REVIEW ESSAY

FEDERAL MENUS AND STATE PROGRAMS: AN INTERGOVERNMENTAL HEALTH CARE PARTNERSHIP FOR THE 1990s

HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES. Edited by Howard M. Leichter. Armonk, New York: M. E. Sharpe, 1992. Pp. 240. $45.00 (trade), $19.95 (paper).

MICHAEL S. SPARER*

INTRODUCTION

As Congress examines the health care crisis and struggles to find a politically acceptable reform package, it seems increasingly likely that federal reforms, if any, will delegate key decision-making authority to the states. Since several states are considered health reform innovators, and since federal officials are unable to reach consensus on a national reform strategy, Congress may well ask these laboratories of democracy[1] to guide

* Michael S. Sparer is an assistant professor in the Division of Health Policy and Management in the School of Public Health at Columbia University. He received a Ph.D. in political science from Brandeis University and a J.D. from the Rutgers University School of Law at Newark.

1. In the words of former Supreme Court Justice Louis D. Brandeis:
It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments without risk to the rest of the country.
New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

and shape the overall reform effort. However, it may not be wise to rely on the states to initiate and implement health policy reforms. If not, and the federal government instead should play the leadership role, what might an appropriate (and potentially feasible) intergovernmental partnership look like?

Health Policy Reform in America: Innovations From the States,[2] edited by Howard M. Leichter, offers a useful starting point to address the issues raised by these questions. Leichter and his colleagues describe and examine several of the leading state-based reform efforts. The efforts examined include the innovative insurance reform strategies developed in Hawaii, Massachusetts, and Oregon, as well as the less-publicized but equally important efforts of many states to implement a rational AIDS policy, and to address issues in long-term care, maternal and child health care, and care for the mentally retarded. Leichter notes that state officials "have shown extraordinary inventiveness and sensitivity in dealing with some of our most intractable health-related problems."[3] The initiatives described by Leichter and his colleagues are even more remarkable in light of the fiscal pressure to reduce state spending, the political pressure to avoid tax increases, and the economic imperative of keeping the business community relatively happy.

Yet, even when states overcome these hurdles, they meet federal barriers that frustrate and undermine their efforts. In Section I of this review, I discuss two examples of such struggles. The Employee Retirement Income and Security Act (ERISA)[4] significantly limits the states' ability to regulate employee health insurance programs.[5] Similarly, federal officials regularly impose restrictive conditions on state efforts to reshape Medicaid programs.[6] As a result, states find themselves unable either to fashion innovative public programs or to seek supplemental funding from the private sector.

This dilemma calls for a new intergovernmental health care partnership, which I discuss in Section II. Two approaches to this solution are possible: either Congress should remove the federal obstacles to state reform, thereby giving states a free hand to experiment, or it should establish a coherent and comprehensive framework for reform itself. In this Review Essay, I argue for the latter approach.

As part of this discussion, I review President Bill Clinton's health reform proposal to see where it fits in the debate over health politics and American federalism. The good news about Clinton's plan was that it

2. HEALTH POLICY REFORM IN AMERICA: INNOVATIONS FROM THE STATES (Howard M. Leichter ed., 1992) [hereinafter HEALTH POLICY REFORM IN AMERICA].

3. Howard M. Leichter, *The States and Health Care Policy: Taking the Lead*, *in* HEALTH POLICY REFORM IN AMERICA, *id.* at 3, 17.

4. 29 U.S.C. §§ 1001-1461 (Supp. IV 1992).

5. *See infra* note 37-64 and accompanying text.

6. *See infra* notes 65-77 and accompanying text.

would have entitled all Americans to a comprehensive set of health care benefits.[7] The bad news was that the means chosen to implement the plan created the wrong sort of intergovernmental partnership. The plan did this by delegating a host of complicated and politically charged tasks to the states. Worse, Clinton's plan not only delegated too much authority to the states, but also delegated the wrong kind of authority. As a result, many of the states would inadequately and inequitably implement these tasks.[8]

I conclude the essay with some preliminary reflections on how to design a more appropriate intergovernmental partnership. Under the model I propose, the federal government would establish a menu of three or four frameworks for reform and would closely supervise the implementation of whichever model each state chose to adopt.

I

THE STATES AS INNOVATORS: LIMITS AND LESSONS

States are key players in America's health care system. The Medicaid program, for example, delegates to the states broad authority to determine eligibility,[9] coverage of medical services,[10] and reimbursement rates.[11] States also supervise much of the nation's private health insurance industry,[12] regulate the quality of care delivered by most medical providers,[13] and, together with local governments, pay over 14 percent of the nation's health care bill.[14] Each state also operates its own worker-compensation system, medical malpractice system, medical education system, and, with local governments, public health system.

7. CCH PROFESSIONAL SUMMARY AND TEXT OF BILL, PRESIDENT CLINTON'S HEALTH CARE REFORM PROPOSAL: HEALTH SECURITY ACT, AS PRESENTED TO CONGRESS ON OCTOBER 27, 1993 §§ 1101-1128 [hereinafter PRESIDENT CLINTON'S PROPOSAL].

8. *See infra* notes 88-94 and accompanying text.

9. 42 U.S.C. § 1396a(10)(A)(ii) (1988 & Supp. IV 1992).

10. 42 U.S.C. § 1396d(a) (1988 & Supp. IV 1992).

11. 42 U.S.C. 1396a(13)(A) (1988 & Supp. IV 1992).

12. The McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1014 (1988 & Supp. V 1993), states: "The business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012(a) (1988 & Supp. V 1993). However, federal laws such as ERISA, which immunize self-insured companies from state regulation, may preempt state law. For a helpful description of the variation in state regulatory activities, see U.S. GENERAL ACCOUNTING OFFICE, GAO/HRD-94-26, HEALTH INSURANCE REGULATION: WIDE VARIATION IN STATES' AUTHORITY, OVERSIGHT, AND RESOURCES (1988).

13. State officials license and supervise physicians, nurses, and other health professionals. While the licensing and certification process varies widely, every state imposes minimum quality-of-care requirements. *See generally* PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, MEDICARE AND THE AMERICAN HEALTH CARE SYSTEM: REPORT TO CONGRESS 148 (June 1993).

14. In 1991, state and local governments paid 14.2 percent of the nation's $752 billion health care bill. Susan W. Letsch, Helen C. Lazenby, Katherine R. Levit, & Cathy A. Cowan, *National Health Expenditures*, HEALTH CARE FINANCING REVIEW, Winter 1992, at 14, 18.

Despite the fact that states have experience in dealing with these health care issues, advocates for health policy reform rarely looked to the states for leadership or guidance prior to the 1970s. On the contrary, liberals targeted for reform the state-based nature of the health care system and the social welfare system more generally.[15] The concerns about the "commitment, capacity, and progressivity"[16] of the states resulted from three historical experiences. The advocates' first and foremost concern derived from the legacy of slavery. They recognized that civil rights advances and progressive social welfare programs would have to overcome the vigorous objections of Southern politicians. During the 1930s, for example, influential Southern members of Congress, concerned that welfare programs might undermine the Southern sharecropper economy, successfully fought for state control over the emerging public welfare system.[17] Thirty years later, during the civil rights movement, Southern leaders fought even harder, though with less success, against desegregation.[18] Considering this historical context and the divergent and inadequate state health care systems, few advocates were anxious to entrust health care reform to the various state capitols. Leichter notes: "The sixties in particular was a time when state governments suffered the reputation as obstructionist and recalcitrant troops in the war on the various social evils identified by liberals."[19]

The second concern arose from reformers' long-held, and justified, concerns that many state officials were inept, corrupt, or simply unprepared to tackle hard policy issues. Most state legislators, for example, worked part-time, without adequate staff or support, and were under obligation to the party bosses that put them in office.[20]

Finally, advocates were concerned because, when state officials did create an activist agenda, as they did during the Progressive Era between 1900 and 1919, they focused on expanding highway systems and improving education—not on creating new and innovative public welfare programs.[21] State bias against redistributive programs is hardly surprising, given that those programs not only benefit the poor, a politically unpopular minority, but that they also undermine a state's position in the interstate competition for business. This pattern persuaded many political analysts that states

15. *See generally* Frank J. Thompson, *New Federalism and Health Care Policy: States and the Old Questions*, 11 J. HEALTH POL. POL'Y & L. 647 (1986).

16. *Id.* at 648.

17. Jill Quadagno, *From Old-Age Assistance to Supplemental Security Income: The Political Economy of Relief in the South, 1935-1972, in* THE POLITICS OF SOCIAL POLICY IN THE UNITED STATES 235, 239 (Margaret Weir, Ann Shola Orloff & Theda Skocpol eds., 1988).

18. There are, of course, numerous descriptions of the civil rights era and the effort to desegregate southern schools. *See, e.g.*, GARY ORFIELD, THE RECONSTRUCTION OF SOUTHERN EDUCATION: THE SCHOOLS AND THE 1964 CIVIL RIGHTS ACT (1969).

19. Leichter, *supra* note 3, at 5.

20. *Id.*

21. JAMES T. PATTERSON, THE NEW DEAL AND THE STATES 3-25 (1969).

should concentrate on economic development policy, since competition from other states prompts them to do it well, but that the federal government should control redistributive welfare programs, since states are biased against such programs.[22]

In light of this distrust, the states' current position in the health care reform debate is all the more remarkable. As Leichter and his colleagues demonstrate, state officials, and not their federal counterparts, are initiating and implementing many of today's most important health care reforms.[23] Perhaps more surprisingly, many advocates and analysts today propose delegating greater authority to the states, which would enable them to adopt even bolder reforms.[24] Four factors explain these surprising developments.

First, health care costs, particularly the cost of Medicaid, currently overwhelm state budgets. In 1988, states spent an average of 10.8 percent of their expenditures on Medicaid;[25] by 1992 that figure increased to 17.1 percent. In some states, the percentage was significantly higher.[26] The traditional health care cost-containment device of reducing eligibility is impractical and counterproductive for a program that serves only 47 percent of the poor.[27] In addition, states are reluctant to reduce the already low Medicaid rates for provider reimbursement.[28] Such reduction may even be illegal, given the federal requirement of reasonable rates.[29]

Second, state officials have become better prepared to meet the difficult policy challenge of health care reform. Continuing a trend that began in the 1980s, most legislators now are full-time policymakers, most legislatures have professional staffs, and most state agencies have attracted capable and committed bureaucrats.[30] Moreover, organizations such as the National Governors' Association have emerged as effective lobbyists on

22. *See generally* PAUL PETERSON, BARRY G. RABE & KENNETH K. WONG, WHEN FEDERALISM WORKS (The Brookings Inst. ed., 1986); ALICE M. RIVLIN, REVIVING THE AMERICAN DREAM: THE ECONOMY, THE STATES, AND THE FEDERAL GOVERNMENT (The Brookings Inst. ed., 1992).

23. Leichter, *supra* note 3; *see also* U.S. GENERAL ACCOUNTING OFFICE, GAO/HRD-92-70, ACCESS TO HEALTH CARE: STATES RESPOND TO GROWING CRISIS (1992).

24. *See, e.g.*, Jerry L. Mashaw, *Taking Federalism Seriously: The Case for State-Led Health Care Reform*, 2 DOMESTIC AFF. 1, 12 (1993/94).

25. THE SECOND REPORT OF THE NATIONAL COMMISSION ON THE STATE AND LOCAL PUBLIC SERVICE, FRUSTRATED FEDERALISM: RX FOR STATE AND LOCAL HEALTH CARE REFORM 15 (1993).

26. *Id.* (New Hampshire, for example, spent 34.4 percent of its 1992 expenditures on Medicaid, while New York spent 22.6 percent)

27. THE KAISER COMMISSION ON THE FUTURE OF MEDICAID, MEDICAID AT THE CROSSROADS 37 (1992).

28. *Id.* at 44.

29. 42 U.S.C. § 1396a(a)(13)(A) (1988).

30. Leichter, *supra* note 3, at 11.

behalf of state interests and have proven to be valuable sources of substantive policy advice and technical assistance.[31]

Third, although Congress has enacted important health care legislation, its effort has been aimed primarily at reducing federal health care costs. It reduced Medicare spending, for example,[32] but did not enact more comprehensive reforms.[33] As Congress has ratcheted down federally funded health care programs, pressure on state officials to act has increased.

Finally, the politics of health care reform is indeed different from welfare politics. Health care reform is not a response to the concerns of poor people, but those of the politically influential, from middle-class workers concerned about declining insurance coverage to major corporations concerned about foreign competition.[34] Pressure from these communities, as well as the enormous fiscal stress imposed by Medicaid, has led state officials across the country to enact and implement various reforms.

But despite the often heroic efforts, state-based reforms have had a rather small impact.[35] Money is part of the problem. As Medicaid costs rise, finding dollars for reform is difficult. Another part of the problem is the threat of a business exodus. Each state must be concerned, for example, that if it is the only state in the region to require employers to provide health insurance to their employees, then at least some employers will move their businesses elsewhere.[36] But a big part of the problem is a federal health policy regime that frustrates and undermines nearly every state reform agenda.

---

31. In 1974, the National Governors' Association established the NGA Center for Policy Research, which provides much of this advice and assistance.

32. Prior to 1983, the federally funded Medicare program reimbursed hospitals for the actual cost of inpatient care. This guaranteed reimbursement encouraged hospitals to spend more. In 1983, however, Congress enacted the Medicare Prospective Payment System, which categorizes patients by diagnosis and reimburses hospitals a set amount for each categorized patient. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, 1983 U.S.C.C.A.N. (97 Stat.) 65, 149. The new reimbursement system has clearly reduced federal Medicare expenditures. LOUISE RUSSELL, MEDICARE'S NEW HOSPITAL PAYMENT SYSTEM: IS IT WORKING? (1989). Hospitals responded to the lost revenue, however, by shifting costs to other payers such as private insurers, and by shifting services to outpatient facilities that are not covered by the new payment system. *Id.*

33. Here, again, the changed Medicare reimbursement formula provides a good example because, while the new system reduced federal expenditures, it did little to reduce health care expenditures more generally, much less address other problems in the health care sector.

34. U.S. GENERAL ACCOUNTING OFFICE, GAO/HRD-90-68, HEALTH INSURANCE: COST INCREASES LEAD TO COVERAGE LIMITATIONS AND COST SHIFTING 10 (1990).

35. *See* Deborah Stone, State Innovation in Health Policy, a paper presented at the Ford Foundation Conference on "The Fundamental Questions of Innovation," Duke University, May 1991.

36. Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access For The Uninsured*, 24 U.C. DAVIS L. REV. 1, 269 (1990); *see also* PETERSON, RABE & WONG, *supra* note 22, at 232.

A. *Seeking More From the Private Sector and the ERISA Barrier*

ERISA, enacted in 1974, was primarily intended to ensure that workers are not unfairly denied expected pension benefits. To achieve that goal, the statute requires that employers disclose relevant information about company pension plans,[37] adequately capitalize such plans,[38] and avoid arbitrary and inequitable vesting requirements.[39] But when enacting ERISA, Congress did more than impose substantive requirements on employee pension plans: it also established an intergovernmental division of labor concerning the regulation of employer health plans. It is this division which frustrates officials in nearly every state today.

This intergovernmental tale is rooted in § 514 of ERISA,[40] which prohibits states from regulating employee benefit plans, including union health plans and the health plans of self-insured companies. At the same time, § 514 permits state regulation of health plans purchased from traditional insurance companies. This provision has had profound effects. States cannot require employers to provide health insurance to their employees;[41] employers who do provide insurance tend to self-insure;[42] and state efforts to add hospital surcharges to help subsidize care for the uninsured have been challenged for their legality.[43]

Consider state efforts to require that employers provide health insurance for their employees—the so-called employer mandate. Reform minded states are attracted to this approach because it builds upon the current employment-based health care system and avoids large outlays of additional government funds. Reformers are also influenced by Hawaii's successful employer mandate, adopted in 1974,[44] which serves as the foundation for that state's impressive array of health care reform programs.[45]

---

37. 29 U.S.C. §§ 1021-1031 (1988 & Supp. IV 1992).

38. 29 U.S.C. § 1082 (1988 & Supp. IV 1992).

39. 29 U.S.C. § 1053 (1988 & Supp. IV 1992).

40. 29 U.S.C. § 1144 (1988 & Supp. IV 1992).

41. Standard Oil Co. v. Agasalud, 442 F. Supp. 695, 707 (N.D. Cal. 1977), *aff'd*, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981) (finding that ERISA preempts a Hawaiian law that required employers to provide health insurance to their employees).

42. Studies suggest that 50 percent to 66 percent of American firms now self-insure. U.S. GENERAL ACCOUNTING OFFICE, *supra* note 34, at 21.

43. *See, e.g.*, Travellers Ins. Co. v. Cuomo, 813 F. Supp. 996, 1001-12 (S.D.N.Y. 1993), *aff'd in part and rev'd in part*, 14 F.3d 708 (2d.Cir. 1993), *cert. granted*, New York State Conference of Blue Cross & Blue Shield Plans v. Travellers Ins. Co., 115 S.Ct. 305 (1994) (holding that ERISA preempts a New York law that imposed surcharges on hospital bills to raise revenue to fund programs for the care of the uninsured). *But see* United Wire, Metal & Machine Health and Welfare Fund v. Morristown Memorial Hospital, 995 F.2d 1184, 1191-96 (3d Cir. 1993) (finding that ERISA does not preempt a New Jersey surcharge program).

44. Hawaii Prepaid Health Care Act, HAW. REV. STAT. § 393-2 (1985); *see generally* Deane Neubauer, *Hawaii: The Health State*, *in* HEALTH POLICY REFORM IN AMERICA, *supra* note 2, at 147.

45. Neubauer, *supra* note 44, at 147.

As a result of this success, Washington has recently enacted its own employer mandate;[46] Florida[47] and Vermont[48] may soon go the mandate route; and others, including Massachusetts[49] and Oregon,[50] are experimenting with a "play or pay" mandate, under which employers must either provide insurance or pay a sum of money to a state program for the uninsured.

Despite this flurry of activity and rhetoric about the need for state experimentation, Congress is unwilling to exempt these states from the restrictions of ERISA. Even Hawaii, which in 1983 qualified for the nation's only ERISA exemption, cannot alter the terms of its waiver to permit changes in its mandate program.[51] Congress has been unwilling to change these policies because the business and labor communities that benefit from ERISA are solidly opposed to any waivers.[52]

Although most states have yet to embrace reforms as comprehensive as an employer mandate, almost every state has developed a set of incremental reforms, many of which are also undermined by ERISA. For example, twenty-six states adopted high-risk pools, under which the state subsidizes insurance premiums for persons with high-cost health conditions, as of 1991.[53] Although widely publicized, these pools have had relatively little impact, covering less than 3 percent of people who are otherwise uninsured.[54] One major problem has been that states that tax private health insurers to fund the pools, as most do, cannot similarly tax companies that self-insure, due to ERISA's protection of these programs. Since over 50 percent of America's companies today self-insure, the high-risk pools are typically underfunded and underutilized due to ERISA restrictions.[55]

Consider also several states' attempts to provide additional funds for financially distressed providers by imposing a special tax, usually called a surcharge, on health care bills. New York, for example, requires that commercial insurers pay a 24 percent surcharge on all inpatient hospital bills;

46. Robert A. Crittenden, *Managed Competition and Premium Caps in Washington State*, HEALTH AFFAIRS, Summer 1993, at 82-88.

47. Lawrence D. Brown, *Commissions, Clubs, and Consensus: Florida Reorganizes for Health Reform*, HEALTH AFFAIRS, Summer 1993, at 7-26.

48. Howard M. Leichter, *Health Care Reform in Vermont: A Work in Progress*, HEALTH AFFAIRS, Summer 1993, at 71-81.

49. Camille Ascuaga, *Universal Health Care in Massachusetts: Lessons for the Future*, *in* HEALTH POLICY REFORM IN AMERICA, *supra* note 2, at 173.

50. Howard M. Leichter, *Rationing of Health Care: Oregon Comes Out of the Closet*, *in* HEALTH POLICY REFORM IN AMERICA, *supra* note 2, at 117.

51. The waiver is limited to the 1974 version of Hawaii's Prepaid Health Care Act. 29 U.S.C. § 1144(b)(5) (1988).

52. *See* Bobinski, *supra* note 36, at 344.

53. THE NATIONAL GOVERNORS' ASSOCIATION, A HEALTHY AMERICA: THE CHALLENGE FOR STATES 63 (1991).

54. *Id.* at 64.

55. Stone, *supra* note 35, at 17.

self-insured companies pay an 11 percent surcharge; and Health Maintenance Organizations (HMOs) pay a 9 percent surcharge, unless the HMO has a sizable Medicaid clientele.[56] In *Travellers Ins. Co. v. Cuomo*,[57] however, the Second Circuit held that each of these surcharges violated ERISA. The court reasoned that surcharges, even those imposed on commercial insurers, cannot stand because they have at least an indirect economic impact on the self-insured. If affirmed by the Supreme Court, the *Travellers* holding will also threaten any other state effort to regulate or tax provider revenue. Minnesota, for example, partially funds its new program for the uninsured, called MinnesotaCare, by a 2 percent tax on all medical providers.[58] Already, however, self-insured businesses are suing the state, alleging that the financing scheme violates ERISA because providers will pass on the tax to consumers.[59]

ERISA also undermines state efforts to regulate the substantive content of insurance policies. Many states require insurance policies to cover particular services in order to encourage comprehensive coverages,[60] while other states exempt some policies from the mandatory coverage requirements to encourage less expensive coverage options.[61] For example, forty states require coverage of alcoholism, thirty-nine states mandate mammography screening, and twenty-nine states require mental health coverage.[62] Conversely, more than twenty states now permit insurers to offer small businesses and other targeted groups bare-bones policies that waive many of the required services.[63] Once again, however, businesses that self-insure are immune from these various state initiatives. Moreover, the federal government has chosen not to regulate the content of these self-insured health policies. Thus, self-insured companies retain enormous flexibility and freedom.[64]

---

56. The surcharges are codified at N.Y. PUB. HEALTH LAW § 2807-c (Consol. 1987).

57. 813 F. Supp. 996, 999 (S.D.N.Y. 1993), *aff'd in part and rev'd in part*, 14 F.3d 708 (2d.Cir. 1993), *cert. granted*, New York State Conference of Blue Cross & Blue Shield Plans v. Travellers Ins. Co., 115 S.Ct. 305 (1994).

58. Howard M. Leichter, *The Trip from Acrimony to Accommodation*, HEALTH AFFAIRS, Summer 1993, at 48-58 (discussing Minnesota's recent health care reform legislation).

59. Telephone interview with Mary Kennedy, Minnesota Department of Health (Apr. 8, 1994).

60. U.S. GENERAL ACCOUNTING OFFICE, GAO/HRD-92-90, ACCESS TO HEALTH INSURANCE—STATE EFFORTS TO ASSIST SMALL BUSINESSES 28 (1992).

61. *Id.* at 29.

62. *Id.* at 27.

63. *Id.* at 29.

64. Perhaps the most publicized example of the extent and consequences of this freedom involves H & H Music Company's response in 1988 to an employee who contracted AIDS. The company dropped its private health insurance policy, which had provided a million dollar payment cap, and instead adopted a self-insurance plan, with a $5,000 payment cap on AIDS-related care. McGann v. H & H Music, 946 F.2d 401, 403 (5th Cir. 1991), *cert. denied*, 113 S. Ct. 482 (1992) (holding that employer did not unlawfully discriminate against employee for exercising rights under ERISA-qualified medical benefits plan because it reduced, within seven months of employee's submission of AIDS-related claim,

B. *Using Public Funds Differently Under Conditions Set by Federal Medicaid Officials*

Since ERISA limits state efforts to regulate the private sector, and since state treasuries cannot afford new public programs without unpopular tax increases, state officials today focus on cost-efficient uses of limited public funds.[65] In almost every state, for example, Medicaid officials seek to enroll clients in managed-care networks, assuming that such systems will steer clients away from expensive emergency rooms and toward inexpensive, more appropriate primary care physicians.[66] Indeed, this policy assumption is so strong that Tennessee officials have developed a managed-care program that seeks to cover 750,000 uninsured residents and one million Medicaid clients *at no extra cost.*[67] States also emphasize home-care services for targeted populations, such as the aged and disabled, to reduce reliance on high-cost institutionalization.[68] And in perhaps the most famous state experiment to date, Oregon Medicaid officials are rationing access to medical services deemed not cost-effective as part of a strategy aimed at providing Medicaid coverage to an additional 120,000 residents.[69]

Typically, efforts like these cannot proceed without a waiver from federal Medicaid mandates. For example, since federal law dictates that Medicaid recipients have the freedom to choose their medical providers,[70] state efforts to require recipients to enroll in managed care networks cannot proceed without a waiver. Federal law also generally requires that services available to one Medicaid client be available to all.[71] Thus, a waiver is a prerequisite for a state to provide certain recipients with special home-care services. Finally, any effort to restrict access to a federally mandated medical service requires a waiver as well.

Until quite recently, states seeking Medicaid waivers complained of numerous bureaucratic hurdles. The federal government took too long to review waiver applications, too often rejected applications for trivial reasons, and too often undermined innovative programs with burdensome conditions and caveats.[72] To his credit, President Clinton seems intent on

---

maximum medical benefits payable to any employee afflicted with AIDS from $1 million to $5,000 dollars).

65. Michael Sparer & Lawrence D. Brown, *Between a Rock and a Hard Place: How Public Managers Manage Medicaid, in* REVITALIZING STATE AND LOCAL PUBLIC SERVICE: STRENGTHENING PERFORMANCE, ACCOUNTABILITY, AND CITIZEN CONFIDENCE 279-306 (Frank J. Thompson ed., 1993).

66. U.S. GENERAL ACCOUNTING OFFICE, GAO/HRD-93.46, MEDICAID: STATES TURN TO MANAGED CARE TO IMPROVE ACCESS AND CONTROL COSTS 2 (1993).

67. *TennCare's "Shock Therapy" Worries Doctors, Patients*, MEDICINE AND HEALTH, Jan. 17, 1994, at 3.

68. Sparer & Brown, *supra* note 65, at 286.

69. Leichter, *supra* note 58, at 70.

70. 42 U.S.C. § 1396ba(a)(23)(B) (1992).

71. *See* 42 U.S.C. § 1396a(a)(30)(A) (1992).

72. Sparer & Brown, *supra* note 65, at 303.

reducing these bureaucratic difficulties, and, at his direction, the process has become somewhat less onerous.[73] For example, when reviewing waiver applications, federal officials now may make only one request for additional information and must issue a final decision within sixty days of submission. In addition, federal officials must publicize approved waivers so that other states can replicate the experiment more easily.[74]

Despite these changes, numerous conditions and restrictions still burden federal waivers. The intergovernmental tension, while reduced, remains significant. Oregon, for example, finally received its waiver after three years of waiting and negotiating.[75] The waiver, however, was conditioned upon compliance with twenty-nine terms and conditions, most of which were serious and substantial.[76] The story in Tennessee is similar. In late 1993, the state received federal approval to proceed with the TennCare program.[77] Again, numerous terms and conditions accompanied waiver approval. Federal officials clearly intend to retain tight control over these various state experiments.

II
A New Intergovernmental Partnership: Options and Opportunities

Despite the impressive array of state reform efforts, states today find themselves overwhelmed by rising Medicaid costs, frustrated in efforts to radically reorganize Medicaid programs, unable to afford universal health insurance programs, undermined in efforts to seek funding from the private sector, and unconvinced that the federal government will, or should, enact a comprehensive reform package.

By illustrating these various conundrums, *Health Politics and Reform in America* offers an important contribution to the health care debate. The book does not, however, grapple with the most important question it implicitly raises: What might a new and better intergovernmental health care partnership look like? In the remainder of this Review I discuss this issue. First, I review various questions any reform framework must address, and then I examine which intergovernmental division of labor is most likely to address such questions successfully.

---

73. Thomas L. Friedman, *President Allows States Flexibility on Medicaid Funds*, N.Y. Times, Feb. 2, 1993, at A1.

74. *See Medicaid Waivers Pave a Pathway for Reform*, Medicine and Health, Sept. 20, 1993, at Insert (reporting the statement of United States Department of Health and Human Services Secretary Donna Shalala that states can replicate other states' policies).

75. *See supra* text accompanying note 69.

76. Robert Pear, *U.S. Backs Oregon's Health Plan for Covering All Poor People*, N.Y. Times, Mar. 20, 1993, at A8.

77. *TennCare's Shock Therapy Worries Doctors, Patients*, Medicine and Health, Jan. 17, 1993, at Insert.

The array of questions that federal, state, and local governments must consider is substantial: Should government guarantee health insurance coverage for all? If not, how should government work to reduce the plight of the uninsured? What medical benefits, if any, should government require public or private insurers to cover? How should government finance the health insurance it provides? How can government reduce rising health care costs? Should government seek to steer the medical education process and, if so, how?[78] How can government best ensure or encourage high quality medical care?

Although these questions are straightforward, the answers are not. Nor is there consensus about which level of government should lead this policy debate. On one end of the spectrum is the proposal to remove the federal barriers to state-based reform and give states increased authority to experiment.[79] At the other extreme is the suggestion that everyone should have access to Medicare and that the federal government should finance and administer a uniform system of national health insurance.[80] In between lie dozens of alternative approaches including President Clinton's model, under which the federal government establishes the general framework for reform but delegates to the states a host of difficult but critical implementation tasks;[81] a Canadian-style system, under which the federal government establishes overriding principles of reform and frees the states to fulfill those principles via whichever system they choose;[82] and the menu model proposed herein, under which federal officials establish three or four frameworks for reform with strict implementation guidelines from which states can choose.

A. The State Autonomy Approach

Given the lack of consensus on health care policy and the proliferation of nascent state health care reform efforts, Congress could decide to remove or reduce the federal barriers to state-based reform and let the states experiment as they wish. To be sure, the politics of this approach present numerous hurdles. Big business and labor oppose easing the ERISA barrier, and federal officials are reluctant to provide federal Medicaid dollars without federal agency oversight. Nonetheless, a Congress frustrated by unsuccessful efforts to fashion a health care compromise could well decide

78. For example, should the government require that medical schools produce an increased number of primary care physicians?

79. Rachel Block, *Navigating Health Care Reform: Why States Should Be Captains of the Ship, in* NATIONAL HEALTH REFORM 41 (1993).

80. The MediPlan Health Care Act of 1993, introduced by Rep. Fortney (Pete) Stark, would establish a Medicare program for all citizens. H.R. 2610, 103rd Cong., 1st Sess. (1993).

81. PRESIDENT CLINTON'S PROPOSAL, *supra* note 7, at §§ 1201-1205.

82. Robert G. Evans, *Canada: The Real Issues*, 17 J. OF HEALTH POL. POL'Y & LAW 739, 742-43 (1992).

to declare victory, perhaps with some uncontroversial insurance reforms thrown in, and then delegate the entire mess to those laboratories of democracy, the states.

Removing federal barriers would enable several states, including Hawaii, Minnesota, Oregon, Tennessee, and Washington, to proceed with innovative and comprehensive reforms. Most states, however, are not likely to follow suit because the fiscal cost is too high, the administrative capacity is still too limited, and the public commitment is too weak. Instead, some states will continue to experiment with incremental initiatives, from high-risk pools to managed-care initiatives to expanded home-care programs.[83] Other states will do nothing.

To be sure, the state autonomy advocates respond to this pessimism with three powerful arguments. First, many states may have delayed reform activity because of an expectation of federal action. With federal reforms now unlikely, state reforms become more likely. Second, with more regulatory flexibility, more states may act. And third, state-initiated activity, as difficult to achieve as it is, is still more likely than substantive federal activity, and should therefore be encouraged. For all of these reasons, there is now an alliance emerging between those who have argued for years that health reform should be led by the states and those who would prefer a national solution but believe it unlikely.

Given the mood of the day, state-based strategies may be a necessity: the new Republican Congress is not about to enact a comprehensive program of national health insurance. Nonetheless, state-led efforts are only a short-term solution, as they will neither ensure universal coverage nor contain health care costs. On the contrary, this new nonsystem, comprised of fifty different jurisdictions, will simply exacerbate the extraordinary inequity inherent in the current nonsystem.

B. Medicare for All

The MediPlan legislation, introduced in the 103rd Congress by California representative Fortney (Pete) Stark, sought to limit state discretion by minimizing state-based and private insurance, substituting in its place an expanded Medicare program.[84] Under this model, all Americans would be entitled to comprehensive health insurance benefits, financed and administered by the federal government. Federal officials would also be responsible for lowering costs by setting a national health budget and regulating providers.[85] Granted, this approach leaves room for considerable state-by-state variation, since significant variation currently exists in health care

83. *See supra* text accompanying notes 53 and 65-69.

84. 139 CONG. REC. E1707 (daily ed. July 1, 1993) (statement of Rep. Fortney (Pete) Stark).

85. *Id.* at E1709.

spending by Medicare beneficiaries,[86] and since states could opt out of the MediPlan system, subject to strict federal supervision.[87] Nonetheless, this model would reduce interstate variation, and citizens in all states would receive guaranteed and comprehensive benefits.

Despite these advantages, there is little likelihood that Stark's proposal will soon be enacted into law, particularly with the newly-elected Republican Congress. MediPlan would require the federal government to levy taxes to raise the billions of dollars currently raised privately through insurance premiums, sounding a sure death-knell in the current anti-tax atmosphere. Moreover, it would entrust the health care system entirely to the federal government, an idea that remains an anathema to most Americans.

C. The Clinton Plan

Under the original Clinton plan, the federal government would establish a complicated and bureaucratic framework for reform and would delegate to the states the difficult task of setting up and implementing that framework. To be sure, the President's plan resolved many of the key policy decisions at the federal level. The plan would entitle all citizens to a comprehensive set of health care benefits[88] funded primarily by an employer mandate[89] and provided most often by large HMO-type health plans.[90] The federal government would begin to decrease costs by regulating the premiums charged by health plans.[91] In addition, the federal government would expand the supply of primary-care providers by requiring medical schools and teaching hospitals to emphasize primary-care residencies.[92]

Despite this federal framework, the plan delegated to the states numerous complicated and politically charged tasks. For example, the linchpin of the plan was the establishment of regional health alliances, created to organize and manage the competition between the various health plans.[93] These alliances would inform consumers of their health plan options, provide consumers with "report cards" on the care rendered by the health plans, determine consumer eligibility for premium subsidies, negotiate insurance premiums with the plans, collect premiums from consumers, distribute payments to the health plans (adjusting the amount paid by the

86. Charles Helbing, *Medicare Program Expenditures, in* HEALTH CARE FINANCING REVIEW: MEDICARE AND MEDICAID STATISTICAL SUPPLEMENT 34 (1993).

87. 139 CONG. REC. *supra* note 86, at E1709.

88. PRESIDENT CLINTON'S PROPOSAL, *supra* note 7, §§ 1101-1128.

89. *Id.* at § 1601.

90. *Id.* at § 1400.

91. *Id.* at § 6003.

92. *Id.* at § 3012.

93. *Id.* at § 1301.

risk status of the plans' enrollees), and establish grievance procedures for disgruntled consumers and providers.[94]

Because such regional health alliances do not now exist, the states would have to determine how to create and staff these entities. States would be called upon to decide the corporate structure of alliances, the number of alliances in each state, and the geographic jurisdiction of each alliance. These decisions are neither trivial nor easy. States would experience significant political pressure to establish numerous health alliances, for example, because wealthier communities would likely resist any alliance structure that pools their residents with those of poorer communities. The resulting risk segmentation would not only undermine the overall reform goal, but also would create very difficult staffing and organizational problems.

The complicated intergovernmental regime envisioned by the Clinton reform plan contributed to its eventual demise. There were, of course, other contributing factors: powerful interest groups which opposed both the employer mandate and the premium caps; consumer concern that the emphasis on managed care would eliminate freedom of choice and undermine existing doctor-patient relationships; a powerful anti-government and pro-Republican political movement; and a political system of checks and balances that makes comprehensive reform difficult to enact. Nevertheless, the President's decision to propose numerous new federal and state agencies heightened public suspicion that the entire effort was too bureaucratic and intrusive to be supported.

D. The Canadian System

Canada is well known for its single-payer health care program. Less well known is the intergovernmental partnership that governs that program. Under the guidance of this partnership, the ten Canadian provinces tailor the system to local needs while meeting five national criteria: the programs must provide *universal*, *comprehensive*, *accessible*, *portable*, and *publicly administered* coverage.[95] The advantage of this national-local partnership is that the national government, by setting forth governing principles, ensures that all citizens receive comprehensive and accessible health care. The provinces, meanwhile, by establishing their own programs, ensure that the system is responsive to local conditions.

In a recent article, Jerry Mashaw suggests a similar model for the United States: let Congress set the minimum standards, such as universal, comprehensive, and portable coverage, and let the states implement those principles as they see fit.[96]

94. *Id.* at §§ 1321-1329.

95. Evans, *supra* note 82, at 743.

96. Mashaw notes:

There is much to recommend this approach. Like the Clinton plan, it entitles all Americans to a comprehensive set of accessible benefits. Unlike the Clinton plan, however, it does not prescribe a preferred means of achieving that goal. Like the state autonomy model, this approach respects and celebrates the differences and diversity among the states. But unlike the state autonomy model, this plan requires reform activity even from the most recalcitrant of states.

But how well and how quickly would this model work? Consider the following scenario. In late 1995, Congress enacts legislation requiring states to implement universal, comprehensive, and portable coverage by 1998. Early in 1996, the debates in the states begin. In early 1997, one state enacts a program of tax credits for low-income workers to subsidize the cost of private health insurance and, ostensibly, to implement the universal coverage requirement. The legislature also encourages medical providers to use restraint in raising fees. But by 1999, 9 percent of the state's population remains uninsured, costs are still escalating, and angry federal officials are threatening sanctions such as withholding federal reimbursement. The state's governor, after negotiations with high-ranking federal officials, promises that by the year 2001 the state will be in compliance with federal law. This time, the state will try a managed-competition approach. Only now, the state will have to decide how many regional health alliances to have, what jurisdictions they should cover, how they should be staffed, and how to create a managed-care infrastructure.

Granted, this scenario probably will not occur in Minnesota, Washington, and Vermont. But it may well occur in much of the country, as state politicians confront and struggle with the hard choices of health care reform. States have powerful incentives to proceed slowly and cautiously, avoiding for as long as possible any programs requiring new taxes or employer mandates.

In the end, however, Congressional adoption of a Canadian-styled intergovernmental partnership would be a significant forward step. While the current political climate makes such adoption unlikely, Mashaw and his colleagues should press the argument.

> [B]ecause of their long experience and heavy involvement with HMOs, Californians may be perfectly happy with some version of managed competition. Vermonters, by contrast, may find the idea of an HMO appalling and the notion of competition among large health insurance cooperatives laughable given the small size and sparse population of their state. Maryland may prefer an all-payer rate-setting system for cost control, in no small part because it has had significant success over the last decade constraining hospital costs by using that approach. The governor of Kentucky has worked out a complex and comprehensive version of play or pay that might well suit Kentuckians and their particular circumstances.
>
> And so it goes. There is unlikely to be any single best system for the whole of these United States. Regions, states, even localities are different in their demographic characteristics, political cultures, and existing styles of medical practice and health care consumption.

Mashaw, *supra* note 24, at 12. *See also id.* at 18.

E. The Recommended Solution: Federal Menus

The intergovernmental partnership for the 1990s should accomplish three goals: guarantee affordable insurance coverage to all Americans, provide states with discretion to choose the reform model that best suits their culture and capacity, and avoid saddling states with the most politically charged implementation tasks. The best way to achieve these goals is for the federal government to establish a menu of choices for reform and to provide supervision of states' efforts.

Congress could offer states four reform frameworks: managed competition, which includes an employer mandate and provisions for federal decisions about the governance and jurisdiction of health alliances; a state-run single-payer system financed primarily by an increased payroll tax, with provider reimbursement based on Medicare fee schedules; a multi-payer system, including an employer mandate and provider reimbursement based on Medicare fee schedules; and an expanded Medicare program, under which the uninsured would receive coverage under the Medicare program, financed primarily by an increased payroll tax.[97] Under such a system, the federal government would make the toughest political choices, such as whether to require universal coverage, but would leave to the states the flexibility and discretion to make many of the other decisions. This model also provides political cover for federal officials who propose national reform, as the states themselves will decide which reform option best meets their local needs.

The new model enables states to become true policy laboratories, trying and testing different approaches in a policy arena with few clear answers. To date, while the concept of state laboratories is widely lauded, and while states clearly are experimenting with numerous reform initiatives, there is remarkably little learning actually being shared between states or with Congress. Indeed, a strength of the Leichter book is its description of the variety of state-based reform efforts now underway. As it stands, the states that are health reform leaders differ enormously in their reform approach. Similarly, while Congress occasionally adopts reforms first tested in the states, most federal programs do not originate in the states.[98] Even in the recent Congressional debates on health care reform, the leading contenders were managed competition and a single-payer system, neither of which is in place in any state.

The menu model, by contrast, provides a theoretical framework under which policymakers could try and test alternative approaches in a relatively controlled environment. Assume, for example, that each of the fifty states

97. This list of proposed options is merely illustrative. There would (and should) be a lively debate over which options would be included on a federal menu.

98. *See, e.g.*, DAVID G. SMITH, PAYING FOR MEDICARE: THE POLITICS OF REFORM 32-35 (1992) (describing how New Jersey's hospital rate-setting program was the model for the federal Medicare Prospective Payment System).

implemented one of four reform models. Over time, researchers would examine, evaluate, and compare the successes or failures of the models. Which model best controls costs? Which encourages good quality care? Which produces the highest consumer satisfaction? Is one of the models well suited for nationwide replication? Or should states maintain indefinitely the ability to choose among a variety of options?

The menu model need not be restricted to financing and reimbursement. Federal officials could, for example, develop three or four benefit coverage packages, several medical malpractice models, and alternative strategies for expanding the number of primary care providers. State officials could then pick and choose from the options developing the system that best suits their needs.

Admittedly, federal menus will not effectively resolve every health policy issue. Capital planning, for example, probably should take place at the state level, because federal agencies cannot appropriately determine how many nursing home beds a particular community should have. Public health policy-making may belong at the local level as well, since communities respond best to their own demographics, epidemics, and delivery systems.

Many state officials will oppose the menu model. While the model provides for some state flexibility, it carefully circumscribes the range of such flexibility. State officials will argue, with justification, that bureaucrats in Washington should not and cannot issue implementation blueprints for health reform activities. After all, local needs do differ, local discretion is important, and burdensome federal regulation is often unhelpful. But the goal of the menu model is not to impose a Kafkaesque federal bureaucracy, with federal supervision of every detail of every plan. Rather, the menu model aims to structure and organize the state decision-making process. Hopefully, this process will both produce a true policy laboratory as well as ensure substantive reform.

CONCLUSION

In the debate over health care reform, issues of federalism and intergovernmental relations are rarely heard. Instead, most reform proposals, whether incremental or comprehensive, delegate to state and local officials enormous levels of discretion and authority. They assume, without foundation, that state and local officials can easily implement complicated and controversial reform programs.

This lack of discussion is particularly unfortunate in light of the obviously inadequate partnership between federal and state governments. Currently, federal law undermines state reform efforts without supplying an alternative reform agenda in its place. This essay suggests that the solution lies not in providing states with expanded discretion, but in fashioning a partnership that both respects the diversity among the states and provides a

federal reform framework. The system of federal menus offers one path toward achieving that goal.

Even under this model, however, Congress needs to make some politically tough decisions. At the time of this writing, the odds that such decisions will include universal coverage are declining rapidly. Nevertheless, a menu model proposal might enable reformers to avoid the charge that any reform necessarily entails an expanded federal government, and just might encourage the kind of bipartisan consensus necessary to achieve substantive reform.