Prescriptions and Placebos

Fixing Health Care in Iowa

Colin Gordon

November 2006

Iowa Fiscal Partnership

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Iowa Fiscal Partnership

The Iowa Fiscal Partnership is a joint initiative of the Iowa Policy Project and the Child & Family Policy Center, two nonprofit, nonpartisan Iowa-based organizations that cooperate in analysis of tax policy and budget issues facing Iowans. IFP reports are available on the web at http://www.iowafiscal.org.

The Iowa Fiscal Partnership is part of the State Fiscal Analysis Initiative, a network of state-level organizations and the Center on Budget and Policy Priorities to promote sound fiscal policy analysis. IFP work is supported by the Annie E. Casey Foundation and the Stoneman Family Foundation.

The Iowa Policy Project

Formed in 2001, the Iowa Policy Project promotes public policy that fosters economic opportunity while safeguarding the health and well-being of Iowa's people and the environment. Based in Mount Vernon, IPP's principal office is at 120 N. Dubuque St. #208, Iowa City, IA 52245.

Child & Family Policy Center

Established in 1989 to "better link research and policy on issues vital to children and families and to advocate for evidenced-based strategies to improve child outcomes," the Child & Family Policy Center works at the community, state and national levels on child and family policy issues. CFPC is located at 1021 Fleming Building, 218 Sixth Ave., Des Moines, IA 50309.

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By Colin Gordon

For too many people, this country's health-care financing system does not work. The United States spends more on health care than any of its peers, but fare worse on most important health outcomes (longevity, morbidity and infant mortality). As the foundation of employment-based insurance crumbles, public programs offer only fragmented and shaky support. Health-care costs, despite the intrusions of "managed care," continue to outpace inflation and claim a ballooning share of family, business, state and federal budgets. The political will to address these problems at the national level was seemingly exhausted by the health-care debacle of the early 1990s. Since then, the task of reform largely has fallen to the states – where the political, fiscal and actuarial challenges are more immediate but also more daunting.

States have risen to (or shirked from) these challenges in many different ways. Most, like Iowa, have pursued incremental solutions designed to stem the collapse of employment-based health insurance and to pick up (in either public programs or private insurance pools) those left behind. Such solutions, in Iowa and elsewhere, have included efforts to regulate or mandate job-based coverage; to create insurance pools for individuals and small businesses that might mimic large-firm, job-based coverage; to subsidize (directly or through the tax system) access to private insurance; and to broaden the categorical or income-based reach of public health-insurance programs (Medicaid and the State Children's Health Insurance Program (SCHIP).

Recent research and state-level experience, however, suggest that piecemeal reform may do more harm than good – further fragmenting coverage, inviting employers to dump coverage, or simply shuffling existing coverage (with little impact on the uninsured) at great public expense. For these reasons, a few states have – in innovative and promising ways – embarked on more comprehensive reform.

This paper examines each of these issues in turn. Part 1 examines the health care crisis in Iowa, the region, and the nation. Part 2 assesses the promise and the record of incremental state-level reforms. Part 3 turns to more expansive state-level efforts. Part 4 looks to the promise of those efforts for Iowa. Throughout, our assessment of various reform options rest on a set of simple, widely shared assumptions and principles:

- **Reform must expand coverage**: Much reform energy is spent bandaging up existing coverage rather than reaching out to the uninsured.
- **Coverage should be seamless, accessible and portable**: Health coverage often hinges on access to group plans whose membership is restricted according to income, employment status, or health status. Group coverage should be an option for all Iowans.

- **Coverage should be affordable**: It is not sufficient to make coverage available, if the costs (not just premiums but all out-of-pocket expenses) bust the budgets of working Iowans.
- **Coverage should be meaningfu**l: More expansive coverage cannot come at the expense of quality. Health coverage should include all basic services, including preventive care. In particular, child health coverage needs to be based upon child health and development needs rather than on an adult health maintenance model.

1. Our Perpetual Health Care Crisis

Health coverage for Iowans flows from a variety of sources (Figure 1). The most important of these remains employment-based group health insurance, which in 2004-05 provided coverage for 66 percent of all Iowans and 71 percent of non-elderly Iowans. Public programs provide coverage to 26 percent of the population. In 2004-05, 422,000 Iowans received Medicare, the federal program of health care for the elderly – comprised of "Part A" hospital benefits financed by lifetime payroll contributions, optional "Part B" coverage for doctor and outpatient services (subject to monthly premiums and a small annual deductible), and the new prescription drug plan. Another 337,000 Iowans were enrolled in Medicaid (state-federal program for certain low-income groups – kids, parents, pregnant women, the disabled) or *hawk-i* (which extends coverage to certain low-income children not otherwise eligible for Medicaid). Military plans picked up another 103,000 Iowans. The least likely source of insurance was a direct purchased private plan. About 15 percent of Iowans were covered by one of these individual plans. After accounting for some overlap between sources of coverage, about 265,000 Iowans, or 9.1 percent of the population, are uninsured.[1]

How Did We Get Here? Our Accidental Health Care System

At the root of our ongoing health crisis lies an historical accident: the peculiarly American reliance on employment as a means of distributing and paying for health coverage. This compromise was struck at a time when the cost of health care was minimal (and dwarfed by the cost of lost wages while sick), when the prevalence of large-firm employment offered an easy way to spread the risk, and when American firms did not face competition from countries where the health care costs and risks were socialized. While all of these conditions have evaporated over time, our reliance on employment-based insurance has not.

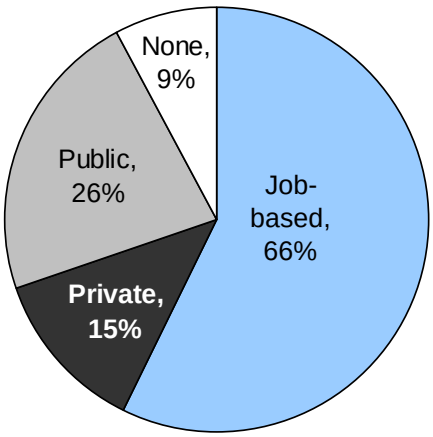
Recent efforts to sustain or supplement employment-based care have been shaped by myths and misconceptions. Prominent among these is the notion of "moral hazard," or the conviction that those with health insurance behave differently (consuming more health care, visiting the doctor for no reason) than those without. This reasoning lies at the heart of the whole "managed care" revolution, which seeks to turn patients into cost-conscious consumers by invoking deductibles and co-payments at the point of provision. And it lies at the heart of current federal health policy, where a fixation with high-deductible plans and health savings accounts is aimed, in the words of President Bush, at "empowering people to make decisions for themselves, owning their own health-care plan, and . . . bringing some demand control into the cost of health care."

In the provision of health care, however, such market metaphors are at best misleading and at worst counterproductive. Demand for health care is driven by need rather than price. People don't relish a visit to the doctor: Insured Americans, or citizens of countries with universal coverage, don't crowd hospitals when they are healthy just because the benefits are "free." By the same token, cost-conscious health care consumers don't necessarily make sage decisions. Indeed, as costs rise, under-insured patients tend to put off important, preventive care. The result is starkly *inefficient* – for patients, for providers, and for the public health.

The central thread in this patchwork of care is the peculiarly American expectation of job-based family coverage (see box, p.2). But this thread is increasingly frayed. Not all employers offer health plans. When they do, it is often not available to all employees or eligible employees cannot afford their share of the costs (especially for family coverage). And this fragile chain of decisions begins again whenever a worker changes jobs. [2]

Employment-based health insurance now covers only 59.5 percent of the U.S. population, down from over 70 percent (at its peak) in the mid-1970s. In Iowa, employment-based coverage reaches just 66 percent of the population, a rate that has also fallen dramatically in recent years. In 2004-05, 74,000 fewer Iowans claimed work-based coverage than just five years earlier.[3]

Figure 1. Health Insurance Coverage in Iowa, 2004-05



Source: U.S. Census Bureau, Historical Health Insurance Tables (Current Population Survey)
Notes: Universe is sources of individual health insurance coverage. Since some individuals have multiple sources of coverage, numbers do not add up to 100.

Through our recent recession and recovery (March 2001 to March 2005), those sectors of the Iowa economy losing jobs offered health care to just over two-thirds (67.5 percent) of their workers. By contrast, growing sectors offered health care to less than half (49.3 percent) of their workers.[4] Indeed, just over a third of American workers now claim health insurance all year, in their own name, from their own employer – and barely half of these include coverage of at least one dependent.[5]

In turn, the terms of coverage have deteriorated steadily: Higher premiums, co-payments, deductibles, and increased restrictions on care have become the rule.[6] The costs of employment-based health-care premiums climbed 73 percent between

Insurance and Employment

The increased cost and declining quality of work-based insurance is confirmed by a recent survey (based on 923 responses from 2,407 randomly-selected Iowa employers) conducted by Des Moines-based David Lind & Associates. Among the key findings of the 2006 *Iowa Employer Benefits Survey*:

- Health insurance premiums rose an average of 10.8 percent from 2005 to 2006, the sixth-straight year of double-digit increases.
- The annual premium for a family plan pushed past $10,000 (to $10,752)

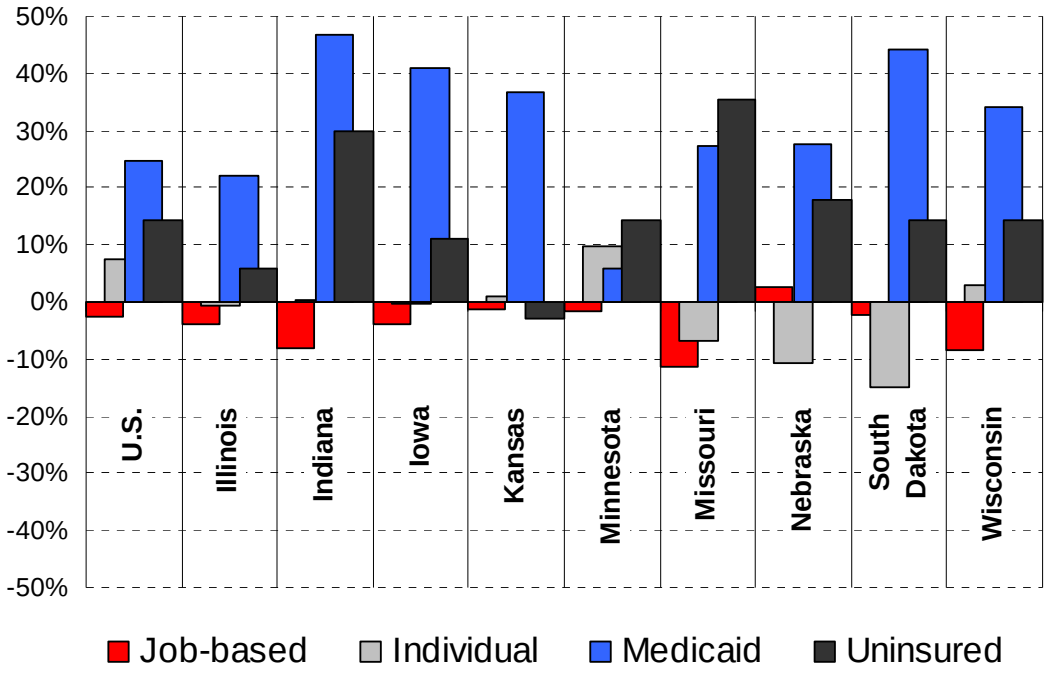
Almost 1 in 5 (19.3 percent) surveyed employers now offer high-deductible health savings accounts, up from 4.5 percent a year ago.

2000 and 2005, during which time workers' incomes grew only 15 percent, and workers' share of health costs (premiums, co-payments, and deductibles) grew dramatically (89 percent for family coverage, 122 percent for individual coverage).[7] Even when health coverage is offered, workers are less able or likely to sign on – especially for family coverage. Recent estimates suggest that every 10 percent increase in costs pushes another 1.4 million Americans (about a third of them children) into either public programs or the growing ranks of the uninsured.[8]

As employment-based coverage evaporates, those left behind have few options. Individual health insurance is prohibitively expensive for most. Despite substantial political encouragement and added tax provisions allowing deductions for individual health-insurance costs, privately purchased non-group coverage has declined steadily over the last decade in Iowa and the nation. Those able to afford private coverage are also the least likely to need it: More than 4 in 5 (83.8 percent) families in the top income quintile are covered by employment-based plans, while barely 1 in 5 (20.7 percent) families in the lowest quintile claim such security.[9]

Some of the slack is taken up by public programs. Medicare picks up most of the health care for those over 65, and Medicaid and SCHIP cover an increasing proportion of the state's children, more than doubling since 1998 to 27 percent of all children in the state. As Figure 2 suggests, recent losses in employment-based coverage have shown up as either increased rates of uninsurance or often-dramatically increased burdens on public programs. Since 2000, national rates of employment-based health coverage have fallen about 5 percentage points for both children (from 65.6 percent to 60.8 percent) and middle-income adults (from 80.6 percent

Figure 2. Change in Health Coverage, 1999-00 to 2004-05
Percentage change in individuals under 65 covered by each source of insurance:
U.S., Iowa, and Midwest Peers



Source: U.S. Census Bureau, Historical Health Insurance Tables (Current Population Survey)

to 75.8 percent). The decline in children's coverage has been matched by increased enrollment in Medicaid or SCHIP; the decline in adult coverage has been accompanied by a corresponding spike in the number and proportion of adults without any health insurance coverage.[10]

This increased reliance on public health insurance is a mixed blessing. It is some solace that our public programs are doing what they are designed to do – serving as a safety net for the failure of private employment or private insurance. But the reach of those programs is uneven; they do a good job with kids and the elderly, but leave many others behind. Eligibility rules trap many working Iowans in a gap between employment-based insurance that is not offered or too expensive, and public programs for which they do not qualify.[11] Equally troubling (in terms of both coverage patterns and potential political solutions), these public programs can serve as a subsidy for low wage employment – a fact reflected in the efforts by a number of states to identify the major employers of their Medicaid and SCHIP recipients.[12]

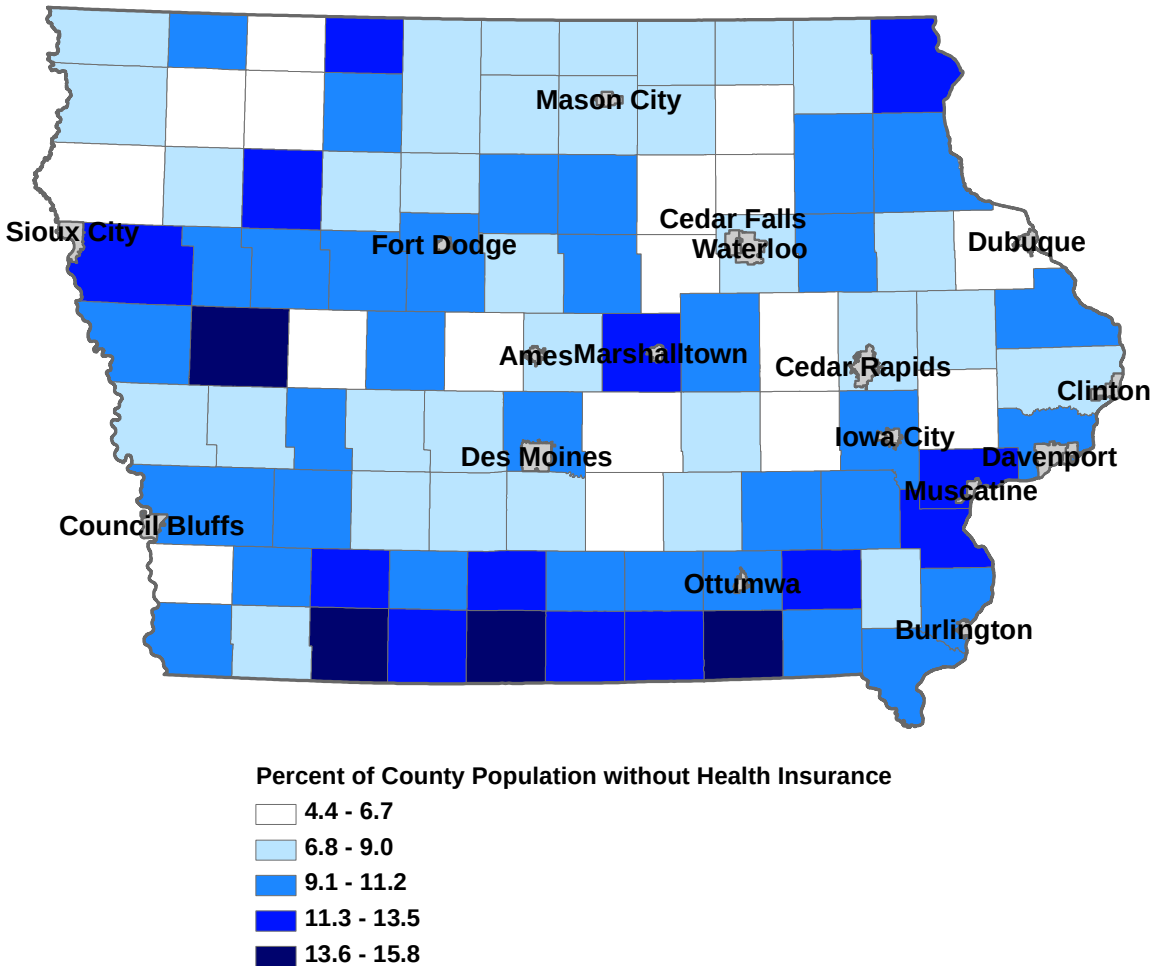
What's left, beneath the shaky framework of job-based insurance and the tattered safety net of public programs, are the uninsured – 16 percent, over 46 million, of the national population; 9.1 percent, just over 264,000, of the population of Iowa. Of Iowa's uninsured, about a third live in households below the poverty line and another third live in low-income households earning less than twice the federal poverty rate. The rate of uninsurance is 40 percent for poor adults but only 18 percent (reflecting SCHIP coverage) for poor children. Still, nearly 20 percent of Iowa's uninsured (about 58,000) are under 18, although most are eligible for coverage under Medicaid and SCHIP, were they to enroll.[13]

Across the state, uninsurance rates do not vary dramatically (Figure 3). Higher uninsurance rates are concentrated along the southern tier of historically low-income counties, and in counties that surround struggling manufacturing centers (Sioux City, Council Bluffs, Fort Dodge, Marshalltown, etc). Better than average uninsurance rates, not surprisingly, are clustered around the state's public-sector employment base in Ames, Cedar Falls, Des Moines and Iowa City.[14]

Most of Iowa's uninsured fall into the gap between the expectation of job-based coverage, and the steady erosion of that coverage – especially in recent years. Fully 77 percent of Iowans live in a household with at least one full-time worker, but 10 percent of those Iowans receive no health coverage as a result – accounting for 73 percent (over 220,000) of the uninsured in Iowa (Figure 4). About 8 percent of Iowans live in a household with only part-time workers, but the uninsurance rate for this group is 27 percent – accounting for 15 percent (over 46,600) of the uninsured. Uninsurance, in other words, is a penalty imposed on hard-working Iowans for whom job-based health care is not offered or too expensive, but for whom public alternatives are not available.[15]

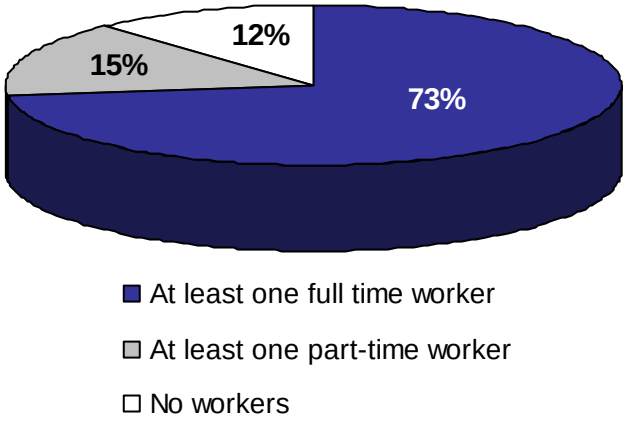
The costs of this neglect are immense. According to recent estimates, the annual cost of health care for the uninsured is close to $100 billion, a third of which is borne by taxpayers or other workers, either directly through publicly-funded health services for the uninsured or indirectly through the higher rates charged by health providers to cover their costs of charity care and bad debt. The less tangible consequences – including poor individual and community health and the costs of late intervention – are estimated to have an equivalent cost (between $65 and 130 billion).[16] All of this feeds an already inflationary logic, reflecting diagnostic overkill and the administrative waste of fragmented and uneven coverage. Health care now

Figure 3. Uninsured Rates by County, 2000



Source: U.S. Census Bureau, Small Area Health Insurance Estimates

Figure 4. Iowa's Uninsured, Non-elderly Population by Family Work Status



Source: Kaiser Family Foundation, State Health Facts

absorbs 16 percent of our GNP, at a per capita cost ($6,167 in 2004) which has almost doubled in the last decade and which is more than twice as high as the average per capita cost of our industrialized peers.[17] In short, America falls far short of universal coverage, but its health costs are much higher. While some Americans have access to the latest medical technology and treatments, at whatever costs, others remain without coverage for basic health services. A significant share of these higher costs are generated by the administration and paperwork needed to figure out who is covered and who is not.

In addition to direct health impacts, the lack of health insurance coverage and affordability means that too many Iowans and Americans end up with medical debt, which is one of the primary reasons for bankruptcy petitions in the country. Families may receive care in hospitals for medical crises and then find themselves with large medical bills that they cannot pay. This also affects their credit ratings, which can affect their ability to buy a home or secure a loan at a reasonable rate. The 2003 Commonwealth Fund Biennial Health Insurance Survey revealed that 77 million Americans age 19 and older — nearly 2 of 5 adults (37 percent) — have difficulty paying medical bills, have accrued medical debt, or both. Unpaid medical bills and medical debt can destroy access to credit, produce bankruptcies, and limit access to health care: Two-thirds of people with a medical bill or debt problem went without needed care because of cost — nearly three times the rate of those without these financial problems.[18]

2. Second Opinions: Options for State Policy [19]

This crisis of costs and coverage has yielded an array of piecemeal — and often quite contradictory — political solutions. Legislators (state and federal, left and right) are torn between sustaining employment-based care — or at least mopping up around its edges — and replacing it. On the left, such solutions include more expansive eligibility for public programs on the one hand, and mandates of employment-based coverage on the other. On the right, such solutions include new options for individual coverage (such as health savings accounts) on the one hand, and subsidies for employers offering coverage on the other.

For a variety of reasons, including federal inaction and the pressure of health costs on state budgets, the states have become the primary arena for health-care reform. At their most expansive (as we discuss below), state efforts have pursued near universal coverage. More routinely, states have offered a mixed array of programs and proposals — promising to sustain or expand coverage for discrete fragments of the population. This is essentially the pattern in Iowa. The 2006 legislative session featured an array of proposed health legislation, most cobbled together from experiments and experience in other states. While none of these made it to the governor's desk last spring, they will undoubtedly set the terms of debate for sessions to come. Let's look at each of these "incremental" solutions.

1) Help for Small Employers

There is considerable political interest in helping small employers provided coverage, but little experience to suggest that such plans work. The problem itself is pretty simple: Employment-based health insurance made some sense in an economy dominated by large firms offering "family-wage" employment. But it was never really an option for small firms (or the self-employed) unable to assemble large and insurable groups of employees. Large-firm, family-wage employment is no longer the rule: Excluding the self-employed, about 1 in 5 employed Iowans work for a firm with fewer than 20 employees, and about 1 in 3 work for a firm with fewer than a hundred employees.[20] This poses an enduring riddle: Small employers are priced

out of the group insurance market, but their employees cannot afford individual insurance and do not qualify for public programs.

Iowa legislators have floated two sorts of solutions. The first would offer tax credits to small business offering health coverage for the first time.[21] Under a House bill introduced last session, small employers (two to 50 employees) and the self-employed would be eligible for a non-refundable tax credit equal to 10 percent of the employer's costs in the first year of a new health plan. Under the Senate version, small employers (fewer than 50 employees) would be eligible for a fully refundable credit equal to the first $1,000 of coverage per employee, subject to a cap of $25,000 and a statewide budget cap ($50 million in the program's first fiscal year).

These are dubious propositions. Neither offered a meaningful definition of "health coverage," allowing even the sparest plans to qualify for tax relief. Because tax credits flow to employers, they do not address the increasing inability of employees to afford or "take up" the coverage offered. The employer gets a tax credit for its contribution to premiums, while the employee taking up coverage may still face significant premium costs, co-payments and deductibles. Under the Senate version even contributions to health savings accounts qualified for the credit, an option that (as we explore below) might actually undermine group coverage.[22] Neither version offered any means of controlling the costs of individual or small-group coverage – essentially using public dollars to purchase a product whose quality is slipping and whose price is spiraling out of control.

Looking to research and experience in other states, it is not at all clear that tax credits would fulfill their promise of expanding coverage. Without tying health coverage to wage thresholds, tax credits could effectively encourage employers to shuffle compensation from wages to benefits in pursuit of tax breaks.[23]

More importantly, the profit margins of many small businesses simply do not enable them to pay the amount they would need to pay for reasonable health coverage for employees, with the incentives provided, and still remain in business. They simply do not earn enough (or pay enough in taxes) to make credits worthwhile. Current research suggests that tax credits would have to be much larger than those proposed (subsidizing at least half of premium costs) to have any appreciable impact on an employer's decision to buy insurance, even if that employer has a relatively decent profit margin.[24] Further, this is particularly true in sectors of the economy that employ lower-wage employees, such as janitorial services, child-care centers, and Main Street businesses such as dry-cleaning establishments – where payrolls make up a major share of the business costs. Providing health coverage in a blue-collar business for three $15/hour employees is a much greater burden than providing health coverage for one $45/hour employee in a white-collar business. While the small-business-oriented incentives might benefit and expand coverage for those small businesses (such as advertising firms or law offices) that have relatively high skilled and salaried personnel, they would do little for those in the much lower-paying service sectors.

The second solution for small employers would be voluntary purchasing pools.[25] This option would open a space in the state's insurance code (among the mutual benefit societies and conventional insurance concerns) for groups of small employers, defined by a common region or occupation, to pool their employees. As proposed in a Senate study bill last spring, one large actuarial group of at least 1,000 covered individuals would be created out of many small ones.

Such private multi-firm insurance pools are designed to open access by reducing the administrative costs of exclusionary underwriting, but their impacts have been limited. A number of states have experimented with such pools (commonly dubbed a "multi-employee welfare agreement" or MEWA) in industries characterized by either self-employment (accountants, auto dealers) or transitory employment (agriculture), but these pools have either had very minimal uptake or been plagued by insolvency and instability.[26] While such multi-firm pools might allow some firms to offer coverage they could not otherwise afford, they also run the risk of eroding the stability and credibility of job-based coverage: An emerging but dangerous provision in such plans, from the perspective of those being covered, is exemption from state insurance regulation — an option embodied in the Bush Administration's proposed "Association Health Plans."[27] At their best, such insurance pools might slightly reduce overall costs or allow for some pooling of risks, but will not address the underlying issue of the affordability — by either employer or employee — of annual health-insurance coverage, which now costs $4,000 for an individual or $11,000 for a family, according to the latest employer-based insurance study.[28]

A further problem with voluntary purchasing pools lies simply in the fact that they are voluntary. "Natural" groups (such as single large employers) are attractive to insurers, but groups formed for the purpose of purchasing health insurance are by their very nature poor risks, or (in actuarial terms) risk magnets. Because high-cost, high-risk groups have the greater incentive to join pools, those pools cannot spread risk or control costs very efficiently. For insurers, a white-collar firm with five young and healthy employees is still a bad bet, because the group is not big enough to spread the risk or absorb the cost of some of its members getting sick. A construction firm with five older and less healthy employees is, by the same standard, an insurer's worst nightmare: Not only is the group too small, but the industry poses more occupational hazards and the employees are already at the doctor's door. Pooling all such groups might make sense, but a voluntary pool might only attract the latter.[29]

Finally, while helping small business has a strong political appeal and small businesses recognize the problems that lack of coverage presents to their employees, such solutions are unlikely to make much of a dent in the uninsured. New small-business coverage (subsidized or pooled) would be subject to many of the same obstacles as conventional job-based coverage: rising costs, declining "take-up" rates (especially for family coverage), and limited reach (to only full-time, full-year employees without pre-existing conditions). Workers who actually qualify for, and can afford, such coverage might be few and far between. Such proposals might reach only a small fraction of the workforce and, because many rely on spousal coverage, an even smaller fraction of the uninsured.[30]

In sum, these plans fail our most basic criteria:

- They do little to reach the uninsured.
- For those they do reach, there is little no guarantee that the resulting coverage will be affordable.
- In exchange for some (but probably not much) new coverage, they give away far too much in the way of basic services and standards.

2) "Pay or Play" Penalties for Large Employers

Since the early 1970s, another option that a number of states have explored for expanding coverage has been the employer mandate. Many states have experimented with versions of a

"pay or play" mandate that taxes employers (although usually not small employers) who do not offer coverage. But a number of such plans adopted in the 1990s were subsequently abandoned and the most recent effort (California in 2002) was repealed by the voters before it was up and running.[31] Following efforts by a number of states to identify the major employers of its Medicaid populations, recent versions of "play or pay" have taken more direct aim at prominent low-wage employers, most notably Wal-Mart.[32]

Iowa's spin on this idea was the "Fair Share Health Care Fund,"[33] proposed last session and modeled after Maryland's "Wal-Mart bill." Under this proposal, all large employers (more than 50 employees) would be required to file annual reports summarizing their full- and part-time employment, the eligibility of employees for employer-sponsored health insurance, the number of employees who "take-up" the employer-sponsored plan, and total health-care expenditures. The state would then levy a "fair share" tax on major employers with over 10,000 in-state employees who spend less than 8 percent of their payrolls on health benefits.[34]

Like any public policy that imposes costs on private business, "fair share" health plans face significant political (and legal*) obstacles. While picking off prominent low-wage, low-benefit employers has an important symbolic impact, the net gain in coverage rates and quality has been modest at best. In turn, such laws raise the specter of competitive disadvantage or employment losses for in-state employers – a prominent charge in the successful campaign to repeal California's plan.

Many of these objections are blunted by the "fair share" legislation proposed in New York (but shelved in late June). Unlike the Maryland version, Fair Share New York would have covered a wide swath of employment: all firms with 100 or more workers and all service workers in buildings over 100,000 square feet. But it also explicitly exempted employers (manufacturing and agriculture) that compete across state lines. The plan required covered businesses to spend at least $3 per hour per worker on health coverage, and assessed the difference between that threshold and their actual health spending. Funds from the assessment would have been used to provide health coverage to uninsured workers at covered businesses. Estimates of new coverage were substantial: 400,000 currently uninsured (about 1 in 6 uninsured New Yorkers), and 200,000 currently covered by public programs, would have moved into job-based plans. And, because coverage is only mandated of immobile service firms, gains in local, labor intensive health-care employment would easily offset any minor adjustment by employers.[35]

For practical and political reasons, "Fair Share" has a certain logic. Private employment remains the easiest source of both insurable groups and the money to pay for their coverage.

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* The relationship between "pay or play" employer mandates and the Employee Retirement and Income Security Act (ERISA) remains contentious and unclear. ERISA, which serves primarily to set federal standards for pension, prohibits state or local action "relating" to job-based health plans. In some settings, including Iowa, the courts have held efforts to mandate health coverage by employers to be a violation of ERISA (see *City of Des Moines v Master Builders of Iowa,* Supreme Court of Iowa, 498 NW 2d 702 (1993), Iowa Sup. LEXIS 106). While some recent litigation surrounding both "pay or play" and "living wage" laws has suggested that ERISA should not be an obstacle -- as long as state (or local) law does not impose a direct obligation or assessment on ERISA plans, remains neutral on the "pay or play" question, and does not set standards for plans. In late July 2006, however, a federal court unexpectedly struck down Maryland's "fair share" law on grounds that it violated ERISA. See Baltimore Sun, Court Voids "Wal-Mart" Law (July 20, 2006); Patricia Butler, ERISA Implications for Employer "Pay or Play" Coverage Laws (California Healthcare Foundation, March 2005), 3-4.

But it also fails to address the larger stability and viability problems of job-based provision. "The soaring cost of health care in America," as Wal-Mart CEO Lee Scott bluntly reminded the nation's governors in late February "cannot be sustained over the long-term by any business that offers health benefits to its employees."[36]

The promise of such approaches is mixed:

- They sustain both the expectation of employment-based plans, and an appropriate distribution of health costs among employers and employees.
- But, because they "pick off" only certain employers, their impact is often more symbolic than substantive.
- And they are largely silent on the quality of health coverage offered.

3) Tax Breaks for Individuals

Perhaps the most pernicious — and potentially damaging — legislative trend is the fascination with "consumer-driven" reform combining tax breaks, high-deductible health plans, and health savings accounts. There is a certain irony to the politics of this: For years, business and medical interests promoted job-based insurance as the best defense against "socialized medicine." Today, many on the left of the health-care debate (with "single-payer" options an increasingly elusive goal) cling to job-based coverage, while conservatives have retreated to the long-dormant notion that health care is just another consumer product.

The last decade has seen considerable federal action on developing pre-tax health spending accounts, the culmination of which is the health savings account (HSA). Early experiments and demonstration projects were cemented into federal law by a provision of the 2003 Medicare legislation. Under the new law, employer contributions to a job-based HSA are not taxed and employee contributions are an "above the line" deduction (claimable without itemizing deductions). In order to set up an HSA, employees must be enrolled in a qualified high-deductible health plan and have no other coverage. The account, invested like an IRA, can be drawn upon for any legitimate medical expense except for the payment of insurance premiums (although the Bush Administration is pushing to drop this restriction). Unlike earlier versions, the new HSAs roll over from one year to the next without any "use it or lose it" penalties.[37]

All of this is embedded in the federal tax code, leaving it to state policymakers to sort out the degree to which state deductions or credits will piggyback on federal law, the discrepancy between federal HSA standards and state insurance regulation, and the wisdom of promoting HSAs at the state level. In Iowa, legislative custom is to incorporate any new federal deductions into Iowa's state income tax laws; the deduction for HSAs "flow through" in this manner. There are no significant regulatory conflicts between Iowa insurance law and federal standards for high-deductible plans. Iowa has moved to make HSA plans available to those enrolled in Medicaid, but does not yet make such plans available to state employees.[38] In addition, there was a proposal last session (not passed) that would have promoted HSA growth with a $10 million interest-free loan program for Iowans looking to start their own accounts.[39]

At first blush, it may seem a reasonable and simple matter to ride the coattails of federal HSA policy and provide another coverage option for working Iowans. But a consensus is emerging that such options may do more harm than good. The combination of high-deductible insurance and savings accounts is most attractive to the young and healthy — those who are already easy to insure. Recent research suggests that as many HSA enrollees would come from

existing job-based plans as from the ranks of uninsured, and that such an option might actually increase uninsurance rates as employers (and healthy employees) make the switch. The vast majority of the uninsured do not make enough money to make the tax advantages of HSAs worthwhile; more than half of uninsured adults have no income tax liability, so a deduction has no value. And those for whom HSAs *are* attractive are more likely to be switching from one kind of insurance to another — sparking a higher premium in the plans (now populated only by higher risks) they are abandoning.[40] There is little evidence that the discipline of consumer choice will reduce costs or improve care, as patients are as likely to forgo necessary and preventive services as they are to forgo "trivial" care.[41] And when children are considered, there is considerable evidence that primary and preventive services are both cost effective and broadly beneficial (improving children's health and healthy development, including success in school) — but these are the very services likely to be forgone by families through HSAs.

It is for all of these reasons that some states are refusing to amend tax and insurance codes to accommodate the spread of these plans. Last May, for example, Governor Doyle of Wisconsin vetoed legislation that would have adopted federal tax treatment of HSAs. Such plans "are only viable for healthy persons with higher incomes," argued Doyle, adding that a combination of lost revenue and adverse selection "would cost taxpayers $50 million, but wouldn't help a single Wisconsin family get health insurance."[42]

Overall, there is little to recommend this approach:

- It promises little expansion in coverage; indeed, by attracting the young and healthy and wealthy (not to mention cost-anxious employers), it is more likely to thin out coverage.
- It makes health care less affordable, both for those who chose high-deductible plans, and for those left behind in conventional plans.
- It cannot help eroding the quality of care, as out-of-pocket costs discourage preventive and ongoing care.

4) Expanding Public Programs

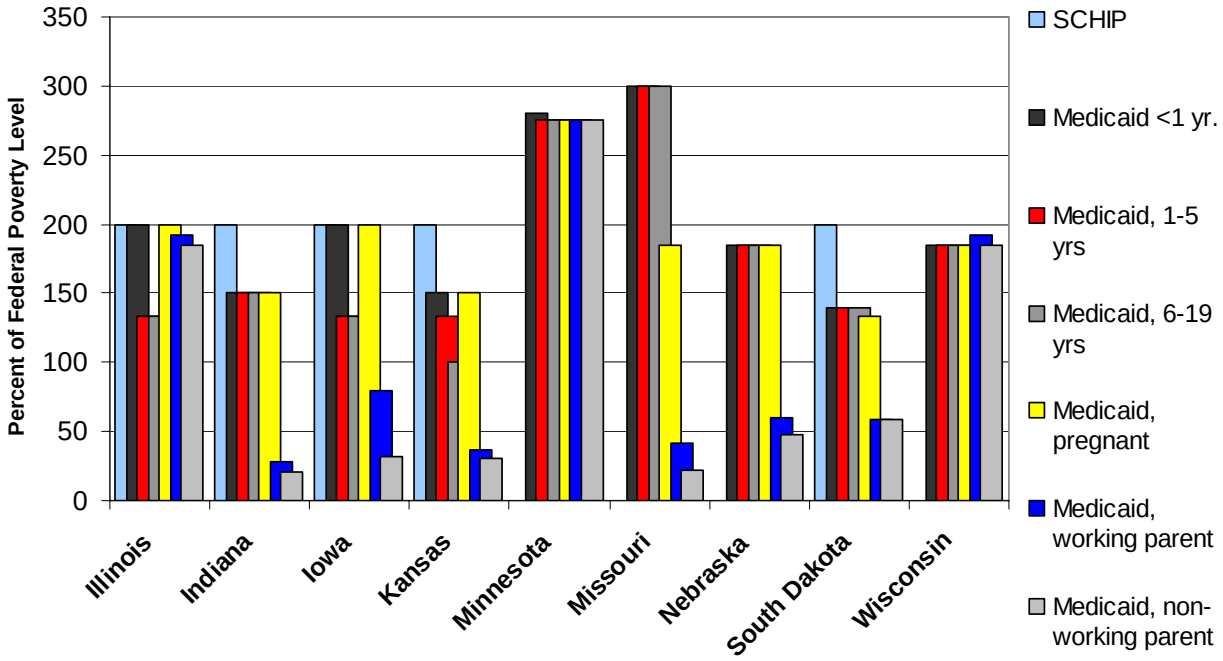
Given the continued decline in job-based coverage, public programs have little choice but to pick up the slack. Like all "means-tested" programs, Medicaid and SCHIP are designed to serve as a safety net to insure that children and other Medicaid-eligible groups (parents of children at very low income levels, persons with disabilities, and the elderly) receive the medical services they need. As job-based coverage becomes less accessible and affordable, these programs now act as a more general alternative. Over the past decade, for example, enrollment in both Medicaid and SCHIP (*hawk-i* in Iowa) has grown steadily across business cycles. The share of Iowa children without any health coverage (about 6 percent) has changed little since 1990 but, over that span, nearly 14 percent of Iowa children have moved from private to public coverage.[43] Children in more and more gainfully employed Iowa families earning modest incomes are joining the ranks of Medicaid and *hawk-i*.

This is, in many respects, a qualified success. Medicaid and SCHIP are serving as effective safety nets, and the latter has — by any measure — stemmed a local and national crisis in child health coverage. It is also worth noting that the relative cost (especially in administration) of these programs is low, and patient satisfaction remains high. In addition, Medicaid offers the type of comprehensive health coverage that all children need, particularly those who have special needs. Arguably, society has the greatest responsibility to ensure coverage for children, while the first responsibility for employers in an employer-based system is to the employees themselves and not to their children and other dependents.

At the same time, as part of the solution to the larger health crisis, expanding public programs continue to pose a series of challenges for state lawmakers. These programs also must contend with rising health costs and are countercyclical: Costs increase as revenues slow. The same economic conditions that create new demand for public programs also make them harder to fund.[44] While eligibility for public health coverage is broader since the "end of welfare" in 1996 and the creation of SCHIP in 1997, it is also much more complicated and varied across states.[45] And expanding public programs can "crowd out" job-based care if employers then decide they do not have to provide coverage (although rising costs and changes in the job environment are important factors in such decisions).

That said, the arguments for expanding public coverage are compelling — and sustained by recent state experience. More uniform income eligibility guidelines for kids, parents and childless adults would reduce both uninsurance rates and administrative costs for states. (A working parent, for example, must have income below 25 percent of the poverty level to qualify for Medicaid in Indiana, while a non-working parent qualifies with income up to 300 percent of poverty in Missouri.) More people would qualify; the rules by which people qualify would be more transparent; and the administrative burden of sorting through those rules would be lessened. As Medicaid and SCHIP have broadened their coverage, they also have increased their popularity and reduced the stigma that previously might have existed regarding enrollment. As Figure 5 underscores, eligibility varies considerably among our Midwestern peers: Some states (Missouri, Iowa, Kansas, South Dakota) vary eligibility quite starkly, especially with regard to coverage of parents; some states (Wisconsin, Illinois, Minnesota) maintain a more uniform, and in some cases very high, income threshold across eligible populations.

Figure 5. Public Program Eligibility Level by Age and Work Status,
Iowa and Midwest Peers



Source: Kaiser Family Foundation, State Health Facts

States have taken a number of approaches to expand public programs. Most commonly, states have raised the income threshold for core programs — pushing these to the limits allowed by Medicaid (275 percent of the family poverty level [FPL] for pregnant women and infants; 200 percent for kids ages 2-18, 100 percent for parents) or beyond. Expansion within the limits set by federal law is costly, but also draws down more federal matching funds for those covered under Medicaid (but this is not true of SCHIP, which is a block grant to states and up for reauthorization next year, with questions of whether Congress will fully fund the existing program and its coverage of children). Expansion beyond those limits requires a federal waiver — an adjustment of federal guidelines that often couples modest increases in coverage (a higher poverty threshold, parent coverage under SCHIP) with managed care or other cost-control measures.[46] Iowa's recent waiver (approved in July 2005), for example, allowed the state to expand a limited set of Medicaid benefits to certain non-elderly adults (including parents of Medicaid or SCHIP eligible children) who previously had been eligible under state-only or county-only programs using a limited provider network.[47]

Any expansion beyond FPL thresholds requires not only a waiver, but money. This money is generated in one of three ways. One source is internal savings: reductions in the cost of delivering care accomplished through administrative streamlining, and new disease management or new diagnostic protocols. Revenue neutrality is a core expectation of the federal waiver system, although most public programs are already much leaner and administratively efficient than their private counterparts.

Another source is the patients themselves, through the use of various cost-sharing mechanisms (deductibles, co-payments) — especially for enrollees in SCHIP or Medicaid programs that offer broader coverage (often under a federal waiver). This is the basic premise of initiatives such as Illinois' "All Kids" program, which opens the state's SCHIP program, on a sliding premium scale, to all children. Many other states have explored the prospect of allowing uninsured adults to "buy in" to Medicaid.[48] The dilemma here, of course, is that such expansions are aimed at those for whom the cost of health care is already an obstacle to coverage.[49]

A third source of money for public program expansion is state revenues — an approach that rests on both fiscal capacity and fiscal commitment. Minnesota, for example, has achieved the nation's leading uninsurance rate of 9 percent by expanding public programs and state-funded gap fillers. These include a General Medical Assistance Program for those left out of Medicaid (mostly single adults), MinnesotaCare (a state-funded, co-paid Medicaid extension for families under 275 percent of the FPL and childless adults under 175 percent of the FPL), a small state-funded high-risk pool, and a small-group pool for local governments[50]

This approach has considerable promise, but the devil is in the details:

- As means of expanding coverage, opening enrollment in well-established (and efficient) public programs makes a great deal of sense.
- If public programs are able to fully close the gap between private plans and eligibility for public plans, we may be able to reap the benefits of seamless and portable coverage.
- But, resources must be sufficient to make public coverage available without undue burden on those covered, and without trading quality of care for expansions in coverage.

5) Managing Risk

Cost is not the only obstacle to coverage for the uninsured; as important (as an obstacle and as a source of high costs) is the high risk presented by small groups of individuals. This risk presents itself in two ways. The first, as we have seen, is the actuarial risk of covering health costs outside large (usually employee) groups. The smaller the group, the harder it is for that group to spread the risk and the cost of covering its sickest members. The second is the disparate risk posed by different individuals. The top 10 percent of the non-elderly population (ranked by their share of expenditures) accounts for almost two-thirds of health spending, the top 5 percent account for almost half, and the top *1 percent* account for almost one quarter.[51] This is a vicious cycle: Just as the chronically ill find it hard to get insurance, those without insurance are more likely to forgo care and become (or remain) chronically ill.

The Malpractice Myth

Some legislators and candidates have pushed "tort reform" as a critical element of health policy. But there is little evidence to sustain the argument that malpractice costs (and the defensive medical practices they supposedly encourage) are a significant problem. The burden of malpractice liability is wildly inflated.

Measured against population and domestic production, the number and cost of tort cases is actually falling. The bulk of these "costs," in turn, represent either the entirely just and appropriate transfer of resources from culpable providers to injured patients, or routine administrative costs which will not be affected by limiting premiums or awards.

Even if we use these inflated numbers, the costs of malpractice claims and insurance amount to less than 2 percent of health spending. Even a substantial reduction in malpractice costs, as the Congressional Budget Office has calculated, would lower health-care costs by less than one-half of one percent. See Lawrence Chimerine and Ross Eisenbrey, "HThe Frivolous Case for Tort Law ChangeH" (Economic Policy Institute Briefing Paper, 2005); and Congressional Budget Office, "HLimiting Tort Liability for Medical MalpracticeH" (January 2004).

One of the major tasks of health reform lies in managing this risk, by making it easier for insurers to absorb it, or by providing "last resort" coverage directly to high risk populations. Iowa, and other states, tinkered with this issue through the late 1990s — tweaking state insurance regulations to make it easier to get and keep group coverage (through a variety of portability and accessibility provisions) and creating a "high-risk" pool for those shut out of traditional coverage by pre-existing conditions, insurance rating or high premiums. These programs, however, have done little to either slow "cherry-picking" by private insurers or close the gap between conventional group coverage and high-risk or individual plans.[52]

One solution, now being tried in a small number of states,[53] is a state "reinsurance" fund to protect private insurers against high risks (individual and small-group) coverage. Reinsurance takes two forms, providing protection either against higher-than-expected costs for an insured group ("aggregate stop-loss" reinsurance) or against very high costs for an individual member of a group ("excess-of-loss" reinsurance). Under a bill proposed last session, an insurance pool would include all uninsured Iowans who are employed, who are not offered health insurance at work, and whose family incomes fall between 200 and 300 percent of the poverty level. The state would set plan standards (covered services and co-payments), and require all HMOs to participate. The reinsurance fund would offer "excess loss" coverage to private insurers, paying 90 percent of any individual claims between $30,000 and $100,000 a year.[54]

This approach has shown some success. The public insurance pool in New York state ("Healthy New York") has an enrollment of just under 60,000. Employers must pay at least 50

percent of a basic health plan. Monthly premiums for enrolled individuals ($194) are substantially lower than either comparable small group ($274) or non-group ($496) coverage.[55] Low premium costs reflect both large group rates, and the reinsurance offered to participating insurers. While less than 1 percent of insured individuals submit annual claims in excess of $50,000, such claims account for nearly 30 percent of all medical spending.[56] The version proposed in Iowa last spring did not specify a source of money for the reinsurance fund (New York used money from the 1998 tobacco settlement), but a "fair share" tax (a levy on employers not offering health coverage) would certainly be one option.

Another option (and a necessary part of any reinsurance fund) is the establishment of a basic health plan. Such reforms rest in part on a state's ability to regulate insurance, and in part on a state's clout (via Medicaid) as a health insurer/purchaser. Basic plans typically establish a "no frills" package of coverage, often replicating the services and reimbursement rates negotiated under Medicaid. Under various state-level proposals, insurance commissions would require all HMOs or (more rarely) all private insurers to offer the basic plan to all falling under a certain super-percentage (200 percent, 300 percent) of the federal poverty level — usually in exchange for "reinsurance" of bad risks.[57] Alternatively, as in Washington state's longstanding plan, basic coverage could be offered on a sliding premium scale as a seamless extension of Medicaid.[58]

The lingering issue around both reinsurance and basic health plans is, not surprisingly, money. Both state reinsurance pools and the state share of basic health plan premiums require substantial and stable funding. Some of these initiatives, including Healthy New York, rode in on the fiscal coattails of the tobacco settlement. They would be harder to launch now. Others, including Washington's basic health plan, have suffered through dramatic swings in state support — and have lost much of their credibility and clout as a result.

Such efforts can be important elements of broader reform, but are insufficient on their own:

- "Reinsurance" protections for insurers and employers can help to manage the risk of existing coverage, but are unlikely to expand it.
- The push to offer "basic" plans may simply spread existing coverage more thinly — trading plan standards for greater access.
- Such efforts often lead to even greater complexity in the health-care system, with subsequent additional costs of administration and oversight if the provisions are not to be used for unintended purposes.

3. Thinking Big

While none of the various reform measures proposed last session saw the light at the end of the legislative "funnel" in March 2006, they are likely to return to the Statehouse in some form next session.[59] Given the ongoing crisis of collapsing coverage and mounting costs, there is little doubt that health care will make its way back to the top of the political agenda in short order. States have been tinkering with incremental solutions for years, but with uneven results. Indeed, by one recent estimate, even a careful combination of tax credits, purchasing pools, expanded Medicaid eligibility, and subsidized reinsurance — in the absence of mandated (individual or job-based) coverage — would reduce uninsurance rates by only about one-third.[60] The limits of particular solutions aside, the strategy of subsidizing certain fragments of coverage or targeting certain fragments of the uninsured poses a series of broader challenges and problems:

- Employment-based provision — now an accessible option for less than half of the nation's workforce — is a shaky foundation for reform. Making it easier for small business to offer plans (tax credits, insurance pools) or harder for big employers not to ("fair share" mandates) may slow the decline in workplace coverage. But, such efforts are a little like pumping water from a sinking ship. Because they do nothing to control health-care costs or reduce their competitive burden, they are unlikely to make much of a dent in the uninsured.

- On their own, incremental solutions (subsidies for new job-based coverage, tax credits for individual coverage) are like stepping on a balloon: they tend to push the problem around, moving the currently insured from one kind of coverage to another. New options for individual coverage are most likely to appeal to those already insured under group plans, encouraging the young and healthy to go it alone and making it harder for group plans to spread risks and control costs.

- Efforts to fill in the gaps (a little more job coverage here, an expanded public program there) fail to address the persistent fragmentation of the American health-care system. Since that fragmentation is a root source of both high costs and high rates of uninsurance, new coverage may overlook (or exacerbate) these larger problems. Incremental solutions, in other words, might cost less in the short run — but they are likely to cost *more* in the long run because they fail to reign in uncompensated care, they perpetuate the "avoid the sick" logic of private insurance and they do little to check further erosion of public and preventive care.

So what is the answer? What are the essential principles or ingredients of meaningful and sustainable health reform? And how do we get from here to there?

The key, if we look to the experience and innovation of other states, lies less in the details of one idea or the next than in the ways in which they are combined. Think of it as a prescriptive cocktail: All the ingredients serve a purpose, but only in combination will they have the desired effect. Incremental solutions that might be insufficient (or even counterproductive) on their own, have much more promise when they are packaged, designed and staged as part of more comprehensive approach. Only in this way can we ensure that initiatives aimed at discrete fragments of the population will not work at cross-purposes, that reform will realize the savings or revenues needed to expand coverage, and that the end result is seamless and affordable access to health insurance for all Iowans.

A few states — most notably Maine, Massachusetts and Vermont — have embarked on just such a path. Their example and experience is instructive for a number of reasons. All were faced by the same pressures (rising costs, declining job-based coverage) facing Iowa. And, also like Iowa, all were in much better shape (in terms of job-based coverage and uninsurance rates) than most of their peers — and took the plunge before it was too late to use existing coverage as a foundation for universal coverage. And all turned to more sweeping solutions after a dissatisfying experience with incremental reform. Let's look at these examples:

Maine

Maine's "Dirigo Health" Plan, launched in 2003, combines an expansion of public programs with a statewide health plan that pools uninsured individuals, the self-employed, and firms

employing fewer than 50 workers — providing at least the option of group rates to all state citizens. As a first step, the state's Medicaid program ("MaineCare") was expanded to cover more low income citizens: to 125 percent of the federal poverty level for individuals and 200 percent of the FPL for adults with MaineCare eligible children. For those still without coverage, Maine created a new comprehensive health plan ("Dirigo Health") open to individuals, families, the self-employed, and small businesses. Premiums to Dirigo health are made on a sliding scale, with those earning less than 300 percent of the FPL eligible for discounts (enrolled employers must pay at least 60 percent of the premium). The plan is designed to minimize "crowd out" — large businesses were eligible to participate after the first year. And it rests on a tripod of revenues: Dirigo health premiums, federal matching funds for base Medicaid population, and a tax on insurers equal to the savings generated by cost-containment and the reduction of uncompensated care.[61]

Early results are encouraging. Maine is one of a handful of states to see its rate of uninsurance actually drop in recent years. As of mid-2006, Dirigo Health claimed an enrollment of over 10,000 — including 2,300 small businesses employees. And the first full assessment of the plan calculated savings in private insurance plans for 2005 at just under $44 million. Under the terms of the agreement between Dirigo Health and insurers, the state can then tax private insurers for their share of those savings and use the revenue to further expand coverage.[62]

Massachusetts

Massachusetts has a long history of health policy innovation (and frustration) — including a stab at an employer-mandate in the late 1980s.[63] In June 2006, Massachusetts launched a new set of reforms. The novel centerpiece is the nation's first "individual mandate" — a requirement that all adult residents have "creditable" health insurance coverage. Coverage must be reported on annual tax returns, and those without coverage lose their personal tax exemption. In order to make such coverage accessible and affordable, the mandate is accompanied by an expansion of Medicaid eligibility, an employer mandate (requiring employers with more than 10 full-time employees to offer "cafeteria" health plans that allow employees to use pre-tax dollars to pay premiums — or pay a "fair share" tax of $295 per employee), insurance market reforms (including pools for individual and small group coverage, and new basic and high-deductible insurance products), and a new public authority – the Commonwealth Health Insurance Connector — charged with making basic, portable, private group coverage available to uninsured individuals. Plans purchased through the Connector will be offered on a sliding scale to those falling below 300 percent of the FPL (but not eligible for Medicaid).

The reform aims to cover just over 500,000 uninsured residents (100,000 with public programs, 200,000 with new subsidized products, and 200,000 with the employer mandate) within three years. Program costs are estimated at nearly $1.2 billion over that span, but only about $125 million of that is new state spending. Federal matching funds (through Medicaid and a revised Medicaid waiver) will pick up some of the cost; internal savings (mostly from uncompensated care) some of the rest. [64]

Still unclear, with actual coverage options uncertain, is how much of the ultimate cost will be borne by Commonwealth citizens of ordinary means — many of whom will be compelled to buy coverage they cannot afford. The levy on employers ($295 per worker/per year) is a tiny

fraction of what actual health coverage would cost; the levy on working families earning as little as $30,000/year is — in the absence of any control on costs — virtually limitless.

While some see the Massachusetts plan as an innovative route to universal coverage, such optimism is probably unfounded. The principal of an "individual mandate" is sound, and makes an innovative (and probably overdue) break from the expectation of job-based coverage. But, without any accompanying effort to make health coverage more universally accessible and affordable, it is nothing more than a peculiarly punitive version of "consumer-driven" reform. This misplaced faith in private markets and individual responsibility may conjure up higher coverage rates, but in doing so it will also shift the burden of that coverage onto the backs of those who can least afford it.[65]

Vermont

A more modest (and less coercive) version of the Massachusetts plan also passed recently in Vermont. The new "Catamount Health" program creates a new standardized health plan (covering primary, preventive and chronic care, as well as acute episodic care and hospital services). Enrollees will pay premiums on a sliding scale, with state subsidies kicking in for individuals or families below 300 percent of the FPL. Funds to kick-start and sustain the program will come from a combination of plan premiums, federal matching funds (for Medicaid-eligible enrollees) and an increase in tobacco taxes. Introduction of the plan (expected to reach about half of the roughly 60,000 uninsured residents) has three steps: At the outset, Catamount Health plans will be offered voluntarily by private insurers; if private insurers do not offer sufficient Catamount coverage on their own, the state will mandate their participation; if (after two years) enrollment still lags, or costs remain an obstacle, the state will assume the risk itself and contract out the plan administration.[66]

4. Thinking Big in Iowa

So far, we've sketched Iowa's health-care crisis, the range of incremental reforms in legislative play, and the summary details of more comprehensive efforts in Maine, Massachusetts and Vermont. The basic storyline is this: We are in a world of trouble. Piecemeal reform has done little to make things better and might well make things worse. Comprehensive reform is more promising.

The adaptability of the Maine, Massachusetts or Vermont experiments to other states depends, of course, on the distinct demographic, coverage and cost patterns in each setting.[67] As Table 1 summarizes, Iowa has a relatively favorable health profile – and one that is quite similar (with a few exceptions) to that of the "big three" reform states. Mortality rates run below national averages. The incidence of cancer, diabetes, heart disease and asthma is generally near or below national rates. The prevalence of poor mental health is quite low. And we rate in the upper third of states in occupational, firearm and motor vehicle deaths. The percentage of Iowans who are obese or overweight, however, is higher than the national average. As a rule, Iowans are safer, saner and fatter than average. More importantly, our demographic profile is quite similar to those of the big three.

Table 1. Health Demographics, U.S., Iowa and Select States

Measure	ME	MA	VT	IA	U.S.	IA rank
Mortality rate (per 100,000)	822.3	778.7	765.3	768.4	832.7	7
Infant death rate (per 1,000)	4.3	4.8	4.4	5.3	7.0	7
Cancer incidence (per 100,000)	508.9	505.8	463.4	469.4	462.2	27
Diabetes incidence (per 100 adults)	7.5	6.4	6	5.7	6.7	13
Heart disease death rate (per 100,000)	200.6	198.4	199.3	208.1	232.3	21
Percent of adults who smoke	20.9	18.4	19.9	20.8%	20.6%	25
Prevalence of asthma (% of adults)	15.0%	14.2%	14.9%	11.6%	12.6%	16
Overweight/obesity rate	55.9%	51.3%	52.1%	58.8%	56.6%	40
Prevalence of poor mental health (% of adults)	33.8%	34.0%	35.4%	29.2%	33.9%	7
Occupational fatality rate (per 100,000)	5.1	1.4	3.7	4	4.3	18
Motor vehicle death rate (per 100,000)	15	8	11.4	14.9	15.3	20
Firearms death rate (per 100,000)	6	3.1	7.5	6.9	10.3	10

Source: Kaiser Family Foundation, State Health Facts

The picture is also quite favorable if we turn to patterns of health coverage (Table 2).[68] Alongside the big three, Iowa has one of the lowest uninsurance rates in the nation. The rate of job-based coverage is high, anchored by very high rates in firms employing 50 or more. At the same time, the rate of job-based coverage in small (under 50 employees) Iowa firms is dismal. And we are losing ground fast: Between 2000 and 2004, Iowa saw job-based coverage disappear (and the Medicaid population swell) at rates near the worst in the nation. This is the time – while the gap is still small – to build the bridge from current to universal coverage.

Table 2. Patterns of Insurance, U.S., Iowa and Select States

Measure	ME	MA	VT	IA	U.S.	IA rank
Uninsured (total population)	10%	11%	10%	10%	16%	2
Job-based coverage (non-elderly)	60%	68%	60%	68%	61%	8
Job-based coverage in big firms (>50)	96.6%	95.1%	98.9%	97.4%	95.4%	12
Job-based coverage in small firms (<50)	42.7%	56.2%	46.1%	37.3%	43.2%	35
Loss of job-coverage (2000-2004)	-6.6%	-5.7%	-6.1%	-7.6%	-4.9%	44
Growth in Medicaid population (2000-04)	10.7%	-2.6%	3.5%	5.2%	2.7%	44

Source: Kaiser Family Foundation, State Health Facts

Comprehensive reform has proven most successful in states with the political will and fiscal capacity to make them work. Massachusetts, for example, built its reforms on the back of an exceptional uncompensated care fund ($720 million). Some (Maryland, New York) dedicated a lion's share of the late-1990s state tobacco settlement to expanded health coverage. Others (Minnesota) have simply relied on stable revenues and a political consensus that expansive health coverage is a public good. Iowa, which for the last decade has precariously balanced budgets by raiding discretionary funds to counter over-enthusiastic tax cuts, sits near the other end of this spectrum.[69]

In any case, it is important to recognize the larger logic of comprehensive reform: Over time it will pay for itself. We are already bearing the costs of fragmented coverage, uncompensated care, and declining private insurance.

Comprehensive reform proposes not massive new spending, but the redirection of existing spending through more productive channels. Near-universal coverage, in turn, promises a combination of administrative efficiency and early intervention sufficient to tame health inflation and provide for the currently uninsured. The costs, in other words, are largely transitional. Comprehensive reform is not only responsible health policy, it is responsible fiscal policy as well. And the costs of covering the uninsured may not be as high as many assume (see box).

What a health plan for Iowa might look like is beyond the scope of this report, and will require a broader conversation among the state's workers, employers, insurers, and providers. What we can say, based on our survey of recent state innovations and experiments, is that *any* such reform (or set of reforms) must adhere to a set of basic goals or principles:

- **Expanded and Accessible Coverage**: We face a growing crisis of uninsurance, and yet political energies are often drawn to its margins; to employers or employees or insurers struggling to maintain existing plans. While such efforts are important, they must be accompanied a systematic effort to provide all Iowans with access to unrestricted, group-based plans.

- **Affordable Coverage:** Expanded coverage has little meaning if the options available are not priced within the reach of ordinary Iowans. As we know from our experience with both "portability" reforms (such as COBRA) and employer provision, simply offering group coverage (especially family coverage) does nothing to guarantee that group members can afford the out-of-pocket costs.

Covering Iowa's Uninsured: How (Not How Much) is the Question

Covering the uninsured might appear to add substantially to already high health costs. In fact, covering the uninsured is more a question of developing an effective way to do so than it is about costs.

- Virtually all of the uninsured are working-age adults (18-64) who are disproportionately young, or children. Most health-care costs are incurred by those over 65, or with severe disabilities who are covered under Medicare or Medicaid. Children and young adults, in particular, are not costly groups to cover.
- Hospitals and emergency rooms still accept and treat the uninsured for emergency or catastrophic conditions, even if they do not have health insurance. The costs, if not recovered from the patients themselves (and there is a high level of medical debt) then falls onto the institutions as charity and bad debt. The institutions must recover these costs, generally through higher charges to those who are insured.
- The primary and preventive care that the uninsured are most likely to forgo now can help avert more costly health care provided later. Many primary and preventive services, like immunizations and treatments for such conditions as asthma and diabetes, actually reduce health costs in the long term.

The cost of covering the uninsured would be quite small in relation to overall spending. In the end, the administrative costs that are incurred in determining who should pay for what care, and negotiating payment and rate agreements with insurers in the current complex system, well exceed the additional cost of expanding coverage to the uninsured population.

- **Meaningful Coverage:** We cannot, in order to make coverage more accessible or affordable, trade away the fundamental benefits – to individuals, to families, and to the public health – of basic (especially primary and preventive) services.

Iowa has the luxury of starting this process from a position of relative strength. Our rate of uninsurance, though climbing, is among the lowest in the nation. Our rate of employment-based coverage, though slipping, is among the highest. A comprehensive package of reforms could reverse these trends and push us toward universal coverage – at substantial benefit to working Iowans, Iowa businesses, and the public health. Piecemeal reform, or doing nothing, is a virtual guarantee that things will get worse.

Notes

[1] Basic rates of coverage are drawn from U.S. Census Bureau, *Historical Health Insurance Tables*. National rates are annual through 2005; state-level rates are two-year averages through 2004-5. See also *Health Coverage in Iowa* (September 2006), and Kaiser Family Foundation, *State Health Facts database* (last updated October 2005).
[2] E. Richard Brown, "America's Uninsured and the Expansion of Coverage: What Future Will We Choose?" (UCLA Center for Health Policy Research, 2006), 2.
[3] For coverage rates, see Carmen DeNavas-Walt, Bernadette Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-231, *Income, Poverty and Health Insurance Coverage in the United States: 2005* (Washington: GPO, 2005). Iowa numbers are from Iowa Fiscal Partnership Fact Sheet, *Health Coverage in Iowa* (September 2006).
[4] Iowa Policy Project, *The State of Working Iowa 2005*, pp10-12; for the national picture see Elise Gould, *Prognosis Worsens for Workers' Health Care* (Economic Policy Institute, October 2005).
[5] See Arindrajit Dube and Ken Jacobs, *Declining Job-Based Health Coverage in California and the United States: A Crisis for Working Families*, (UC-Berkeley Center for Labor Research and Education , January 2006); Heather Boushey and Joseph Wright, Health Insurance Data Brief #3 (Center for Economic and Policy Research, April 2004).
[6] Heather Boushey and Joseph Wright, *Improving Access to Health Insurance*, (Center for Economic and Policy Research, April 2004); Kaiser Foundation, *Health Coverage in America: 2004 Data Update* (2005), 75. Since 1982, the cost of employment-based health coverage has increased (in real dollars) by 260 percent; the employees' share has increased 350 percent. Between 1988 and 2003, the share of covered workers required to contribute to a family health plan grew from 66 to 92 percent, and the workers' monthly premium cost (family coverage) increased almost four times, from $52 to $201.
[7] See Kaiser Family Foundation, *Employer Health Benefits: 2005 Annual Survey*, (2006); John Gabel et al, "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24:5 (2005), 1273-1280; Dube and Jacobs, *Declining Job-Based Health Coverage*, pp20-22.
[8] Dube and Jacobs, *Declining Job-Based Health Coverage*
[9] Elise Gould, *Prognosis Worsens for Workers' Health Care* (Economic Policy Institute, October 2005).
[10] Elise Gould, *Prognosis Worsens for Workers' Health Care* (Economic Policy Institute, October 2005).
[11] In Iowa, as in most states, Medicaid is aimed at specific vulnerable populations – children, persons with disabilities, low-income seniors, and parents who qualify for public assistance. Single adults and childless families are categorically excluded. Under the terms of a recently negotiated waiver from federal rules, the new IowaCare program offers limited Medicaid coverage to low-income adults previously covered by the county-based "State Papers" program. See Iowa Fiscal Partnership, *IowaCare: Need for Caution* (October 2005).
[12] See Arindrajit Dube and Ken Jacobs, *Hidden Costs of Wal-Mart Jobs: Use of Safety Net Programs by Wal-Mart Workers in California* (UC Berkeley Labor Center, August 2004); Ohio Department of Job and Family Services, *Employer Report* (February 2006). In just the last five years the, number of households claiming both employer-provided insurance and Medicaid has increased steadily (from 4.4 percent of low wage workers in 1992 to 8.7 percent in 2002). Between 1999 and 2002 alone, the share of child Medicaid recipients living in a family where other members had employer-provided health insurance more than doubled to 11.1 percent. See Heather Boushey and Joseph Wright, *Health Insurance Data Briefs #5: Public Versus Private Health Insurance* (Center for Economic and Policy Research, April 2004).
[13] These numbers and rates are extracted by the author from the Kaiser Family Foundation, State Health Facts database, (last updated October 2005). Uninsurance rates also vary widely by race. Nationally, the rates are 13 percent for whites, 24 percent for blacks, and 34 percent for Hispanics. In Iowa, the black population is too small to estimate coverage rates; the two-year (2003-4) average for whites is 11 percent and for Hispanics is 30 percent.
[14] For a good snapshot of national patterns of health coverage (2000), see the county map generated by the Census Bureau's Small Area Health Estimates.
[15] John Graves and Sharon Long, *Why Do People Lack Health Insurance?* (The Urban Institute, May 2006), 8-10.
[16] J. Hadley and J. Holohan, "How Much Medical Care Do the Uninsured Use, and Who Pays for It?" *Health Affairs* 3 (2003); Institute of Medicine, "Hidden Costs, Value Lost: Uninsurance in America" (June 2003). Nearly half (45%) of nonelderly adults without insurance report chronic health conditions; more than a third have no usual source of care; more than a quarter report no visit to health professional in the preceding 12 months. See Amy Davidoff and Genevieve Kenney, *Uninsured Americans with Chronic Health Conditions* (Urban Institute, May 2005), 4-5.

[17] See California Health Care Foundation, *Health Care Costs 101* (2005); Organization for Economic Co-operation and Development, *Health Spending* (2006).
[18] Michelle M. Doty, Jennifer N. Edwards, Alyssa L. Holmgren, *Seeing Red: Americans Driven into Debt by Medical Bills* (The Commonwealth Fund, August 2005).
[19] The following draws on two excellent clearinghouses for state health policy: The Commonwealth Fund, *States in Action: A Quarterly Look at Innovations in Health Policy*; The Robert Wood Johnson Foundation, *State Coverage Initiatives*.
[20] Statistics on employment by firm size are from the Census Bureau, *Employment Size of Firms* (2003).
[21] House File 2119 and Senate File 2225.
[22] Under federal law (Section 223.d of the Internal Revenue Code), health savings accounts are allowed alongside high-deductible "catastrophic" health plans. This is a combination likely to appeal only to those who expect few claims (the young and healthy), encouraging them to bail out of conventional group-coverage, raising the risks – and the costs – for those left behind. Alongside SF 2225, the Senate also proposed (see SSB 3195) a $10 million dollar loan program to jump start health savings account by loaning participants the difference between the deductible in the accompanying high-deductible insurance plan, and the balance in the health savings account. This is, in many ways, a peculiar proposal considering the mantra of "individual responsibility" which typically accompanies the HSA/high-deductible option.
[23] In establishing eligibility for other benefits (such as economic development assistance), the state conventionally uses some version (or super percentage) of the average county wage. Under HF 2119, employers would need only meet the *lower* of three thresholds: the average county wage, the average county wage *excepting the county's largest city,* or the average county wage *excepting the county's largest employer.*
[24] California Budget Project, *Are Employer Tax Credits the Most Effective Way to Expand Health Coverage for California's Uninsured?* (May 2000), 1-2.
[25] Senate Study Bill 3049.
[26] See *Report on Multiple Employer Welfare Arrangements* (California Department of Insurance; December, 2001); Mila Kofman, Eliza Bangit, and Kevin Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (The Commonwealth Fund Issue Brief, March 2004).
[27] SSB 3049 was silent as to the regulatory status of the proposed pools.
[28] Kaiser Family Foundation, *Employer Health Benefits: 2005 Annual Survey* (2006)
[29] California Health Care Foundation, *What Health Insurance Pools Can and Cannot Do* (November 2005), 2-3.
[30] Richard Kronick, *Is Small Business the Key to Insuring More Californians?* (CHCF, November 2005), 2-9.
[31] See T. Oliver, *State Employer Health Insurance Mandates: A Brief History* (California Health Insurance Foundation, March 2004). On California, see Arindrajit Dube, *Impact of SB 2 on Health Coverage* (Berkeley Institute for Labor and Employment, Sept. 2003).
[32] See "Maryland Passes Rules on Wal-Mart Insurance," Washington Post (April 6 2005); David Nitkin, "Health care tax to target big employers," Baltimore Sun (April 6, 2005); National Conference on State Legislators, *"Pay or Pay" Bills* (January 2006). For a digest of state-level disclosures, see Good Jobs First, *Disclosures of Employers Whose Workers and Their Dependents are Using State Health Insurance Programs* (July 2006).
[33] HF 2430.
[34] In Iowa, the only employers meeting the employment threshold are Hy-Vee and Wal-Mart. In 2004, Wal-Mart employed just over 17,000 in the State, and also led the list of state employers of Medicaid recipients (about 900). See Ryan Foley, "IA Medicaid Employers," Associated Press (March 4, 2005). The proposed tax would equal the difference between actual health spending and the 8 percent threshold.
[35] For these estimates, see Working Families Party, *Fair Share for Health Care* (2006); Center for A Changing Workforce, *New York's Fair Share for Health Care: No Significant Employment Impact* (May 2006).
[36] Lee Scott, *A New Commitment for America* (February 26, 2006).
[37] See Beth Fuchs and Julia James, *Health Savings Accounts: The Fundamentals* (National Health Policy Forum, 2005), 4; California Healthcare Foundation, *Consumer-Directed Health Plans: Implications for Health Care Quality and Cost* (June 2005), 8; Jonathan Gruber, *The Cost and Coverage Impact of the President's Health Insurance Budget Proposals* (Center on Budget and Policy Priorities, February 2006), 2.
[38] National Conference on State Legislatures, *2004-6 State Legislation on Health Savings Accounts and Consumer Driven Health Plans* (2006); Council for Affordable Health Insurance, *HSA State Implementation Report* (2006); Mila Kofman, *Health Savings Accounts: Issues and Implementation Decisions for States* (Academy Health: State Coverage Initiatives, September 2004), 3-4.
[39] SF 2345.
[40] See Jonathan Gruber, *The Cost and Coverage Impact of the President's Health Insurance Budget Proposals* (Center on Budget and Policy Priorities, February 2006), 3-5; Sherry Glied and Dahlia Remler, *The Effect of*

Health Savings Accounts on Health Insurance Coverage (The Commonwealth Fund, April 2005), 2-3; Timothy Sweeney, *Reforming Healthcare Brief #1: Taking a Closer Look at Health Savings Accounts* (Georgia Budget and Policy Institute, March 2006); E. Richard Brown, "America's Uninsured and the Expansion of Coverage: What Future Will We Choose?" (UCLA Center for Health Policy Research, 2006), 2.

[41] In some states, insurance regulations compel even high-deductible plans to offer preventative services. See Paul Fronstin and Sara Collins, *Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey*, (The Commonwealth Fund, December 2005); Government Accountability Office, *Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Health Plans* GAO-06-798, August 8, 2006; California Healthcare Foundation, *"Consumer-Directed" Health Plans: Implications for Health Care Quality and Cost,* (June 2005), 7.

[42] Doyle Veto Message on Assembly Bill 4 (26 May 2006).

[43] Child and Family Policy Center, *Iowa Child Health Coverage: 2007 Federal Policy Options* (May 2006); Elise Gould, *Prognosis Worsens for Workers' Health Care* (Economic Policy Institute, October 2005), Table 4.

[44] See Donna Cohen Ross and Laura Cox, *Out in the Cold: Enrollment Freezes in Six State Children's Health Insurance Programs Withhold Coverage from Eligible Children* (Center on Budget and Policy Priorities, 2004); Academy Health, *State of the States: Cultivating Hope in Rough Terrain* (State Coverage Initiatives, 2004); Cindy Mann, Samantha Artiga, and Jocelyn Guyer, *Assessing the Role of Recent Waivers in Providing New Coverage* (Kaiser Commission on Medicaid and the Uninsured, December 2003, 9-11.

[45] See Urban Institute, *Assessing the New Federalism: Eight Years Later* (April 2005), 27; *Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities* (Children's Partnership/Kaiser Commission on Medicaid and the Uninsured, April 2006), 4; John Holohan, and Mary Beth Pohl, "States as Innovators in Low-Income Health Coverage" (Urban Institute, 2002), 2-8; Dawn Horner and Beth Morrow, *Opening Doorways to Health Care for Children: 10 Steps to Ensure Eligible but Uninsured Children Get Health Insurance* (Children's Partnership/Kaiser Commission on Medicaid and the Uninsured, May 2006); California Budget Project, *Lasting Returns: Investing in Health Care Coverage for California's Children* (February 2005).

[46] See Robert Wood Johnson Foundation, State Coverage Initiatives, *State Coverage Matrix* (November 2005); for examples of recent state efforts, see *New Mexico State Coverage Insurance* (Academy Health: State Coverage Initiative, March 2006); Health Management Associates, *Assessment of State Options for Expanding Health Coverage: A Report to the Health Insurance for Indiana Families Committee* (Dec. 2003); Nebraska Health Insurance Policy Coalition, *State Options for Expanding Health Coverage and Strengthening the Health Care Safety Net* (August 2005); Health Management Associates, *Options for Expanding Health care to Michigan's Uninsured* (August 2005).

[47] See Iowa Fiscal Partnership, *IowaCare: Need for Caution* (October 2005).

[48] See, for examples, Health Care Advisory Panel, *Improving Health Coverage in the District of Columbia* (May 2006), 14-16; Health Management Associates, *Assessment of State Options for Expanding Health Coverage: A Report to the Health Insurance for Indiana Families Committee* (Dec. 2003).

[49] See The Commonwealth Fund, *Illinois: Universal Coverage for Children* (Spring 2005).

[50] Deborah Chollet, *Approaching Universal Coverage: Minnesota's Health Insurance Programs* (February 2003).

[51] Estimates for 2002. The exact percentages are: top 10 percent - 64%; top 5 percent – 49%; top one percent – 22%. William W. Yu and Trena M. Ezzati Rice, *Concentration of Health Care Expenditures in the U.S. Civilian Noninstituionalized Population* (Agency for Health Care Quality and Research, Statistical Brief #81, May 2005).

[52] Nancy Turnbull and Nancy Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market–Findings from a Study of Seven States* (The Commonwealth Fund, February 2005).

[53] As of 2004, 14 states had active reinsurance pools. Iowa (IA Code 513C.10) was one of 7 states with inactive pools. See Deborah Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage* (Academy Health: State Coverage Initiatives, October 2004), 2-3.

[54] Deborah Chollet, *The Role of Reinsurance in State Efforts to Expand Coverage* (Academy Health: State Coverage Initiatives, October 2004), 2-3. For the Iowa version see Senate File 2215.

[55] See Healthy New York, *Coverage for Eligible Small Businesses, Sole Proprietors and Individuals* (2003).

[56] Katherine Swartz, *Reinsurance: How States Can Make Health Care Coverage More Affordable for Employers and Workers* (The Commonwealth Fund, June 2005).

[57] Recent proposals in West Virginia and Rhode Island are profiled in The Commonwealth Fund, *States in Action* (March 2006).

[58] State of Washington Health Care Authority, *Study of Washington State Basic Health Program* (July 2002); Economic Opportunity Institute, *Washington's Basic Health Plan*, (October 2005).

[59] The Blouin campaign outlined a series of proposals aimed (in turn) at seniors, kids, women. Representative Fallon came out in favor of universal health care but his plan offered few details. The Culver campaign had sketched a fairly detailed health care plan, built around expanded eligibility for SCHIP (including parents of SCHIP eligible kids), a sliding-scale open enrollment in SCHIP for all children in Iowa, and open enrollment in the State Employee Health Plan for individuals and small businesses. The Nussle campaign had no specific health-care proposals as of this writing.
[60] John Holohan et al, *Roadmap to Coverage: Synthesis of Findings* (Blue Cross-Blue Shield Foundation of Massachusetts, October 2005), 7-11.
[61] See National Academy for State Policy Research, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine* (June 2004). The current health plan, DirigoChoice, is offered by Anthem Blue Cross of Maine.
[62] For the cost savings, see *Decision of the Board of Directors of Dirigo Health on Aggregate Measurable Cost Savings for the Second Assessment Year* (2005); Enrollment estimates are from the Dirigo Health website,
[63] John McDonough, *The Road to Universal Health Coverage in Massachusetts: A Story in Three Parts*, *New England Journal of Public Policy* 20:1 (2004-5).
[64] Details of the Massachusetts plans drawn from Commonwealth of Massachusetts, Executive Office of Health and Human Services, *Section 1115 Waiver Amendment* (June 2006); Kaiser Commission on Medicaid and the Uninsured, *Fact Sheet on Massachusetts' New Initiative To Cover the Uninsured* (April 2006), 1-2; *In Massachusetts, Health Care for All?, Business Week* (April 4, 2006).
[65] See, for example, Nina Owcharenko and Robert Moffit, *The Massachusetts Health Plan: Lessons for the States* (Heritage Foundation, July 2006).
[66] Christina Kent, *Vermont Approves "Catamount Health" Chronic Care Initiative*, *State Health Care Notes* (May 15, 2006).
[67] *Massachusetts-Style Coverage Expansion: What Would it Cost in California?,* (CHCF, April 2006), 4-12.
[68] For purposes of comparison, Table 2 uses the average for 2003-4 as its most current measure.
[69] Elaine Ditsler, Peter Fisher, Charles Bruner, *A Chronic Budget Crisis: Can Iowa Keep its Promise?* (Iowa Policy Project, January 2005).