

Table 2.2. Pre-HIPAA MSAs

<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>
MO	AZ	IN	LA
	CO	MT	OH
	ID	NM	CA
	IL	NV	PA
	MI	OK	
	MS	UT	
		WA	
		WV	

Table 2.3. MSA Maximum Contributions Specified

<u>\$5000</u>	<u>\$3000</u>	<u>\$2000</u>
IN (95)	CO (94)	AZ (94)
	IL (94)	ID (94)
	MI (94)	OK (95)
	MT (95)	UT (95)
	OH (96)	
	PA (96)	
	WV (95)	
	NM (95)	

Table 2.4. States with Penalties on Nonmedical Withdrawals

<u>20%</u>	<u>15%</u>	<u>10%</u>
WV (95) ^(b)	AZ (94)	CA (96)
	LA (96)	ID (94) ^(b)
	MS (94)	IL (94)
	NM (95)	IN (95)
		MI (94)
		MT (95)
		OK (95)
		PA (96)
		UT (95) ^(a)

(a) penalty only if account balance falls below \$4,000

(b) no penalty if nonmedical withdrawals are made after the age of 59½

CHAPTER THREE

STATE POLICY INNOVATION AND MEDICAL SAVINGS ACCOUNTS: A REVIEW OF THE LITERATURE

Introduction

In order to address the question as to why 19 states adopted MSAs over a period of four years, I considered the broader question of why state governments adopt policies in the first place. The question of why states adopt the policies that they do has been considered often in the policy innovation literature.

Review of Policy Innovation in the States

Much of the policy innovation literature in political science begins with Jack Walker's study (1969) on the diffusion of innovation in the American states. Walker defines "innovation" as a "program or policy which is new to the states adopting it" (Walker 1969, 881). In his study of 88 different policies adopted by at least 20 states, Walker says that a state is more likely to adopt a particular policy if surrounding states have previously adopted a similar policy. Walker envisions a diffusion process whereby there would be policy leaders, followers, and laggards. The leaders of policy adoption would be more urban states that are more professional with more resources

than those of the follower or laggard states. Walker's "leader states" are leaders across policy types.

Walker's study is followed by Virginia Gray's (1973) study of civil rights, education, and welfare. She comes to the conclusion that adoptions vary according to the type of policy. States that lead in one policy area would not necessarily lead in another. Furthermore, she finds that the temporal pattern of these adoptions resembles an "s-curve" in which a few initial states take the risk of adoption. This initial phase is followed by an increase in the rate of adoptions. After the burst of adoptions, the rate of adoptions declines.

Models following Walker and Gray tend toward either an "internal determinants" approach which focuses on influences within a state or a "regional diffusion" approach which focuses on the emulation of adoptions across state lines. Berry and Berry (1990) observe this segregation in the policy innovation models following Walker and Gray. They provide a unified theory of policy innovation in which both internal determinants and regional diffusion are utilized in the explanation of why states adopt the policies they do.

Berry and Berry (1990) base their unified adoption model on Mohr's (1969) Theory of Organizational Innovation. Mohr's theory proposes a relationship among innovation, motivation, and the obstacles and resources that states possess. Berry and Berry use Mohr's framework in explaining that when neighboring states adopt a policy (the regional/external approach), this act provides information (a resource) and reduces uncertainty (an obstacle) to the state considering whether or not to adopt. Berry and Berry

categorize their explanations of policy adoptions as "motivation," "resources," and "obstacles." The interplay of these factors can be explained in terms of economics, culture, politics, and region. Berry and Berry follow with a similar approach in their 1992 research on state tax innovation. In that work they consider economic development, fiscal health, proximity of elections, party control, and region as explanations for adoption.

Since the early 1990s there has been a surge in the number of policy diffusion studies in areas such as abortion (Mooney and Lee 1995), the death penalty for the mentally retarded (Emmert and Traut 2003), digital government policies (McNeal et al. 2003), education (Mintrom 1997a, 1997b; Mintrom and Vergari 1998; Wong and Shen 2002), electricity regulation and deregulation (Ka and Teske 2002), Indian gaming (Boehmke and Witmer 2004), interstate compacts (Dodson 1998), living will laws (Glick and Hays 1991), Medicaid waiver policies (Arsneault 2000), right to die (Glick 1992a, 1992b), taxes (Berry and Berry 1992), and tort law (Lutz 1997). Nice (1994) analyzes state innovations in the areas of teacher competency training, balanced budget provisions, sunset laws, public campaign finance, rail passenger service, property tax relief, deregulation of intimate behavior, and the state ownership of freight railroads. Together these studies provide various explanations for state policy adoptions, explanations that can be characterized as socioeconomic, political, economic, and regional.

Many of these same explanations for adoptions have been used by policy scholars to provide explanations for health policy innovations. Carter and LaPlant (1997)

consider the major influences on health policy adoptions to be 1) problem environment 2) population density 3) political factors and 4) region. In his research on small business insurance reform Stream (1999) categorizes the explanations of adoption as 1) political context 2) fiscal health 3) problem/severity demand 4) interest group 5) regulatory environment and 6) diffusion. Both Carter and LaPlant (1997) and Stream (1999) consider fiscal, political, and regional influences as determinants of innovation.

Review of Medical Savings Accounts

While there have been a large number of state policy innovation studies since Berry and Berry (1990) and even some in the health policy area, to date, there have been no peer-reviewed articles or texts dealing with the adoption of MSAs in the American states. Much of the conversation about the MSA at both the national level and state levels began with the book *Patient Power* by John Goodman and Gerald Musgrave (1992). In *Patient Power* Goodman and Musgrave offer readers a market-oriented approach to health insurance. In their introduction the authors state their thesis that common-sense principles must be applied to health care decisions as they are to other goods and services. It was in this work that the MSA idea was presented. This 672-page book was later abridged by the Cato Institute and received a wide circulation (Goodman 2004).

According to Goodman (2004), *Patient Power* delivered a death blow to the Clinton-managed competition plan. While *Patient Power* did not mention the Clinton plan *per se*,

Goodman states that the MSA policy outlined in the book became a rallying point for several members of Congress. About 40 Republican senators embraced the MSA as an alternative to the Clinton plan. It is Goodman's view that once those Republicans embraced the MSA policy, the Clinton plan was dead.

After *Patient Power* and after attempts to get the MSA adopted at the national and state levels, discussions about the MSA began to appear in the academic and popular literature. Debates over the MSA were centered more on national-level than on state-level issues and covered several topics such as the attempt by Congress to pass MSA legislation in the early 1990s (Goodman and Musgrave 1992, 1993; Gramm 1994; Harris 1996; Nichols 1995; Pauly and Goodman 1995a, 1995b) and design issues (Ambrose and Butler 1997; American Academy of Actuaries 1995; Litow 1994, 1996; Litow and Muller 1996; Moon, Nichols, and Wall 1996, 1997; Thorpe 1995). Opponents of the MSA wrote of the potential negative effects that the health care system might incur because of MSA implementation such as adverse selection (Nichols 1995), the undesirable condition of expanding an income tax subsidy to one more exception (Pauly 1994), the undermining of managed care (Bodenheimer 1996), the thwarting of policy goals aimed at achieving universal coverage (Lav 1994), and the apocalyptic forecast that MSAs would wreck the health insurance system (Burry 1994a, 1994b). However, others that were generally supportive of the MSA included Barchet (1995), Barchet, Anderson, and Chapman (1995), Ferrara (1996a, 1996b), Goodman and Musgrave (1993), Jensen and Morlock (1994), Matthews

(1996), Norquist (1996), Pauly and Goodman (1995a, 1995b), Roth (1994), and Tanner (1995).

The policy debate over the MSA and the issues surrounding that debate can be illustrated by Mark Pauly and John Goodman and their critics in an exchange that took place in 1995 in the academic journal *Health Affairs*.

In their article "Tax Credits For Health Insurance and Medical Savings Accounts," Pauly and Goodman (1995a) say that a problem with the health insurance system is that it provides a tax subsidy for employer-purchased health insurance which results in more funds going to purchase unnecessary health insurance (and thereby increasing inefficiency) and in discrimination against those who are self-employed or not employed. They suggest that political conditions will not allow for comprehensive health care reform, noting that "removing the tax subsidy by wholesale revisions of the tax code seems politically improbable" (131). Instead, they suggest that the tax system be changed at the margins. This could be done by allowing for a tax credit of \$750 for the voluntary purchase of catastrophic health insurance in lieu of the current tax subsidy. Receiving the tax credit would be conditional on whether or not consumers had met a minimal requirement of obtaining catastrophic health insurance along with an MSA. The tax credit would be fixed: consumers would not get a greater tax credit if they purchased more health insurance.

The tax credit would be one of three policy goals: the second would be the purchase of a catastrophic health insurance policy with the third goal being the opening of an MSA for the purpose of saving after-tax dollars in order to pay the high deductible. Revenue earned from the account

could be tax-free, but there would be a limit on how much tax-free revenue could accumulate.

Several critiques followed the Pauly and Goodman article. Nichols (1995) criticizes Pauly and Goodman's attempt to achieve tax reform at the expense of encouraging risk segmentation. According to Nichols tax favorability granted to employers in paying health insurance premiums is important to the pooling of risk. Nichols maintains that the tax incentive in the MSA would undermine the pooling of risk, encouraging risk segmentation and resulting in costlier health insurance premiums for those at risk.

Pauly and Goodman (1995b) reject the claim that MSAs necessarily lead to adverse selection and risk segmentation as suggested by Nichols (1995). They point out that the market is already segmented and that MSAs would probably have the effect of bringing in consumers currently uninsured, like those that are healthy and young.

Other respondents included Chollet (1995) who critiques the Pauly and Goodman proposal on efficiency grounds saying that catastrophic plans are likely to increase the amount of health care debt consumers incur. This would only transfer the cost of health care to providers. Also, increased out-of-pocket health care expenditures would encourage a reduction in "necessary health care" especially among those with a lower income. Hsiao (1995) says that the market power of physicians greatly surpasses that of patients, a power which allows providers greater latitude in setting prices. The author uses the example of Singapore's experience with Medisave accounts to show how health care costs have risen in spite of the accounts.

Those generally supportive of the MSA tend to use two lines of support for the MSA. The first line of support is based on findings from the Rand Corporation's Health Insurance Experiment (HIE). The HIE finding of most interest to MSA supporters is that participants are more cost conscious about their health care spending as the insurance co-payment increased, yet this increased frugality by the participants does not result in a decline in health (Newhouse 1993). Those who use this first line of support include Barchet (1995), Bunce (2001), Goodman and Musgrave (1993), Jensen (2000), Jensen and Morlock (1994), Keeler et al.(1996), Scandlen (2001), and Tanner (1995).

The second line of support used to state the positive features of the MSA is to report the past successes of MSAs in the corporate world. As was mentioned in Chapter Two, Golden Rule Insurance Company, Dominion Resources, and Forbes all adopted some form of MSA as a part of their employee health benefits package. Typical of this line of support is to describe the plan and to report the savings to both the company and the employee (Barchet 1995; Barchet, Anderson, and Chapman 1995; Buckeye Institute 1999; Bunce 2001; Ferrara 1996b; Goodman and Musgrave 1993; Gramm 1994; Jensen 2000; Jensen and Morlock 1994; Tanner 1995; Wildavsky 1993).

Opponents also tend to use two lines of support in their opposition to the MSA. While MSA supporters tend to rely on the simulation of the Rand HIE, MSA detractors tend to cite the simulation from the American Academy of Actuaries (AAA) in support of their position (American Academy of Actuaries 1995, 23). Speaking of the MSA "winners and losers," the AAA concluded that "the greatest

savings will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women." While the AAA does say that the average person would do well under the MSA plan, the AAA estimates that among employees with the highest medical expenses, the amount of premium increase could be as much as \$926 under the MSA as opposed to a traditional plan (American Academy of Actuaries 1995, ii). Those using this line of argument include Bodenheimer (1996), Burry (1995a, 1995b), Dreyfuss and Stone (1996), Kennedy (1996), Moon, Nichols, and Wall (1996), Nichols (1995), Stark (1995), and Warsh (1996).

Second, opponents tend to cite a study by the Congressional Budget Office (CBO) which states that "in the long run, the existence of any type of catastrophic-plus-MSA (medical savings account) option that would be attractive to a large number of people could threaten the existence of standard health insurance" (Congressional Budget Office 1994). MSA opponents citing this projection of the CBO include Burry (1995b), Dreyfuss and Stone (1996), Judis (1995), Kendall (1996), Kennedy (1996), Moon, Nichols, and Wall (1996), Pallone (1996), and Quinn (1995a, 1995b).

While most of the recent focus on MSAs has been at the national level, the focus of this study is on MSA adoptions at the state level. Between 1993 and 1996, 19 states enacted non-HIPAA MSA legislation in their states. Most of the state MSA studies have been a review of what states have done so far and the potential implications for MSA

implementation (Holahan and Nichols 1996; Manchester 1994; Minnesota Department of Health 1994; Moon, Nichols, and Wall 1997). However, in their dissertations, Dolfini-Reed (2000) and Karch (2003) provide some analysis for state MSA activity.

Moon, Nichols, and Wall (1997) simulate the effects of introducing MSAs into the current mix of employer-sponsored health insurance arrangements. They also examine the experience of 13 states that enacted some form of MSA legislation. They conclude that MSAs hold some promise, especially for healthy workers. However, they also report that MSAs may trigger higher premiums for those less healthy and produce other negative consequences for the health insurance market.

Scott Manchester (1994) did a briefing paper for the Oregon Department of Health in which he evaluates the MSAs in seven states and compares them with two congressional MSA proposals. He raises the point that the MSA creates a "concern" for managed care systems and may cause adverse selection to existing Oregon health plans. Minnesota Department of Health (1994) is more forthright in stating that the MSA concept is incompatible with the concepts of universal coverage and managed care.

There have been some suggestions as to why MSAs might have received favorable attention within a state, including the influence of Golden Rule Insurance Company (Andrews 1993; Calabrese 1994),²⁴ Republican governors (Freudenheim 1992; Norquist 1996; Roth 1994) or Republicans in general

²⁴ For Golden Rule's political activity at the state level in other areas besides MSAs see Andrews (1992a, 1992b), Feaver (1994), Ketzenberger (1989), Monk (1994), and Strange (1991).

(Peterson 1997),²⁵ conservative ideology (Dolfini-Reed 2000; Karch 2003; Peterson 1997), state laws that prohibited the sale of health plans other than the "standard, state-defined benefit packages" (*American Medical News* 1994), the result of budget constraints (Carter 1997), and Congress's failure to enact comprehensive health care reform (Parish 1994; Sneider 1993).

Two dissertations have provided some analysis of state MSAs. Dolfini-Reed (2000) includes the MSA in her evaluation of the "laboratories of democracy" thesis by comparing health care policies that are mostly state-dominated with those that are Washington-dominated and comparing them across the adoption and implementation phases of the policy process. The MSA along with child health insurance, health alliances, high-risk pools, and market reforms are analyzed. She challenges the oft-held assumption in the state policy literature that innovation is largely an act of liberal ideology. Rather, in her conclusion, she states the following:

It is not the case that the states that innovate first and most frequently are those with a liberal ideological orientation. State policy innovation is not only a liberal act reflective of liberal ideologies. Instead, state policy innovation is an act of change that may reflect conservative or liberal ideologies depending upon the ideological leanings of the state. It is an act of change realized under the American federal

²⁵ Peterson (1997, 1105) says, "Republicans swept the congressional elections in 1994, took control of the legislature for the first time in forty years, and advanced MSAs as a feature of conservative market orthodoxy." While this is a reference to the Republican Party at the national level, it is not too far a field to infer here that if the MSA was an important part of the Republican national agenda, the same can be said for state parties. Also, see Karch (2003).

structure and reflective of the responsive nature of American democracy. (201)

Dolfini-Reed also finds evidence in her baseline model for the influence of socioeconomic, market, and regional influences on state MSA adoptions.²⁶ In his dissertation on state health care policy innovations Karch (2003) finds evidence that supports the conclusion that socioeconomic, political, regional, and national influences are affecting state MSA activity at different times in the policy process.

Like Dolfini-Reed and Karch, I also provide an analysis of state MSAs; however, in this dissertation, I focused only on the state MSA adoptions. Another distinction between these two studies and mine is that I utilized the Berry and Berry unified adoption model explained in the next chapter. Interpreting policy adoption within this framework led to some explanations different from what Dolfini-Reed or Karch found. A third distinction between this study and theirs is that I considered the influences on one policy rather than the influences across several policies. Focusing on one policy allowed me to

²⁶ There is a discrepancy between my research and Dolfini-Reed's over whether or not certain states adopted the MSA. First, she excludes California, Nevada, and Pennsylvania as adopters (164, Table 61). However, I find that those states were adopting states. Second, she specifies Maine as having adopted MSAs in 1995 (164, Table 61). However, I find no evidence that Maine ever adopted them. Sheila Bearor, the Reference Librarian for the Maine State Law and Legislative Reference Library confirmed my research (Bearor 2004 Electronic Mail, August 25) as did Colleen Reid, Legislative Analyst for the Joint Standing Committee on Insurance and Financial Services at the Office of Policy and Legal Analysis in Augusta (Reid 2004 Electronic Mail, August 25). Third, she specifies Oregon as adopting an MSA in 1991 (164, Table 31), yet I find no evidence that Oregon adopted MSA legislation then. My findings on Oregon were confirmed by David Harrell, Legislative Librarian for the Oregon State Capitol (Harrell 2004 Electronic Mail, August 26). Oregon did adopt an MSA law in 1997.

concentrate on what might have been the influences on the adoption of the MSA irrespective of other policies.

As for Dolfini-Reed's research specifically, the distinction between my research and hers is that there are a number of differences between her research and mine as to what states actually adopted the MSA. As to Karch's research specifically, this dissertation is distinct from his in that I am providing an analysis of only those MSAs that were adopted just prior to HIPAA. Second, Karch includes Virginia and Wisconsin in his analysis. However, I exclude these two states because their adoption of an MSA was conditional on a national MSA adoption. In effect, congressional and presidential inaction was tantamount to a veto on the state MSA, even though it was passed by the legislature and approved by the governor.²⁷

²⁷ In addition, Karch says that Ohio adopted the MSA in 1994. However, my findings indicate that Ohio did not adopt its MSA until 1996 (HB 179, adopted July 2, 1996). Greg Schwab, a staff attorney for the Ohio Legislative Service Commission confirmed my findings (August 27, 2004).

CHAPTER FOUR

THE UNIFIED POLICY ADOPTION MODEL AND MSAS

Introduction

In the analysis of state MSA adoptions, an EHA using probit is employed. The probit analysis provides the potential empirical support for the hypotheses pertaining to state MSA adoption. This statistical model is presented in Chapter Six of the dissertation. Within this chapter the unified policy adoption model that provided the framework for the analysis is presented.

The fundamental research question in this project is "Why do states adopt the policies they do?" One descriptive answer to that question is that "policy adoption" occurs when there is sufficient agreement between the majority of the state house members and the governor to vote for a specific bill. This explanation of policy adoption has the virtue of providing the analyst with a clear and distinct boundary between the place where an event has not yet occurred and the place where the event has occurred.

As for the causation of the policy event, earlier policy adoption studies have tended to focus on models that consider those influences that are regional or internal to the state. Berry and Berry (1990) offer an approach that unifies the two types of models. In their review on innovation and diffusion research, Berry and Berry (1999,

187) propose the following model of state government innovation:

$$\text{ADOPT}_{i,t} = f(\text{EXTERNAL}_{i,t}, \text{MOTIVATION}_{i,t}, \text{RESOURCES}/\text{OBSTACLES}_{i,t}, \text{OTHER POLICIES}_{i,t})$$

Berry and Berry define each of the variables as follows:

$\text{ADOPT}_{i,t}$ is the probability that state i will adopt the policy in year t . $\text{EXTERNAL}_{i,t}$ denotes variables reflecting diffusion effects on state i at time t ; thus, they would measure the behavior of other states at time t , or in the recent past. $\text{MOTIVATION}_{i,t}$ represents variables indicating the motivation to adopt the policy of public officials in state i at time t $\text{RESOURCES}/\text{OBSTACLES}_{i,t}$ denotes variables reflecting obstacles to innovation and the resources available to overcoming them....[f]inally, $\text{OTHER POLICIES}_{i,t}$ is a set of dummy variables indicating the presence or absence in state i of other policies that have implications for the likelihood that the state will adopt the new policy. (188)

As in this model created by Berry and Berry (1999), my explanations can also be considered in terms of motivations, obstacles, resources, external influences, and other policies. Below, I provide an explanation of MSA adoption within the context of the Berry and Berry framework, along with the hypotheses to be tested (See Table 4.1 for a summary of the model factors with their hypotheses.).

The Motivation to Innovate

The Unified Model of Policy Adoption (Berry and Berry 1999) states that adoption is, in part, a function of the motivation to innovate. Lawmakers are more likely to be motivated to innovate when faced with a crisis, when the policy offered is also consistent with their own ideology,

and when their party has control over the government. As it pertains to the MSA, the motivation to innovate is likely to be highest in states where lawmakers are Republican, conservative, and reside in states that have a high rate of uninsurance. Further analysis of the motivation to innovate follows and includes a discussion about the electoral hypothesis as a motivation to innovate as well as the role that uninsurance, political party, and ideology played in the adoption of state MSAs.

The Electoral Hypothesis

Much has been made of the electoral hypothesis as an explanation for the motivation to innovate (Berry and Berry 1992). According to the electoral hypothesis, lawmakers are likely to be influenced by public opinion as the time for reelection approaches. Therefore, lawmakers are more likely to support popular programs just prior to an election and to delay passing unpopular programs until right after an election, creating as large a buffer of time as possible between passing the unpopular program and the next election. Furthermore, lawmakers are likely to be more receptive to timing their support of policies based upon the degree to which they are vulnerable on Election Day. The more vulnerable they are, the more likely they are to support popular programs just prior to election time and to delay supporting unpopular programs until after the election. The electoral hypothesis seems reasonable especially if lawmakers adopt unpopular policies that are highly salient with the public.

However, it is not likely that elections act as a significant motivation in the adoption of MSAs. Insurance

issues are not normally salient with the public; this lack of public interest has been attributed to their complexity (Meier 1988; Randall 1999).²⁸ For example, the MSA idea was difficult to understand (a complaint made by insurance agents after the passage of HIPAA) (Bunce 2001). If the MSA is not a salient issue with the public, lawmakers need not fear that MSA adoption will generate voter retaliation. Nor do lawmakers need to fear retaliation from the market sector as the MSA is voluntary, and thus, not likely to generate the kind of resistance normally associated with regulatory policies.

State Uninsurance

Though fear of public retaliation can reasonably be ruled out as a component of MSA adoption, some element of fear may have been at play in the motivation to innovate. For example, earlier works address the relationship between a crisis and policy innovation (Carter and LaPlant 1997²⁹; Gray 1973; Gray and Lowery 1990; Nice 1994; Savage 1985; Stream 1997; Walker 1969). Reformers often allude to a

²⁸ Randall (1999, 626, n.3) says, "Consumers do not participate in insurance issues for a number of reasons...insurance issues are typically complex, requiring special knowledge and expertise. Individual insurance consumers can obtain and understand information about the issues only with great effort and at great cost." Meier (1988, 17) says "insurance regulation is a widely ignored segment of political economy." McNeal et al. (2003) finds that citizen demand is not a factor in the adoption of a technical policy like digital government policy. States with households with greater internet access are actually less likely to be innovators in digital policy.

²⁹ Carter and LaPlant (1997, 21) state that the "problem environment" (as measured by the "percent of the population aged 65 and over, per capita Medicaid spending, and state health/hospital spending as a percentage of general expenditures") has a "limited effect" on the adoption of state health care policy innovations. This "problem environment" variable correlated with some innovations but not with others.

"crisis in health care" that demands that new policies be enacted. Given the attention by states on health insurance reform and the related rising rate of uninsurance, it is likely that the motivation to innovate is, in part, an attempt by lawmakers to manage a perceived crisis in health care resulting from lack of health insurance. Innovative health care reforms would be aimed at raising the number of insured citizens in the state.

The motivation to innovate is likely to be greater if there is some crisis in the mind of the lawmaker that raises the saliency of the issue. According to Nice (1994, 33), "a crisis, a deteriorating situation, or a vague perception that current performance is not satisfactory can spur decision making into researching for new approaches, assessing their merits, and adopting those innovations that offer some prospect for improving the situation." A rising or already high rate of uninsurance will likely be perceived by lawmakers as "a deteriorating situation" and thereby raise its level of saliency. There is some indication that uninsurance is a salient issue (Barrilleaux and Brace 2001).³⁰ If lawmakers deem the state's uninsurance level as severe enough, they may surmise a "deteriorating situation" that Nice speaks of and respond by adopting innovative policies.

Gray (1994, 1352) notes that one way that problems can be identified is by "data already collected" that provides a measure for some problem. An important indicator to lawmakers of the state's insurance problem would be the state's rate of uninsurance. This statistic can serve as a

³⁰ Barrilleaux and Brace (2001, 4) say that "...uninsurance represents the most salient health policy problem of the decade."

benchmark for assessing how the state is faring in controlling the rising rate of uninsurance. It can also provide a measure for comparing one state with the next. Lawmakers can assess how their state fares with other states in addressing their state's health care problems.

However, there are some limitations to the use of a measure of uninsurance. There is the limitation of time; any response by lawmakers to a measure of uninsurance would have a time lag. Information on insurance rates must be gathered and assessed. Normally, a lawmaker receives knowledge of insurance rates the following year. However, a lawmaker receiving and reacting to information on uninsurance rates for 1992 in 1993 would probably not have time to respond to that information in the 1993 legislative year, but would have to wait until at least 1994 to advocate a policy adoption. Therefore, it appears that there would be at least a two-year lag on the effect that the rate of uninsurance could have on the motivation to adopt.

If Nice (1994) is correct that a crisis can spur innovation, then it is reasonable to assume that a high or rising rate of uninsurance provides a platform for reform-minded lawmakers to compete in promoting innovative policies in their states. As the saliency of the issue increases among lawmakers, greater pressure will be placed on them to pass some reform to deal with the problem. My conclusion is that such states will be more receptive to adopting MSA legislation.

Therefore, I hypothesize that

H₁ the probability that a state will adopt the MSA policy increases as its rate of state uninsurance increases.

Ideology

A second component of the motivation to innovate surrounds the potential influence of ideology on policy adoption. Other policy studies have remarked on the influence that legislative ideology has on state policy adoption (Carter and LaPlant 1997; Ka and Teske 2002; Skocpol 1993; and Starr 1982). Barrilleaux, Brace, and Dangremond (1994, 28) consider ideology "the most persistent force underlying state health reform efforts." In short, the motivation to innovate is likely to increase when policy proposals threaten the lawmaker's ideological principles, with the lawmaker reacting to protect those principles. This reaction could extend to promoting an alternative policy to counter an offending policy.

An ideology is defined by Ball and Dagger (2004, 4) as "a fairly coherent and comprehensive set of ideas that explains and evaluates social conditions, helps people understand their place in society, and provides a program for social and political action." As lawmakers rely on their ideologies to guide them in making policy changes, their policies will likely clash with other lawmakers who deem those policies a threat to their own ideology. Should that occur, it is possible that those lawmakers who feel threatened will propose their own policies to counteract the policies that they deem threatening.

The persistence of ideology as an influence in health policy may be due, in part, to the polarity between conservative and liberal views on health policy. Balla (2001, 234) summarizes the distinctions between conservative and liberal views about health care, noting that "in general, conservatives are less favorably disposed

than liberals toward economic regulation, and this pattern typically holds in the health sector" (See also Goldstein 1997; Johnson and Broder 1996). Liberals tend to support government regulation as a solution to market failures. On the other hand, conservatives are likely to point to government intervention as being one of the causes of market failure (Weissert and Weissert 1996).

An example of this ideological conflict between liberals and conservatives occurred when President Bill Clinton attempted to implement his managed care program. Since liberals are more likely to view regulation of the market as a remedy to state problems (like rising uninsurance rates), they were more likely to have supported Clinton's managed care plan. Conversely, since conservatives are more likely to view regulation of the market as being one source of market failure, they were more likely to have opposed Clinton's plan. This is, in fact, what we do find with conservatives, referring to Clinton's plan as "socialized medicine."³¹

Conservative lawmakers are apt to see increased government regulation of the market as an ideological threat. The reaction by conservatives that Clinton's managed care policies would lead to socialized medicine increased the likelihood that conservatives would offer policy alternatives to the Clinton plan if given the opportunity. The MSA appears to have been such an alternative offered at both the state and the federal

³¹ The pejorative of "socialized medicine" originally came from the American Medical Association (AMA) and was leveled by them against Harry Truman's plan to nationalize health insurance in 1945 (Hogeboom 1994).

levels (Bordonaro 2002; Brown 1994; Goodman 2004; Parish 1994; Schoch 1994; and Sneider 1993).

Once President Clinton's managed care plan was introduced in 1993, conservatives began to mobilize in opposition to it. On July 1 the Chairman of the American Conservative Union (ACU), Donald Devine, said that "we don't want a government-managed system that will lead to rationing" and joined ALEC to actively oppose the Clinton plan (Priest 1993, A3). It was also at this time that a coalition of conservative organizations called the Citizens Against Rationing Health (of which ACU and ALEC were a part) began denouncing the Clinton managed care plan and promoting the MSA as an alternative (Priest 1993; *The Record* 1993). By December of 1993, Vice President Dan Quayle's chief of staff, William Kristol, a prominent neoconservative, began issuing memos to congressional Republican lawmakers urging them to oppose the Clinton plan (Patel and Rushefsky 1999).

Not only was there a reaction among national conservative lawmakers to the Clinton plan, but there was also a reaction by conservative state lawmakers. Bordonaro (2002) notes that during her time at ALEC, conservative lawmakers were looking for policy alternatives to the Clinton plan. By 1993 ALEC was promoting the MSA and wrote an MSA model law for state lawmakers to introduce into their state legislatures. During 1995, 28 state legislatures proposed ALEC's MSA model laws; eight states adopted them (*State Capitol Reports* 1995). In several states conservative lawmakers were promoting the MSA as a market solution to existing health care problems by changing incentives toward individual choices (Greenwald

1994), by making the patient a consumer (PR Newswire 1994a), and by creating competition among providers (Chen 1996). Based on what we know about the ideologies of state lawmakers, these market solutions were more likely to be viewed positively by conservatives than by liberals.

If ideology is important to the motivation to innovate in the case of the MSA we should expect that conservative state lawmakers would be more likely to respond positively to the MSA policy than liberal lawmakers. Because the conventional wisdom is that the MSA is a conservative policy and that the intense discussion about its merits took place in the aftermath of the proposed Clinton health care plan, I hypothesize that

H₂ the probability that a state will adopt the MSA increases as its rate of state government liberalism decreases.

Political Party

A third component of the motivation to innovate is the influence that state political parties have on the adoption of policies. McNeal et al. (2003) reports on the importance of the Republican party in digital government policies while Hays and Glick (1997) report on the Democratic party's influence on the adoption of living will laws. Political parties provide the motivation to innovate to the degree that their party can control the state government. The chances of the MSA being adopted are greater with the Republicans in control than with the Democrats in control.

There are several reasons for state parties to provide ample motivation to innovate. First, parties historically and currently provide the means by which competition takes place within the legislative process. Almost all lawmakers, whether they are legislators or governors, have chosen to

run for office as either Republicans or Democrats. Second, Dye and McManus (2003) note that the party has influence with lawmakers by communicating expectations via roles. The party can relay to its lawmakers its expectations that they be loyal to the party and its goals. Third, members of the majority party exercise control over the main instruments of the legislative process. In many states the majority party caucus selects the speaker in the lower house, the president of the senate in the upper house, and committee chairs (Dye 2000). The majority party may also caucus to discuss the policies they should support. Such opportunities are likely to be used by the majority party leadership to advance their goals within the legislature. With actual control over the legislature, lawmakers in the majority party are likely to reason that their pet projects can become policy realities. This confidence would undoubtedly increase if the same party controlled both chambers of the legislature as well as the governor's office.

Should the Republicans have opportunity to increase their control over the lawmaking process, they would also be the ones more likely to promote the MSA. There are at least two reasons why it is more likely that the Republicans are the ones to promote the MSA. First the Republican party tends to be supported by pro business organizations such as the NFIB and midrange insurance companies, both of which are generally supportive of the MSA. Second, the historical record indicates that support for the MSA comes mostly from the Republicans (Norquist 1996; Roth 1994).

During the 1990s the rise of interest in and promotion of the MSA corresponded with the rise of Republican party control of state governments. The 1990 census and ensuing redistricting in 1992 marked a decline in control by the Democrats over state houses nationwide. By 1992 Democrats had dropped to 57% from 60% control of legislative seats that they held just before the census. By 1994 Democratic party control had slipped further to about 52% (Patterson 1996). Prior to the 1994 elections, Republicans had control of only eight of the state legislatures; after the 1994 election, they controlled 19. With regard to the governor's mansions, Republicans occupied only 19 of them just prior to 1994; after the election they occupied 30 (Bibby and Holbrook 1999). This slippage by the Democrats and the surge by the Republicans just prior to the first MSA adoptions may provide some explanation for the attention that the MSA was receiving in the early 1990s. Gray (1994, 1354) notes that "a change in administration—a new governor or a different party in control of the legislature—allows new ideas to surface."

Because it appears that political parties motivate lawmakers to take sides on specific policies, and because it is more likely that the Republicans supported the MSA, I hypothesize that

H₃ the probability of state MSA adoption increases as Republican control over the state legislative and executive branches increases.

Obstacles to Innovation and the Resources to Overcome Them

The second factor in the Berry and Berry state adoption model pertains to the agents that provide the resources and obstacles to state policy adoption. Four such

agents are considered as possible obstacles or resources that affect policy adoption. First, the federal relationship is likely to have some effect on adoption because of the financial assistance provided by Washington to the states. The resources that Washington provides are likely to steer states toward policies that Washington desires and away from individual state initiatives. These resources will probably have a negative effect on MSA adoption. Second, state professional associations are also likely to influence the MSA adoption. The state professional association most likely to have an effect is the National Association of Insurance Commissioners (NAIC). NAIC has the potential to influence choices in state policy through its process of accrediting state insurance programs and through its insurance model laws which are likely to promote uniformity of policies among the states. Like federal assistance, NAIC's resources probably decrease the likelihood that states will develop unique policies. Third, legislative professionalism provides legislators with additional money and time to consider potential innovations. However, not all policies are equal; some may require only a small number of resources. A policy requiring few resources like the MSA is more likely to be adopted by a state having fewer resources and more likely to be overlooked in a state having more resources. Therefore, the resources provided to state legislators are likely to have a negative effect on MSA adoption. Finally,

policy entrepreneurs³² are likely to influence MSA adoptions. Since few state lawmakers have training in insurance and since insurance issues are characteristically technical, the policy entrepreneur could prove to be a valuable resource by providing information. Such information may be valuable to state lawmakers actively seeking solutions to problems related to health insurance that are compatible with their own ideals. The influence that the policy entrepreneur has on MSA adoption is likely to be positive. Below, I provide a further analysis of each of the variables above.

Federalism

Washington's program of providing financial assistance to the states has been dubbed by scholars as "fiscal federalism" (King 1984; Musgrave 1959; Oates 1972). An important part of fiscal federalism is the financial assistance that reaches states through the federal grants-in-aid. According to Hanson (1999, 45), "Financial grants-in-aid are the chief incentives by which national policy makers induce state government to enact programs and policies intended to serve national objectives." If, as Hanson wrote, the grants are the "chief incentives" of states' legislative actions, this would seem to imply that Washington policymakers assume they can enlist state

³² Kingdon (1984) describes the policy entrepreneur as one who is in the policy community and who is willing to commit resources "in the hope of future return" (129). According to Kingdon, the "hope of future return" could include the political acceptance of a policy for which they advocate.

lawmakers in meeting their own national objectives.³³ Along with the grants Washington attaches regulations governing the grants in the form of conditions-of-aid. According to Wilson and DiIulio (2001) the regulations that accompany the money may steer the states away from generating and adopting their own innovations in health policy.

We should expect that federal grants and their accompanying regulations would influence state policy adoptions and that the type of grants offered would be conditional on the party that controlled Congress. A change in party control of the Congress would likely lead to a change in what grant programs were introduced, continued, or cancelled. Such a party change did occur in 1994 when the Republicans took the majority position away from the Democrats in the Congress. When Democrats control Congress, it is likely that they will discourage state lawmakers from adopting the MSA. But given that many congressional Republicans promoted the MSA at the national level it is likely that when Republicans control Congress, they will encourage the adoption of MSAs by the states. Therefore I hypothesize:

H₄ When Republicans control the Congress, as the percentage of state health care financed by Washington increases, so does the likelihood that states will adopt the MSA. However, when Democrats control the Congress, as the percentage of state health care financed by Washington increases, the likelihood that states will adopt the MSA declines.

As party control shifts in Congress from Democrats to Republicans, we should expect that this change would affect

³³ Nice (1994, 22) says that "state adoption of the 55 MPH speed limit was spurred by a requirement attached to federal highway aid." Also see Walker (1969) and Welch and Thompson (1980).

the substance of the federal grants offered which would, in turn, affect the policy decisions of state lawmakers. However, there is good reason to be suspicious of the above hypothesis as it pertains to the adoption of state MSAs and that federal grants during this period would have a negative effect on MSA adoption. Given the time period under investigation, there was probably not sufficient time for a change from the Democrats to the Republicans in Congress in 1994 to affect state policy outcomes. The federal grants that the states were exposed to during the 1993-6 period were policies that were made while the Democrats controlled the Congress. Any changes in the federal grants would have been made toward the end of the period under investigation and it is unlikely that sufficient time would have elapsed for state policy to be affected. Therefore, my hypothesis for the specific period of MSA adoptions is that

H₅ states are more likely to adopt MSAs as their dependence on Washington to assist them in financing health care decreases.

State Professional Associations

Another likely influence on the adoption of the MSA is that provided by state professional associations. Frances Berry (1994) suggests that state officials with memberships in national associations might influence state policy adoptions. McNeal et al. (2003) findings point to the important role of state professional networks in policy adoption. The state professional association most closely related to health insurance is the National Association of Insurance Commissioners (NAIC). According to Randall (1999, 668) "the NAIC membership is composed of state

officials with regulatory powers and responsibilities in their respective states, who may also wield substantial influence in their own state's legislatures." Existing evidence points toward NAIC resources having a negative effect on MSA policy adoption. Following are four reasons why NAIC membership is likely to lead states toward policies contrary to the MSA.

First, state professional associations are likely to encourage policies that are uniform state-to-state, thus reducing the probability that NAIC will encourage the adoption of innovative policies. (Randall 1999, 666-7) indicates that because of its model laws and its accreditation of the state's insurance program NAIC "eliminates the possibility of regulatory experimentation". According to Brady et al. (1995), this power exists because NAIC's model laws and accreditation process are attractive incentives for state legislators wishing to save time and money that they would otherwise spend in conducting research. Such research may be needed by lawmakers to find policy solutions to the problems relating to health insurance. Brady et al. (1995) state that because only about 4% of legislators have a background in insurance, such a deficit of expertise on insurance would be all the more reason for lawmakers to defer to state professional organizations such as NAIC within their state. Recognizing that NAIC provides model laws sets the standards for accreditation, and provides expert knowledge regarding matters related to insurance, there would be little incentive for state lawmakers to adopt unique policies tailored to their state.

Second, the evidence supports the conclusion that NAIC discourages the adoption of the MSA policy. Norton (1995) finds that NAIC opposed the MSA at the national level. In 1995 NAIC opposed the national Family Medical Savings Account Act because they said that the MSA would raise insurance rates for those for whom the MSA was unavailable. NAIC's opposition to the MSA on the premise that its passage would increase insurance rates for some people appears to fall in line with the association's policies of lowering insurance rates. It seems reasonable to assume that if NAIC opposed the MSA at the national level, it would also oppose it at the state level.

A third reason why NAIC membership could discourage MSA adoption is that the MSA as an incentive policy is voluntary. NAIC tends to emphasize the regulation of insurance and insurance companies, and not voluntary initiatives.

Fourth, disagreement and sometimes antagonism has been noted between NAIC members and Golden Rule Insurance Company, a major proponent of the MSA (Andrews 1992a, 1992b; Carlson 1989). Patrick Rooney and Golden Rule had earlier initiated numerous lawsuits against state insurance commissioners in states such as Iowa, Massachusetts, North Carolina, and West Virginia (Carlson 1989), earning a reputation as the scourge of insurance regulators. Golden Rule's attempts are not likely to be well received by state insurance commissioners and NAIC, the organization which is made up of state insurance commissioners.

Many of NAIC's model laws and standards for accreditation are formulated within the NAIC committee system. Each committee within NAIC is composed of a

selected number of the states' insurance commissioners. Balla (2001) analyzes the influence of professional associations by studying the committee system within NAIC and asks whether or not an insurance commissioner's presence on an NAIC committee has a bearing on whether a commissioner's state adopts HMO reform laws. Balla finds that commissioners that sit on specific NAIC committees are more apt to have influence within that specific area of policy within their state. My reasoning parallels that of Balla except that while Balla speaks of NAIC's influence in encouraging the passage of legislation, it is my assertion that its influence can extend to the obstructing of policies, specifically MSAs. Therefore, I hypothesize that ***H₆ a state's likelihood of adopting MSAs decreases as the state's insurance commissioner's involvement in NAIC increases.***

Legislative Professionalism

Another resource for the adoption of state policy is that provided by state legislative professionalism. According to Dye (2000, 117), a professional legislature is one that is "a well-paid, full-time, well-staffed body" that has "less turnover in members and more experience in lawmaking." The relationship between professionalism and policy adoption appears to be that lawmakers are able to be more innovative as they have more resources. Resources turn part-time legislators into full-time legislators. It follows that as more legislators view their law-making task as a career rather than a part-time job, the more time they have to devote to legislative tasks such as specializing in a specific area of policy making as well as conducting oversight in the implementation of policy. Such a

professional approach will allow legislators the option of developing more elaborate regulatory schemes with the aim of achieving policy goals.

More resources also allow legislators to consider the broad range of options that may meet their state's needs. This may be especially important if the policies are technical in nature. For example, Ka and Teske (2002) and McNeal et al. (2003) find that state legislative professionalism has a positive effect on the adoption of technical policies of digital government and electricity regulation respectively. With regard to professionalization and policy, an increase in resources for the legislator should result in an increase in the policy options from which to select.

While it may be true that increased resources will increase the policy options for state lawmakers, having more resources will not necessarily increase the probability that those lawmakers will adopt any specific policy. When the number of policy options increases, the probability that any one policy will be selected should decrease. Lawmakers with more resources have a broader range of options from which to choose and, therefore, have a greater chance of adopting elaborate regulatory policies than those lawmakers from states with fewer resources have. Increased resources translate into more staff members who can take care of routine legislative matters and thereby free up the legislator to do further research and consider a wider range of policy options.

However, according to Nice (1994, 11) "resources may not be critical for comparatively inexpensive or technically simple innovations" (Also see Downs 1976; Jacob

1988; Savage 1985). Should lawmakers with more resources focus on regulation, they are likely to have their attention diverted from so-called "barebones" policies, whereas lawmakers with fewer resources are likely to be attracted to such policies because they require fewer resources to implement.

Support for this hypothesis can be found in Dodson (1998, 124) who finds that, contrary to his prediction, "less capable" states are more likely to adopt interstate compacts. He reasons that less capable states may be willing to join in cooperative efforts for the disposal of radiation waste while more capable states are "less willing to join a compact due to being saddled with problems less capable states may bring to the process." Similarly, Carter and LaPlant (1997, 23) found that, contrary to their prediction, legislative professionalism is negatively associated with the adoption of state high-risk insurance pools. They reason that "high-risk insurance pools are perhaps the simplest type of reform. Little if any state funding is needed, and in some cases, the entire program is delegated to the private sector."

Like the risk pool, it can be said that the MSA is a "simple" policy. The MSA can be monitored basically within the existing state framework and needs little additional funding. The high-deductible policies sold by the insurance company are monitored by state insurance commissioners, and the tax-deduction features of the MSA are monitored by the state tax commission. The major financial concern seems to be the loss of state revenue should the state allow for the MSA deposits to be tax exempt.

Because less professional legislatures apparently have less time and staff to consider and implement comprehensive reforms, these legislators are prone to look for reforms that will not make great demands on existing scarce resources. Also, since the MSA policy is voluntary and, for the most part, would be implemented and monitored by already-existing state systems, it does not appear to call for an extensive amount of resources on the part of state legislatures. Based on this conclusion, I hypothesize:

H₇, The probability that the state will adopt the MSA decreases as the rate of state legislative professionalism increases.

The Policy Entrepreneur

Another resource to consider for advancing policy adoption is the policy entrepreneur.³⁴ Mintrom and Vergari (1998, 130) define the policy entrepreneur "as people who

³⁴At one level it would be desirable to encompass all health insurance companies in a single variable. However, for this study, I have chosen to center my attention on one entrepreneur and one health insurance company that I believe to be pivotal to the adoption of state MSAs for the following reasons (In chapter five, I consider the overall strength of insurance interest group strength). First, earlier, Andrew Rich (2000) confirmed my focus when he wrote in an e-mail that I should search for the "Golden Rule Effect." Second, it is unlikely that health insurance companies would be uniform in their advancing of the MSA. In 1993, five of the largest health insurance companies (Aetna, Cigna, Metropolitan Life, Prudential, and Travelers) broke with HIAA and started their own trade organization that promoted managed competition. Their break with HIAA was due, in part, to their heavy investment in managed care. Third, Freudenheim (1994) notes that the larger insurers are not likely to have the same interests as smaller insurers that operate off of a fee-for-service basis. There are other reasons why large insurance companies and small insurance companies are not likeminded when it comes to interest. Larger companies blame the smaller companies as the indirect cause of rising health insurance prices (Garland 1990) by accusing them of "skimming" the best risks. This is why, in part, larger health insurance companies have advocated small market reform, something that smaller health insurers have opposed (Garland 1992). Also, larger companies are likely to welcome the uniformity of federal regulation rather than the mosaic of state regulations (Pear 1993).

seek to promote policy innovations." Gray (1994, 1355) remarks that the policy entrepreneur is someone that is "outside of government."³⁵ While policy entrepreneurs may not view their efforts as innovative per se, the effect of their behavior is to influence the adoption of legislation that probably would not have been adopted without their efforts.

One notable policy entrepreneur in the area of insurance is Pat Rooney. Prior to his lobbying for the MSA, Rooney was no stranger to lobbying at the state level. Rooney is described as a policy entrepreneur in an earlier study by Mintrom (1997b) that deals with the issues of school choice and educational vouchers. Rooney spearheaded a school voucher program in Indianapolis in 1991 and later established the Educational CHOICE (Creating Hope and Opportunity in Children's Education) Charitable Trust to provide vouchers to low-income children to enable them to attend the school of the family's choice (Farnan 1993; Meyerson 1999).

Rooney not only lobbied state governments, he also litigated against them. As mentioned earlier, Golden Rule initiated several lawsuits against state insurance departments that limited Golden Rule's capacity to raise premiums more than once during a year (as in Florida [Andrews 1992a]) or to sell types of insurance products other than those scripted by the state (as in Vermont [Andrews 1992b]). In the midst of litigation, Rooney

³⁵ Gray (1994, 1355) distinguishes between the policy entrepreneur who works to change government policy but has no formal government position, and a "policy champion" who holds a formal government position.

