

# STATE HEALTH AND WELFARE PROGRAMS

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The American states were mugged by the Great Recession of 2007-2009. Before the assault, states were flush, and perhaps even a little tipsy. During it, they needed additional care precisely when they could least afford it. Now, they remain seriously ill, and they are slowly recovering, but their prognosis is uncertain. Meanwhile, there is a major new ‘doctor’ in the house: President Obama’s Patient Protection and Affordable Care Act (ACA).

The ACA, if implemented, will dramatically alter the nation’s health care landscape. Two elements of the ACA, in particular, will affect state policies (Center for Healthcare Research and Transformation 2011). The first substantially expands the Medicaid program by broadening eligibility to all poor individuals. The second directs the states to establish ‘health insurance exchanges’ for individuals and small businesses; if the states choose not to do this, the federal government will do it for them.

It is a challenging time for state health and welfare programs and policies. This chapter focuses on the most important programs that deliver medical services and economic support to the needy, as well as state policies for health and welfare more generally. I attempt to answer several questions: What are the major health and welfare programs in our nation, and what roles do the states play in designing, funding, and implementing them? What are the main patterns regarding the state programs over time and across the states regarding recipients, benefits, and expenditures? What are the states now doing to reform their health and welfare programs? What are the politics of these programs? What are the states doing to promote personal health and economic independence so that these medical and income support programs will be less necessary in the future? And how will the ACA affect them, if it is upheld by the Supreme Court, which will ultimately rule on the law’s constitutionality, given the numerous legal challenges to the law?

## THE PROGRAMS

Social welfare programs transfer income or provide services to individuals to improve the quality of their lives. The vast majority of social welfare spending is not aimed specifically at those in poverty. Social Security and Medicare are national programs that serve the elderly. State involvement is confined to public assistance (or **means-tested**) programs. State governments administer a broad variety of welfare programs (involving, for example, medical care, cash assistance, food, energy, housing, job training, and education, among others). Much, but not all, welfare assistance is considered an entitlement: any person eligible for benefits can obtain them, and the government is obligated to provide the benefits necessary to fill all claims. In 2008 state and federal governments spent about \$610 billion on public assistance programs (U.S. Census Bureau 2011, 350).

### *Medicaid*

Medicaid provides medical care to low-income persons who are aged, blind, disabled; to poor families with children; to certain other pregnant women and children (for a summary of Medicaid eligibility, services, and financing, see Klees, Wolfe and Curtis 2010). The federal government and state governments share responsibility for Medicaid. The federal government establishes program guidelines concerning eligibility, services, and financing, and the state governments design and administer the program. The state and federal governments split the cost of the program based on the federally established matching rate that requires the more affluent states to pay a higher share of the cost.

The federal government requires states to provide a broad list of medical services within Medicaid, including inpatient and outpatient hospital services as well as physicians’ services, to the **categorically needy**. States are allowed to offer additional services, such as the provision of drugs, eyeglasses, or psychiatric care, and they are also permitted to establish limits on recipients’ use of the services.

Until 2014, when the Affordable Care Act is scheduled to expand program eligibility, Medicaid does

not provide medical assistance to all those in poverty. Beginning in 2014, all individuals under age 65 living in families with incomes below 138 percent of the “family poverty line” become eligible for Medicaid if the ACA is fully implemented. Until then, all states must provide Medicaid to individuals in “categorically needy” groups—for example, those eligible for SSI – although the states have broad discretion to determine who is eligible to receive Medicaid services. States can also provide coverage to those in “medically needy” individuals who have extensive health needs but who do not quite fall within the administrative definition of poor. As of 2008, thirty-four states (and the District of Columbia) offered at least some services to the medically needy (Klees, Wolfe and Curtis 2010, 24). States are required to provide more extensive services to the categorically needy than to the medically needy.

Medicaid does not have its own team of doctors. Instead, states reimburse private health care providers who deliver services to Medicaid recipients. States decide, within federal guidelines, the reimbursement rates. The states are required to set reimbursement rates high enough so that Medicaid services will actually be available to recipients, at least to the extent that they are available to other residents in the state. Health care providers cannot charge Medicaid patients additional fees above these amounts.

Medicaid is the King Kong of state welfare program: it alone accounts for about 60 percent of public assistance spending. In 2010 Medicaid served over 60 million individuals at a cost to the states of some \$150 billion (NASBO 2011, 43), which was about 1/3 of the program’s total cost. Medicaid consumed about 22 percent of all state spending in that year, and for many states it was the largest single budget item (NASBO 2011, 43).

### *Temporary Assistance for Needy Families*

The Temporary Assistance for Needy Families (TANF) program aspires to improve poor families’ economic conditions and reduce their dependence on government by promoting work, encouraging marriage, and reducing out-of-wedlock pregnancies (for a summary, see Office of Family Assistance n.d.) Created in 1996, TANF replaced the AFDC program, fulfilling President Clinton’s promise to “end welfare as we know it”. Although established by the federal government, TANF gives substantial authority to the states to determine who is eligible, what obligations they face, and what benefits they receive as well as how the programs will be designed, implemented, and evaluated.

Unlike Medicaid, TANF is not an entitlement program: states can deny benefits to any family or category of poor family—and some have done so with gusto. Each year the federal government gives each state a block of funds to pay for the program, based on a federal formula. The states are required to spend at least 80 percent as much as they did for AFDC in 1994; if they impose effective work requirements, they need spend only 75 percent as much. The states can—and do—use a substantial portion of their TANF funds for purposes other than providing cash benefits.

When TANF was reauthorized by the federal government in 2006, the federal government agreed to provide \$16.6 billion each year to the states between 2006 and 2010, implying that the “real” federal support for this program would decline at the pace of inflation. The American Recovery and Reinvestment Act (better known as the “Stimulus Bill”) provided an additional \$5 billion for 2009-2010. Perhaps because assistance provided through TANF was already low, few states (California, Florida, and Hawaii) cut benefits further during the Recession (NASBO 2010, 11).

### *Supplemental Security Income*

The SSI program provides cash payments to elderly, blind, or disabled persons who are also poor (for a summary, see Social Security Administration 2010). Maximum SSI benefits are available to those individuals who are without other resources; benefits are reduced as a recipient’s earned income rises or if the recipient is living with another person.

SSI is the second-largest state-supported cash assistance program, but it is mainly a federal program. The federal government establishes eligibility requirements, sets national benefit levels, and administers the program; states have the option of supplementing the **federal benefit standard**. All but six states—Arkansas, Arizona, Mississippi, North Dakota, Tennessee, and West Virginia—provide some form of supplemental benefits, although typical benefits are quite small (Social Security Administration 2011). The

federal government pays for federal benefits and administration; the state governments fund the supplemental benefits and their administrative costs. Federal SSI benefits are indexed to inflation, so recipients receive the same cost-of-living adjustments as do Social Security beneficiaries; as with TANF, state benefits are not indexed.

## THE POLITICS

In 2009 the Medicaid, TANF, and SSI programs together spent approximately \$450 billion to assist some 50 million recipients (Kaiser Family Foundation n.d.b.; Center for Budget and Policy Priorities, n.d.; Social Security Administration 2010a, 16). These programs are a complex mix of federal and state designs, funds, and administration. What factors influence the programmatic mix? Economic and demographic attributes are certainly important, but political factors ultimately dominate. The reasons for this are clear. Economic and demographic conditions provide policymakers with opportunities and constraints, but these conditions do not by themselves make policies; politicians do. Politicians make program decisions based on their electoral concerns, their ideological beliefs, and their pragmatic judgments about what is best for their constituents, state, and country.

### *Federalism*

Ours is a federalist country. Authority over health and welfare policy is shared—not always agreeably—among state and national governments. This has three main implications for state policies. First, states do not have sole jurisdiction over health and welfare policy because they are constrained by national laws. Second, state and federal governments often attempt to gain control over health and welfare programs and shift burdens to the other party. Efforts toward control can be seen in federal mandates on the states, which require the states to perform certain functions and obtain waivers whenever they want establish their own standards. States, moreover, are often tempted to play these programs so as to obtain the maximum federal financial support at minimum cost to themselves.

Third, state governments compete and, at times, cooperate with each other. Some of the competition is political, as ambitious politicians strive to build their national reputations by developing innovative programs to address social problems. The competition can also be economic, as politicians seek to make their states more attractive for businesses and workers and less attractive to the poor who consume welfare dollars. Political and economic competition can lead in different directions; politicians have reasons for making their states distinctive but not so distinctive that they scare away economic resources. Politicians do not want their states to become “welfare magnets”.

### *Internal Politics*

State policy choices are also influenced by political, economic, and demographic factors that vary across states and over time. The political cultures, ideologies, institutions, and public opinions of states all affect their health and welfare policies (Rom forthcoming.a). The economic conditions of the states, their wealth, and the sources of it can influence state politicians as they choose among policies. The states also differ in the age of their populations, the composition of their families, and the ethnicity of their citizens, each with potential significance for the policies.

Political culture affects policy choices, as chapter 1 explained. In moralist political cultures, “both the general public and the politicians conceive of politics as a public activity centered on some notion of the public good and properly devoted to the advancement of the public interest” (Elazar 1970, 174). Traditionalist or individualist political cultures, in contrast, view politics as a way of preserving the status quo or gaining personal enrichment, respectively. Moralist political cultures tend to be more activist and generous in their health and welfare programs than traditionalist or individualist states. A state’s political culture changes only slowly, moreover, so it is the most stable of the political variables.

Political ideology involves the durable views of politicians about what the government should do and how it should do it. Americans tend to have conservative or liberal ideologies regarding health and welfare programs; liberals are generally in favor of expanded benefits and more inclusive eligibility standards, and conservatives typically prefer more restrictive benefits and eligibility. Political culture is related to, but by no means identical to, political ideology (Erikson, Wright, and McIver [1993, 150–176]). Moralist states are

not necessarily liberal, nor are individualist states invariably conservative, although traditionalist states almost always are conservative. Political conservatives in moralist states might believe that governments best help the poor by making welfare difficult to obtain; liberals in individualist states might seek to increase welfare spending merely to enhance their own political fortunes.

The political institutions of American governments—their legislatures, bureaucracies, political parties, interest groups, electoral systems—can also influence health and welfare policies. In general, governments with professional legislatures and competent bureaucracies are more active in developing programs and openhanded in supporting them. Interest groups are more involved, and more influential, in some states than in others and in some issues than others (Gray *et al.* 2004). States with more highly mobilized publics and more competitive elections may also be more likely to support social welfare programs (Rom forthcoming.a).

Policymakers pay attention to public opinion, and these opinions vary across the states, over time, and among health and welfare issues (Berry *et al.* 1998). The citizens of Minnesota and Mississippi, for example, have different opinions about the appropriate role of their governments in social policy and that state policies in part reflect these opinions. Still, the sentiments of the nation as a whole also change over the years, with the public looking more favorably on welfare recipients in the 1960s than more recently. The American public also appears to be more sympathetic to programs that provide goods and services (such as food and health care) to the poor instead of cash. Certain types of recipients are more politically popular. The “deserving poor” (the disabled, children, and the elderly, for example) are viewed sympathetically and provided greater governmental support, whereas the “undeserving poor” (such as young men or women bearing children out of wedlock) are scorned by the public (Katz 1986). Public approval for programs that promote work is much stronger than for programs that do not help the poor help themselves.

Interest groups are also active in welfare and, especially, health politics (Gray, *et al.* 2009). Medical providers have an interest in how health programs are designed, administered, and financed. Certain types of patients—particularly the elderly and disabled—also have organizations that routinely promote their claims (welfare mothers, in contrast, usually do not). Interest groups are less pronounced in income-assistance programs, where the main actors are typically welfare officials, charities, and religious organizations.

### *Economic and Demographic Factors*

Social welfare policies intend to address economic conditions, but the policies are also influenced by the conditions they hope to alter. The principal economic factors influencing health and welfare policies are both cyclical (like weather) and structural (like climate). In the cycle, if the economy goes into recession, more people become poor and the number of people eligible for welfare programs increases program costs rise. When the economy is growing, fewer individuals are eligible for benefits and so costs are reduced. Structural shifts are slower to occur, longer lasting, and harder to change. The economic and demographic structure of the population establishes durable conditions in which social welfare programs operate.

Figure 11.1 compares state poverty rates in 1999 and 2009. Poverty rates vary substantially across the states, with the rate in New Mexico twice that of Utah, for example. Only five lucky states had lower poverty rates in 2009 than 1999. In the least fortunate states – Indiana, South Dakota, and Arizona, for instance – poverty rates soared. Even though poverty rates grew across racial groups, family types, ages (except the elderly) and among the states, this too should also be remembered: median family income was actually higher in the U.S. in 2009 than in 1999. The higher poverty rates do not reflect a poorer country, but one with more families in poverty.

[Figure 11.1 about here]

The economic and demographic characteristics of the states provide the context for politicians. Richer states have more resources to devote to health and welfare programs, if they wish to do so. States with more favorable demographics have fewer welfare needs. Those in the greatest need of help – the young, minorities, female-headed families – are also likely to have the least political power. Ultimately, neither resources nor needs determine what policies will be chosen. Policymakers do.

### *Interstate Competition*

The states are politically independent of each other, yet they are all part of a nationwide economic and political system. State politicians seeking to develop a national reputation accordingly have incentives to conduct bold policy experiments. When running for president, Bill Clinton and George W. Bush pointed to educational reforms they had pioneered as governors of Arkansas and Texas, respectively. If innovations prove successful or otherwise attractive politically, other states often imitate them. This pattern of state innovation and diffusion is a well-recognized pattern in American politics (Walker 1969).

States also engage in economic competition with each other regarding finance, commerce, and labor. Politicians find it far easier to run for reelection if they can boast that under their direction the state has a booming economy and low taxes. This interstate economic competition has led some scholars to conclude that states are ill-suited to have responsibility for welfare programs (Peterson 1995). The logic behind this claim is simple. Individuals, whether citizens or politicians, are assumed to act in their own self-interest. If a state offers generous health and welfare benefits, it will become a **welfare magnet** attracting the poor who need benefits and repelling the affluent who pay the taxes to support them. Politicians thus have incentives to keep their states from becoming welfare magnets; in fact, states have incentives to provide welfare programs that are less generous than the programs of their neighbors. If each state acts the same way, welfare benefits would become increasingly stingy and welfare eligibility increasingly stringent as the states “race to the bottom.” There is solid evidence that interstate competition has restricted state welfare generosity (Rom forthcoming.a).

It is worth remembering that state policy choices are far more complicated than a simple tallying of economic, demographic, and political forces would suggest. Policies vary among the states for unique historical reasons. An unusually forceful leader, a public scandal, a temporary surge in public opinion can all have lasting effects on policy choice, not only for the individual states but also for the nation. Massachusetts governor Mitt Romney approved the universal health care insurance program that would become the model for President Obama’s Patient Protection and Affordable Care Act. Vermont Governor Peter Shumlin campaigned on a promise to create a “single-payer” healthcare system for the state – and he succeeded. As Shumlin put it, “We want to figure this one out and get it right. Then we hope that perhaps that others will follow” (NPR 2011).

## THE PATTERNS

Turning to the patterns—and the anomalies—in health and welfare policies, let us examine the broad trends since 1980 in recipients and expenditures for Medicaid, TANF, and SSI.

### *Trends in Number of Recipients*

Welfare caseloads between 1980 and 2010 are shown in Figure 11.2. Each program has a different trajectory. Medicaid has grown, and grown, and grown still further, increasing by over 40 million people in 30 years. Increases during the 2000s reflect the rising number of Americans without private insurance, the growing poverty rates, and the expansion of Medicaid eligibility. If the ACA is fully implemented, Medicaid enrollments are expected to grow by another 20 million by 2019 (Foster 2011). AFDC, in contrast, was stable during the 1980s before undergoing what seemed to be alarming growth in the early 1990s, which helped trigger the 1996 reforms that ended the program. Since TANF was created in 1996, the number of recipients fell by more than two-thirds before edging up during the recession. SSI caseloads, in contrast, have grown slowly during the entire period.

These trends—strong growth in Medicaid rolls, decline in TANF, and stability in SSI—are important for state politics and policy. These trends are not caused purely by economic or demographic changes. They do reflect the clear preference of state and national politicians for providing medical care to the elderly, disabled, or children who are poor while withholding income support from impoverished, able-bodied adults who, presumably, should not have to rely on the government for support.

[Figure 11.2 Welfare Recipients, 1980–2010 about here]

### *Trends in Expenditures*

Program spending trends have closely paralleled those for recipients: Medicaid has soared, TANF has shrunk, and SSI has grown modestly. In 2010, total spending for Medicaid was about \$366 billion, with states paying about one-third of the total; in contrast, total TANF spending was a mere \$31 billion, with the states paying almost exactly half. SSI was larger than TANF at around \$50 billion, but only a modest slice (less than \$5 billion) of this comes from state coffers (Social Security Administration 2011). In real dollars, the states spend substantially less on TANF and SSI today than they did during the 1970s, and vastly more on Medicaid. Increasingly, welfare spending *is* health care spending.

As TANF spending has declined, its purposes have changed, too. Under AFDC most spending was for cash assistance, with the remainder covering administration and other services. In contrast, only about 35 percent of the \$31 billion that state and federal governments spent on TANF programs in 2009 went towards cash benefits, with the other 65 percent going towards a wide variety of other purposes, including work-related activities, child care, transportation, among others (Administration for Children and Families 2010).

The ACA, if implemented, will have an enormous impact on Medicaid. It is predicted that between 2014 and 2019 the ACA will add a total of \$455 billion in additional Medicaid spending *above* what would otherwise be expected, of which 91 percent would be picked up by the federal government due to the higher federal matching rate for newly eligible enrollees (Centers for Medicare and Medicaid Services 2010, iv). Overall, Medicaid spending is expected to more than double, reaching \$840 billion in 2019.

### *State Welfare Benefits and Recipients*

The national trends feature diverging recipient populations and program expenditures, with Medicaid growing rapidly, SSI growing slowly, and TANF generally shrinking. These trends have not affected all states equally, nor have all states responded in the same way to the changing times.

*Benefits.* It is difficult to report succinctly state welfare benefits because welfare recipients have different needs and states offer different services. Hence each state has a different mix of recipients joining and leaving the rolls at various times. For example, the elderly and disabled account for only 25 percent of the Medicaid caseload nationally (Smith *et al.* 2010, 12), but they account for over two-thirds of Medicaid spending, so states with higher proportions of persons in these categories will have higher costs than other states, all else being equal. Finally, states vary in how – and how well -- they administer their welfare programs, and such variation influences administrative costs per recipient.

Figure 11.3 shows the average payments to all Medicaid recipients by state, ranked in declining order, as well as the average payments to disabled recipients who are, as noted above, the most expensive category of recipients individually as well by overall. Average state annual Medicaid benefits per recipient in 2008 were \$5051. New York, the state with the highest spending per recipient (\$9000), spent three times as much as the lowest state, Wisconsin (\$3000). State Medicaid spending on the disabled is even more variable, with per-recipient spending more than four times higher in New York (\$30,000 annually) than in Alabama (\$7400). These differences are much greater than the variation in cost-of-living across the states, and they indicate real distinctions in how the states treat their low-income residents. Higher spending on medical care does not invariably translate into better care, of course, but it is reasonable to suspect that when spending levels are too low, care also suffers.

For TANF, 43 states spend more on non-cash assistance than on cash benefits, and this is especially true in the most generous states: the top ten spend an average of less than 20 percent of TANF funds on cash benefits. The most generous state – Illinois – spent nearly \$20,000 per recipient in 2008, of which only \$1200 came in the form of cash assistance. The least generous state – Tennessee – spent about \$2200 per recipient, evenly divided between cash and non-cash assistance. A TANF recipient in Arkansas would on average receive a check for about \$75 per month. That amount would not go far, even in Arkansas.

Historically, there has been a modestly strong relationship between state generosity in Medicaid and TANF: if a state had relatively high expenditures in one program, it was likely to be more generous in the other, too. As Medicaid and TANF have become increasingly separated programmatically, however, they have also become more disassociated in terms of their generosity. By 2009, state TANF expenditures and Medicaid benefits were almost entirely unrelated: the correlation coefficient was 0.07. Wisconsin has the

lowest per recipient Medicaid spending and the 6<sup>th</sup> highest TANF expenditures per recipient, while Rhode Island has the 4<sup>th</sup> highest Medicaid expenditures and only the 33 highest TANF expenditures.

More affluent states do generally support more generous social welfare programs than their poorer peers. The correlation coefficient between per capita income (PCI) and Medicaid benefits is 0.57 and between income and TANF spending is 0.39. The relationship between prosperity and generosity does not hold in every state, however. Virginia is fairly affluent (7<sup>th</sup> highest income) and nonetheless stingy (40<sup>th</sup> highest TANF expenditures); West Virginia is poor (next to last in per capita income) but willing to spend on health care (13<sup>th</sup> highest Medicaid expenditures). Perhaps surprisingly, welfare generosity is more closely tied to economic affluence than to political ideology. The correlation between “state government ideology” (as defined by Berry, *et al.* 2010) and Medicaid and TANF benefits is 0.24 and 0.19, respectively.

Virtually every state enacted measures to control Medicaid spending during the Recession. A record number of states – 20 in 2010 alone – trimmed Medicaid benefits. For example, Arizona, California, Hawaii and Massachusetts ceased offering some or all adult dental services (Smith *et al.* 2010, 7). Even more states cut provider (e.g., physician) reimbursement rates. While cutting the amount that Medicaid pays to providers did allow states to save money in the short run, it also threatens the ability of the states to ensure that enough providers will offer Medicaid services. If the rates fall too low than providers may refuse new patients or cease to participate entirely.

*Recipients.* A few broad patterns can be identified in Medicaid and TANF caseloads across the states and over time. First, Medicaid populations were vastly bigger than TANF caseloads in *every state*: the narrowest gap was in Nevada, where less than one percent of residents were enrolled in TANF and almost 10 percent were on the Medicaid rolls. Second, despite large differences in the rates of change among the states and across the programs, most states had growing Medicaid caseloads and falling TANF caseloads. On average, 18.5 percent of state residents received Medicaid during 2009, compared with 17.9 percent in 2003. In 2009, the state with the proportionately (and absolutely) largest Medicaid population was California, where almost 30 percent of the residents received Medicaid services at some point during that year. The state with the smallest caseload was Nevada, with just under 10 percent Nevadans receiving Medicaid benefits. The increase in Medicaid caseloads was not spread evenly across the states, however; 18 states witnessed declining caseloads between 2003 and 2009, although the declines were generally modest. A few states (Massachusetts, Michigan, Pennsylvania, and Iowa) had increases of over 20 percent in their Medicaid populations. TANF caseloads fell 25 percent from an average of 1.6 percent to 1.2 percent, on top of the one-third caseload decline experienced from 1998-2003.

The relation between program generosity and caseload might seem obvious: states with higher benefits would have relatively larger caseloads, both because more people would be eligible for benefits and benefits would be more desirable to obtain. But this is definitely not the case, at least for TANF. There is a fairly strong negative correlation (-0.41) between TANF expenditures per recipient and the relative size of the caseload. With a fixed budget, larger caseloads must by definition have lower average expenditures, and vice versa. In the old days, caseloads drove spending. Today, policy drives caseloads, and spending runs on autopilot.

Medicaid caseloads and expenditures are mildly and negatively correlated (-0.20): states that have relatively large Medicaid populations have somewhat lower per-recipient expenditures than states with smaller caseloads. The most extreme example is California, which has the largest Medicaid population and the lowest per-recipient expenditures. As usual, there are exceptions to the pattern, as New York has the most expensive Medicaid program per recipient, and it also has the 2<sup>nd</sup> largest caseload overall.

## HEALTH CARE REFORM

During the 1960s and 1970s the federal government was the leading innovator in welfare policy; more recently states have been in the vanguard. State health care reform proposals are usually built around three goals. The first is to control costs, both for the state’s citizens and for the state itself. The second is to provide access, so that the health care needs of the citizens are met. The third goal, high-quality care, is also

important but more controversial and difficult to define.

To accomplish these goals, state policymakers have focused on three types of reforms. They have sought to expand insurance coverage for children and other vulnerable populations, to make insurance more affordable and available to individuals and the small-business community, and to control short- and long-term health care costs. This section examines the bold health insurance reforms in Massachusetts and Vermont, Medicaid managed care, and insurance for children. It concludes with a discussion of state efforts to develop the health insurance exchanges mandated by the ACA.

### *Universal Health Care Coverage in Massachusetts*

Massachusetts led the way in innovation when in 2006 it enacted legislation to provide nearly universal insurance. The law requires all individuals to purchase health insurance or face stiff tax penalties. Businesses with ten or more employees must offer health insurance or pay a “fair share” contribution to help workers buy insurance on their own. To assist low-income individuals obtain insurance, Massachusetts expanded Medicaid eligibility and established the Commonwealth Care Health Insurance Program, which provides sliding-scale subsidies to individuals earning less than 300 percent of the poverty line, with poor individuals paying no premiums at all.

By 2010 over 98 percent of Massachusetts residents were covered by health insurance, by far the highest coverage rates in the country. Access to health care had improved, and so had affordability, although one-fifth of survey respondents reported problems finding a doctor who would see them or in paying their medical bills.

Still, health care in Massachusetts remains too costly. As a result, Governor Patrick has proposed a new plan to control costs and transform the medical payment system by creating “accountable care organizations” that would reward doctors for how healthy they keep their patients, not how much service they provide (Salsberg 2011). Despite concerns over cost, the Massachusetts programs retains broad support, with about two-thirds of the public supporting the reforms, most employers believing the reforms were good for the state, and the vast majority of doctors concurring that it had improved (or did not harm) the quality of care (Blue Cross Blue Shield Foundation of Massachusetts 2011, 3).

### *‘Single Payer’ Health Care Reform in Vermont*

Vermont took a large step to becoming the first state to adopt a ‘single payer’ health care system in 2011 when Governor Shumlin signed its health reform law with overwhelming support in the state legislature. The law calls for establishing Green Mountain Care, the government-run insurer that will cover all residents. Green Mountain Care will provide – the state hopes – comprehensive, affordable, high-quality, publicly financed health care coverage to all Vermonters. Green Mountain will pay providers a fixed sum to care for a specific population, providing them incentives to favor preventive care and control costs. The Green Mountain Care Board, composed of five governor-appointed and Senate-confirmed members, will oversee GMC’s payment and delivery system in order to provide quality care and to control its costs (Teague 2011).

The law would not be phased in until at least 2014, and two barriers must be surmounted for the program to become operational. Vermont must obtain waivers from the federal government to create Green Mountain Care and the single payer system. The state must also develop a plan to finance the system, which would involve a combination of public and private money.

Progress towards implementation depends on Vermont’s political environment. Most private insurers will oppose implementation: after all, the plan could put them out of business in that state. Fortunately for Vermont, its largest health insurer, Blue Cross/Blue Shield, supports the plan because it is poised to administer the payments system (Klein 2011). Because businesses that already provide health insurance would have to pay into the system, they might find the taxes too high and drop coverage or consider moving elsewhere. Pharmaceutical companies, which are not favored by the plan, are sure to send out their lobbyists to stall, change, or eliminate it.

### *Medicaid Managed Care*



Medicaid initially was a **fee-for-service program**: medical providers were simply reimbursed for their services. States established reimbursement rates, and medical providers were required to accept the reimbursements as payment in full for their services. This system did not please providers, who believed the rates were too low, nor did it guarantee access to care for Medicaid recipients, who often found it hard to obtain services. Under the system total costs grew rapidly as providers sought higher payments and recipients sought more care.

Such fee-for-service problems, also experienced by private insurers, led firms to experiment with **managed care programs**. One important element in many programs is that they are **capitated**—that is, the program receives a fixed amount of money per enrolled person to provide a set of services. If the program spends less than this amount per patient it runs a surplus; if it spends more, it incurs a loss. This creates incentives for programs to reduce costs by delivering care efficiently, by minimizing unnecessary care, and, many fear, by withholding appropriate care.

Managed care programs now dominate both private and public health insurance markets, with over 90 percent of those with private insurance and 70 percent of those with Medicaid in managed care (Kaiser Family Foundation 2010a, 1). Only the two most rural states, Alaska and Wyoming, lack managed care programs.

Two trends in Medicaid managed care are worth noting. First, commercial managed care organizations are playing a diminishing role, as recipients increasingly enroll in Medicaid-only or Medicaid-dominated organizations. Second, many states now offer (or mandate) Medicaid managed care programs for more complex populations than ‘regular’ families and children, such as those with “disabilities and chronic illnesses, persons with HIV/AIDS, and ‘dual eligibles’ – low income seniors and severely disabled individuals who are covered by both Medicare and Medicaid” (Kaiser Family Foundation 2010a, 3-4). To serve these more-complex populations, states are now innovating ways to coordinate and manage care (see Kaiser Family Foundation 2010a, 4-5).

### *State Children’s Health Insurance Program (CHIP)*

Based in part on state experiments, the federal government created CHIP in 1997 to help states create or expand programs providing medical care to children in moderately poor families. At that time, about one-quarter of the nation’s poor children lacked health insurance; with CHIP, the vast majority now have it, and those who do not are often eligible but not yet enrolled. Initially, the federal government provided funding to the states based on each state’s proportion of the nation’s poor and uninsured children. The states, provided matching funds, at a lower rate than for Medicaid, and administered CHIP. The states can use federal funds to expand Medicaid, create a separate program, or both. The states pick up about 30 percent of the tab for CHIP, with the federal government providing the rest.

Unlike Medicaid, CHIP is not an entitlement program. Instead, the federal government provides each state a a block grant that it can spend at its discretion, within federal guidelines. For example, the states can require cost-sharing for CHIP services – that is, families participating in CHIP may have to pay for services, although 17 states have chosen not to use this option – and limit benefits in ways that are not allowable in Medicaid. If CHIP spending is higher than states have budgeted, they can establish waiting lists for the program or otherwise limit enrollment.

Congress encouraged the states to expand CHIP eligibility and simplify enrollment when it reauthorized CHIP in 2009 (Kaiser Family Foundation 2009a). Federal funding for the program was substantially increased, with the federal cigarette tax the main source of the necessary revenue. The states’ block grants were altered to reflect how much they actually were spending, or were expected to spend in the future. The reauthorized CHIP was expected to provide health insurance coverage to an additional 6.5 million children (Kaiser Family Foundation 2009).

States are using their discretion to design an assortment of CHIPs. Eleven states have incorporated CHIP into their existing Medicaid programs, while the other thirty-nine states have created separate programs although, it appears, the states with combined programs have had somewhat better outcomes (Georgetown University Health Policy Institute n.d.b). States also have broad flexibility on setting eligibility standards. Forty-seven states cover children from families with income at 200 percent of the

federal poverty level or higher; 25 states cover children in families with incomes up to 250 percent of the poverty level, and 16 states cover children up to 300 percent of the poverty level or higher. States can, at their discretion, cover “lawfully-residing immigrant children” -- i.e., children who were born in the US to undocumented workers -- without imposing a five-year waiting period. By 2011, 21 states had opted to provide coverage to such children, and 17 states provided coverage to lawfully-residing pregnant immigrants (Georgetown University Health Policy Institute n.d.a).

### *State Health Insurance Exchanges*

The ACA requires each state to have a “health insurance exchange,” providing residents an “Expedia” for shopping for health insurance, operating by 2014. The states can design their own exchanges either individually or in groups or, if they choose not to develop them, the federal government will do so for them.

The exchanges have several purposes (Kaiser Family Foundation 2009b). First, provide consumers a choice of private health insurance plans from an approved list so that the plans can be compared by price and benefits. To promote this, exchanges would be structured so that services and costs would be standardized, making the comparisons easier, and limiting the ability of insurance companies to vary benefits in order to attract healthier (and lower cost) enrollees. Additional information could be provided to consumers regarding performance measures of the various insurance plans. Next, the exchanges would facilitate enrollment by providing information and assistance on eligibility and subsidies. The exchanges would also help make insurance more portable, enabling individuals to maintain their insurance as they move from job to job or between Medicaid and subsidized private insurance for those with low and variable incomes. Finally, the exchanges can help the states reform their insurance markets by, for example, determining how much insurance premiums and coverage can vary.

Most states are moving towards creating exchanges. By June 2011, 32 states had introduced legislation to establish exchanges, and at least six other states appear headed in that direction. Ten states had enacted legislation establishing exchanges, with California leading the way when it approved the idea in the fall of 2010. Only one state (Louisiana) had officially rejected the prospect of creating an exchange, while Massachusetts has already established one (Center for Budget and Policy Priorities 2011, 1-3).

As they progress toward establishing exchanges, states will consider the political and policy opportunities and challenges. Establishing exchanges gives states the opportunity to maintain regulatory authority over the health insurance market; coordinate eligibility rules and benefits across Medicaid, CHIP, and the exchanges; mitigate risk selection among the insurance policies offered within and outside the Exchange; and promote the state’s reform priorities. The challenges are to create a new program at a time of great fiscal stress, ensure that the exchange is “self-sustaining” by 2015 as required by the ACA, and hold administrative costs down while satisfying voter demands for good service (Carey, 2010, 2).

States will continue to confront two core problems: caring for the ill and controlling costs. Even during the Recession, numerous states expanded Medicaid eligibility or simplified enrollment procedures. Despite enormous budget pressures, 41 states implemented Medicaid expansions in 2010. Although most expansions were quite modest, some states (such as Colorado and Wisconsin) adopted broader reforms, and Connecticut decided to enroll childless adults ahead of the ACA requirement that they do so by 2014 (Smith *et al.* 2010, 7). Still, the states are likely to remain under continued heavy stress in Medicaid in the coming years. As the expanded federal support for Medicaid ends in 2011, it is expected that state Medicaid spending will grow as much as 25 percent in 2012, even though state revenues are still at pre-Recession levels (Smith *et al.* 2010, 9). If the states have to expand their Medicaid programs further, as the ACA requires, the budgetary pressures will intensify.

## **PREVENTION**

Our health and welfare programs provide care to the sick and assistance to the poor. They do relatively little to prevent individuals from becoming sick or needing public assistance. American health and welfare programs emphasize treatment rather than prevention.

From a policy perspective this makes little sense, but there are good reasons to emphasize treatment over prevention from a political viewpoint. Policymakers usually face the situation in which people need immediate assistance and there is not enough money to help them with their needs and at the same time prevent others from requiring the same assistance later. As demands for treatment are almost always louder than requests for prevention, the former is politically favored over the latter. Yet the maxim is true: A dime of prevention is worth a dollar of cure. It is cheaper to stay well than to become healed, to stay out of poverty than to get out.

State health and welfare policies have, to their credit, tilted somewhat more to prevention in recent years. Medicaid managed care has a better chance to emphasize wellness programs such as prenatal care, well baby care, and routine screenings, among others, than had traditional Medicaid. The ACA requires that insurance companies provide recommended preventive care free and, to the extent that state exchanges actually enroll individuals in insurance, more people will have access to this care. As a matter of policy, however, federal and state governments typically spend far more on treatment than prevention, at least on matters of public health: spending on prevention has never reached 10 percent of overall health expenditures (Miller *et al.* 2008).

Even when both political parties are committed to prevention they may have strong differences about what real prevention is. Liberals generally view prevention as a set of positive incentives offered by the government. To keep individuals healthy, programs must provide education or services so they can become physically strong and economically self-sufficient. Conservatives usually reject this view, placing responsibility for physical and economic health more squarely on the individual citizens. Government, from the conservative perspective, mainly creates incentives for persons to become dependent and diseased by providing welfare and health benefits in the first place. Accordingly, government practices prevention best by ensuring that individuals bear the consequences of their own actions.

Nonetheless, it is worth considering: Why do people become ill and thus in need of medical care? Although the answers no doubt involve social and even metaphysical elements, I will focus on behavioral answers: people need medical treatment in part because of the way they behave. Behavior is, of course, affected by social forces, genetic endowments, personal choices, and public policies. State efforts at prevention therefore will need to address behaviors.

Behavioral factors are largely responsible for about half of all premature deaths each year. Almost two decades ago researchers demonstrated that big three factors—tobacco use, obesity and lack of exercise, and abuse of alcohol—caused approximately 40 percent of all deaths and 75 percent of premature deaths in the United States. The other major factors—preventable microbial or toxic agents, firearms, sexual behavior, motor vehicles, and illicit drugs—accounted for most of the other 25 percent of premature deaths (McGinnis and Foege 1993). The big three remain devastating today: tobacco use is responsible for nearly 500,000 deaths each year, obesity and lack of exercise for about 400,000 deaths, and alcohol abuse for some 60,000 fatalities (Danaei, *et al.*, 2009).

Behavioral risks that damage public health have distinctive politics. All involve personal activities—smoking cigarettes, eating too much and exercising too little, drinking alcohol, shooting firearms, and having unsafe sex—that raise strong emotions in the political arena (Meier 1994). Because they involve highly personal behaviors of millions of individuals, they are difficult for governments to control or change. There is some good news on the behavioral front: the rate of fatalities linked to driving while intoxicated has fallen by almost 30 percent in the past decade, although drunk driving is still responsible for about one-third of traffic fatalities (National Highway Traffic Safety Administration n.d.). Smoking rates dropped continuously for almost 40 years, although they appear to have stabilized at about 20 percent of the adult population (CDC 2009). Other behaviors are even less susceptible to change. The public's willingness to adopt healthier sexual behaviors has not been firmly established, and America has not proved capable of greatly reducing its gun violence. Other trends are worrisome: in 2011, the “slimmest” state was “fatter” than the “fattest” state 20 years ago (Trust for America's Health 2011).

### *Tobacco*

Tobacco use, especially cigarette smoking, is by far the largest behavioral threat to public health.

The magnitude of the problem can be difficult to grasp: each year, tobacco kills the equivalent of the 9/11 terrorist attacks...every third day.

In the mid-1990s various state governments concluded that smoking-related health problems imposed large costs on the public through the Medicaid and Medicare programs and began to challenge the tobacco companies to reduce smoking rates. Four states (Mississippi, Florida, Minnesota, and Texas) successfully pressed their claims against the tobacco industry before the industry reached a global settlement with all 50 states in November 1998. Under the terms of the settlement, tobacco companies will pay an expected \$246 billion to the states over twenty-five years (Action on Smoking and Health 1998). A large portion of revenues from the settlement was to be used to reduce smoking rates.

Most states have failed to use this windfall primarily to reduce tobacco use as they had pledged, however. State spending on tobacco control declined substantially in the early 2000s, and during the Recession the states increasingly diverted the tobacco settlement revenues to other purposes. In 2011, the states were expected to devote a mere two percent (about \$500 million of the \$25 billion) of those funds to programs to prevent smoking or to help smokers to quit: nearly a 30 percent decline over the previous three years. Only two states – Alaska and North Dakota – were spending as much as the Centers for Disease Control and Prevention (CDC) had recommended, and only five other states were spending even half of the CDC-recommended amount. Nevada, New Hampshire, and Ohio had allocated no funds at all to smoking prevention programs (Wilson 2010).

States are using various other means to reduce tobacco-related risks, although the intensity of the effort has varied across the states and over time. By the end of 2010, 27 states had passed ‘comprehensive’ bans on smoking in all public places and workplaces, including restaurants and bars (American Lung Association 2010, 3). Eleven states enacted comprehensive laws between 2006-2007, but the pace has been slowing: only six more states approved comprehensive bans during the next three years. Every state requires smoke-free indoor air in some places to some extent, but seven states (Indiana, Kentucky, Mississippi, South Carolina, Texas, West Virginia and Wyoming) continue to allow smoking in workplaces, restaurants, and bars (Centers for Disease Control and Prevention 2011a).

All states also have cigarette excise taxes, with the average state charging \$1.46 per pack (and the federal government imposing an additional \$1.01). New York had the highest taxes, at \$4.35 per pack; Missouri had the lowest, at \$0.17 (American Lung Association 2011a, 3). Still, the CDC concluded that state cigarette taxes were not nearly high enough to cover the economic costs of smoking; it estimated that the average economic productivity lost per pack was \$5.16, the average medical expenses lost per pack were \$5.31, and the cost to Medicaid per pack was \$1.63 (Centers for Disease Control and Prevention 2006). It is clear that higher cigarette taxes reduce demand for cigarettes. For example, Rhode Island raised its cigarette tax from 71 cents in 2001 to \$3.46 in 2009, and during that period the rate of smoking among those in high school decreased from almost 25 percent to about 13 percent during that period (American Lung Association 2011, 3)

States also make it more difficult for youth to smoke. All states prohibit the sale and distribution of tobacco products to minors, and forty-three states have laws that bar minors from buying, possessing, or using tobacco products (American Lung Association n.d.). No state allows vending machine sale of cigarettes to minors, and most states have other policies to prevent or restrict teen smoking.

States are taking additional steps to prevent or reduce smoking. Hawaii, for example, now requires its Medicaid managed care plans to cover all smoking cessation medications and to provide at least one type of anti-smoking counseling. Kentucky – a major tobacco-producing state – substantially improved access to cessation treatment for its Medicaid population. By the end of 2010, six state Medicaid programs provided comprehensive coverage for all FDA approved cessation medications and counseling services. Several states also provide such services for state employees and their families (American Lung Association 2011c, 10-11).

Laws do not necessarily mean results, of course, because state enforcement of tobacco laws is notoriously lax, particularly regarding sales to minors (Campaign for Tobacco-Free Kids n.d.). Although smoking rates among youth are much lower than they were two decades ago, cigarettes remain the most

commonly abused substance among those in high school, with about 20 percent of seniors current smokers (Johnston *et al.* 2011, 30).

### *Diet and Activity*

Diet and activity contribute to about 400,000 premature deaths each year (Danaei *et al.* 2009). The problem is that Americans in general eat too much and exercise too little. Over 60 percent of Americans were overweight in 2009, with 27 percent of adults being obese (Mendes 2010). Yet state and federal policymakers have done much less to reduce the threats to public health from obesity than from tobacco or alcohol.

The political dynamics of obesity make it difficult for policymakers to take effective action to reduce or prevent the obesity epidemic (Engelhard, Garson and Dorn 2009). Obesity has no clear villains, nor are there silver bullet policies. However, as the weight of evidence about the harms caused by obesity has grown along with the weight of the American public, state legislatures, if not the public, have become increasingly concerned.

The major policy focus has been on childhood obesity. There has been a flurry of legislative activity to reduce youth obesity and to promote exercise (National Conference of State Legislatures 2010a). Legislative activity includes some form of **body mass index (BMI)** or fitness screening programs for school children; diabetes screening and management; insurance coverage for obesity prevention; physical activity, education, or recess; school nutrition, taxes and tax credits; and task forces, commissions, or other studies. In 2009, 40 laws or resolutions addressing youth obesity were enacted, with the most popular laws involving school nutrition; a similar number of laws were approved in 2008 (National Conference of State Legislatures 2010a, 2009; for a summary list of laws, see Kaiser Family Foundation n.d.d).

Policy initiatives have not just targeted children, although addressing adult obesity has proven to be a much greater challenge for the states. Forty states impose taxes on sugared beverages and snacks (in some states, just as on other groceries), but these taxes are too low to reduce demand for junk food (Brownell and Frieden 2009). States that have tried to impose larger and broader junk food taxes have not fared well. For example, in 2008 New York Governor David Patterson proposed an 18 percent tax on soda, but this proposal faced overwhelming opposition in the legislature and among the public and was not even seriously considered. Public opinion on junk food taxes varies widely, depending on the survey, but it is most supportive when the tax revenues are dedicated to obesity prevention and reduction efforts (Brownell and Frieden 2009). The public appears skeptical that junk food taxes would actually do anything to reduce obesity, however (Montopoli 2010). Although states are starved for revenue, and a well-crafted junk food tax could fatten public coffers while slimming individuals' waistlines, the states remain reluctant to take the next step in that direction.

The ACA includes a number of provisions that give states opportunities, incentives, or mandates to promote wellness (which includes weight management, among other behaviors). In response to the ACA, as well as to their own political concerns, states have been busy: in 2010, over 80 bills were introduced on wellness measures ranging from allowing "insurance discounts, rebates and incentives to people who buy individual coverage for participating in a wellness program; permit[ing] discounts to group rates of insurance for participating in a wellness program; rais[ing] awareness about wellness and the benefits of healthy lifestyles; creat[ing] wellness commissions or studies; provid[ing] wellness and prevention programs for public employees; and implement[ing] wellness related tax credits" (National Conference of State Legislatures 2010b)

Given the complexities of reducing obesity, it is unclear if states can make an impact on this problem. To this point, they have not: the rate of obesity continues to grow. Medical costs will probably grow apace. In 2008 it was estimated that health problems associated with obesity cost the nation approximately \$150 billion in medical expenses, with Medicaid and Medicare bearing much of the weight (Finkelstein *et al.* 2009).

### *Alcohol*

Every year, some 60,000 Americans die at least in part from abusing alcohol. These deaths can occur

through alcohol's effect on the body (for example, cirrhosis of the liver or fetal alcohol syndrome) and, more importantly, on behavior. Between about a quarter and a half of all homicides, assaults, car and boat fatalities, drowning and fire fatalities, and the like can be attributed at least in part to alcohol consumption (Emergency Nurses Association, Injury Prevention Institute 2006).

There are old and new politics of alcohol. The mainly religious call for prohibition defined the old politics. The public health consequences or the costs and benefits of alcohol use did not enter into the debate; the debate was about whether drinking was a sin. These politics still prevail in many parts of the country. Although no states maintain prohibition, numerous dry counties dot the map, especially through the parts of the country known as the Bible Belt. It is no small irony that the Jack Daniels distillery, which produces Tennessee bourbon, is located in a dry county.

The new politics of alcohol divide sharply between personal use and public misuse. Millions of Americans drink moderately, and there is little opposition to responsible alcohol use. Alcohol use is not inherently harmful, and medical research suggests that moderate consumption might, in some circumstances, be healthful. The alcohol companies themselves urge their buyers to drink in moderation, albeit at the end of commercials relentlessly promoting their products.

Virtually no one defends excessive drinking. Public misuse—especially drunk driving—is vigorously attacked around the country. Groups such as Mothers against Drunk Driving (MADD) and its offshoots (for example, Students against Drunk Driving [SADD]) have mobilized much political and social support for their goal. The states have led the way in these attacks, although not always willingly. The major impetus to state action was the 1984 federal law that required states to enact a minimum drinking age of twenty-one by 1986 or lose a portion of their federal highway funds (O'Malley and Wagenaar 1991). Prior to this law, only fourteen states prohibited the purchase of alcohol by those under the age of twenty-one; all fifty states prohibited it by 1988. All fifty states have also made it a crime for a driver to have a blood alcohol content (BAC) of 0.08 or above—up from fifteen states in the mid-1990s when the typical BAC was 0.10 (Insurance Institute for Highway Safety 2007).

States continue to tighten the tap on drinking and driving. In 2009, 229 bills were introduced in 46 states to reduce drunk driving further, and 25 states adopted new laws. Forty-three states have laws imposing stiffer penalties, such as additional fines or ignition interlock devices, on drivers with high BAC levels. Nine states require ignition interlocks – devices that prevent a car from starting if the driver has alcohol on the breath – for all those convicted of drunk driving. (Savage, Tiegen and Farber 2010, 1, 6-8). The federal Transportation Equity Act requires the states to impose specific sanctions on repeat offenders and, by the end of 2009, 39 states had enacted legislation bringing them into compliance.

The combination of tougher drunk-driving laws, increased penalties for violators, and expanded enforcement, together with changing social mores, has contributed to the substantial decrease in the rate of deaths, injuries, and accidents attributed to alcohol-influenced driving. The alcohol-related traffic fatality rate has dropped almost continuously over the past 25 years, and in 2009 it was at the lowest level since these statistics have been collected (Century Council 2010, 8).

### *Firearms*

Horrible violent crime is a staple of American life. In 2011, the story focused on the attempted assassination of Representative Gabrielle Giffords in a shooting that left six dead and 19 wounded. Just over a year earlier, 12 were murdered and another 31 shot by a lone gunman at the Fort Hood army base in the largest, but hardly the only, mass shooting that occurred in 2009 (Associated Press 2009). And no one will forget the slaughter at Virginia Tech in Blacksburg, Virginia, in 2007, where thirty-two students and faculty were slaughtered in the classrooms and halls.

Shocking as these specific crimes are, they do not reveal a trend towards a more dangerous society. Violent crime rates in 2009 were at their lowest levels since data began being collected in 1973, with murder, rape, robbery and assault all less than one-third of the 1970s peak (Bureau of Justice Statistics 2011). Surely, that is news worth celebrating.

Just as surely, the United States remains unique among wealthy nations in the toll taken by firearms.

Each year firearms are associated with more than 30,000 fatalities by homicide, suicide, and accident (Xu *et al.* 2010, 89). Unlike the violent crime rate, the fatality rate for firearms has not budged from about 10 deaths per 100,000 individuals over the past decade. Not all groups are at equal risk, however: men are six times more likely than women to be killed by a firearm, and black men are twice as likely as white men to die from a bullet (Xu *et al.* 2010, 91). The extent of firearm violence does vary widely from state to state and over time. In general, the southern and western states have much higher levels of violence than states in the Northeast or Midwest. Louisiana, for example, had over 11 firearm-related homicides per 100,000 residents in 2007, whereas New Hampshire had 1/20<sup>th</sup> that amount; the fifty-state average was about 4 per 100,000 residents (Bureau of Justice Statistics n.d).

Unique, also, is the constitutional right of individuals to own guns. The Second Amendment states that “A well regulated Militia, being necessary to the security of a free state, the right of the people to keep and bear Arms, shall not be infringed,” but not until recently had the Supreme Court considered whether this right extended to individuals. Then, in *The District of Columbia vs. Heller* (2008) and *McDonald vs. City of Chicago* (2010) the Court narrowly decided (in two 5-4 votes) that federal, state, and local governments cannot violate fundamental individual rights to gun ownership. These rulings mean that state and local governments are not able to *ban* firearms entirely; the extent to which firearms can be regulated remains open question.

States themselves have a wide variety of policies to regulate and control the purchase, carrying, or ownership of firearms, and over the years many attempted to strengthen these laws. (For a state-by-state summary of laws and regulations concerning firearms, see National Rifle Association [2011a].) The advocates of more permissive gun laws have perhaps had more numerous victories. In 2011 Wisconsin enacted one of the nation’s strongest “right to carry” laws, leaving Illinois as the only state which does not provide citizens an option for carrying concealed weapons (National Rifle Association 2011b). The NRA has also been extraordinarily successful in pressing for state “Castle Doctrine” laws, which allow citizens to use force – including deadly force – “against an attacker in their home and any place where they have the legal right to be,” while also protecting individuals from civil lawsuits from the attacker when force is used (National Rifle Association 2001c). First adopted by Florida in 2005, similar laws have since been approved in 26 other states, most recently by Pennsylvania in 2011.

One gun policy issue aligns the interests of gun control supporters and 2<sup>nd</sup> Amendment advocates: the belief that the mentally ill should not have access to firearms. This issue rose to the policy agenda after the Virginia Tech shootings, and again after the attempt on Representative Giffords life. In 1968, spurred by Sirhan Sirhan’s assassination of Robert F. Kennedy, the federal government approved legislation barring anyone with a history of severe mental illness from buying firearms, but that ban was never vigorously enforced. Although more than 2.5 million mentally ill persons were prohibited from purchasing weapons under this law, at the time of the Virginia Tech massacre the FBI database contained only approximately 235,000 names, as federal law neither required the states to report this information nor provided them any funding to do so. The federal government subsequently required the states to share the names of the mentally ill and supplied funding to do so, but only a fraction of the pledged funds were actually distributed and no penalties have yet been enforced. The results are hardly encouraging: after the deadline for reporting had passed, nine states have not supplied any names and 17 other states have given 25 names or fewer, meaning that the background check lists are still woefully incomplete (Associated Press 2011). Political agreement does not necessarily mean policy effectiveness.

### *Sexual Behavior*

Alas, one of life’s greatest pleasures is one of its greatest problems. Unprotected sexual intercourse can kill, injure, and deprive—and not just by transmitting the virus that causes AIDS. The good news is that AIDS is no longer the death sentence it once was; improved treatment regimes reduced the number of persons dying from AIDS from 33,000 in 1996 to just over 17,000 in 2008. The sad news is that approximately 1–1.2 million Americans are living with HIV, about 20 percent of them “undiagnosed and unaware of their condition” (Centers for Disease Control 2011b). But unprotected sexual intercourse also contributes to approximately 30,000 deaths annually from “excess infant deaths” (from unintended pregnancies), cervical cancer (linked to certain sexually transmitted diseases), and hepatitis B infection each

year. In addition, some 15 million persons become infected with a sexually transmitted disease (STD) each year, and about half of all pregnancies are unplanned (American Pregnancy Association 2011).

Drugs are available to make HIV a chronic condition rather than an invariably fatal disease, but this creates substantial financial challenges for some states' public health systems. Although every state has persons with HIV/AIDS (PWAs) as residents, AIDS is not spread uniformly across the country: California, Florida, and New York alone account for about 40 percent of total AIDS cases up through 2008 (Kaiser Family Foundation n.d.c). A large proportion – about 40 percent of those with HIV receiving medical care – are enrolled in Medicaid, most often because they are both poor and disabled (see Kaiser Family Foundation 2009c for a discussion). The result is that much of the health care cost of HIV/AIDS is borne by the public sector; in 2008 federal and state governments spent about \$7.5 billion on AIDS through Medicaid (Kaiser Family Foundation 2009c), with the federal government picking up the entire tab for “dual eligibles” who also received benefits through Medicare. States with large numbers of PWAs, in particular, have thus been under tremendous pressure to contain the costs they have imposed on the public. A principal way states have tried to cope is to seek **Medicaid waivers** so that PWAs may receive home or community-based long-term care, rather than more expensive hospitalization, and at least 15 states have experimented with this approach.

The politics of sex have been characterized by the struggle between those who view sexual behavior as a moral issue and those who consider it a policy issue only to the extent that sexual behavior threatens public health (Rom forthcoming.b). The attitudes and policy preferences of those holding these views are fundamentally different. The former group believes that government policy should encourage or enforce only “moral” sex—that is, monogamous relations within a heterosexual marriage – by advocating “abstinence only” education. The latter group argues that sexual relations between consenting individuals are acceptable to the extent that they do not cause unintended pregnancies or spread disease; as a result, this group favors “comprehensive education” focusing on risk reduction as the appropriate policy. State policies toward sexual behavior have to a large extent mirrored these divisions within their populations; more conservative states and localities have emphasized abstinence only; more liberal states and localities, comprehensive education.

The politics of sex have been especially unhelpful in regard to welfare policy. Unprotected sexual intercourse is literally the beginning of the nonmarital births to teenagers that put families at risk of needing public assistance. But prevention policies that tell teenagers either to “just say no” or “just be safe” apparently have little impact on teenage pregnancy rates. It is intriguing—a hopeful sign—that policies emphasizing both moral restraint and safer sex are more successful at reducing unwanted pregnancies and sexually transmitted diseases than either approach alone (Manlove et al. 2002). During President Bush administration, however, the federal government provided states financial inducements to offer abstinence only education, and the states generally accepted those inducements (Bleakley, Hennessy, and Fishbein 2006; Guttmacher Institute 2006). Although some states have moved away from an exclusive focus on abstinence, those policies still dominate sex education (Kaiser Family Foundation 2010b).

It is also apparent that youth who become pregnant, or who impregnate, often have academic, economic, and emotional difficulties before the conception occurs. Dropping out of school, living in poverty, and having little hope for the future help create conditions that lead teenagers to become parents (Lawson and Rhode 1993). Research suggests that it is important to address teenagers' social conditions as a way of preventing teen pregnancies. Rather than focusing on pregnancy prevention by itself, public policy needs to improve the educational, economic, and emotional circumstances of adolescents most at risk (Sawhill 2001). Perhaps the best form of birth control is the realistic hope for a better future if childbearing is delayed. Providing such realistic hope for teenagers is not always an easy task even for parents. The states face even greater challenges in providing this hope: the United States has the highest rates of teen pregnancy in the industrialized western world.

There are glimmers of hope. Although high by international standards, the teen pregnancy rate was at an historical low for the United States in 2009, having fallen by 37 from its peak (Reinberg 2011). The decline was attributed both to decreasing sexual activity among teens and higher contraceptive use. Predictably, the teen birth rate varied dramatically from state to state. The states with the highest birth rates tended to be southern states with high poverty rates states (e.g., Mississippi, New Mexico, and Texas, with



over 60 births per 1,000 teens) while those with the lowest tended to be more affluent, northern states (New Hampshire, Massachusetts and Vermont, at about 20 births per 1,000) (Kaiser Family Foundation n.d.e).

## HEALTH OUTCOMES: STATE COMPARISONS

States are engaged in numerous efforts to improve the health of their residents. Their progress can be assessed by what they are doing or by what they have accomplished. The first approach focuses on state policies by, for example, using “report cards” that have been developed by various organizations. In 2007, when the previous edition of this book was published, the states were not performing well in their policy choices: the overall “grade point average” (GPA) was a 1.94 (or just below a C). The “good students” appeared to be to be the usual suspects: New York and California were both in the top three. Other states were more surprising: Arkansas ranked fourth, for instance. Some states scored quite high on some measures and much lower on others: Pennsylvania rated an A– for obesity prevention and a D+ for tobacco control, while South Carolina earned an F for tobacco and an A– for obesity. Perhaps the generally poor scores indicated that the rating organizations were tough graders; more likely, these grades reflected the fact that the states had not been particularly engaged in health promotion.

The second approach focuses on health outcomes. Outcomes allow us to compare the states against each other, rather than to some standard as in the report cards. Outcomes are influenced by policies, but policies do not determine them, of course: other powerful social, economic, and demographic determinants exist.

Outcomes can also be measured in diverse ways, but here the states are rated based on a single salient indicator of the main behavioral risks: tobacco use, obesity and inactivity, alcohol abuse, firearms, and sexually transmitted diseases. “Tobacco” is defined as the percentage of the adult population that currently smokes cigarettes, which ranges from a low of 9 percent in Utah to a high of nearly 27 percent in West Virginia. “Overweight” averages the percentage of adults who are overweight and those who do not regularly exercise. Again, Utah is the healthiest state on this dimension, although the overweight average is still a shocking 50 percent; again, West Virginia is the laggard with fully two-thirds of its adults overweight or inactive. “Alcohol” is the percentage of adults who engage in binge drinking, defined as consuming five or more drinks in a single day. Tennessee is the most abstemious (seven percent), perhaps due to the fact that in much of the state alcohol cannot be legally bought, while about a quarter of Wisconsin’s adults are binge drinkers. “Firearms” is firearm deaths per 100,000 in the population: Louisiana is the deadliest state (20 deaths) and Hawaii is the most peaceful (2.6 deaths). “STD” is the number of cases of Chlamydia – the most common sexually transmitted disease – per 10,000 in the population: in New Hampshire, the rate is 16; in Mississippi, it is more than four times higher.

Insert Table 11.1 about here

To create the overall ranking, the individual risk factors were weighted roughly by the importance of that factor in causing premature deaths – for every one million premature deaths, the overall index assumes that 500,000 were caused by smoking, 400,000 from diet and activity, 60,000 from alcohol abuse, 20,000 from firearms and 20,000 from sexual behavior (so, for example, the smoking rate was multiplied by 0.5, the obesity/inactivity rate by 0.4, and so forth).

Table 11.1 shows the overall rankings as well as the ranking for each individual factor. Those at the very top and very bottom are probably not surprising: West Virginia, Mississippi, and Alabama are better known for college football than for healthy lifestyles, while Utah and Vermont may bring wholesome images of hiking and skiing. More interesting are how the personalities of the states come through in the differing kinds of risks they apparently accept or avoid. Hawaii is among the healthy leaders regarding tobacco, weight, and firearms, but it is a comparative laggard in alcohol and STDs. West Virginia, highest in most risks, is comparatively safe in terms of alcohol and STDs, although one wonders if this also reflects data reporting priorities.

## CONCLUSION

How well and how quickly the states recover from the Recession is yet unknown. Whether the ACA will be implemented is uncertain. Of this we can be confident: the states will continue to grapple with

poverty and the health care needs of their citizens. How they do so will reflect the economic, social, and demographic features of the states as they affect the choices that state politicians make. One hopes that future editions of this volume will reveal states that are more prosperous and healthier. Time will tell.

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### *Internet*

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Office of Family Assistance, Administration for Children and Families (U.S. Department of Health and Human Services). [www.acf.hhs.gov/programs/ofa/](http://www.acf.hhs.gov/programs/ofa/). The Office of Family Assistance oversees the TANF program, and this Web site links to information on recent program developments.

State Health Facts (Kaiser Family Foundation). [www.statehealthfacts.org](http://www.statehealthfacts.org). This Web site provides a wide array of data on health status and health programs; it summarizes data across the states and also provides state-by-state profiles.

State Health Policy (Commonwealth Fund). <http://www.commonwealthfund.org/>. The State Health Policy section of the Web site for the Commonwealth Fund evaluates state health care systems, explores possible reforms, and tracks public opinion on health policy.