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- The Senate Finance Committee's May 14 Report, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*, contains several alternative proposals for a public plan, including a "State-Run Public Option." The state-run option is minimally described in the Finance Committee document as being either "mandatory or optional," with the details of its administration left to the states.

- States already have the authority to create a public plan option. None have done so yet nor seem likely to do so without federal leadership. Leaving a public health insurance plan as an option for the states, therefore, is an illusory approach.

- State employee plans function much like private insurers. They are unlikely to be opened to the general public and do not appear to be a promising approach to controlling the cost of health care and improving its quality.

- The Tenth Amendment prohibits the federal government from literally "mandating" the states to provide a public plan option.

- Congress could, under its interstate commerce regulation authority, invite the states to provide a public plan option and administer a public plan as a "fallback" measure in states that failed to do so. This approach was used to implement the insurance portability requirements of the Health Insurance Portability and Accountability Act. Results were on the whole not encouraging.

- Congress could also encourage the states to implement a public plan by offering incentives under its spending authority. Experience with Medicaid and CHIP demonstrates that this approach results in a dramatic lack of federal uniformity and difficulty in enforcing federal requirements.

- Congress might alternatively use its taxing power to incentivize the states to offer a public plan. This is unlikely to succeed unless the states are otherwise inclined to offer a public plan.

- Congress should give Americans the choice of a uniform, nationally-available, public health insurance option to broaden access, control costs, and improve the quality of health care.

STATE RUN PROGRAMS ARE NOT A VIABLE OPTION FOR CREATING A PUBLIC PLAN

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One of the most promising approaches currently being considered for expanding access to health care for Americans while controlling its costs and improving quality is to create a "public plan" that would compete with private insurers to provide health insurance coverage. The Senate Finance Committee's May 14 Report, *Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans*, contains several alternative proposals for a public plan. This paper addresses one of those proposals, the "State-Run Public Option."[1]

The state-run option is minimally described in the Finance Committee document as being either "mandatory or optional," with the details of its administration left to the states. The proposal further states that "One possible option for the States might be to allow individuals to purchase coverage through the State-employee plans."

The Optional State Approach

It is not clear how giving the states the "option" of creating a public plan would in any way improve our current situation, particularly if the details were left to the states. The states currently have plenary power to regulate health insurance and to establish their own programs to promote the public health and welfare, at least as long as they do not adopt laws that conflict with federal laws and regulations. Current federal law does not significantly limit the ability of the states to regulate insurance as such, indeed the McCarran-Ferguson Act recognizes that the primary authority to regulate insurance resides in the states.[2]

State attempts to create a public health insurance plan could conceivably be limited by the Employee Retirement Income Security Act of 1974, which prohibits the states from regulating employee benefit plans.[3] A state law that required small employers to offer their employees the option of participating in a public plan, for example, might be preempted under section 514 of ERISA.[4] If a state were not allowed to require employers to offer their employees a public plan option, the public plan might be limited to the individual market and to groups in which the employer volunteered to offer a public plan option. This would likely result in serious adverse selection against the public plan, and might result in the public plan becoming essentially a high risk pool rather than a true option available to all. ERISA could be amended to allow states greater flexibility in shaping public plan coverage, but the preemption provisions of ERISA are jealously guarded by the business community because of their desire to be able to provide uniform national benefit plans, and any attempt to amend ERISA to give states greater discretion will be difficult.

The suggestion that states open their government employee's plans to the public generally is also problematic. Each state has a health plan for its employees, some administered by the state's department of administration, some by its civil service commission, some by a dedicated special administrative body, and some by a governing body that includes employee representatives.[5] In some states, the public employee program is governed by collective

bargaining agreements with state employees. Most plans function like self-funded employer plans in the private sector. They offer a PPO plan administered by a large private insurer acting as at third party administrator which manages the plan's provider network, pays claims, handles administrative and actuarial duties, and sets provider payment rates. These plans are virtually indistinguishable from plans offered by private insurers. The state plan usually has to small market share in any particular market to have considerable market power and does not see its mission as improving the quality or lowering the cost of health care. Opening these plans to individuals who cannot find affordable health insurance would not be popular with state agencies or employees, who would see their premiums increase, and would be unlikely to contribute much to health reform.

The biggest problem of relying on the states to offer public options, however, is that they are unlikely to do it. States can already offer a public option, but none have done so (except for high risk pools, which are not the same thing as a true public option and are expensive and poorly subscribed in most states). Health care reform has proved very difficult at the state level, as failed reforms in California, Illinois and other states demonstrate. Reforms opposed by providers or by the business community, who often have even stronger lobbies at the state than at the federal level, are unlikely to happen. Reforms that require state expenditures, particularly in the current tight fiscal environment, are also unlikely. Relegating the public plan to a state option is essentially a polite way of dismissing the idea.

The Mandatory Approach

The other alternative would be to require the states to create a public plan option, the "mandatory" option. The federal government cannot literally "mandate" states to implement a public plan option. The Tenth Amendment has been interpreted to preclude Congress from "commandeering" state government to carry out federal programs.[6] Congress has, however, three constitutional means for encouraging states to implement programs desired by the federal government–the use of its interstate commerce power, the spending power, and the taxing power.

The Federal "Fallback" Approach

First, Congress can, under its interstate commerce power, invite the states to implement federal programs and require the federal government to implement a federal "fallback" program for those states that choose not to accept the invitation. This was the approach that Congress used in 1996 when it adopted the portability provisions of the Health Insurance Portability and Accountability Act.[7] HIPAA invited the states to adopt reforms in the group insurance market (guaranteed issue and renewability and limits on pre-existing conditions exclusions) and individual insurance market (guaranteed issue and limits on pre-existing conditions clauses under some circumstances and guaranteed renewability). The Department of Health and Human Services was designated to ensure that states implemented each of these specific requirements and to use its "fallback" authority to implement the requirements itself against insurers in states that failed substantially to implement any of the requirements or in states that in fact failed to do so.[8] States were given alternative means of implementing the individual mandate, such as the creation of high risk pools.[9]

The results of the law must be regarded as decidedly mixed.[10] Most states had already implemented the group market reforms and those that had not already done so adopted them quickly. The states had been much less active in regulating the individual market and a number of states failed to implement these reforms. Most states that did implement them chose one of the options permitted by the law other than the federal fallback position. In most states the option chosen was to offer individuals coverage in the state high risk pool. Some states, however, simply did not comply. Some of these states notified HHS that they did not intend to comply and helped HHS to itself enforce the law. Others notified HHS that they would not comply at the very last minute before HHS enforcement was to begin and offered HHS no assistance with implementation. Finally, some states simply did not implement parts of the law but failed to communicate this to HHS, leaving HHS uncertain as to how to proceed.

Implementation of the law by HHS was slow and uneven. Repeated GAO reports criticized HHS for its failure to enforce the law and implement the federal fallback requirements.[11] The HHS enforcement effort was understaffed and under-resourced, and regulatory guidance was slow in coming. HHS apparently made minimal efforts to monitor HIPAA compliance by government plans, which was an additional part of its responsibility. Eventually, after more than a decade, compliance was nominally achieved in all states. Testimony presented to the House Oversight Committee last year, however, revealed that compliance oversight at HHS has largely ceased.[12] The four person office at HHS responsible for compliance relies solely on complaints, and has received only five complaints in the last five years. Blatant violations of the individual plan guaranteed renewal provisions widely reported in the press had been completely ignored by HHS.

Several lessons can be gained from this experience. If states are already committed to a policy adopted by the federal government, they will probably implement it. This is not, of course, true with the public plan. If the states are not on board, the federal government must be willing to commit considerable resources to implementation of a fallback program, and must be strongly committed to making it work. But if these conditions exist, why not simply implement a federal program nationwide to begin with?

Use of the Spending Power

The second alternative is to use the spending power to encourage the states to implement a public plan program. The federal government could, for example, offer income-adjusted subsidies for the purchase of health insurance, but only in states that implemented a state public plan option. There are many precedents for the use of the spending power to secure state compliance with federal requirements, most notably the Medicaid and CHIP programs. These programs have in certain respects been very successful. Medicaid makes medical care available to 59 million Americans, most of whom would not otherwise have been able to afford medical care, while CHIP covers 7 million children, many of whom would otherwise have been uninsured.

Neither program has succeeded, however, in implementing a national program. Medicaid eligibility categories and benefit coverage vary widely from state to state, and many individuals eligible to receive a complete range of medical services in one state would be ineligible for

coverage altogether or would receive a much narrower range of services in another. Many states pay providers, particularly physicians, such low rates that recipients find it very difficult to obtain treatment. The 1115 waiver program has led to even greater disparity among the states than that permitted by the statute.[13] Indeed, 1115 waivers have arguably been used by some administrations to permit statutory violations and evade congressional oversight.[14] The states have proven very adept at manipulating federal financial matching funds to achieve state ends through provider taxes, disproportionate share payments, and manipulation of upper payment limits.[15] Neither CMS nor Congress has been completely successful in responding to this manipulation. CMS has rarely challenged state noncompliance with program requirements. This has left enforcement to the federal courts. Litigation by recipients and providers has been common and has often uncovered egregious state abuses. Federal court litigation, however, is not an efficient means for achieving state compliance with federal requirements.

Past experience demonstrates again, that use of the spending power to encourage the states to implement programs is a poor means of achieving a national health policy goal. Implementation is likely to vary significantly from state to state. Some states might create exemplary public insurance plans. Many are likely to implement the minimal program necessary to secure federal funding. The promise that a public plan holds for expanding access and controlling the cost and improving the quality of health care is unlikely to be achieved in this way.

Use of the Taxing Power

The third approach would be to use the taxing power of Congress. Tax credits could be offered to subsidize the purchase of insurance, but only in states that implemented a public program. This was the approach used in implementing the health savings accounts tax subsidies offered by the Medicare Modernization Act. HSAs received federal tax subsidies only when the HSAs were coupled with high deductible health plans.[16] These tax subsidies were only available, therefore in states where high deductible plans were permitted. This in turn meant that some states had to repeal or amend laws limiting plan deductibles.[17] Most states that had provisions limiting high deductible plans quickly fell into line, although a few did not, at least initially.[18] In most states, however, compliance with the MMA requirements necessitated only minor changes in state law, amending a provision prohibiting the imposition of deductibles for home health visits to recently delivered mothers, for example. It did not require states to implement a major new health insurance program and to set up a new structure for administering it. It is likely that such a requirement would be met with much greater resistance and attempts at evasion by the states.

Use of the taxing power, moreover, to implement a new program would probably mean that the IRS would need to oversee implementation. The IRS currently has minimal resources and expertise in dealing with health insurance programs. Although it in fact oversees major health care programs–the employee benefits tax exclusion for example–these programs are largely self-regulating and rarely end up in litigation.[19] Enforcement actions, moreover, are directed at private parties, not at the states. Overseeing the implementation of fifty state public plans would require significant additional resources for the IRS, as well as a major reorientation of its enforcement efforts and philosophy.

Conclusion

We need a national public insurance plan alternative, available equally to all Americans. Expertise exists in the federal government–in OPM which administers the FEHPB, in the DOL which oversees ERISA, in CMS which oversees the Medicare Advantage and Medicare Part D prescription drug program–that could form the foundation for creating a public plan. Relying on the states to implement a national program would be a serious mistake, indeed would likely doom the program from the start.

Endnotes

[1] Labeled as "Approach 3," on p. 14.
[2] 15 U.S.C. § 1011.
[3] State laws allowing employers to offer coverage through a public plan would also have to comply with the insurance requirements of the Health Insurance Portability and Accountability Act and facilitate employer compliance with COBRA coverage continuation requirements and with a handful of other federal laws mandating coverage for specific services. These laws should not present a major impediment to state public plan creation, but they would shape the details of state public plan administration. State plans that covered small groups, for example, would probably have to guarantee issue and renewal and limit pre-existing conditions clauses.
[4] 29 U.S.C. § 1144. See Peter Jacobson, The Role of ERISA Preemption in Health Reform: Opportunities and Limits, http://www.law.georgetown.edu/oneillinstitute/projects/reform/Authors/Jacobsen.html
[5] See AFSME, State Employee Health Plans (April 2009).
[6] Printz v. United States, 521 U.S. 898 (1997); New York v. United States, 505 U.S. 144 (1992); Candice Hoke, Constitutional Impediments to National Health Reform: Tenth Amendment and Spending Clause Hurdles, 21 Hastings Const. L. Q. 489 (1994).
[7] 42 U.S.C. §§ 300gg, 300gg-11, 300gg-12, 300gg-41, 300gg-42
[8] 42 U.S.C. § 300gg-61.
[9] 42 U.S.C. § 300gg-41(c).
[10] See Karen Pollitz, et al., Early Experience with "New Federalism" in Health Insurance Regulation, Health Aff., 19(4), July./Aug. 2000, at 7.
[11] See GAO, Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve (GAO-01-652R, May 7, 2001); GAO, Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/HEH-00-85, March 31, 2000); GAO, HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-21R, July 22, 1998).
[12] See House Committee on Oversight and Government Reform, Hearing on Business Practices in the Individual Insurance Market: Termination of Coverage, July 17, 2008, http://oversight.house.gov/documents/20080818093759.pdf
[13] See on 1115 waivers, Kaiser Family Foundation, The Role of 1115 Waivers in Medicaid, Looking Back and Looking Forward (March 2009), http://www.kff.org/medicaid/upload/7874.pdf
[14] See, e.g. GAO, Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Programs Raise Concerns (GAO-02-817, July 12, 2002).
[15] See, e.g. GAO, Medicaid: CMS Needs More Information on Billions of Dollars Spent on Supplemental Payments (GAO-08-614, May 2008); GAO, Medicaid, Improved Federal Oversight of State Financing Schemes is Needed (GAO-04-228, Feb. 2004).
[16] I.R.C. §§ 223(c)(2)(A)(i).
[17] See I.R.S. Notice 2004-43, 2004-27 I.R.B. 10.
[18] See Timothy S. Jost and Mark A. Hall, The Role of State Regulation in Consumer-Driven Health Care, Am. J. L. & Med. 31(2005), 395
[19] See Timothy S. Jost, Disentitlement (New York: Oxford University Press 2003), 38.