Notes from the Laboratories of Democracy: State Government Enactments of Market- and State-Based Health Insurance Reforms in the 1990s

Charles Barrilleaux
Florida State University

Paul Brace
Rice University

Abstract  We identify two policy strategies that state governments pursue to reduce uninsurance, and we classify policies as being either state based or market based. The two policy strategies are distinguished by whether states rely on the institutional capabilities of the state or market processes to provide insurance. We develop and test models to explain states’ adoptions of each type of policy. Using Poisson regression, we evaluate hypotheses suggested by the two strategies with data from U.S. states in the 1990s. The results indicate that institutionally more-capable state governments with strong liberal-party presence in the legislature adopt more state-based policies and fewer market-based policies. By contrast, the model of market-based, business-targeted reforms reveals that government capability plays a smaller role. Instead, these policies are driven by economic affluence, political competition, higher incomes, greater uninsurance, and more previous attempts to address the uninsurance problem.

These findings reveal distinct institutional, partisan, electoral and demographic influences that shape state-based and market-based strategies. First, policy choices can be driven by the presence or absence of state capability. The domain of feasible policy choices open to states with institutional capability may be decidedly different than that available to states with fewer institutional resources. Second, while market-based policy approaches may be the most feasible politically, they may be the least successful in remedying practical uninsurance issues. These results thus reveal that institutional characteristics of states create an important foundation for policy choice and policy success or failure. These results would suggest that the national government’s strategy of pursuing market-based solutions to the problem will not result in its being solved.

Data to replicate the analysis will be available at the Interuniversity Consortium for Political and Social Research publication-related Web site at www.icpsr.umich.edu. We are indebted to Brad Kile for his assistance with the section on State Children’s Health Insurance (SCHIP).
The United States is beset with the difficult-to-solve problem of having millions of citizens without health insurance. Health insurance coverage expanded incrementally during the twentieth century, resulting in the patchwork system of coverage that now exists. Many Americans received insurance during World War II and immediately after, when employers responded to federally imposed wage freezes with health and pension benefits meant to attract and retain workers. Those benefits were institutionalized in the immediate postwar years via legislation mandating favorable tax treatments of employer-provided pension and health insurance benefits, giving rise to the current system of health insurance, which is geared toward providing coverage through the workplace (Pauly 1986). Insurance coverage for the poor and the aged was provided by the creation of Medicaid and Medicare, respectively, in 1965, and those programs provide coverage for millions of Americans. Coverage for children was expanded with the State Children’s Health Insurance Program (SCHIP) in 1997. Following this nearly seventy-year stretch of policy expansion, a large block of Americans — around 46.6 million — has proved to be difficult to insure and forms the base of the present uninsured population.

Beginning in the late 1980s and through the 1990s, states and the national government passed numerous policies intended to solve the problem of insurance coverage. The problem has proved tenacious: despite state-level policy activity, despite the Clinton administration’s attempt to reform the full health system, despite the economic boom of the 1990s, and despite the second Bush administration’s touting of health savings accounts and attempts to limit medical liabilities, millions of Americans have no health insurance. The number of uninsured people has crept up annually since the 1990s, and in 2004 the number was reported by the U.S. Census Bureau to have reached 45 million, more than 15 percent of the total U.S. population (Isaacs and Knickman 2004). This percentage is roughly consistent with that reported in the mid-1990s, when it averaged around 16 percent annually (Loprest and Gates 1993). The extent of the uninsurance problem varies considerably among the states. Recent estimates show the percentage of uninsured nonelderly to range from about 9 percent in Minnesota and Rhode Island to more than 25 percent in New Mexico and Texas (Glied and Gould 2005: 260–261). Recent estimates reveal uninsurance among eighteen to sixty-four-year-old noninstitutionalized civilian population to have increased in most states in the 1992–2001 period (Nelson et al. 2004).

One of the recurring themes to emerge from work published throughout the 1990s was that state governments would, ideally, function as policy
laboratories whose initiatives would provide information about the viability of particular approaches to health care reform (see, e.g., Sparer and Brown 1996). Sparer (2003) finds that the most promising innovations in this period were in programs financed primarily by federal dollars such as Medicaid and SCHIP. He views intergovernmental partnerships as the most promising avenue for innovative health policy leadership but notes states appeared reluctant to spend their own funds on programs for the uninsured. He finds that state efforts to make private insurance more affordable for the small-business community and to regulate the managed care industry were largely unsuccessful.

In this good news–bad news scenario, it looks like the news is mostly bad. While potentially capable of expanding federal-state partnerships, the federal proportion of total health care expenditures declined since 1990 (U.S. Census Bureau 2006). At the same time, the state proportion of total health care expenditures remained constant at slightly less than 14 percent.

Two Logics of Health Insurance Policy

During the 1990s, most states enacted some state policies (distinct from federal-state partnership policies) designed to improve the extent of health insurance coverage among their citizens. Consistent with the history of health insurance policy debates in the United States, which focus on the efficacy of private versus public provision of insurance (Fuchs 1986), the majority of the 1990s policies may be categorized as being either market based or state based. With market-based policies, state governments seek to improve health insurance coverage by introducing incentives for individuals and businesses to purchase insurance. By contrast, state-based policies use the state as an insurer, assuming risk. Distinct assumptions about the nature of health insurance underlie each approach. The market-based approach assumes that health insurance can be provided via a free-market mechanism when the correct incentives are in place. The state-based approach assumes market failure in health insurance and relies upon the state in place of a free market. The market-based approach relies on voluntary behavior by individuals, firms, and insurers, and the state-based approach relies on coercion. Proponents of market-based approaches commonly underscore the efficiency of this approach, while state-based proponents commonly point to perceived inadequacies in the depth or breadth of market provision.

We identify models containing variables that explain states’ enacting market-based and state-based policies to address the health insurance-
coverage problem. We estimate these models empirically and assess the extent to which they account for the number of state policy adoptions of private- and public-sector approaches to solving the uninsurance problem. The results illustrate how states’ institutional, political, and socioeconomic contexts lead to the enactment of market-based and state-based policies to mediate the same public problem. They also demonstrate that these forces may operate simultaneously within a single jurisdiction. Most notably, the institutional capacity of states is positively related to government-based strategies and inversely related to market-based strategies. In sum, choices are conditioned by the institutional capacity of the states.

Understanding the dynamics that produce either market-based or state-based health policies helps explain why the insurance-coverage problem continues despite these policy adoptions. In addition, understanding what influences state health policy making may prove valuable as state governments seek to reform Medicaid, in some cases privatizing the program by placing current Medicaid enrollees in programs more like those presently covering Americans whose premiums are paid privately. Additionally, state governments’ experiences in crafting policies to expand insurance coverage may prove instructive for understanding state actions vis-à-vis Medicaid reform.

**State Governments and Health Policy**

American state governments play important and enduring roles in the provision and regulation of health services (Leichter 1996). Because the uninsured are for the most part employed and earn wages that exceed Medicaid means-test amounts, they do not have access to services provided by states’ Medicaid programs (Thompson and Nathan 1999). In addition, SCHIP, the single new welfare medicine program of the past generation, is aimed at children and as a result does not cover the working poor, who make up a large part of the uninsured population. The absence of insurance limits individuals’ abilities to seek medical care and, when care must be provided, exposes providers to financial losses from not being paid or to costs of seeking payment for bad debts. Providers understandably wish to be paid for their services and may refuse to treat the uninsured, increasing problems of access for the poor or working poor. State governments face compelling incentives to address the problem. States’ budgets are confronted with increasing Medicaid expenses in the face of increased budget constraints. In 2005, reducing Medicaid expenses was the central item on the National Governors Association agenda, with that organization calling for radical reform of the program. According to
the association, the program should be greatly restructured, a move that would include tightening eligibility requirements and no longer serving as the principal mechanism to provide access to long-term care (National Governors Association 2005). And it gets worse: Medicaid spending increases since 1998 are only about one-half the size of price increases in private coverage over that same period (Holahan and Ghosh 2005). Thus, uninsurance pressures come from public and private programs, with each creating pressures that make insurance more expensive and difficult to gain for the uninsured.

Numerous legal, political, financial, and managerial barriers place constraints on the tools available for states that wish to address the uninsurance problem. The Employee Retirement Income Security Act (ERISA), enacted by the U.S. federal government in 1974, constitutes the greatest single legal barrier to state enactments of health reforms. ERISA was passed by a reform-spirited Congress to assure the safety of employee pensions and benefits. Although ERISA does not explicitly prohibit a wide range of strong state regulations, the key ERISA provision that limits state regulation of health insurance coverage holds that the act, as federal law, supersedes any state regulation of pension or health benefits. States may regulate health benefits indirectly through their power to regulate insurance within their borders, but some employers avoid this regulation by self-insuring. Practically, this means that many large businesses self-insure, so the state’s ability to influence business purchase of insurance comes largely in the small-business sector (Employee Benefits Research Institute 1997). This immediately makes the states’ problem greater: small businesses represent relatively diffuse blocs of risk and as a result are difficult to organize for purposes of insurance. Another hurdle to state action is the cost of insuring the uninsured: most state governments do not have the budgetary slack to take on the task of either purchasing insurance for or bearing the financial risk of providing insurance to their citizens. Additionally, there is a significant political barrier to government involvement in health insurance. Americans are reluctant to embrace state action to mitigate social problems, including health care problems (Skocpol 1993), so states may not have public support for enacting policies that require strong state action. Finally and possibly most important, state governments contend with what Lindblom (1977: 170–188) described as “the privileged position of business” in market-oriented systems. Business interests may limit governmental actions through their explicit or implicit expression of disapproval. Providing insurance to the uninsured, whether it is through a state-financed program or mandates on employers, is unlikely to be embraced
widely by business and especially not by small businesses. The cumulative effect of these limits to state government action is that governments must focus their policy efforts on groups that are poorly organized and have disparate demands—the working poor, persons employed by small businesses, and small-business owners—and must seek ways to provide insurance that require neither state funding, which is scarce, nor strong state action, which is limited by ERISA and by state governments’ inherent institutional and political limitations. Given this, the fact that states do anything about providing insurance for the uninsured may be surprising in itself. Below, we describe and seek to explain the types of policies states pursue.

State-Based and Market-Based Health Policies

The trade-off between public and private solutions to the health insurance problem has long been a part of the U.S. health policy debate (Weissert and Weissert 2002). State-based policies typically carry a rights orientation and involve commitment of state money and managerial expertise. Their passage invokes traditional welfare politics, and this creates difficulties in an era in which traditional U.S. welfare models are under close scrutiny even among their supporters (Skocpol 1993). Although they exact high financial and political costs, the virtue of traditional welfare models is that they are effective in delivering coverage to more commonly uninsured populations. Market-based health policies typically use the workplace as the entry into health insurance and require a diminished state role in management and virtually no immediate financial risk to the state. Proponents of the market-based approach argue that these policies are most appropriate because they provide businesses assistance and, as a result, serve an economic development function (Battistella and Kuder 1993). They offer advantages in that they are seemingly financially inexpensive and politically expedient. Early observers were hopeful that they might help increase insurance coverage (Battistella and Kuder 1993; Rousch 1994;
Morrissey and Jensen 1996; Hall 2000). Unfortunately, evidence of the effects of market-based policy interventions in seven states suggested that those policies achieved mixed success; they encouraged the development of new health insurance markets but did not demonstrably increase insurance coverage (Hall 2000). Evaluations of the mid-1990s reforms showed an increase in the number of firms offering insurance to their employees but no increase in the number of persons opting for the coverage, likely due to high out-of-pocket costs for workers (Sloan and Conover 1998; Jensen and Morrissey 1999).

Varieties of State Health Reform Strategies

State governments might plausibly pursue any of several strategies of health policy reform. First, they may choose to do little regarding uninsurance, enacting few or no reforms and relying on the national government or good fortune to remedy the uninsurance problem. While this is inexpensive in the short run, it provides no assurance that something will be done to mitigate the problems of inadequate insurance coverage, as even national policies can be expected at best to provide variable solutions to uninsurance across the states (Glied and Gould 2005). Second, states might choose a mix of state-based and market-based reforms to create a balanced policy portfolio. A balanced set of policies might provide some benefits: relying on state-based policies would ensure that coverage is provided to certain blocs of the population and might provide a fallback in the event of rising unemployment, which would lead to a reduction in employment-based coverage. By contrast, effective market-based policies limit the state’s financial obligations during times of economic prosperity. Third, states may follow purely state-based or purely market-based policy strategies. With a wholly state-based policy portfolio, states assume large financial risk but receive great assurance that citizens will receive coverage through active state intervention. With a market-based policy focus, legislatures may claim credit both for addressing the uninsurance problem and for improving the business climate, and the state assumes little financial risk. However, the ultimate adequacy of this approach turns on the incentives offered to business and the insured. It is one thing for employers to offer insurance benefits, but it is another to make those benefits truly accessible to employees. Much like Otto von Bismarck setting retirement at seventy because few lived that long, market-based solutions might hold false hope if they were realistically out of reach of the target populations. Passing such policies might solve a political imperative to take action
while not adequately addressing the uninsurance problem. Alternatively, selling state-based strategies in the modern era may be politically untenable even if the ultimate effects were beneficial for providing more broad-based insurance coverage.

To what extent do states act on these different approaches to policy? We construct two measures of state health policy adoptions to illustrate the range of state-based and market-based activities that existed during the mid-1990s, the heyday of state government attempts to expand the scope of coverage. State governments enacted numerous policies during that time, and the handful selected for inclusion in the measures best fit the distinction developed here.

State-Based Policies

Three non-Medicaid policies adopted by states fit the redistributive, state-based, public-sector approach to addressing the uninsurance problem. We focus on non-Medicaid redistributive policies because they, like the developmental policies, are not supported by national government finances. Research in income redistribution reveals that policies funded solely from state coffers are the products of different politics than policies that receive national government funds (Barrilleaux and Bernick 2003). Medicaid is paid for jointly by the states and the national government. By 1995, twenty-six states had adopted state-only Medicaid indigent care programs, but the first of these adoptions occurred in 1967, so the policy is inappropriate for inclusion in our measure. The programs included are:

1. State-only indigent care programs that extend some or all of a state’s Medicaid benefits to specified groups within a state, thus taking advantage of some of the administrative infrastructure set in place by Medicaid, but under which the state receives no national government match for the state-only population costs.
2. Pre-SCHIP child health insurance programs that provide benefits to persons under age eighteen, although the age varies among the states, and are targeted toward a particularly sympathetic welfare population. Nineteen states had adopted child health insurance programs by February 1995. Note that these programs preceded SCHIP, which now has diffused broadly among the states (Volden 2006).
3. Other low income insurance subsidies; twelve states adopted programs that rely on special state programs or state subsidies for private insurance.
4. Universal coverage of citizens. Seven states had adopted legislation calling for universal coverage of citizens by 1995. In these seven cases, the state agreed to accept the risk of those persons not covered under private programs. By 1995, twenty-six states had enacted none of these policies, thirteen had adopted one, five had enacted two, five had enacted three, and one had adopted all four of the policies. The fact that twenty-six states adopted none of these policies by 1995 may reflect the disfavor that now surrounds redistribution as a policy form as well as state concerns about redistributive health care spending, given state governments’ experience with near-constant increases in Medicaid spending.

Market-Based Policies

We measure market-based enactments using Stream’s (1999) index that measures market reforms enacted during the years 1990 – 1995. The index contains items representing five policy domains: access to care, pricing and packaging, purchasing alliances, the definition of small groups, and rating restrictions. Most states adopted some of the ten state market-based policies that address the uninsurance problem. Index scores range from 0 – 10.

1. Access to care. These policies include guaranteed issue of health insurance, which requires insurers active in a state’s small-group market to offer coverage to any group irrespective of health conditions of employees. Another access to care policy, guaranteed renewal assures that insurers continue to cover previously insured groups, even if the covered group has a change in health status. A third access reform, preexisting condition limitation, defines the maximum period that a person may be excluded from insurance due to a preexisting condition. The limits are typically from six to twelve months. The fourth access reform assures portability of care. Portability assures that a person changing jobs is allowed to retain his or her coverage without a waiting period or other limits. Note that these reforms differ from the state-oriented reforms in that they assume that risk will be placed on a private organization rather than on the public (Stream 1999: 516 – 517).

2. Regulations on carrier pricing. These pricing reforms restrict insurers’ rating practices and limit the amount by which premiums may increase.
3. Introduce competition. The principal vehicle for this has been to expand the definition of a “small group,” often from twenty-five employees to fifty, which was expected to induce more companies to enter the health insurance market.

4. Purchasing alliances. Some states sought to jump-start competition by creating purchasing alliances designed to assist small purchasers in driving down prices by banding to increase their numbers to act as larger purchasers in the market.

5. Rating restrictions. Some states place restrictions on the extent to which insurers may define the risk they are willing to insure. States may impose rating bands, which limit the distance between the highest and lowest premium rates that may be charged to employers. Alternately, states may adopt a set of restrictions recommended by the National Association of Insurance Commissioners that establish a sort of “best practices” for insurers to follow. Or states may choose from one of two types of community rating, either full-community rating or modified-community rating (Stream 1999: 517 – 518).

These market-based policies attempt to increase health insurance coverage, but they all rely upon voluntary efforts in the private market to achieve that goal. By the end of the 1990s, only Alabama had adopted none of the market-based reforms. Iowa, North Carolina, and North Dakota had enacted all ten. The median number of policy enactments is seven. It is evident that market-based policies represent the more popular approach for addressing health care problems during the 1990s.\(^2\)

State-based and market-based policies, although directed at the same problem, use different policy tools. In the state-based case, the policies designed to solve the problem rely on states as service providers or financiers. The policies suggest legislative support for a larger state role in the provision of health care inasmuch as the state seeks to expand coverage via direct state activity in the health insurance marketplace. In each of the state-based policies measured here, the state role involves some element of redistribution, as each involves using state resources to provide benefits to people who are unable to afford them otherwise. This is a difficult strategy to pursue in the United States, as appeals to the social good often fail when confronted with the reality of costs (Skocpol 1993).

\(^2\) Medicaid expansions were, of course, the largest area of expansion during this period, and SCHIP dominated the years immediately following the period covered by these data. However we limit our focus to state-paid policies as we seek to isolate independent state government actions (i.e., actions not driven by federal government incentives).
Market-based policies seek to coerce businesses to purchase insurance or, in the case of risk pools, use state leverage to reduce insurance prices (but without imposing a cost on insurers). Here, the policies are presented as a means for saving businesses money while reducing uninsurance (Rousch 1994) and thus may be viewed as policies that aid in the development of the state’s economy (Eisinger 1988; Brace 1993; Peterson 1995). We expect policies defining the insurance problem in welfare terms and those defining it as a market problem to be the products of different political and economic circumstances in the states.

States are arrayed by their state-based and market-based policy adoptions in table 1. We view states with higher state-based policies as high-redistributive states. Additionally, states with more market-based policies are categorized as higher-developmental states. We place states with zero or one state-based adoption in the low-redistributive cell and those with two or more adoptions in the high category. “Low” market-based policy activity is defined as four or fewer policy adoptions, “medium” activity is five to seven adoptions, and “high” market-based policy adoption is eight to ten of the policies. Immediately obvious from the array is that, in the mid-1990s, market-based health policies were more popular among states than state-based health policies. Twenty-three states are included in the high market-based policy category while only eleven states are in the high state-based policy group.

These data reveal no pattern linking the two types of policy adoptions. Tests of association for the table yield no statistically significant relationships among the patterns of policy adoptions among the states. The likelihood ratio chi-square statistic is 0.57 ($p = 0.75$), and the tau, statistic is -0.093, indicating a weak negative relationship between the two measures.\(^3\) These data illustrate that states do not choose one or the other approach in a clearly patterned way. We recognize that there are differences in the internal contents of the states’ policies (i.e., guaranteed issue in state A may be more stringent than in state B). Nonetheless, the measures presented meet our goal of describing the general contours of state policy adoptions even if they miss some of the nuances of policies.

However, if we consider the approaches to reform discussed in the preceding section, the five states in the northwestern cell are pursuing a path of little activity with regard to health insurance legislation. States in the

\(^3\) We defined the cuts in a variety of ways, including a two-by-two array with states at or below the median in either category coded in the low cell and the others in the high cell, and we find no statistically significant patterns.
northeastern cell are pursuing the strategy of low (or no) state-based and high market-based policy enactments. States in the north-central cell are pursuing modest market-based policy adoptions but eschewing state-based policies. The two states in the southwestern cell are noteworthy in their adoption of no market-based policies, and the states in the middle-southern and southeastern quadrants are devising what might be viewed as the most balanced health policy sets, with moderate and high market-based adoptions and high state-centered adoptions.

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<tr>
<th>Source</th>
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<td>Note</td>
<td>The numbers of states' redistributive and developmental enactments, respectively, are noted in parentheses following state names.</td>
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The Sources of Reform Legislation

As noted in the introductory section of this article, the core question driving this analysis is that of why states adopt state-based and market-based health reform policies. We test a model of state health policy making in which state actions are determined by a mixture of political and economic factors. If, as has been argued elsewhere (Lowi 1972; Baumgartner and Jones 1993; Salamon and Lund 1989; Schneider and Ingram 1993), different policy tools may bring into play differing politics, two distinct views of health politics should emerge from our estimates. We expect different dynamics when predicting the influence political and economic factors have on the enactment of state market-based and state-based policies.

Dependent variables for the analysis are the number of adoptions in each area enacted in each state by February 1995. Data for the dependent variables were collected from a report by the Intergovernmental Health Policy Project (1995) and represent policy adoptions as of the beginning of 1995. We consider the sums of the adoptions of four redistributive health policies and the ten developmental policies discussed above. Models are estimated using a Poisson regression model (Maddala 1983; King 1988, 1989; Liao 1994). The Poisson regression model was the appropriate specification, as indicated by the statistical test, to denote that the conditional mean was equal to the conditional variance, thus allowing us to reject the need to specify the model using the negative binomial.

The models of state health policy making focus on both internal and external influences on state decisions. Four of the internal influences are intended to capture behavioral and institutional characteristics of state politics. The two behavioral measures represent liberal-party strength and electoral competition. The first is included to account for the policy motivations of political parties and the latter to account for parties’ electoral motivations (see Aldrich 1995; Barrilleaux, Holbrook, and Langer 2002). Liberal-party strength is expected to be associated positively with

4. We estimated the models using Poisson and negative binomial estimators. The negative binomial is appropriate in some instances, particularly where the data are overdispersed. The negative binomial estimates indicate no evidence of overdispersion (i.e., the overdispersion parameter was not statistically significant), leading us to reject that specification. We also conducted regression-based tests for overdispersion in the Poisson estimates, using a method devised by Cameron and Trivedi (1990), again finding no evidence of overdispersion. King (1989) offers a generalized event count estimator, which is appropriate in the event that the data are underdispersed. Underdispersion might occur if the act of enacting one of the policies were expected to reduce the chance that another would be adopted. There is no conceptual basis for expecting these data to be underdispersed.
state-based policy activity and negatively with market-based policy activity. Liberal parties should enact more state-based policies both as an expression of politicians’ ideological preferences (Erikson, Wright, and McIver 1993) and as a reward for constituent support (Brown 1995). Electoral competition, conceived as the closeness of races in terms of votes, rather than as the distribution of seats in the legislature or other offices, is expected to be associated negatively with state-based policy adoptions and positively with market-based policy adoptions. Since the effects of ideology are controlled, electoral competition should induce candidates and parties to propose policies that appeal to the median voter, irrespective of the policies’ ideological caste (Barrilleaux, Holbrook, and Langer 2002). During the period under study, the first half of the 1990s, welfare policies were in disfavor among the American public, as was the general idea of expanding state power (Teles 1996), leading us to expect electoral competition to be associated inversely with state-based enactments and directly with market-based policy proposals.

Two institutional characteristics are measured: institutional capability of state government and indication of a state’s other health reform policy making. They are included to account for the effects of the relative abilities of state governments to address public problems and for the effects of prior learning and custom on policy making. Stronger state institutions are linked to more innovative public policy making generally (Hedge 1998; Brace 1993). Leichter (1996) identifies the quality of state institutions as a crucial ingredient for establishing states’ abilities to undertake health reform. More-capable state governments should produce more state-centered policy solutions, as the strength of governing institutions is an important determinant of both what polities do and how they do it (Steinmo and Watts 1995). Strong governing institutions have well-established organizational and political capacity and organizations that have bureaucratic and political incentives to build their budgets and authority. Moreover, stronger institutions exist in states in which citizens are relatively more liberal and have a greater preference for public-sector solutions. Given this, we expect state-based policy enactments to rise with increased governmental capability. Conversely, we expect market-based policy enactments to be associated inversely with the capability of state governments, as those policies do not rely upon the presence of a strong state for their implementation or finance. We construct a score that captures the strength of state executive-branch and legislative-branch offices by factor analyzing indicators of the quality of state executive-branch administration (e.g.,
numbers of publications, proportion of public employees covered under civil-service protection, salaries of public employees) and the resources available to legislative staff (e.g., salaries, size of staff, staff education). The measure is described in the appendix.

The second indicator is intended to capture the extent to which health policy making is institutionalized within states. Governments are often cautious in policy making and are reluctant to move into areas in which they have limited expertise (Lindblom 1968). Upon developing a track record in a policy domain, however, the hurdle to initial policy adoptions is lowered, and governments build upon their new expertise by enacting additional public policies or reforming those on the books. The measures used here are the counts of each state’s total 1990s health reform policy adoptions less the policies counted as dependent variables in these models. Scores are scaled so that their means approach zero. These reforms focus on four distinct areas: market-based reforms, state-based reforms, provider and insurance regulation, and Medicaid reforms. In each of the two models, the indicator counts all the reforms excepting those in the area of interest (i.e., in the market-based model the variable is all reforms less the market-based enactments, and the state-based model variable includes all reforms but the state-based enactments). The intent with this measure is to account for a state’s tastes for health reform as revealed by past actions; more active states are viewed as being more aggressive in seeking health care solutions in other areas and as a result are expected to be more active with respect to the policy adoptions that are of interest here. We expect a positive slope in each of the models.

Aside from the behavioral and institutional influences discussed above, we consider two additional terms that are internal to the states and one term to test for the effects of external influences. Among the internal influences, we measure the percentage of employed persons who are uninsured to indicate the need for relief and the demand for policy action. We assume that state governments are, for the most part, responsive to public problems. Early experience with the Clinton administration’s attempt to reform health insurance and various states’ reforms illustrate both the salience of the problem to large portions of the public and the initially nonpartisan nature of the issue (Nelson 1994). We expect the count of each type of policy enactment to rise with decreased insurance coverage because both types of policies should emerge where the demand for solutions is greatest. The second internal characteristic considered is state wealth, measured as per capita personal income in 1990, which is expected to influence the
number of policy adoptions in each area positively. State wealth has long been recognized as a factor influencing state policy making. Following a well-established logic (e.g., Dye 1966), we expect richer states to enact more of both types of health reform policies.

States are expected to consider neighboring states’ actions when choosing to adopt policies in either policy domain. Research on welfare policy points to two distinct possibilities: states may view their neighbors as sources for innovative policy, including policies that expand the state role as a provider of services (Beamer 1999; Volden 2006), or states may engage in a race to the bottom in which they compete with their neighbors to provide the least generous benefits (Peterson 1995; Berry, Fording, and Hanson 2003; Bailey and Rom 2004). Some existing research shows limited empirical support for a competition effect among states in health policy making (Kenyon 1996). To test the competition thesis, we expect states’ redistributive policy scores to decline where at least one among their neighbors is higher than average. The logic of the “race to the bottom” holds that state governments seek to provide less-generous state-based policy bundles than their neighbors in order to avoid being welfare magnets. If that is the case, they may also wish to do the opposite with market-based policies, given their portrayal as being friendly to business. Hence, we expect states’ market-based policy scores to increase where at least one among their neighbors is higher than the average.

The general model for explaining variations in state policy adoptions in each policy domain is expressed:

\[
policy_i = \text{constant} + \text{legislative liberalism}_i + \text{electoral competition}_i + \text{institutional capability}_i + \text{prior adoptions}_i + \text{uninsurance}_i + \text{income}_i + \text{neighbors’ adoptions}_i + \epsilon_i
\]

Where, for the \( i \)th state, \( policy \) equals the count of all possible policy adoptions in each area, the constant represents the point of origin for the regression line; legislative liberalism is the average percentage of each state’s lower house (except in unicameral Nebraska) in the Democratic party, weighted by ideological liberalism within the state and calculated using data for the years 1986–1992; electoral competition is Holbrook and Van Dunk’s (1993) district-level measure of electoral competition, averaged for the years 1986–1992; institutional capability is the mean of a factor measuring legislative professionalism constructed by Bowman and Kearney (1988) and a factor measuring state executive branch capability, scaled so that low product scores represent low capability and high scores...
high capability; prior adoptions is the count of other state health reforms adopted, excluding adoptions for the non-Medicaid poor and for businesses in each respective model (Intergovernmental Health Policy Project 1995); uninsurance is the percentage of each state’s employed population not covered by health insurance in 1990 (Loprest and Gates 1993); income is per capita personal income in the $i$th state in 1990; neighbor’s adoptions are coded 1 if any of a state’s neighboring states is above the national median in the percentage of policies that have adopted in each area (i.e., distinct measures are used in each model); and $E$ is a stochastic error term. Data sources and calculation are described in the appendix.

Results

Estimates of the two models are displayed in table 2. Each is statistically significant overall, and the directions of the coefficients support our expectations with few exceptions. The two measures of political behavior—legislative liberalism and electoral competition—perform differently in each of the two models. In the state-based policy model, the measure of electoral competition is positive but is not statistically significant. By contrast, electoral competition is positive, as expected, and statistically significant in the market-based policy model. A state at the mean of electoral competition, holding all other forces constant, would be expected to have about 0.4 total market-based adoptions. Moving competition up or down one standard deviation from the mean produces only about 0.10 additional enactments, so the effects of electoral competition are not especially strong.

Legislative party liberalism has a significant positive effect on state-based policy adoptions and a negative but statistically insignificant effect on market-based adoptions. At the mean value of liberal-party strength, a state would adopt 1.6 redistributive policies, and a state one standard deviation above the mean would produce 2.1 redistributive policies. A state one standard deviation below the mean of legislative party liberalism would adopt about 1.1 redistributive policies.

5. We tested two additional measures in the models to assess the effect of Medicaid programs on health reforms. First, we included a measure to indicate whether states have Medicaid state-only programs to determine whether the presence of that program influences state behavior with regard to the adoption of either set of policies. It has no significant effect and does not meaningfully affect the results we report. Second, we tested for the effects of Medicaid spending effort, defined as indigenous Medicaid spending as a ratio of total personal income within states. It had no meaningful effect and does not alter the results we report.
The measure of institutional capability enters each model significantly and supports our expectations, evincing a positive effect on the number of state-based policy enactments and a negative effect on the market-based policy adoptions. Because the independent variable’s mean approaches zero, the expected number of state-based policy adoptions when institutional strength is fixed at the mean also approaches zero (0.0002). A score one standard deviation above the mean in the institutional capability score results in a 0.48 increase in state-based policy adoptions (0.54 × 0.88), while a score one standard deviation below the mean produces 0.48 (0.54 × 0.88) fewer policy adoptions. The effect of institutional capacity on market-based policy enactments is the opposite. States at the mean value of institutional capability are estimated to adopt -0.0001 developmental policies and states one standard deviation below that mean are predicted to enact 0.25 more policies (0.28 × 0.88) while those one standard deviation above the mean will enact 0.25 (0.28 × 0.88) fewer market-based policies. In this case, greater state capability reduces state efforts to promote market-based policies. This is a unique result, as the majority of research links heightened institutional capability to increased government activity (Walker 1969; Grupp and Richards 1975). This result links greater capacity to greater reliance on state-based policy changes and a lesser reliance on market-based policy.

The effect of demand as expressed through the percentage of people

| Table 2 Poisson Regression Estimates of State-Based and Market-Based Health Reform Policy Enactments |
|----------------------------------|------------------|------------------|
| Independent Variables            | Redistributive Policies | Developmental Policies |
|                                 | Coefficient | error | t   | Coefficient | error | t   |
| Liberal Party Strength           | 0.03        | 0.01   | 2.09* | -0.005      | 0.005  | -1.13 |
| Electoral Competition            | 0.01        | 0.02   | 0.79  | 0.009       | 0.005  | 1.55** |
| Institutional Capability         | 0.55        | 0.23   | 2.43* | -0.28       | 0.09   | -3.09* |
| Uninsured Workers                | -0.12       | 0.07   | -1.91* | 0.05       | 0.02   | 2.59* |
| Personal Income/Capita           | -0.05       | 0.03   | -1.80* | 0.02       | 0.01   | 1.76* |
| Prior Adoptions                  | 0.11        | 0.06   | 1.65* | 0.11       | 0.03   | 4.34* |
| Neighbors                        | -0.38       | 0.44   | -0.86 | 0.01       | 0.14   | 0.08  |
| Constant                         | 1.45        | 2.12   | 0.68  | 0.36       | 0.71   | 0.51  |

N = 50

χ² = 29.31; p < 0.001
χ² = 26.22; p < 0.001

*Probability t < 0.05, one-tailed test
**Probability t < 0.10, one-tailed test
uninsured likewise differs in the two models. Increases in those lacking insurance are linked to fewer adoptions of state-based policies and more adoptions of market-based policies. The effect is significant in each of the two models. A 1 percent increase in those lacking insurance leads to the adoption of about 1.8 fewer state-centered policies (when insurance coverage is at its mean of 15.4 percent) and an increase of 0.77 market-based policies. Since the state bears the financial burden of state-based policies and may claim credit for addressing the problem while incurring no substantial immediate financial costs with market-based policy adoptions, this effect is certainly plausible. That is, heightened demand for relief may have the perverse effect of leading state governments to enact policies that attempt to shift the problem to the marketplace. States may be reluctant to intervene actively in the presence of larger uninsured populations, choosing to intervene in situations in which the problem is more soluble and favoring market-based approaches in instances in which the problem appears more intractable. If this is so, positive findings concerning state intervention and the mixed record on market-based strategies may result at least partly from the conditions in which they are implemented.

State governments’ prior adoptions of policies to address the uninsurance problem are associated with higher adoptions of both state-based and market-based policies. A state that is one standard deviation above the mean of all previous policy enactments will adopt about 0.28 more state-based policies than a state at the average. In the market-based policy model, a state one standard deviation above the mean will adopt about 0.29 more policies than a state at the mean. This implies that states continue to seek to find ways to address the problem after their initial attempts to solve it and may indicate the relative intractability of uninsurance. Upon placing the policy on the agenda and acting, states continue to seek solutions. Thus the most difficult hurdle to state action appears to be getting the insurance problem on the legislative agenda.

These results indicate that a state at the mean of per capita income will adopt about 1.62 fewer state-based policies, all things being equal. States with average per capita incomes will adopt 0.62 additional market-based policies. Clearly, the poorest states are less likely to enact state-based

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6. We expected both sets of policy adoptions to be associated positively with income. To amend our prior expectations, we hypothesized that the negative effect of income on redistributive policy adoptions may reflect the fact that wealthier states entered the 1990s, the period during which we measure policy adoptions, with more redistributive health policies in place and as result turned to developmental policies in their stead. To test this, we reestimated the model with a measure of whether a state had adopted a state-only indigent policy (a state-financed
policies than their wealthier cohorts are but are more likely to resort to private-sector solutions to the problem than wealthier states are.

Neighboring states’ adoptions exert no statistically significant effect on state-based or market-based policy enactments, although the signs of the coefficients are as expected. The lack of significance in this variable suggests that states do not compete or emulate their neighbors in either state-based or market-based health insurance policies.

**Discussion and Conclusion**

Estimation of models of state-based versus market-based policies designed to address the insurance-coverage problem leads to different conclusions about the nature of state health policy making. State-based policy making increases in states where liberal parties are stronger, elections are less competitive, institutions are stronger, and the state has been more active in passing health reform policies. The number of state-based policies adopted lessens in the face of higher incomes and rising uninsurance. By contrast, the model of market-based reforms links governmental capability to a lower number of adoptions. Additionally, greater electoral competition, higher incomes, greater insurance-coverage problems, and more prior policy adoptions are shown to result in more adoptions. In sum, institutionally more-capable state governments with strong liberal-party legislative presence adopt more policies that provide direct aid to the uninsured and fewer policies that rely on private solutions to the insurance-coverage problem. Institutionally less-capable state governments adopt more policies that use the private-sector mechanism to address the insurance-coverage problem and fewer state-based policies.

State provision may be most productive for the uninsured, as evidence suggests that programs that use the state as the locus of insurance are more successful than workplace-based reforms in increasing health insurance coverage (Sloan and Conover 1998). Our results indicate, however, that state-based strategies were more likely to occur in states with lower levels of uninsurance. As noted above, while evidence shows the business-directed reforms to have scant effect on changes in insurance coverage Medicaid add-on) prior to the 1990s. The result was negative, as expected, but not statistically significant. More important, the added term did not alter the signs or significance of other measures in the model, including income. Additional diagnostic tests show the negative effect not to be a result of heteroscedasticity or multicollinearity. It is not unrealistic to conclude that, having held constant the effects of governmental capability and past policy, wealthier states are less apt to adopt redistributive reforms.
(Sloan and Conover 1998; Jensen and Morrissey 1999; Hall 2000), our results also reveal that market-based strategies were more likely to be pursued in states where the uninsurance problem was greater. Paradoxically, state-based strategies are more likely to be pursued in states where uninsurance problems are less severe and political obstacles are less pronounced. Market-based strategies occur more frequently in states where political resistance to state-based measures would be higher but also where the uninsurance problem is greater. The conditions for policy shape the policy strategy and likely many of the effects of that strategy. This set of circumstances is consistent with the history of U.S. health policy decisions. Morone (1990) argues that Americans’ antipathy toward the state weakens any attempt to solve social problems; citizens simultaneously demand that their government solve problems and limit its power to do so by insisting that institutions be weak. Another factor limiting states’ abilities to address insurance-coverage problems is the tendency for citizens to link health care issues with broader welfare issues, ensuring that health policy issues get conflated with broader welfare issues, often thwarting improvements in health policy (see, e.g., Kronebusch 2001). Strong state institutions result in state-based solutions to problems. In the absence of strong state institutions, private-sector institutions fill the void and, not surprisingly, arrive at private-sector solutions to problems.

Skocpol (1993) argues that the persistent failure of national health insurance schemes in the United States is largely political: would-be reformers often assume that the rhetoric of rights will carry the day. Policy changes in health and welfare during the 1990s underscored the limited appeal of rights-based rhetoric (Teles 1996). Given the variable strength of political institutions in the states, targeting business as the beneficiary of health reforms may prove to be a successful strategy for enacting health reforms. However, the mixed results of the 1990s reforms to date suggest that improvements in the manner in which the programs are designed will be needed to ensure that additional enactments are more effective than those put in place through the mid-1990s.

Massachusetts enacted a sweeping reform in 2006 that seeks to blend the market-based designs of past reforms with a state guarantee. The Massachusetts plan, which was championed by a coalition of labor, business, provider, and insurer groups (most notably Blue Cross–Blue Shield of Massachusetts), calls for a number of the coverage reforms that emerged a decade past, but it also charges large employers who do not insure for any state general pool health expenses that accrue to their employees, charges people who have the resources to insure but do not do so for the costs of
any state general pool health expenses that are accrued on their behalf, and seeks to broaden Medicaid coverage. The plan’s proponents argue that it removes the complexity and duplication that has plagued past plans (Haislmaier 2006). Its critics argue just the opposite, claiming that it is unrealistic and is unlikely to reduce uninsurance because it does not get to the root cause of uninsurance, which is that the price of health insurance is simply too high for most people to pay out of pocket, in part because the low price plans that policy makers believe exist do not (Woolhandler and Himmelstein 2006).

Massachusetts’s “hybrid” scheme may ultimately determine whether private insurance models can contribute to solving the uninsurance problem. Part of its ultimate success hinges on the emergence of private coverage that will be affordable for people of modest income (those with incomes at 300 percent of the poverty level) who will be required to purchase insurance. To date, private plans offer the greatest political promise yet do not deliver care. Americans’ beliefs in the virtues of the private market and preferences for private over public provision of various goods and services are well known, so private schemes are most salable. But with health reforms intended to address the insurance-coverage problem, evaluation results demonstrate that the private sector—based policies have had no demonstrable effect on the rate of insurance, while the public programs are associated with some modest increases in insurance coverage (Sloan and Conover 1998). As it is now, there is a standoff: institutionally strong state governments prefer state-based reforms, and those reforms are difficult to secure. Institutionally weak governments support private-sector reforms, and the ineffectiveness of the private-sector programs may be a function of the weak institutional apparatus that surrounds their implementation. Unfortunately the states with the weakest institutions tend to have the highest uninsurance, so state governments are least able to help solve the problem where it is greatest.

Viewing Justice Louis Brandeis’s “laboratories of democracy” metaphor in light of what it tells us about politics, the states fulfill an important role. By evaluating states’ attempts to address the uninsurance problem, we learn that, left to their own devices (i.e., when forced to pay without the federal contributions that accompany Medicaid or SCHIP), states act in ways that may be valuable politically yet do little to solve the problem. Thus, state actions tell us a good bit about health politics. The results vis-à-vis health policy are not so encouraging: if the states are fulfilling their roles as policy laboratories, they are doing it more slowly than was hoped in the 1990s. National policy makers appear to be focusing on the
political lessons of the state experience rather than on the policy lessons. The agenda has changed markedly, especially nationally, with little being said about the prospects for single-payer systems or universal coverage. Instead, the national government focuses on a variety of tax code–based schemes designed to induce individuals to purchase insurance, continues to push for medical savings accounts, and otherwise pursues policies that treat health insurance coverage as a normal commodity despite strong theoretical and empirical evidence to the contrary (see, e.g., Arrow 2001).

One dramatic departure from this trend was the 1997 adoption of SCHIP in which the federal government provided the incentive structure to push states to address the problem of insurance coverage for children. Not surprisingly, states moved relatively quickly to seize the opportunity to develop SCHIP programs that offer a policy option that is both financially and politically expedient. SCHIP appears to signal that policy makers may be resigned to the notion that no combination of policies will adequately address the problem of insurance coverage for all segments of the population. By focusing on children, policy makers can achieve both policy and political goals with relative ease compared to pursuing more comprehensive insurance policies that come with high political costs and uncertain substantive effects on the insurance-coverage problem. Although SCHIP has been threatened in the present wave of state cost cutting, leading the National Governors Association to worry that attempts to broaden coverage through that program would be thwarted (Coughlin and Zuckerman 2005), the election of a Democratic Congress in 2006 may produce increased support for the program.

The wave of state-government policy innovations in health care during the first half of the 1990s provided at least two important lessons. First, it is clear that market-based solutions have not produced increases in insurance coverage. The introduction of SCHIP in the late 1990s and the 2006 enactment of health reform in Massachusetts both appear to recognize this problem. Financed by the national government, SCHIP is a success. The Massachusetts program is yet to be implemented, so it is unclear whether it will succeed. The second lesson is that it is easier and less expensive to enact what are essentially palliative policies that allow elected officials to claim credit for addressing the problem while having no discernible effect on the insurance-coverage problem. It is this second lesson that appears to resonate most strongly with many elected officials, as the national government now pursues several of the market-based reforms first tested in the states, and state governments rely on market solutions to reduce costs. Perhaps most notable is the 2003 enactment of federal policy to expand
Medicare to include outpatient prescription-drug coverage. This policy, which relies on market-based mechanisms funded by the national government to sustain a benefit that marks the biggest expansion of the Medicare program since its inception in 1965, offers policy makers a politically attractive option for addressing a salient problem. Although it is unclear whether the policy will have a discernible effect on the problem of access to affordable medications for Medicare beneficiaries, the fact of its being paid for by the government suggests it has a greater chance of success in its goal of increasing benefits to cover prescription drugs.

Finally, it is striking that, after a decade’s attempts to improve the situation, the percentage of Americans without health insurance is remarkably stable, and states that had high uninsurance in the 1990s have high uninsurance in the 2000s. Whether this status quo will remain in the ensuing decade remains to be seen, particularly given ongoing attempts by state governments to scale back Medicaid.
Appendix: Data Sources

State-Based Policy Adoptions
Source: Intergovernmental Health Policy Project (1995). Alpha = 0.68, range 0–4, mean = 0.84, sd = 1.09.

Market-Based Policy Adoptions
Source: Calculations from data provided by Stream (1999) via personal correspondence. Alpha = 0.95, range 0–10, mean = 6.8, sd = 2.59.

Liberal-Party Strength
Average percentage of each state’s lower house Democratic population, 1986–1994, weighted by Americans for Democratic Action congressional ratings to account for party ideological differences. Source: Berry, Ringquist, Fording, and Hanson (1998). Mean = 54.34, sd = 15.66.

Electoral Competition

Institutional Capability
Average of legislative staff capability and administrative agency capability. Authors’ calculations from data published in Bowman and Kearney (1988) and reported in Barrilleaux, Feiock, and Crew (1992). The factor scores used to construct the executive branch weights are drawn from measures of state employee salaries, education, publications, and administrative overhead. Mean = 0.0004, sd = 0.88

Percent Uninsured
Source: Loprest and Gates (1993). Mean = 15.74, sd = 4.33
Personal Income Per Capita, 1990 (in Thousands)


Prior Adoptions

Authors’ calculations. Mean for state-based model = -6.5E-16, sd = 2.55; mean for market-based model = -5.34E-16, sd = 2.62.

Neighbors

Authors’ calculations. Binary measure, coded 1 if any of a state’s neighbors have adopted more reforms than that state.

References


