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As the nation gears up for another presidential season and a major national debate over the reform of our health-care system, policy makers in Washington would be well advised to look to the states for advice and experience. There is not a state in the country that is not currently struggling with the skyrocketing cost of Medicaid. Employers are crying for relief from health insurance costs that have risen by over fifty percent in the last three years. Businesses and unions are telling governors across the country that something has to be done to control workers' compensation costs—costs that are being driven up largely by the runaway cost of health care.

A handful of states are far ahead of the federal government in seeking to develop universal and affordable health-care systems. Thus, as has happened so often in American history, the states are likely to serve as models for Congressional action. Practices in other countries like Canada and Germany have received considerable media attention lately and may influence the course of national health-care reform here. Since outright adoption of public national health insurance seems unlikely, however, such influence will be indirect and will be modified by state-level experimentation in the United States.

Two states, in particular, stand out: Hawaii and Massachusetts.[1] Both states have generous Medicaid programs. Hawaii approved legislation requiring all employers to provide health insurance for their employees in 1974[2] and created a state health insurance program (SHIP) in 1989[3] to cover all those not otherwise insured under the 1974 law. Massachusetts enacted an employer-based universal plan in 1988. Each state's successes and failures are well worth examining as we prepare for a critically important national debate on the future of health care in America.

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1. Oregon recently adopted a universal health insurance law with an employer mandate that is scheduled to go into effect in 1995. The Oregon plan is discussed in detail in Michael J. Garland, *Light on the Black Box of Basic Health Care: Oregon's Contribution to the National Movement Toward Universal Health Insurance* in this volume.

2. HAW. REV. STAT. § 393 (1988).

3. HAW. REV. STAT. § 431N (Supp. 1991).

I. HAWAII: A NATIONAL MODEL

Hawaii is the pioneer among the states. Its legislature approved the state's Prepaid Health Act in 1974. That law requires all employers to provide their employees with comprehensive health insurance so long as those employees have worked for at least thirty days and at least twenty hours per week. Employees may be required to help finance their insurance by contributing either fifty percent of the premium or one-and-a-half percent of gross wages, whichever is lower. Hawaii's employers are not required to cover their employees' dependents, but most of them do so voluntarily, usually insisting that the employee make an additional contribution for coverage of the dependents.[4]

Thanks to its employer mandate, Hawaii had a smaller percentage of residents without health insurance than any other state in the country even before the passage of SHIP in 1989. Approximately 50,000 people out of a total population of 1.1 million in the island state lacked health insurance in 1989.[5] SHIP, which is financed by general state revenues, has begun to bridge that gap. Nearly 16,000 people are currently insured under SHIP.[6] Hawaiian health officials expect to achieve their goal of universal coverage in the near future.[7]

SHIP recipients are permitted to choose the insurance provider with which they would like to be affiliated. The Hawaii Medical Services Association (HMSA), the local Blue Cross affiliate, manages most SHIP benefits. Approximately 1200 SHIP-eligible recipients have chosen instead to join Kaiser-Permanente,[8] the dominant HMO in Hawaii, and they receive full benefits under the Kaiser Plan. There is a network of community-based primary health-care centers providing basic health services in poorer communities. These centers are serving increasingly as major recruiters for the SHIP program.

Hawaii's health delivery system is very similar to the delivery system in most mainland states. It is primarily a fee-for-service system. Most hospitals are nonprofit, trustee-run institutions. Some of the general hospitals on the neighbor islands have been owned and operated by the State Health Department, but the Department is in the process of turning them into autonomous free-standing institutions with independent boards of trustees.

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4. Small business owner, Jean Pinc, articulated a common concern among employers: "[W]e want to keep our good people, and one way to keep somebody loyal is to give them good benefits." Timothy Egan, *Hawaii Shows It Can Offer Health Insurance For All*, N.Y. TIMES, July 23, 1991, at A16.

5. CENTER FOR HEALTH RESEARCH, KAISER PERMANENTE, THE STATE HEALTH INSURANCE PROGRAM OF HAWAII: FROM LEGISLATIVE PRIORITY TO REALITY xi (1991).

6. DEPARTMENT OF HEALTH, STATE OF HAW., STATE HEALTH INSURANCE PROGRAM: MEMBERSHIP BY MONTH REPORT (Mar. 1992).

7. Interview with State Health Director, Dr. John Lewin, in Honolulu, Haw. (Mar. 1991).

8. CENTER FOR HEALTH RESEARCH, *supra* note 5, at xii.

A majority of Hawaiian residents are insured by HMSA.[9] Another eighteen percent of Hawaiians are covered by Kaiser-Permanente.[10] Both HMSA and Kaiser have a single risk pool for all small businesses (no more than 100 employees) with a single average, or community, rate. Unlike most private insurers, they do not set different premiums based on predicted health-care costs for particular groups or individuals. Rather, they use one rate for all businesses in the pool regardless of the health status or history of any particular employee. As a result of the use of community rating, small businesses in Hawaii do not face the kind of rate discrimination and escalating premium charges associated with the "experience-based" rate system used by most insurers on the mainland.[11]

Dominating the market, HMSA is in a good position to try to keep health costs down. Working in combination with the State Health Department, which administers the state's certificate-of-need law,[12] HMSA tries to control costs by, among other things, setting limits on reimbursement for certain kinds of procedures and on inpatient costs.[13] Another way to control costs is to limit the amount of expensive, high-technology equipment used in hospitals. Hawaii, for example, has only five approved magnetic resonance imaging scanners.

Nobody who has been to Hawaii can fail to notice that its cost of living is thirty to forty percent above the national average. Comprehensive Blue Cross/Blue Shield coverage is nonetheless available for approximately $1300 per person and $4000 per family—well below the cost of similar coverage in many mainland states. One might think that bad health would accompany low health bills; yet, Hawaiians are now the healthiest people in America.[14] Life expectancy in Hawaii is the highest in the nation,[15] and the infant mortality rate is among the lowest.[16]

Last June, Governor Waihee announced new plans for what he called "a

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9. Commercial insurers cover only 8% of the state's 1.1 million residents. HMSA holds 53% of the market, Kaiser has 18%, 17% are covered by Medicaid and Medicare, and the remainder by other small plans. Mark Holoweiko, *Health-Care Reform: What Does Hawaii Have to Teach?*, MED. ECON., 158, 161 (Feb. 3, 1992).

10. *Id.*

11. HMSA president, Marvin B. Hall, said, "[W]ithout community rating, some small businesses [on the mainland] end up with unbelievable rates, like $1000 per person per month. If they don't have to buy insurance, they just drop out.... By mandating coverage for everyone, the [Hawaii] law stabilized premiums for groups of under 100 employees." *Id.* at 161. *See infra* p. 7 for further discussion of the problems small businesses face in trying to insure their employees.

12. HAW. REV. STAT. § 3230D-43 (1988).

13. *See generally* Holoweiko, *supra* note 9, at 172.

14. NORTHWESTERN NAT'L LIFE INS., STATE HEALTH RANKINGS 12 (1991). State Health Director, Dr. John Lewin, strongly disputes the notion that cultural or environmental factors are responsible for the good health of most Hawaiians: "One criticism I hear is that we are different, as if we're all sipping mai tais on the beach and dancing in coconut shell bras. We have a lot of poor people in Hawaii. We have all the health problems of the rest of the states. But what makes us different is that we decided to do something about it." Egan, *supra* note 4, at A1, A16.

15. Holoweiko, *supra* note 9, at 158 (quoting Dr. John Lewin).

16. *Id.*; NORTHWESTERN NAT'L LIFE INS., *supra* note 14, at 43.

seamless system of health-care services."[17] The Governor wants to make the primary physician in Hawaii the health-care system's gatekeeper. Specialty care would be paid for only on referral of a primary care physician. Primary care physicians would receive a case management fee for each of their patients. Doctors would have to accept all patients under the proposed plan.[18]

Although HMSA and Kaiser already use community rating, Waihee would require by law that all insurers adopt community rating and a universal claim form. He would also create a new state Health Cost Commission to collect data and to certify insurance rates and with authority to set provider rates. In addition, the proposed plan would require all employers to insure the dependents of their employees.

Hawaii would need an additional exemption from the Employee Retirement Insurance Security Act of 1974 (ERISA) to implement the proposed program. ERISA preempts states from regulating employee welfare benefit plans. Since Hawaii's Prepaid Health Act preceded ERISA, the state was able to obtain an exemption from Congress for the Act. Any new legislation will not be covered by the initial waiver, however, and Congress has been extremely reluctant to grant any other waivers, including a supplemental one to Hawaii.

II. MASSACHUSETTS: A ROCKY ROAD AHEAD

The history of Massachusetts's efforts to provide universal access to health care for its people differs in many ways from that of Hawaii. Hawaii's approval of a health insurance act, nonetheless, was a major impetus to action in Massachusetts. If a broad-based employer mandate could work in Hawaii, why not try it in Massachusetts?[19]

The drive for universal insurance in Massachusetts, particularly in 1987 and early 1988, gained a great deal of support from constituencies with an interest in health-care provision and cost control. As the state faced the deadline of expiring health-costs-control legislation, a growing consumer coalition was pushing hard for universal access. Employers became increasingly upset over the escalating costs of health care and their continuing obligation to subsidize care for the uninsured (often referred to as "free care") through surcharges on insurance premiums. Furthermore, hospitals complained that neither Medicaid nor Medicare was fairly compensating them for the total cost of medical care.

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17. Kevin Dayton, *Universal Health Coverage Outlined as Goal For State*, HONOLULU STAR-BULL. & ADVERTISER, June 23, 1991, at A1.

18. *Id.* at A5.

19. For a detailed discussion of events leading up to the passage of the Massachusetts universal health-care law, see Susan Goldberger, *The Politics of Universal Access: The Massachusetts Health Security Act of 1988*, 15 HEALTH POL. POL'Y & L. 857 (1990).

Meanwhile, Massachusetts Blue Cross and the state's private insurers were locked in a battle over who should bear the brunt of cost shifting. Earlier compromise legislation[20] designed to smooth over cost shifting problems was not working well, and by 1985 the coalition that had helped to create the original legislation was coming apart at the seams. In short, conditions were ripe for health-care reform; a situation not unlike the one that is driving the nation toward a national debate on the issue in 1992.

The eventual passage of the Massachusetts law, however, was preceded by more twists and turns than a back-country New England road. What seemed to be a growing consensus in the summer and fall of 1987 in support of a universal coverage bill soon collapsed amidst bickering among key health-care constituencies over who would bear the responsibility for coverage and how costs could be controlled. Lobbying on all sides was so fierce that the House of Representatives finally threw up its hands in the fall of 1987 and passed a six-month extension of the existing state health finance law. Only the intervention and leadership of a key Senate committee chairman kept the bill alive, and it was not until the spring of 1988 that I signed the bill into law.[21]

The final bill represented a significant achievement: the first effort by a state to provide universal access to health care to all its residents.[22] It required all employers in the state with six or more employees to insure their employees and their employees' dependents by January 1, 1992. Employers that could not, or would not, purchase insurance for their employees on the open market were required to pay $1680 per employee per year into a state fund that would purchase insurance for uninsured employees and their dependents. To enable the Commonwealth to subsidize health insurance for the uninsured unemployed population, the bill also required employers to pay a surcharge of $16.80 per employee on their unemployment insurance tax. Furthermore, the bill mandated that students within the state—some sixty thousand of whom were uninsured—purchase insurance, usually through relatively inexpensive plans negotiated with private insurers by their colleges and universities. Additional provisions of the bill guaranteed state-subsidized insurance for several thousand disabled adults and children.

Implementing the new legislation turned out to be almost as difficult as passing it. The law committed Massachusetts to providing direct state aid to hospitals whose Medicare payments were not fully meeting Medicare costs and to making up shortfalls in the state's free care pool which the new law capped. The state has had difficulty meeting those commitments principally because a regional, and now national, recession has dried up state revenues. Furthermore, Governor Weld has vowed to repeal the employer mandate. Although

20. 1982 Mass. Acts 372.
21. 1988 Mass. Acts ch. 23.
22. Hawaii did not pass SHIP until 1989. *See supra* note 3 and accompanying text.

he has not yet been successful, his efforts have eroded the sense of urgency necessary for speedy implementation of the mandate. It will now not go into effect until January 1995 at the earliest.

Despite difficulties with the financing and passage of its employer mandate, Massachusetts has made significant progress in implementing some parts of the new law. Students are now fully covered either under family policies or through low-cost insurance negotiated with insurers by their schools and colleges. Nearly thirteen thousand disabled adults and children are now insured. Thousands of residents who have lost their jobs in the current recession are receiving health insurance for themselves and their families along with unemployment compensation checks.

As a result of the law, approximately 80,000 more Massachusetts residents now carry some form of health insurance.[23] Unless the employer mandate goes into effect, however, nearly four hundred thousand people will remain uninsured. Furthermore, as the cost and amount of free care increases, required contributions to the free-care pool from employers who insure their employees will rise.

In addition to expanding access to care, Massachusetts has attempted to curb the excesses of malpractice in the insurance system and to cut down on defensive medicine. In 1986, the legislature approved a major tort reform bill which, among other things, eliminated double payments for medical expenses, imposed caps on attorneys' fees, and limited payments for pain and suffering in malpractice cases.[24] The new law has already affected the cost of malpractice insurance. Premiums decreased by twenty-five percent last year, and Massachusetts doctors and dentists now pay substantially less for malpractice insurance than do many of their colleagues in other industrial states.[25]

In 1991, the legislature approved new health financing legislation which includes some protection for small businesses against exorbitant rates and denial of coverage.[26] The new legislation, however, provides nowhere near the safeguards that Hawaii's single-risk pool guarantees for small and medium-sized employers.

23. As of the end of 1990, approximately 77,000 people had obtained insurance coverage for the first time as a result of the new law. Robert J. Blendon et. al., *The Uninsured and the Debate Over the Repeal of the Massachusetts Universal Health Care Law*, 267 JAMA 1113, 1114 (1992).

24. 1986 Mass. Acts ch. 351 (codified at MASS. GEN. L. ch. 231 §§ 60F-I (1992)).

25. Tracy Gehan Leu, *Physician Premiums Reduced*, JUA TODAY, Fall 1991, at 1, 2.

26. 1991 Mass. Acts ch. 495.

III. Six Lessons from the Experiences of Hawaii and Massachusetts

The experiences of Hawaii and Massachusetts can provide both political leaders and citizens with many important lessons as the great debate over national health-care reform moves forward.

Lesson 1: *Real protection for small businesses must be built into any new employer-based system.* It is no secret that the fiercest opposition to a national employer mandate comes from small business, and with good reason. The nation is struggling to get out of a prolonged recession. Many businesses, especially small businesses, are fighting to hang on. Employers are finding it increasingly difficult, if not impossible, to continue providing adequate and affordable insurance coverage to their employees. Many employers are being quoted rates three and four times what they were being charged a few years ago. Others are being denied coverage altogether because a single employee or a member of that employee's family is suffering from a particularly serious health problem.

The Hawaiian experience provides a useful lesson in trying to solve the problems employers are facing in continuing to insure their employees. HMSA committed itself to community rating for small businesses seventeen years ago and has never wavered on that commitment. In addition, it never denies coverage to individuals or small businesses on account of preexisting conditions. Because of the community-based rating systems, small businesses in Hawaii do not have to fear the kind of wild escalation in prices and denial of coverage that has plagued their colleagues on the mainland.

The use of community rating may be one reason why Hawaiian employers do not complain about the employer mandate. Employers must provide health coverage, but the cost of that coverage is reasonable. Thus, the business community accepts the employer mandate as a cost of doing business, and citizens consider the mandate a source of valued social protection.

Massachusetts did not include safeguards like community rating in its health security act. If it had required community rating then it might have persuaded the small business community to accept an employer mandate.[27] The primary lesson to be learned from Hawaii and Massachusetts therefore is this: unless Federal employment-based health insurance legislation incorporates community rating and other protective measures, such legislation will continue to face the opposition of thousands of small businesses.[28]

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27. Recently, the Massachusetts legislature passed a law designed to better protect small businesses from excessively costly insurance. The law, however, offers only limited protection. It permits insurers to charge some businesses up to double what they charge others. 1991 Mass. Acts ch. 495 § 42.

28. There seems to be a growing bipartisan consensus for such legislation in Washington. President Bush's health-care proposal includes recommendations for small business insurance reform. *See* THE PRESIDENT'S COMPREHENSIVE HEALTH REFORM PROGRAM 17-26 (Feb. 6, 1992). Senator Bentsen has

Lesson 2: *A dominant payer can reduce administrative expenses and use its market power to support government efforts to control cost.* With a majority of the market, HMSA in Hawaii is in a position to call the shots when it comes to hospital and physicians' rates. While there is some tension and occasional unpleasantness between HMSA and Hawaiian providers, all providers know who the major payer is in the Hawaiian system, and HMSA does not hesitate to use its economic clout to hold costs down.[29]

HMSA possesses several incentives to keep health-care costs down. On the one hand, it takes its responsibility as a community institution very seriously. Its board includes representatives of both the business and labor communities with a strong interest in cost control. On the other hand, it must keep its eye on Kaiser-Permanente, which provides some vigorous competition for the Hawaii Blue Cross affiliate. Kaiser-Permanente controls nearly twenty percent of the Hawaiian market and seems to enjoy a good deal of loyalty from its members.

Lesson 3: *Coverage for the previously uninsured should begin with primary care.* The skyrocketing costs of health care are fueled, in part, by millions of uninsured patients who wind up in emergency rooms and clinics when they need primary care. One of the quickest ways to give these patients better care at lower cost is to make sure that their insurance coverage includes access to primary care.

People in Hawaii spend a lot less time in the hospital than do people on the mainland.[30] This is not the place to attempt to disentangle the complex epidemiological, cultural and clinical practice variables that may contribute to this trend. It is worth noting, however, that Hawaiians make *more* visits to the doctor than people on the mainland, a pattern that may account for less need for acute inpatient care.[31]

Since virtually everybody in Hawaii has primary coverage, the need for free care is minimal compared with the need in states such as California where approximately five million residents are uninsured.[32] I remember talking with

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included comprehensive insurance reform for small businesses in the tax bill recently approved by the Senate. While insurance reform was eliminated by the Senate-House conference committee on tax legislation, it seems likely that a comprehensive small business insurance reform bill will be approved by the Congress and signed by the President this year.

29. Holoweiko, *supra* note 9, at 161. "Fee-for-service doctors can hardly ignore what one physician calls the 'monopolistic' power of the Blues. 'They've been able to hold down prices.'" *Id.* One way HMSA has helped to cut rates is by keeping its own administrative expenses relatively low. In fact, HMSA's administrative expenses are lower than that of most Blue Cross plans on the mainland and half of what they are for private health insurers. *Id.* at 163.

30. State Health Director, John Lewin explains, "Hawaii has twice as many out patient visits per capita as the rest of the nation, and 40% fewer inpatient visits. That's one of the reasons why costs are lower here." *Id.* at 158.

31. *Id.; see also supra* note 14.

32. SUBCOMM. ON HEALTH FOR FAMILIES AND THE UNINSURED, SENATE COMM. ON FINANCE, HEALTH INSURANCE COVERAGE: A PROFILE OF THE UNINSURED IN SELECTED STATES 12 (Feb. 1991).

a Hawaiian businessman who told me he was paying about fifty percent more for health care for his employees in California than he was in Hawaii, and he could not understand why. When I pointed out to him that his health insurance premiums in California were helping to provide health care for millions of uninsured Californians, he understood quickly how important universal coverage in Hawaii was to his ability to insure his employees at a reasonable cost.

Lesson 4: *Unlimited choice of specialists is expensive and unnecessary.* There has been much discussion recently about the concept of the primary or family physician as the "gatekeeper" for individual health care. It is a principle deeply embedded in most other national health-care systems. Until recently, it was part and parcel of the American health-care system.

Take my father, for example. He was an old-fashioned family doctor who practiced medicine in Boston for fifty-two years. He was a wonderful doctor, and his patients loved him. But I watched him scold a patient on more than one occasion when he discovered that the patient had seen another doctor without his consultation. It was not a matter of ego, as far as my father was concerned. He simply could not provide the patient with quality medical care if the patient visited other doctors and took medication without my father's knowledge or approval.

We are beginning again to realize how important the primary physician can be in assuring that patients receive quality, cost-effective care. Dr. John Lewin has explained that in an ideal system:

> Everyone would have a primary care case manager, a physician, well versed in medicine, and committed to the family and psychological needs of an individual. This case manager should be the person who helps this individual make sense of the complex maze that is modern medicine. The role of that gatekeeper is experienced medical consultant and (hopefully, friend) which would most appropriately use the wide range of medical and health resources available including the tremendous potential of allied health personnel, particularly nurses, to carry out the many specialized functions of primary care. Such a gatekeeper would work closely with nurses and would insure that most preventive services and routine follow-up of established diagnosis of chronic care and education be done by nurses or other allied health persons. Expensive specialty care would be available only on referral of a primary care physician. A case management fee would be paid to the primary care physician for every case he/she managed, for every person who worked with him/her as primary care physician.[33]

In virtually all other national health-care systems, the primary practitioner plays a central role in managing a patient's care. Most of these systems require that specialists show proof of a documented referral from a general practitioner before receiving reimbursement at the specialist rate. Hawaii is now moving to incorporate the concept of primary practitioner referral into its health-care

33. John C. Lewin, Toward a Seamless System of Access to Health Care: The Time Is Now, Address Before the Hawaii State Board of Health 5 (July 1991) (transcript on file with the Department of Health, State of Hawaii).

system. Governor Waihee's new proposals not only would bar reimbursement of specialists at the specialist rate without a referral from the family doctor, but also would pay the general practitioner a modest fee to "manage" the patient's care.

Lesson 5: *All employers should be able to "play."* Most employer-based plans that have been unveiled in Washington would require employers to either "play" by buying insurance for their employees in the private market or "pay" into a public insurance fund through a tax on payrolls. Nearly all the proposals include a small across-the-board payroll tax on *all* employers to cover part-time employees.

In Hawaii, employers do not have an option of either paying a tax or offering private insurance coverage: everyone "plays." This system is possible because Blue Cross (HMSA) and Kasier-Permanente are available at reasonable rates on a nondiscriminatory basis. Interestingly, Hawaiian employers do not seem to mind this employer mandate.

The Hawaiian system is also unique in that even SHIP, the small state health insurance program designed to insure those not covered by the employer mandate, is "privatized." Although general state revenues pay for SHIP, it is managed by HMSA or Kaiser-Permanente, depending on which plan a SHIP-covered patient selects. The state thus has avoided both the need for elaborate administrative machinery and the headaches of trying to administer a public insurance plan covering a large portion of its residents. The plan also makes it unnecessary for workers who have been laid off from their jobs to shift out of their current plans into a new "public" system. They continue to be covered by either Blue Cross or Kaiser-Permanente, and when they find a new job, no interruption or change in their insured status results.

Massachusetts did not have the option duplicating Hawaii's system because of the ban on employer insurance mandates under ERISA.[34] As a result of ERISA, Massachusetts was forced to design a convoluted new system under which an employer who did not voluntarily choose a private insurer would have to contribute to a state fund. Had Massachusetts been able to obtain the same kind of ERISA exemption that Hawaii received, it almost certainly would have followed the Hawaiian model.

ERISA, however, presents no such problems for Congress or the President in designing a national employer-based system. They are free to create a system much like Hawaii's, which avoids the kind of bifurcated insurance arrangements contained in most employer-based proposals currently before Congress. In fact, Congress would be well advised to follow Hawaii's lead in designing the small "gap filler" for those not covered by either employers or

34. *See supra* p. 400. Hawaii's Prepaid Health Act preceded ERISA, and Congress made an exception for it. Congress has been extremely reluctant, however, to grant waivers to other states.

the private insurance market. This "gap filler" could contract with selected insurers to provide comprehensive benefits for those not covered by the employer mandate. Individuals who were laid off would then be able to continue their insurance or managed care arrangements without confusion or disruption.

Lesson 6: *A national employer-based plan can provide coverage for the "gap group" without new taxes.* One of the most vexing problems Massachusetts faced was how to pay for those not covered by its employer mandate. Employers understandably were fed up with having to pay ever-increasing amounts not only for their own employees' insurance but also for care for the uninsured. Hawaii, which is in relatively good fiscal shape, chose to provide gap-group coverage using general state revenues. Hawaii's method, however, was not a fiscal or political option for Massachusetts. As the full effects of the recession began to be felt, the state treasury had fewer and fewer funds with which to cover the uninsured.

One alternative to funding the uninsured through state revenues would be to set aside a small portion of the premium base for that purpose. If all employers were required to provide insurance for their workers, the number of uninsured people would drop dramatically, thereby lowering the financial burden of providing free care. Two-thirds of all uninsured Americans today would be covered by employers under most of the employer-based bills that are currently before the Congress.[35] Approximately ten million people would be left without insurance.

A study conducted at the University of Hawaii's School of Public Health estimates that a four-percent set aside of the premium base under most employer-based plans would be sufficient to provide insurance for those ten million Americans.[36] While admittedly imposing a small continuing burden on employers and employees, a four-percent surcharge on premiums represents a sharp discount from current premium set-asides for the uninsured. Today, the costs of "free care" are either explicitly added to health insurance premiums or, more often, "buried" in hospital and doctors' charges.

Furthermore, internal system savings could help to defray the cost of the surcharge. Most employer-based plans currently before the Congress contain proposals for literally billions of dollars in savings from, for example, reducing administrative expenses. Once an employer mandate has been phased in nationally, it would require approximately thirteen billion dollars in savings at present prices to offset the cost of the premium set-aside for the uninsured.

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35. "In 1980, 55.6% of those without insurance were working.... Another 22.3% were dependents of uninsured employees, and 10-12% more were uninsured dependents of insured employees." Lawrence D. Brown, *The Medically Uninsured: Problems, Policies and Politics*, 15 J. HEALTH POL. POL'Y & L. 413, 414 (1990).

36. 1 Michael S. Dukakis & Cyril Roseman, UniHealthCap: A Proposed Universal Health Access Plan 22 (May 16, 1991) (unpublished manuscript, on file with author).

Coverage for the uninsured thus could—and should—be financed fully from savings within the existing health-care system.

IV. Conclusion

The experiences of Hawaii and Massachusetts do not provide answers to all questions concerning health-care reform. Neither state, for example, has attempted to impose system-wide expenditure ceilings or experimented with anything like global budgeting. What makes the experiences of Hawaii and Massachusetts so important, however, is the fact that they are home-grown health-care systems. Both states, through trial and error, have attempted to demonstrate the feasibility and affordability of universal access to health care. In so doing, they have discovered several essential elements for an effective health-care system:

(1) require all employers and employees to participate in and contribute to the new system;

(2) provide small businesses protection from exorbitant, experience-based rates;

(3) finance insurance for the unemployed and their families through cost saving practices such as the "general-practitioner-as-gatekeeper" approach; and

(4) enable insurers and HMOs to play a major role in cost containment by bargaining directly with providers.

Other nations also may teach us about the challenges of designing a truly universal and affordable national health-care system. The lessons with which the states have already provided us, however, ought not be ignored.