained several waivers to change its Medicaid program during the late 1980s and early 1990s, the Oregon legislature found it could not enact one of the final components of its reform package in 1995 because of the U.S. Congress's unwillingness to grant a waiver from the Employment and Retirement Income Security Act (ERISA). The legislature requested the waiver to enact a mandate that all employers offer a minimum insurance-benefits package to their employees. Although many Republicans opposed the mandates, several supported them. One senior Republican stated his reasons for supporting the measure, which had drawn widespread criticism in the national health-care debate the previous year:

> I'm troubled by the fact that in Oregon there are employers who don't want to pay for health insurance. It should be a part of doing business. I'm a small businessman, and it's unfair that I bear that cost in my pricing but my competitor won't, because then I pay again when my competitor's employees go and get uncompensated care. I think in Oregon we can move to universal coverage. I think we should.

With the support of several Republicans and most Democrats, Oregon legislators felt there was some likelihood of enacting an employer mandate. However, the issue became moot when Senator Robert Packwood passed the word that Congress was unlikely to grant the waiver. Republicans and Democrats recognized the irony that the Republican Congress that emphasized allowing states greater latitude for policy innovations would not grant a waiver for Oregon to reform its health-care system. One Republican suggested that his counterparts in Congress had no interest in granting a waiver from a federal mandate that would allow a state to enact a "Clinton-style" mandate that might work in the particular context of Oregon's health system.

Several Oregon representatives mentioned a dilemma that their incremental approach created in conjunction with the prospect of not receiving a congressional waiver from ERISA. By creating a state program to provide low-cost insurance to individuals but not placing an onus on employers to either provide such insurance or contribute to the state fund for it, legislators worried that they would make Oregon a health-care magnet: firms would locate in Oregon offering low- to medium-wage jobs without

health-insurance benefits and then direct their employees to seek assistance obtaining health insurance from the state. The system would consequently be strained by the increasing demands on it.

The Oregon experience with health care was one in which a bipartisan group of lawmakers in both legislative chambers built support for health-care reform by promoting incremental changes each biennium and by detailing both savings from the changes and safeguards that would allow the state to contain costs if they began to skyrocket, as they had with Medicaid. Several legislators commented on the credibility Governor John Kitzhaber had developed on the issue by working with Republican legislators on the Oregon Health Plan as early as 1987.

Vermont. In some instances, the content of policy alternatives and their merits mattered less than the political appeals of promoting or opposing changes in Medicaid. A senior Republican Vermont legislator who favored shifting Medicaid to a managed-care program told me how his colleagues complained that the bipartisan reform compromise he promoted had too many benefits for their tastes:

> I kept telling them [that] to get the waiver, we can only trim so much from what we're now offering, and they'd keep saying the benefits in managed care were too generous. And I'd say, "But we have fewer benefits in that than we do in the current fee-for-service Medicaid, you dummies!"

Vermont legislators failed to enact a sweeping health-care reform package in 1993. Many attributed much of the failure to the legislature's inability to agree on a funding mechanism for the package (Pear 1994b). In 1995 the House passed a bill to provide subsidies for managed-care memberships to between 20 and 25 percent of the state's sixty thousand uninsured individuals. Republicans and Democrats supported a modest increase in tobacco taxes as the principal funding mechanism with the realization that the Republican-controlled Senate would accept only this tax change and that they could scale it back so that insurance might be offered to between five thousand and eight thousand people.

Washington. In Washington, legislators passed comprehensive health-care reform in 1993 that built on the state's Basic Health Act of 1987. In

1993 the legislature mandated that all employers offer health insurance to their employees by July 1995 and subsidized costs for small-business employers with tobacco, alcohol, and gasoline taxes.

Most Democrats and several Republicans supported these sin-tax increases. Later in 1993, however, Initiative 601 called for their repeal, thereby leaving health financing in peril. In response, several moderate Republicans developed and spearheaded the drive for Initiative 602, which limited the future growth of government but left the 1993 tax increases intact.

Sponsors of Initiative 602 suggested that they did not want to derail health reforms.[7] Given the initial popularity of Initiative 601 and the general "less government, lower taxes" mood pervading the state, the architects of Initiative 602 recognized the political necessity of offering an alternative initiative if the state was to have any resources with which to move forward with health-care reform. Thus, Initiative 602 preserved current revenues but limited future growth. In the absence of Initiative 602, legislators feared that Initiative 601 would pass and they would lose the health-reform funding.

Supporters of Initiatives 601 and 602 agreed that the strategy for Initiative 602 worked. Initiative 601 failed, and Initiative 602 passed narrowly. One of the architects of Initiative 601 noted that his plan had enjoyed broad support until Initiative 602 was introduced. Shortly before the election, the revelation that tobacco companies heavily financed advertising in support of Initiative 601 further eroded its support. Legislators agreed that this decline at least implicitly promoted Initiative 602.

Colorado. As in Washington, the citizen referendum process played a role in legislators' support for health-care reform in Colorado. The state began planning for health-care reform under the rubric of Amendment 1, which limited state and local spending and subjected tax changes to a statewide vote. This provision dampened legislators' enthusiasm for any reform plan that could not be enacted on a pay-as-you-go basis within the existing tax structure. Republican and Democratic legislators complained that even if they could guarantee savings with a managed-care alternative to Medicaid, they could not support any proposal that included new taxes or fees that would be subject to a statewide vote. As one Democrat noted, "We don't want to start anything new because no matter how good it may be or [even if] we can cut other taxes a year from now, if we try to do anything involving money Doug Bruce [the leader of the antitax movement] sues you."[8]

Some Republicans initially opposed Governor Roy Roemer's managed-care plan on the grounds that it limited physician choice. But this argument lost steam in Colorado when leading Republicans argued that the cost savings from Colorado Care could offset any loss of physician choice among Medicaid beneficiaries and that physician choice was either nonexistent or not a priority for Medicaid beneficiaries. One Colorado Republican stated that he felt nationally prominent Republicans were performing a disservice to Republican state legislators who needed to find Medicaid savings to balance their budgets. He explained:

> On the issue of choice—that's really a Trojan horse to talk about preserving the status quo. Besides what you may hear from the national parties, managed care does not mean you won't have any choice in health care. You can choose your managed-care network, and these may be employer based in many cases. Now the only choices you have are who your employer enrolls with or what plans they sponsor, and people are getting pulled away from their physicians by their employers. I see managed care as a means of unraveling some of that dilemma.

The overriding reason Coloradans gave for moving away from Colorado Care was that in early 1994 the Medicaid funding crisis abated for the first time in eight years. By February 1994, the Republican chairperson of the House Appropriations Committee had announced that Medicaid expenditures would fall $200 million below projections because of lower-than-expected medical inflation and an overall improvement in the state's labor market. This windfall decreased the necessity of shepherding a contentious program through a legislature controlled by a slim Republican majority and presenting it to a Democratic governor. With a divided legislature and a contentious issue, representatives from both parties indicated that they preferred to wait until after the 1994 elections to grapple with health care.

Discussion

The debate over health care has developed many elements at both the national and subnational levels. Three of these elements are of particular interest with respect to benefit/tax ratios and the role of representatives in changing the economic and physical well-being of their constituents. First,

legislators seek to maximize their constituents' benefit/tax ratios and will not tolerate a program that consistently decreases those ratios. Lawmakers will offer policy changes when a government program clearly lowers the benefit/tax ratios of a majority of citizens, as was the case with Medicaid, where large, persistent cost increases necessitated cuts in other programs or tax increases. Just as legislators pursue revenue dependability, they also seek spending regularity.

Second, tax options matter. Legislators change policies when they perceive constituents are not well served by them. If constituents will not tolerate further tax increases for programs or perceive that they unfairly benefit certain groups of citizens, legislators will act to remedy the situation. In such cases, legislators act not just as revenue maximizers but as agents for citizens' utility maximization. In the case of health care, most legislators felt that they could not justify changing broad-based taxes to pay for Medicaid reforms and thus supported increasing alcohol and tobacco taxes as the only viable alternative.

Although state representatives favored expanding health coverage and saving money, their willingness to tap new revenue sources to provide subsidies restricted the scope of their reforms. No legislator indicated a willingness to raise either income or sales taxes to finance health-care reform, although several Vermont legislators hoped that the state might do so after a managed-care program restored public confidence in public-health programs. With pressure to cut taxes, resolve local property tax issues, and fulfill various mandates, legislators found that they had little latitude to finance Medicaid reform. Consequently, legislators in nearly every state turned to sin taxes as the only viable route. Among the legislators who commented specifically on sin taxes, thirty-four indicated support, while six Republicans opposed any tax increases as part of their limited-government philosophies.

A third element in the debate over health care that is germane to benefit/tax ratios and representatives' roles in changing them regards federal politics. From a policy perspective, the waivers granted or denied by Congress, the Health Care Financing Administration, and the Clinton and Bush administrations created the parameters for state health reform. From a political perspective, the relationships among officeholders at the state and federal levels influenced both the direction for health reforms and the enthusiasm with which various groups either promoted or opposed reform. In this federal context, representatives attempted to build

support for transforming Medicaid and sought adequate revenues to finance their reform proposals.

Federal laws and politicians played important roles in state health-care reform. Federal regulations administered primarily by the Health Care Financing Administration guided both the timing and the parameters of state-proposed Medicaid changes. The ability of state legislators and administrators to convince federal officials to grant Medicaid waivers determined the structure of state reform. Politically, legislators' and governors' relationship with members of Congress and President Clinton played a role in encouraging reform in Tennessee and to a lesser extent in Washington.

Finally, the nature of the program—whether it is a particular-benefits program or a public-good—matters not only in economics but also in politics. The particular benefits provided by Medicaid and to whom they were provided contributed to its lack of political accountability. Legislators hope that the public-good (i.e., less exclusionary) nature of state-subsidized managed-care policies will expand the scope of coverage and address the deserves-to-pay principle sufficiently to engender support for new public-health-assistance programs.