Federalism And Health Policy

Medicaid is an appropriate and feasible base on which to build basic health care coverage.

by Richard P. Nathan

ABSTRACT: This paper presents a cyclical theory of U.S. federalism and social policy: Many social policy initiatives are tested and refined at the state level, especially during conservative periods, and later morph into national policies. The paper describes such federalism cycles and offers an interpretation of why and how they occur, focusing on Medicaid. State activism has preserved and expanded Medicaid through policy innovation and resistance to retrenchment, especially in conservative periods, by taking advantage of the flexibility the program provides. I conclude that Medicaid's incremental/partnership approach is appropriate and feasible to build on for a future expansion of health care coverage.

MODERN FEDERALISM WAS INVENTED in Philadelphia. Before 1789, a federal country had been defined as a league or club of member states. Under the U.S. Constitution, what is distinctive is that each citizen is a citizen of two governments—national and state.[1] Experts agree that a functioning federal system must have a democratic form that provides opportunities for access and participation by citizens at both the central and regional levels; otherwise, the idea of self-expression by the regional governments would not be meaningful. Most experts also agree that an effective federal form needs to operate under a written constitution that deals with the responsibilities of the central and regional governments, the role of regional governments in the amendatory process, and the rights of citizens. However, experts disagree about the efficacy and durability of the federal form. Advocates of federalism see it as a way to protect against central tyranny, increase the participation of citizens, encourage innovation (states as "laboratories"), and strengthen community identity, with the fundamental objective of reconciling unity and diversity. Opponents of the federal form criticize its slowness to respond to new challenges, its inequities in the treatment of citizens from different regions, its inability to take advantage of technological changes, and the perceived cumbersome nature of governmental decision-making and implementation processes. Such opponents stress the intricate nature of federalism and its complexity.

Over two centuries, the U.S. federal form has proved to be opportunistic. The role and activities of U.S. governments have changed as U.S. societal values and

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DOI 10.1377/hlthaff.24.6.1458

conditions have changed. The principal question examined in this paper is: Does U.S. federalism enhance or impede the development of social programs, particularly for health care? The argument here is that U.S. federalism's dominant effect has been to expand the scope and spending of the social sector. The recent history of Medicaid provides evidence for taking this position. In the current period, the national government has tried a number of retrenchment strategies for Medicaid. However, state governments have dug in their heels; Democrats and Republicans alike have staved off Washington's attempted Medicaid rollbacks. Lawrence Brown and Michael Sparer expressed a similar view in 2003. They found that fiscal federalism was a factor in "prompting coverage expansions during good times (the feds paid most of the bill) and deterring cutbacks even in bad times (every state dollar saved meant two or three federal dollars lost)."[2] It is arguable that we are seeing another health-related example of this upward push of state policy initiative in the actions of California, Illinois, Connecticut, and New Jersey to support embryonic stem cell research, which are now, and surprisingly quickly, being expressed in a changed, supportive national policy on this controversial issue.

I return now to comments that federalism is dynamic and opportunistic. Where one stands depends on where one has power. Although it might be easier and more efficient for a political faction to advance its goals centrally, when one's faction is out of power at the center, it is equally logical to advance them from the periphery.

Federalism Cycles

Medicaid's experience demonstrates an important, related characteristic of U.S. federalism: its cyclicality. Generally, over time, the national government has been the source of social policy initiatives in liberal periods in our history. In conservative periods, on the other hand, some states have been sources of innovation and expansion in the social sector. In the 1920s, for example, when the country was "Keeping Cool with Coolidge," states were the source of progressive initiatives such as unemployment insurance, public assistance, and workers' compensation. James T. Patterson noted that the states "preceded the federal government in regulating large corporations, establishing minimum labor standards, and stimulating economic development."[3] He added that "the most remarkable development in state government in the 1920s was the increase in spending."[4] State initiatives planted the seeds of Franklin D. Roosevelt's New Deal.

This same pattern can be seen further back in time. A surge of state initiatives in domestic affairs characterized the conservative Republican period in the 1880s. Allen Nevins and Henry Steele Commager wrote that "the first great battles of the reform movement were fought out in the states."[5] Compulsory school attendance laws and the creation of state boards of education, reforms of political processes, a growing role for state boards of charity, child labor laws, and state regulatory policies in licensing and zoning are examples of state domestic policy innovations at

the turn of the century.[6] A specific health example of state initiatives later followed by federal action is school vaccination laws, which originated in the nineteenth century. Massachusetts led in 1855; New York followed in 1862; and Indiana, in 1881. All states now have such laws, often coupled with compulsory school attendance laws. Federal grants-in-aid and safety regulations for vaccinations came much later, in 1986 and 1993.[7]

In the 1980s, when the pendulum of social policy nationally swung toward conservatism, there was a similar spurt in state activism in response to President Ronald Reagan's policies to cut domestic spending. States reshaped programs to reflect state priorities, increased their funding of programs in areas in which the federal government had become less active, and assumed more control over the activities of local governments and nonprofits.[8] In these and other ways, states increased their influence vis-à-vis the federal government and their relationships with local governments and nonprofits. More recently, Randy Bovbjerg and other Urban Institute scholars pointed to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 as an example of a state initiative that stimulated national policy activism: "HIPAA adapted some state and small group insurance market reforms and applied them nationally."[9]

The key to the argument about the essentially pro-governmental activist influence of federalism cycles over time is to convince the reader that in liberal times nationally, recalcitrance and opposition to change by some states have not been as important for social policy as the state-push factor in conservative periods. The historical record and the Medicaid experience support this position, but I grant that definitive proof is a hard standard to satisfy for theories of this kind.

Medicaid In The Federalism Context

Although it is complex territory, we need to try to unpack the whys and hows of the state-push factor for Medicaid in U.S. federalism. Intrinsic characteristics of federalism have put liberal/innovative states in a position to lead in conservative periods. Changes that states make in these periods, because they are easier to develop and test in relatively small places (as opposed to having to be adopted nationally), have a demonstration/replication effect on other states. Such changes would not be as likely to occur and be diffused in a unitary political system. When a particular state policy innovation is shown to be substantively and managerially feasible, this gives activist leaders in other states confidence that they can do similar things, providing them with a knowledge base for adopting new or changed policies and reducing apprehensions about doing so.

This state-push factor in the case of Medicaid in recent years has had a notable protective and expansionist influence, despite the U.S. political culture in which individualism and general skepticism about government's role in social policy is strongly manifest. An underlying reason why this occurs is that many federal grant-in-aid programs, including Medicaid, are structured to give states flexibil-

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ity in setting benefit levels and determining how benefits are defined. If there had to be one nationwide standard ("one size fits all") for the benefits and services provided under social programs such as Medicaid, the ultimate effect would be less expansive. This floor-setting accommodation to diversity in social policy (sometimes aided by federal waivers for human services for "demonstration-type" initiatives) permits establishing higher standards and benefits in some states. It has also been an instrument for providing federal matching funds for existing health programs (such as mental health and retardation, drug and alcohol treatment, and school health programs), such that in New York, as the saying goes, "Medicaid is a verb," by enabling the state to use Medicaid funds for programs that are already part of a strong base of publicly supported health care services.

There is an important additional point about program management under Medicaid that has aided and undergirded Medicaid's growth. Among health care delivery systems, it is Medicaid that has made the most progress in the adoption of managed care as a mechanism for defining services and controlling costs. This is especially the case for acute care; it is also being advanced now in a number of states for long-term and institutional care.[10]

One impression people have about Medicaid, and it is largely true, is that richer states have richer programs; hence, the federalism state-push factor for Medicaid is primarily from liberal states. However, a recent Lewin Group–Rockefeller Institute report has shown that poorer states are closing the gap: "In middle and late 1990s, Medicaid spending growth slowed or even stalled among wealthier states—not surprisingly, given the strong economy and possible downward pressures on Medicaid caseloads exerted by welfare reforms. But the poorest states continued to show increases in spending even in the late 1990s. By 2000, differences between the richest and poorest states in per capita spending on Medicaid had narrowed substantially."[11] Exhibit 1, showing the most recent data available for a five-year period, supports this point. The largest number of states are those with below-average per capita income and above-average growth in Medicaid spending, which suggests a convergence effect nationally for spending.

The history and politics of the Medicaid program have a lot to do with its growth and patterns of spending. The composition of Medicaid spending has facilitated its growth and the state-push nationally in the program's forty-year history (Exhibit 2). Medicaid is not only or primarily a program providing acute care for the very poor (the conventional welfare population). It materially benefits people at higher income levels, particularly the elderly, who have exhausted or divested themselves of their resources; and people who are disabled, mentally retarded, or emotionally disturbed and their parents and dependents who often are

EXHIBIT 1
Real Percentage Growth In Medicaid Spending, FY 1998 To FY 2003

Above U.S. average growth in Medicaid spending				Below U.S. average growth in Medicaid spending			
Below U.S. average per capita personal income		Above U.S. average per capita personal income		Below U.S. average per capita personal income		Above U.S. average per capita personal income	
State	Percent	State	Percent	State	Percent	State	Percent
AZ	96%	NV	71%	OH	32%	WA	30%
NM	72	DE	50	SD	30	VA	30
ID	71	WY	48	AL	29	PA	30
GA	56	MD	46	KY	23	RI	29
VT	53	CA	42	ND	22	NY	26
WI	50	CO	37	LA	20	NJ	25
OK	49	AK	34	MI	20	IL	23
MS	49			WV	18	MA	21
FL	49			MT	13	DC	7
MO	46			HI	13	CT	7
IN	44					NH	7
AR	43					MN	4
ME	40						
KS	40						
UT	39						
TN	38						
IA	37						
TX	36						
OR	35						
NE	35						
SC	35						
NC	34						

SOURCE: Rockefeller Institute analysis of data from the Centers for Medicare and Medicaid Services, CMS-64 forms, and from the U.S. Census Bureau.

NOTES: U.S. average is 33 percent. In fiscal year (FY) 2003, U.S. average per capita personal income was $31,472. Medicaid spending data are adjusted to inflation using the Bureau of Economic Analysis's price index for Medical Care Personal Consumption Expenditures, Table 2.3.4: Price Indexes for Personal Consumption Expenditures.

not (and maybe never were) poor. Spending for the aged and disabled is almost three times that of acute care spending on families and others, although the aged and disabled make up less than one-third of the total Medicaid population. According to John Holahan and Arunabh Ghosh, growth in 2000–2003 in spending

EXHIBIT 2
Growth In Health Spending (Billions), FY 1998 To FY 2003

Source of spending	1998 ($)	2003 ($)	Change ($)	Percent change
Total	1,010.0	1,441.0	431.0	42.7
Medicaid	160.0	248.5	88.5	55.3
Medicare	202.5	274.9	72.4	35.8
Private	397.8	578.7	180.9	45.5
Out-of-pocket payments	175.6	230.5	54.9	31.3
Other	73.9	108.2	34.3	46.4

SOURCE: Rockefeller Institute analysis of data from the Centers for Medicare and Medicaid Services, National Health Accounts, Table 4.

"Advocates of broader coverage are likely to be best served by making changes in either or both Medicaid and Medicare."

on the aged and disabled was larger, in both absolute and relative terms, than for the family group that receives acute care, emergency care, and other services.[12] This is not meant to gainsay the worthiness of such benefits but is a reminder that Medicaid is often mischaracterized as an antipoverty program. The services of Medicaid to the elderly and the disabled give it political insulation. The combination of broad coverage and the wide range of provider interests (physicians, hospitals, unions, and drug companies) provides a strong coalitional base to Medicaid and the State Children's Health Insurance Program (SCHIP), enacted in 1997.

Looking Ahead

In the current setting of multiple and complex health care delivery systems, holistic strategies for dismantling large systems and replacing them with new ones are nearly impossible to design, very hard to implement, and even harder to build political coalitions for. Advocates of broader coverage and additional benefits and services are likely to be best served by making changes in either or both the Medicaid and Medicare programs in bite-size increments, and I would argue especially under Medicaid.

Slightly more than a quarter of the U.S. population with health insurance is covered by Medicare and Medicaid. In 2003, 84.6 percent of the U.S. population was covered by a health insurance program. Among those covered, 68.6 percent were covered by private insurance, 13.7 percent by Medicare, 12.4 percent by Medicaid, and 3.5 percent by military health care.[13] Moreover, within the covered population there is variation in the ways people are served. This is definitely true for Medicaid. It is also true for Medicare.[14] There is a need for implementation research in many areas of health care coverage, both public and private, to study variations in the mechanisms providing coverage and to probe the reasons (policies, procedures, institutional channeling, and so forth) why services and benefits differ.

Medicaid policies, services, and costs are especially diverse. Costs vary from $245 per person in Nevada to $1,700 in New York. New York and Nevada are very different states, of course, but even within regions of the country, Medicaid programs vary enormously. For example, New Jersey spends two-thirds of what Connecticut spends per capita and 40 percent less than New York spends.[15] States have different policies, but they also have different populations, economies, and medical care infrastructures. Among major questions that need to be addressed are the following: How much of Medicaid spending variation is attributable to differences in government policies and practices, health status, income, poverty, prices, and choices by the medical profession and consumers? How are states' Medicaid policies implemented? To what extent do Medicaid spending differ-

ences affect health care quality?

Medicaid research on how benefits and services differ by state can increase understanding of how differences in state Medicaid protection and expansion measures have occurred, how they have been diffused, and how they have ratcheted up benefits and services.[16] This applies both to conservative periods, in which state actions have been particularly instrumental, and to liberal periods, when national action could be expected to support and help facilitate the expansion of social benefits and services.

Health Care: A Right Or A Commodity?

At a recent forum at the Rockefeller Institute, a physician asked: Is health care a right or a commodity?[17] My answer was that it is both. It is a limited right; it is limited in terms of the basic level of care that can be provided to citizens. It is also a commodity in that well-off citizens can and will buy more, and more sophisticated, care than we can provide for everyone. I believe that an appropriate and feasible approach for providing basic health care coverage is under the protective shield of the Medicaid program. In saying this, I want specifically to challenge the often-easy assumption that health care can be managed so well centrally with information technology (IT) that by using IT, there are few limits to what the country can provide.

This is not to deny that computer systems can improve care. But IT is not a silver bullet for reform and program management. In reviewing studies of performance management systems, I have been struck by how hard it would be to control national social spending by relying on performance management systems that require state and local governments and other service-providing organizations to measure their results and costs and manage programs to achieve specified goals. The performance management movement can be seen as part of a shift toward what Gais calls "executive federalism."[18] Building on this concept, goals (mostly crafted and overseen by bureaucrats and program experts) have been put forward as major devices for program implementation. Experience with doing this challenges the assumptions about their efficacy in many areas—for schools, job programs, and health care—because of the bureaucratic gaming behavior that can and does occur.[19]

There is no reason to be negative or defensive about the conclusion here that the Medicaid program is an appropriate and feasible health care base to build on. The Center on Budget and Policy Priorities recently issued a report about the history and value of this program that helps provide the right perspective. Medicaid has come a long way.

> Extensive evidence demonstrates that Medicaid and SCHIP have greatly reduced the number of people without health insurance, substantially facilitated access to medical care and long-term care, and improved health for large numbers of low-income people.... Today, Medicaid and SCHIP (which began in 1998) provide more than 50 million economically vulnerable children, senior citizens, people with disabilities, and other adults with access to life-saving and life-preserving health care.[20]

The cyclical and federalism-incrementalism approach to analyzing the Medicaid program in this paper is rooted in the history of the program and recent experience. In his heyday, the master Medicaid manipulator, Rep. Henry Waxman (D-CA), showed how astute maneuvering in Washington could be a pull factor to stimulate state actions to improve benefits. Based on his own words, the following are examples of Waxman's accomplishments in the 1980s: (1) allowing states to cover home- and community-based services as an alternative to institutional care for the frail elderly and disabled (1981); (2) defeating the "Medicaid cap" proposed by President Reagan and budget director David Stockman to shift the cost of the Medicaid program from the federal government to the states (1981); (3) providing basic health care coverage to low-income women and their families to enable them to make the transition from welfare to work (1988); (4) covering the Medicare premiums and deductible and coinsurance requirements for millions of low-income Medicare beneficiaries to protect them from excessive out-of-pocket costs (1988); (5) guaranteeing basic health care coverage, including preventive benefits, to all children in poverty (1990); and (6) guaranteeing coverage for prenatal care, maternity care, and basic health care for pregnant women and children under age six with family incomes at or below 133 percent of the federal poverty level ($17,263 per year in 1996 for a mother with two children) (year not indicated).[21]

THE EXPANSION OF MEDICAID in the 1990s and in recent years, however, has not been so much a function of congressional initiatives as it has the product of state initiatives.[22] Historically, states have performed this role, providing a state-push factor in social policy. In fact, as states have taken measures in recent years to protect and expand their Medicaid programs in the face of Washington's efforts to damp down the growth of the program, a nascent political and programmatic base may be building now for a future expansionist cycle in national policy to improve health care benefits and services—when the stars are aligned centrally for doing so.

Thomas Gais, Martha Derthick, Donald Boyd, and Lucy Dadayan provided assistance in the preparation of this paper. The author thanks them for helping.

NOTES

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