August 2008

What Works and What Doesn't
A Review of Health Care Reform in the States

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1. Introduction

Since the failure of HillaryCare at the national level in the early 1990s a number of states, including Washington, have made attempts at health care reform of their own. Each of these have been based on some form of government-managed system, generally including an open-ended taxpayer funding commitment combined with a generous set of mandated benefits.

In each case, these programs have failed to achieve their policy goals and have often proved unsustainable as originally enacted. Naturally, backers of these health care programs are reluctant to talk about their original ideas once they have failed, so past state efforts at health care reform tend to be forgotten.

This is unfortunate because the hard-won experiences of other states, and of Washington's own attempt at state-managed reform, provide a valuable guide to today's state lawmakers. The purpose of this paper is to summarize efforts by other states, in order to guide Washington lawmakers about what works and what doesn't when it comes to enacting health care reform laws.

This study includes a review of six states, Washington, Oregon, Tennessee, Hawaii, Massachusetts, and Maine, that enacted government-managed health care reform plans, two states, Wisconsin and California, where such plans were proposed but failed to pass, and three states that have recently taken a different approach. These three states, Florida, Georgia and Indiana, have enacted reforms that move decision-making about health care to the individual, work with market forces, and create voluntary incentives that increase choice and expand access to health care coverage.

2. Government-Managed State Reform Plans

Washington – The Washington State Health Plan

In 1993, Washington had 600,000 uninsured residents, which represented 11 percent of the population. That year the legislature passed sweeping health care reform legislation, called the Washington State Health Plan, in an effort to reduce the number of uninsured and make health coverage more affordable.

The basis of the program was to require all state residents not in the Medicare program to join a managed competition plan. The primary goal of the program was to provide universal coverage for all Washington residents. The policy elements of the program included:

1. Price controls, in the form of state-imposed caps on insurance premiums;
2. Statewide community ratings and universal access;
3. New mandates on employers and individuals;
4. A guaranteed issue law, and;
5. Increased emphasis on public health and prevention.

The plan added a powerful new state bureaucracy, raised taxes, added more mandates and restrictions on employers and individuals, and gave state government more control over health care.

From a practical standpoint, the consequences of the plan were devastating. Fourteen health insurance carriers left the state and the few remaining insurance companies were forced to raise their rates by up to 40 percent. The number of uninsured in Washington rose by 20 percent, as people were forced to drop policies they could no longer afford. The state began attracting sick patients from all over the country because of the guaranteed issue provision.

The guaranteed issue law required insurers to sell their product to anyone, regardless of medical risk or pre-existing health conditions. One insurance company received a polite letter from one satisfied policyholder, who said she had purchased an insurance policy during her recent pregnancy and, now that her baby was born, she no longer needed the policy and was dropping her coverage. She assured the company she would certainly choose them again when she needed to pay for medical care in the future.[1]

The community rating law required premiums charged by an insurance company to be an average of all premiums (for sick and healthy, young and old, etc.) in a given region. Exceptions were allowed for some factors, such as age, but the required community rating "bands" (legal limits on how much the cost of coverage could vary) worked as a price control. The restriction kept insurers from setting monthly premiums accurately to reflect the real risk involved in selling someone a particular insurance policy.

Together, community rating and guaranteed issue rules created two perverse incentives. First, they encouraged healthy people to avoid buying health insurance, since the average rate they would pay was far higher than what they would pay in an unregulated market. Second, they encouraged people to wait until they got sick before buying insurance.

Community rating makes the price less than what a sick person would pay in an unregulated market and guaranteed issue forces insurance companies to sell a sick person, after a waiting period, a policy without taking all the medical risks involved into account. These rules resulted in higher health insurance prices for everyone.

By 1994, it was obvious the plan was not working and a citizen revolt occurred at the voting booths. The governing party in the legislature lost its majority, and the governor who had signed the reform plan was forced to approve a repeal of the program, in order to avoid an embarrassing public vote on the issue through a popular initiative.[2]

While most elements of the 1992 reform plan were repealed, Washington's health insurance market has never fully recovered. This is in part because the guaranteed issue law, though modified, remains in place, the market is burdened by more than 52 state-imposed mandates, and the state levies a special tax on all insurance policies sold in Washington.

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[1] Once this story became known in the legislature, lawmakers eased the guaranteed issue law to allow insurers to require a nine-month waiting period before a newly-purchased insurance policy would cover a pre-existing medical condition.

[2] "The rise and repeal of the Washington State Health Plan: Lessons for America's state legislators," by Dr. Robert Cihak, MD, Bob Williams, and Peter J. Ferrara, June 11, 1997, at www.heritage.org/research/healthcare/bg1121.cfm.

When passed, supporters said the Washington Health Plan would provide universal coverage and lower health care costs, but the plan failed in both respects. Instead, the legacy of the Washington Health Plan is an insurance market burdened with costly regulations, particularly the high number of mandates, the guaranteed issue law and the community rating requirement. Today in-state health costs are higher than ever, and the uninsured rate is no lower than when the plan was first proposed.

Oregon – The Oregon Health Plan

The Oregon Health Plan was created in 1994 and by the following year it had 132,000 enrollees. The Plan offered coverage to all Oregon residents under age 65 who could not afford individual plans or were not covered by their employers, but whose income was not low enough to make them eligible for Medicaid.

The plan did, however, require people in the state Medicaid program to join a managed care plan. Consequently the cost of Oregon Medicaid grew from $750 million a biennium before the Oregon Health Plan started, to $1.7 billion in the first biennium after the program was introduced.

Oregon lawmakers soon found they could not afford the rising costs of the plan they had created. Similarly, insurance carriers in the state dropped out of the Oregon Health Plan because the state's low reimbursement rates made participation economically impractical for them.[3]

By 2004, because of the high cost of the program, Oregon stopped taking new enrollees and total enrollment fell to only 18,000 people. In 2008, Oregon is holding a statewide lottery in an effort to control spiraling costs while adding 6,000 new enrollees.[4] In the process, Oregon Health Plan officials have given up on trying to provide universal coverage.

Oregon lawmakers learned that the ambitious plan enacted in 1994 was fiscally unsustainable, and the program has only survived by being sharply cut back. In the long run, the Oregon Health Plan has failed to reduce significantly the number of uninsured, or to control rising health care costs in the state, as supporters had promised.

Tennessee – The TennCare Plan

In 1994, lawmakers in Tennessee created TennCare, a state health plan based on eleven state-run managed care organizations (MCOs) offering unlimited doctor visits, hospital stays and a prescription drug benefit. As part of TennCare, the state required 800,000 Medicaid recipients to move into the MCOs, and then added 500,000 uninsured or high risk individuals to the program. In 1995, Tennessee officials were forced to close the program to new enrollments because of rising costs.

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[3] "The Oregon health insurance lottery," by Alan Katz, Health Care Reform Blog, March 4, 2008, at www.alankatz.wordpress.com/2008/03/04/the-oregon-health-insurance-lottery.
[4] "Prize in Oregon lottery is health insurance," by Sarah Skidmore, *The Seattle Times*, March 2, 2008.

Because of rapidly escalating program costs, doctors working under TennCare were financially squeezed until 1999, when they lobbied strongly to receive a certain percentage of the state money paid to MCOs. This new mandate highlighted the fact that MCOs were failing to control costs and provide adequate medical care. Three of the original MCOs soon went out of business, and the state itself nearly went bankrupt, even though the federal government was paying two-thirds of program costs. By 2005, state officials dropped 160,000 people who were not Medicaid eligible from the program.[5]

With TennCare in financial shambles, the legislature enacted Cover Tennessee in 2006, in an effort to provide coverage for people state officials had barred from the original plan. Cover Tennessee is designed for enrollees who earn less than 250 percent of the federal poverty level. It provided mandated first dollar coverage, but no catastrophic coverage above $25,000 per year. Only $15,000 of this $25,000 can go toward hospital bills. It is too early to determine whether Cover Tennessee will prove any more successful than TennCare, although the new program suffers from the similar structural weaknesses: state-management, lack of enrollee control over benefits, and numerous top-down mandates.[6]

Hawaii – The Individual Mandate Plan

Hawaii has had an employer mandate in place since 1974, when two percent of the population was uninsured.[7] Currently, employers must either provide a set level of health care benefits, as defined by law, to their employees or pay a special tax into a state-managed fund. The program is a real-world example of the "pay or play" approach to health care reform that has been considered in concept by many other states. After more than thirty years with a universal state-imposed health care mandate, Hawaii continues to experience rising health care costs, and today has an uninsured rate close to 10 percent.

Massachusetts – The Connector Plan

The Massachusetts legislature passed comprehensive health care reform in the spring of 2006 to deal with escalating costs as well as 550,000 uninsured people (8.6 percent of the population), and to ensure that all state residents have health care coverage.[8] Proponents said a major benefit of the plan would be universal coverage, and that the state's uninsured population would be reduced to zero.

The basics of the plan are a mandate on every resident between the ages of 18 and 64 to purchase a state-defined health insurance policy. This is combined with a mandate on all employers with more than 10 workers to provide state-defined health care coverage, or pay a special tax of $295 per employee into a state fund. The state created a Connector program for the individual and small group markets to help residents and employers buy the state-mandated coverage.

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[5] "HillaryCare in Tennessee, the disaster that might have been for the entire country," Review and Outlook, *The Wall Street Journal*, December 6, 2004, at www.opinionjournal.com/editorial/feature.html?id=110005987.
[6] "Cover Tennessee is no magic cure for the uninsured," by Drew Johnson, Tennessee Center for Policy Research, April 28, 2008, at www.tennesseepolicy.org/main/article.php?article_id=709.
[7] "Too many residents lack health insurance," editorial page, *Honolulu Star-Bulletin*, October 18, 2005, at www.starbulletin.com/2005/10/18/editorial/editorials.html.
[8] "Massachusetts sets health plan for nearly all," by Pam Belluck, *The New York Times*, April 15, 2006.

The state provides subsidies on a sliding scale for residents with incomes of less than 300 percent of the federal poverty level. Residents with incomes below the federal poverty level pay nothing; the state provides them with subsidized coverage.

The Connector takes over the role of private-sector insurance agents by matching individuals with state-approved health plans. Although the program did not add new mandates, plans purchased through the Connector must include all existing state mandates for medical services and coverage. The Connector also increased the risk pool and enhanced the portability of insurance. Individuals are able to retain their Connector-based coverage as they leave the workforce or move from job to job.[9]

As of July 2008, approximately 350,000 people who previously had no insurance are covered by the state plan.[10] Unfortunately, the majority of these residents are in an entitlement program called Commonwealth Care that is partially or wholly subsidized by the state.

Individual private plans are not selling well. In April 2007, the Connector Board was forced to exempt 20 percent of the uninsured from the individual mandate and increased the subsidy to low income residents. Proponents of the Massachusetts plan are no longer saying it will provide universal coverage.

The plan has resulted in a dramatic increase in demand for medical services, to the point where primary care doctors are in short supply. Waiting times to see a family physician are up to one year in parts of western Massachusetts.

Costs have likewise skyrocketed with early budget over-runs of 30 percent. Originally, backers provided no budget beyond the first three years of the program, and the current governor has asked for an additional $869 million in 2009. He admits that number may be low and could reach as high as $1.1 billion. In the next decade there is a predicted cost over-run of $4 billion. In the short term, the governor has proposed a tax increase of $129 million in an effort to shore up the program.[11]

To control costs further, the legislature is considering cutting payments to doctors, increasing the special tax on employers (currently $295 a year), increasing the state tobacco tax, and imposing additional regulations on insurers and drug companies. There is no proposal to decrease state-imposed mandates on individual insurance plans, and consequently Massachusetts insurance carriers are unable to offer low-cost plans.

Maine – The Dirigo Health Plan

Maine lawmakers enacted a sweeping health care reform plan, Dirigo Health, in 2005 with the intention of containing health care costs, insuring broad access and improving quality. Dirigo, Latin for "I direct" or "I lead," is Maine's state motto.

[9] "The Massachusetts health plan: The good, the bad, and the ugly," by David Hyman, Policy Analysis, The CATO Institute, June 28, 2007, at http://www.cato.org/pub_display.php?pub_id=8431.
[10] "The Price of Romney Care," Editorial page, *The Wall Street Journal*, July 29, 2008.
[11] Ibid.

Supporters predicted a total enrollment of 130,000 people by 2009. Dirigo would initially be available to uninsured individuals and to business owners with fewer than 50 employees (90 percent of Maine businesses have fewer than 50 workers). The plan includes a guaranteed issue requirement and both low- and high-deductible plans are available. The overall program is run through Anthem, a private insurance carrier.

Funding comes from individual enrollees, a one time $53 million state "grant," and federal subsidies for people earning less than 200 percent of the federal poverty level. Employers must pay 60 percent of premium costs and the state pays on a sliding scale for people earning between 200 percent and 300 percent of the poverty level. Other premium costs are borne by individuals. Insurance companies are assessed a special tax of four percent on all health insurance policies sold in the state. The Dirigo plan also includes additional Certificate of Need restrictions, thus making it difficult for doctors and clinics to provide new medical services.[12]

Like other state-directed plans, Dirigo has not provided the level of health coverage promised by advocates, nor has it succeeded in controlling costs. In fact, the opposite has occurred. After the first few years the program proved unsustainable. In an effort to save it, lawmakers are considering a new employer mandate (based on the pay-or-play model used in Hawaii), a separate state high risk pool, and imposing more Medicaid price controls. Also, Maine is considering administering the program itself instead of the private insurance company, Anthem.

In April 2008, the legislature enacted a tax increase on soft drinks, beer and wine, and added a 1.8 percent tax on health care claims. Revenue from the new taxes is intended to shore up the Dirigo program.

At present, fewer than 13,000 people are covered at a cost of $50 million per year, and the program is no longer accepting new enrollees.[13] Dirigo's website carries a notice, "We are not offering subsidized coverage to new members at this time due to lack of funding."[14] Dirigo administrators are urging Maine residents to contact the governor and lawmakers in Augusta to express their views about the uncertain future of the program.[15]

3. State-Managed Plans Recently Proposed, but Not Adopted

Wisconsin – The Healthy Wisconsin Plan

The "Healthy Wisconsin" plan was proposed in 2008 and would have begun in 2009, but it failed to pass the legislature this year. The plan would have mandated coverage for all state residents not enrolled in an existing government program such as Medicaid and Medicare. The framework for the program was a governor-appointed board that would negotiate payment rates with doctors and solicit uniform health plan bids from insurance carriers. The board was to be composed of eleven members, five representing labor unions,

[12] Universal Health Care Initiative – Maine, The Equity Sector, March 9, 2005.
[13] "As health plans falter, Maine explores changes," by Pam Belluck, *The New York Times*, May 30, 2007.
[14] Dirigo Health, main page, at http://www.dirigohealth.maine.gov/, accessed July 30, 2008.
[15] Ibid.

four representing businesses other than insurance carriers, and two named by farming organizations.

Like previous state health care plans, Healthy Wisconsin promised universal coverage while lowering costs. As its promoters describe it:

> "Healthy Wisconsin will for the first time guarantee that all Wisconsinites get the same high quality health care that our state legislators have had for years, while being affordable for Wisconsin families."[16]

The plan's funding was based on a new 14.5 percent payroll tax, 10.5 percent of which would be levied on employers, and four percent directly on employees. In practice, of course, all 14.5 percent of the tax would have been paid by workers, since for employers, paying the tax would simply become part of the routine cost of hiring one new employee. As such, 10.5 percent of the economic value of hiring a new worker would be paid to the state government, instead of going to the worker in the form of salary or other compensation.

If passed, Healthy Wisconsin's new 14.5 percent payroll tax would have added to the existing 15.3 percent tax workers already pay to fund Social Security and Medicare. The combined 29.8 percent tax would have ranked Wisconsin as highest in the nation in payroll taxes.

Supporters say much of the tax on employment would have been offset by employers not having to buy separate insurance coverage for their workers.

The first year's budget estimate for the Healthy Wisconsin plan was $15.2 billion, which would have essentially doubled the state budget. Out-of-pocket expenses for individuals would have been limited to $3,000 a year and there would have been no co-payments or charges for preventative and pediatric care.

Even though the plan was enormous in scope, it was offered this year as a last minute amendment to the state budget, with only one rushed hearing.[17]

Interestingly, the politically-powerful teachers' union was made exempt from the plan, and a substantial loophole allowed other labor unions out of the program. The broad exemption had the effect of muting labor opposition to the plan.

Even proponents acknowledged that Healthy Wisconsin's taxes would have potentially caused job losses for up to 8,000 mostly low paid workers. They claimed a family earning less than $50,000 a year would have potentially saved money, and that a family earning more than $50,000 a year would have spent more on health care. The Secretary of the Administration was charged with containing costs if individuals in the plan spent more on health care than the national average.

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[16] "Healthy Wisconsin, Your Choice, Your Plan," Institute for One Wisconsin, at www.healthywisconsin.net, accessed July 30, 2008.

[17] Author interview with Christian Schneider, Health Care Analyst, Wisconsin Policy Research Institute, May 13, 2008.

Although it failed to pass this year, proponents say Healthy Wisconsin may be considered in the 2009 session.

California – Coverage for All Californians

In 2007, Governor Schwarzenegger, working with the State Assembly leadership, proposed a sweeping health care reform plan. The plan was based on a mandate on individuals requiring everyone not in Medicare or MediCal (California's Medicaid program) to purchase health insurance, plus a mandate on employers to either provide worker health insurance or pay an additional business tax of 10 percent to the state (the pay or play model). The employer mandate applied to all firms with more than nine employees. The plan also included a guarantee issue provision under which insurers were required to sell their product to anyone who asked for it, regardless of medical risk.[18]

Funding was to be provided by an additional six percent payroll tax, a two percent tax on physicians and a four percent tax on hospitals, plus an additional $1.50 to $2.00 per pack tax on cigarettes. The new state payroll tax would have been added to the 15.3 percent tax workers already pay in federal Social Security and Medicaid taxes. State officials planned to secure $5 billion more by expanding the definition of the MediCal program, making it eligible to receive increased federal funding. Total cost of the plan was estimated at $14 billion per year.[19]

From the start, the governor's plan faced serious political and economic obstacles. Even without a new payroll tax and employer mandate, California ranked fourth from the bottom in a national poll of "best states to do business."[20] Also, in 2007 California faced a budget deficit of $14 billion, making many lawmakers reluctant to take on new, permanent financial responsibilities.

In December 2007, the California Assembly approved the new health care plan on a party line vote, with Democrats voting in favor and most Republicans, despite the governor's support, opposed. The following month, however, the Senate Health Care Committee rejected the plan, ending prospects for passage in 2008.[21]

The recent rejection of broad-based universal health care plans in Wisconsin and California indicates that enthusiasm for government-managed reform may be fading among state lawmakers. The proposals in these two states contained most of the elements of classic single payer-style plans: universal coverage, new payroll and business taxes, expansion of the state Medicaid program, new mandates on employers and individuals, and central management through a state-appointed board or agency.

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[18] "The Governor's Health Care Plan," at www.fixourhealthcare.ca.gov/plan, accessed June 26, 2008.
[19] "California Health Insurance Plan a Bad Idea," by Jeff Emanuel, *Human Events*, December 20, 2007.
[20] "State Business Tax Climate Index Ranking (Fifth Edition)," by Chris Atkins and Curtis S. Dubay, Background Paper No. 57, National Tax Foundation, 2008, at www.taxfoundation.org/research/show/22658.html.
[21] "State Watch, California Senate Health Care Committee Rejects Plan to Overhaul State Health Care System," at www.kaisernetwork.org/DailyReports/rep index.cfm?DR ID=50084.

Fifteen years of debate and trial at the state level indicate that this policy approach has not been successful in expanding access to affordable health care or in reducing the number of uninsured.

4. A Different Approach – Using Individual Choice and Market Competition to Lower Costs

While several states attempted, with little success, to reduce costs and help the uninsured by enacting versions of single payer-style plans, leaders in three states have taken a different approach. Lawmakers in Florida, Georgia and Indiana have enjoyed success by enacting reforms that reduce costs by trimming state regulations, promoting individual control over health care spending and tapping competitive market forces.

These plans do not promise universal coverage. Instead, they direct reform policies toward people who need the most help in getting health coverage: low-income families, the chronically ill and the uninsured.

Florida – The Cover Florida Plan, Promoting Market Competition

The Cover Florida plan was enacted in May 2008 to provide health care coverage for the 20 percent of Floridians who are uninsured. The plan is voluntary and is available to people earning less than 300 percent of the federal poverty level and who have been uninsured for more than six months.[22]

Cover Florida lowers monthly premium costs for each enrollee to $100 to $150 by streamlining regulations and legalizing economical, low-cost health coverage. The state plan has sparked a competition among private insurers to offer attractively-priced plans which, under Cover Florida, are exempt from Florida's fifty health care mandates. National studies show that state mandates add 15 percent to 25 percent to the cost of health care coverage.[23]

While free of most top-down regulations, the plans must include basic preventative and primary care services, such as screening, office visits, outpatient and inpatient surgery, urgent care, prescription drugs, durable medical equipment and diabetic supplies.[24] To keep the plans affordable, they do not cover prolonged hospital stays or specialty care. Insurers must offer policyholders an option for catastrophic care, and may charge a higher monthly premium for this higher level of coverage.

Cover Florida uses a fifteen-member oversight board to negotiate rates and handle claims for the state's small businesses (those with fewer than 50 employees). Again, the plan

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[22] "Florida passes bill to boost private health coverage for uninsured," by Doug Trapp, *amednews.com*, June 2, 2008, at www.ama-assn.org/amednews/2008/06/02/gvsb0602.htm.
[23] "How Mandates Increase Costs and Reduce Access to Health Care Coverage, by Paul Guppy, Policy Brief, Washington Policy Center, June 2002, at www.washingtonpolicy.org/Centers/healthcare/policybrief/02_guppy_mandates.html.
[24] "Cover Florida, Statement by Governor Crist regarding release of intent to negotiate for Cover Florida plan," Office of the Governor, June 2008, at www.flgov.com/cover_florida.

is voluntary. Small business owners are not required to participate, and may use competitive offerings in the private market to design their own health care benefit plan if they wish.

The Cover Florida plan avoids centralized government management of people's health care. Instead, the plan taps the participation of private insurance companies that agree to accept all enrollees, and uses market competition to lower costs and expand access to coverage for the uninsured. The plan has been successful at increasing affordable options for Floridians seeking health coverage. To date, nine insurers have submitted proposals to participate in the program.[25]

Georgia – Access to Health Coverage through Low-Cost HSAs

Georgia passed a law in May 2008 that encourages the voluntary use of portable, low-cost Health Savings Accounts (HSAs) to provide health care coverage.[26] The law goes in to effect in January 2009.

Under the new plan residents will be able to deduct all of the cost of HSA-related insurance premiums from their income when calculating their state income tax liability. The result is an immediate six percent reduction in the cost of health coverage for individuals.[27]

Small business owners (those with 50 or fewer employees) who offer HSA coverage to their employees will receive a $250 tax credit per worker. Under current law many small employers could not afford to provide an employee health benefit, or had dropped benefits they had provided in the past. Under the new plan a small business owner with, say, ten workers who provided them with HSA coverage would see an immediate reduction of $2,500 a year state taxes.

In addition, Georgia lawmakers repealed state and local taxes on HSA-based insurance premiums, thus further lowering the market price of HSA plans.

The legislature estimates Georgia's consumer-friendly approach will reduce the cost of HSA-based insurance plans by $146 million a year, lower taxes for employers by $64.8 million a year, and save workers $6.7 million a year.[28] The reduction in regulations and taxes is expected to expand access to affordable health coverage to 500,000 uninsured Georgia residents.[29]

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[25] "Nine insurers seek to 'Cover Florida,'" The Buzz, *St. Petersburg Times*, August 18, 2008, at www.blogs.tampabay.com/buzz/2008/08/nine-insurers-s.html.

[26] H.B. 977, State insurance premium taxes; certain high deductible health plans; exempt," Georgia General Assembly, signed May 7, 2008, www.legis.state.ga.us/legis/2007_08/sum/hb977.htm.

[27] "Georgia Passes HRA/HSA Health Insurance Reforms," National Center for Policy Analysis, May 2008, at NCPA.org, "Georgia HSA tax break bill signed into law," by Jerry Geisel, Business Insurance, May 8, 2008, at www.businessinsurance.com/cgi-bin/news.pl?id=12918.

[28] "Impact of Insuring 500,000 Georgians Previously Uninsured," by Ron Bachman, Senior Fellow, Center for Health Transformation, May 9, 2008, at www.healthtransformation.net/galleries/wp-consumerism/TheEconomicImpactofHB977.pdf.

[29] Ibid.

Indiana – The Healthy Indiana Plan

The "Healthy Indiana Plan" started in January 2008, and is limited to the first 120,000 applicants who had no health care insurance for at least six months and who earn less than 200 percent of the federal poverty level.

The program has two parts: a state-funded HSA, each with a high deductible health insurance plan. Low-income individuals can use money placed in the HSA to pay for preventive care and routine health services. If funds in the HSA prove insufficient, benefits from the catastrophic health plan are then available to cover major medical costs.

To keep the HSA plans affordable, an individual's contribution is limited to no more than five percent of gross family income.[30] The federal government granted Indiana a Medicaid waiver to allow state officials to lower HSA costs for low-income families.[31] The legislature enacted a 44-cent increase in the state cigarette tax to help fund the program.

The main advantage of Healthy Indiana is it puts low-income residents in charge of their own health benefit, rather than placing them in the position of being passive recipients of a traditional welfare program. Program participants are not restricted to public health clinics or to public health hospitals. With the HSA funds they can choose their own doctors and make decisions about their own health needs, without facing the barriers commonly imposed by public assistance programs. In addition, funds placed in the HSA become the recipients' private property, thus helping low-income families rise out of poverty.

5. Conclusion

There are a number of conclusions policymakers can draw from the experiences of states with failed government-managed health care plans, and from states that have taken a market-oriented approach.

The first and most obvious lesson is that the health care problem cannot be solved with more government control. In each case studied, increased government management of health care led to higher costs, lower accessibility and, in many cases, fewer people being covered.

Second, the conclusion that flows from this experience is that top-down mandatory approaches do not work. State leaders should not force either mandated benefits or mandated enrollment upon their constituents. Mandated benefits restrict choice in type and amount of insurance a person can purchase, without taking account of an individual's personal situation or life needs. Mandating individual enrollment has not been effective, as demonstrated by Hawaii's experience. After more than thirty years of imposing the broadest individual mandate possible – that all state residents must have health coverage – Hawaii's rate of uninsured is higher today than when the law passed.

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[30] Healthy Indiana Plan, Courierpress, January 1, 2008.

[31] "HHS approves Medicaid waiver to create new Indiana Health Plan for uninsured Hoosiers," press release, U.S. Department of Health and Human Services, December 14, 2007, at www.hhs.gov/news/press/2007pres/12/pr20071214a.html.

Third, price controls do not lower costs, but they do lead to rationing and an increase in the number of uninsured. Community rating, guaranteed issue, and insurance premium caps are efforts by policymakers to limit rising costs by simply banning price increases. But, as political leaders have learned through the centuries, price controls never work. Normal prices are set by the interaction of supply and demand. No amount of political will or government power can change this basic economic principle.

A fourth lesson from the states is that policymakers should not promise the public universal coverage. A common theme among states that imposed mandatory health care reform is that, in return for accepting government management of health care, all citizens would receive coverage. In every case, from Maine to Washington, government-managed systems failed to achieve universal coverage. They often had the opposite effect, as increased taxes and regulations reduced competition among insurers, drove up premiums, and led many individuals and employers to drop their existing coverage.

Rather than focusing on universal, top-down approaches, policymakers should recognize that the most important person in any health care reform is the individual. It is incumbent upon state governments to provide a free and open market so people can access medical care in an efficient and cost effective manner.

Dr. Robert Moffit of the Heritage Foundation succinctly outlined the key tests that legislators should apply to any health care reform proposal:

- The new plan should focus on changing the existing system – not merely expanding existing programs;
- It should make individual patients the key decision makers;
- It should create dependable coverage, not subject to the whim of the political process;
- It should limit the role of government;
- The value of the new plan must be much greater to the patient than to anyone else in the system, such as regulators or politicians;
- It should comply with existing federal law.[32]

State lawmakers who support individual-based reform have achieved positive results by not promising a utopian vision of universal access. They recognize there will always be a role for tax-funded safety net health programs, but that with the right public policies, most people can access affordable health coverage through a competitive private market. In a functioning health care market, prices, innovation and services would be determined by voluntary transactions between patients and providers, with government regulations providing necessary public safety and consumer protections.

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[32] "State health reform: Six key tests," by Robert E. Moffitt, Ph.D., Web Memo #1900, The Heritage Foundation, April 23, 2008, at www.heritage.org/Research/healthcare/wm1900.cfm.

The needs and situation of every state are unique, yet the principles of successful health care reform apply across all states. The people of Washington have already had one bad experience with universal health care reform, one they are unlikely to want to repeat. Looking ahead, Washington lawmakers can benefit from a close examination of reform efforts in other states, and adopt a policy approach that will lower health care costs and increase access for the people of Washington.

About the Author

Dr. Roger Stark is a health care policy analyst with Washington Policy Center. Dr. Stark graduated from the University of Nebraska College of Medicine and completed his general surgery residency in Seattle and his cardiothoracic residency at the University of Utah. After practicing in Tacoma he moved to Bellevue and was one of the co-founders of the open heart surgery program at Overlake Hospital. He retired from private practice in 2001 and became actively involved in the hospital's Foundation, serving as Board Chair and Executive Director. Dr. Stark has been a member of many local and national professional societies. He currently serves on the Board of the Washington Liability Reform Coalition, the Governing Board of Overlake Hospital, and is an active member of the Woodinville Rotary.

Published by Washington Policy Center

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