THE CASE FOR FEDERALISM AND HEALTH CARE REFORM

Jerry L. Mashaw[*]
Theodore R. Marmor[**]

Americans are not particularly well-served by their current medical care arrangements. In comparison to all of our major trading partners and competitors, we are less likely to be insured for the cost of care, and the care that we receive is almost certain to be more costly. Although American medicine has produced many "miracles," we are not the undisputed leader in medical innovation, only in the costliness and ubiquity of high-technology medicine.[1] Most of us "covered" by some form of health insurance still worry about its continuation should we or a close family member become seriously ill. Some of us are "locked into" employment we would gladly leave but for the potential catastrophic loss of existing insurance coverage.

While everyone decries our peculiar ability to combine insecurity with high cost, substantial reform of American medicine at the national level has been enormously difficult to achieve, and comprehensive reform has been impossible. This is not simply a description of the Clinton Health Plan debacle of 1993-94. On multiple occasions since the Second World War, comprehensive national reform has been attempted (and between 1973-74, appeared imminent), but has fallen short of the necessary political majorities. Each of these failures has its own peculiar history, and in each there are many contributing causes of the failure.[2] One simple fact remains, however. Americans have been dis-

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* Sterling Professor of Law, Yale Law School. B.A., LL.B. 1964, Tulane University, Ph.D. 1969, University of Edinburgh.

** Professor of Public Policy and Management, Yale School of Management. B.A. 1960, Harvard College, Ph.D. 1966, Harvard University.

1. Based on several indicia, one source has determined that the United States lags behind other industrialized countries in health care quality. *See* JEREMY HURST, THE REFORM OF HEALTH CARE: A COMPARATIVE ANALYSIS OF SEVEN OECD COUNTRIES (1992).

2. *See* Theodore Marmor, *The Politics of Universal Health Insurance: Lessons from Past Administrations?*, 27 POL. SCI. & POL. 194 (1994). *See also generally* PAUL STARR, THE SO-

satisfied with the nation's medical arrangements, but our political system has been unable to come up with a solution that satisfies enough of the people to overwhelm the other barriers to reform.

It is precisely here that American federalism can play a crucial role in making genuine medical reform viable, successful, and acceptable to most citizens. Political judgments about particular reform proposals are products of personal experience, political ideology, and local economic and social conditions. These factors change substantially as one moves about the United States. If change is to be workable and acceptable, it must take account of the real differences between New York and Idaho, Wisconsin and Louisiana.

For example, because of their long and widespread experience with health maintenance organizations (HMOs), Californians *may* be happy with some version of "managed competition"[3] among large plans. Vermonters, by contrast, may find the idea of an HMO appalling, and the notion of competition between large health insurance cooperatives laughable given the small size and sparse population of their state. Maryland may prefer an "all-payer" rate-setting system[4] for cost control, in no small part because this approach has had relative success over the last two decades in constraining the state's hospital costs. The governor of Kentucky has worked out with the state legislature a complex and comprehensive version of "play or pay" statewide insurance[5] that seems to suit Kentuckians, or at least a majority of their legislators.[6] The big problem in Alabama may be coverage, in Connecticut it

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CIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (history of medical care from colonial times to the present); ODIN W. ANDERSON, HEALTH SERVICES IN THE UNITED STATES: A GROWTH ENTERPRISE SINCE 1875 (1985) (general history of health services from 1875 to the present); ELI GINZBERG, THE MEDICAL TRIANGLE: PHYSICIANS, POLITICIANS, AND THE PUBLIC (1990) (analysis of social factors influencing the development of health care systems since World War II).

3. "Managed competition" can be defined as "combin[ing] market forces and government regulation . . . [to] both restrain prices and encourage high-quality care and responsiveness." THEODORE R. MARMOR, WITH MARK GOLDBERG, *American Health Care Reform: Separating Sense From Nonsense, in* UNDERSTANDING HEALTH CARE REFORM 1, 12-13, 263 (1994).

4. An "all-payer" system can be defined as "[a] system of reimbursement under which government and private insurance plans ('all payers') pay the same amount for the same service." *Id.* at 256.

5. "Play or pay" can be defined as "[a] health insurance reform plan in which employers either provide their workers with a basic health benefits package ('play') or pay into a government insurance pool." *Id.* at 12, 265.

6. Governor Jones signed the Kentucky Health Care Reform Act into law in April 1994, after a lengthy debate in both houses of the Kentucky legislature. For a complete discussion of the legislative compromises and final bill, see Julia F. Costich & Mike Helton, *The Kentucky*

is cost escalation.[7]

And so it goes. There is unlikely to be any single system that either is or appears "best" for the whole of these United States. Regions, states, even localities, differ in their demographic characteristics, political cultures, existing styles of medical practice, and appetites for medical services. What is both practical and desirable varies enough to make federalist variation both normatively attractive and politically wise as an alternative to national stalemate.

Why not, then, let states choose how to reform American medicine? If it is uncertain how any new proposal would work out in practice, why run a single experiment, which might fail, on the whole country at once? Is it not precisely the genius of American federalism to permit not only experimentation to discover what works at one time, but continuous variation in policy prescriptions over time to accommodate changing conditions and differing preferences?

Our answer to these questions is "yes", but we must recognize that there are serious and plausible objections to leaving much of health planning to the states. We cannot here, of course, consider either all aspects of or objections to the federalist proposal, and the analysis of the issues we do address will have to be brief. In the next section, therefore, we will sketch our basic approach and then conclude by considering some of the major concerns a federalist approach to reform raises.

I. THE BASIC SCHEME

How would a proposal for state-led health reform work? First, Congress would enact enabling legislation offering fiscal support (at least maintenance of current levels of federal medical financing) to all states establishing health insurance plans that meet federally-established standards of national health reform. Thus, for example, states wishing to avail themselves of federal support would be required to enact health reforms that meet the following standards:

Health Reform Act, 22 N. KY. L. REV. 381 (1995).

7. Alabama's Medicaid experience with the large number of Alabamians living well below the federal poverty level suggests that state-sponsored universal coverage is infeasible. *See, e.g.* Robin E. Margolis, *State Health Insurance Reforms: Models or Impediments for National Health Care Reform?*, 9 No. 10 HealthSpan 17 (1992). In Connecticut, rapid and continued health care cost increases make the estimated subsidies required to provide universal access to health insurance cost-prohibitive, particularly in light of the administration's avowed goal to eliminate the state income tax. Barry Zitser, *Be Flexible in Molding the Budget*, HARTFORD COURANT, Jan. 8, 1995, at C1.

- Universality. All citizens and resident aliens must be guaranteed health insurance coverage. Insurance coverage may not be denied for preexisting medical conditions. Community rating is mandated. Insurers may not sever coverage.
- Comprehensiveness. Congress should specify a minimum benefits package which leaves states the option of adding required coverage for additional services.
- Portability. Each participating state would recognize the health insurance coverage of citizens from other participating states.
- Accountability. States must designate a public agency responsible for overseeing their medical care system.
- Fiscal viability. States must establish a reasonable plan for cost containment. States exceeding national targets for medical inflation will themselves be financially responsible for excess expenditures.[8]

Congress, it should be noted, must also enact accompanying legislation (such as reform of the Employee Retirement Income Security Act (ERISA)[9] provisions for self-insuring companies) that allow states sufficient legal discretion to pursue health care reform realistically.[10] In addition, states should be allowed (with federal approval) to fold Medicare and Medicaid into their "reformed" health insurance systems. Although including Medicare and Medicaid will complicate matters for states, including these programs is necessary: 40% of current health care expenditures involve government funds; in many states, the elderly are the dominant consumers of medical care; and Medicaid funds compose the bulk of nursing home revenues.

Federal funding would be available to states meeting the national reform standards. Funding ideally would be in the form of a block grant. The size of the total grant (and the per capita components) should vary with a state's income, its demographic profile, and its history of medical inflation.[11] Federal monies would constitute only a portion of the financing base. States, accordingly, would choose how to finance their portion of the health budget.

While the national standards for reform would apply nationwide,

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8. For an elaboration of these standards, see Theodore R. Marmor & Joseph White, *Understanding the Choices in Health Care Reform*, 19 J. HEALTH POL., POL'Y & L. 499 (1994).

9. *See* 29 U.S.C. §§ 1001-1461 (1994).

10. *See generally* JOHN J. DIIULIO, JR. ET AL., IMPROVING GOVERNMENT PERFORMANCE (1993).

11. Although it is easier to say than do, governments should not lock in an inflated base; we have forty years of Canadian, Australian, and German history to see how federalist financial problems can be handled. *See* JOSEPH WHITE, COMPETING SOLUTIONS (1995).

states would retain autonomy in deciding how to make these standards operational. States could implement a plan resembling the Clinton administration's proposal of 1993-94. They could pursue managed competition without mandatory alliances, or they could select a single-payer or all-payer form of regulation, individual mandates, vouchers, subsidies, or a combination of these approaches. As long as they satisfied the basic national standards, states would be free to create the health insurance system of their choice.[12]

II. PERSISTENT QUESTIONS: FEDERALIST ANSWERS

A. *State Variation*

Should states be permitted to vary who is entitled to health insurance coverage? Put another way, what does *universal* coverage mean operationally, and what, if any, variation is permissible?

The answer, in our view, is simple. Citizens and resident aliens are the proper beneficiaries of guaranteed health insurance and no good case exists for permitting variation in this national standard. Universal coverage is a precondition for the economic security expected from substantial medical reform. We cannot reach that goal without requiring that our citizens and legal residents have health insurance.[13]

There are, of course, grounds for treating the health costs of illegal aliens (and the burdens they impose on localities) as a serious, but quite separate issue in spreading the financial burden of expensive medical care. Adjusting to the realities of illegal entry into the United States is certainly an important feature of national burden-sharing. But it is not one that should be built into a basic health insurance entitlement. After all, the psychological security we hope to produce from "universal coverage" is for those legitimately within our borders. Dealing with the financial consequences of illegal residents is crucial for states like Florida, Texas, California, and New York, but this is part of

12. Although there is both widespread American ignorance and widespread caricaturing of Canada's health system, in fact there is great variation in how the ten Canadian provinces meet the five conditions (accessibility, portability, public administration, comprehensiveness, and freedom to choose one's caregivers) of the Canada Health Act. *See* Theodore R. Marmor, *Health Care Reform in the United States: Patterns of Fact and Fiction in the Use of the Canadian Experience*, AM. REV. CAN. STUD. 47 (1993), *reprinted in* THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 179 (1994); Robert G. Evans, *"We'll Take Care of It for You": Health Care in the Canadian Community*, 117 DAEDALUS 155 (1988).

13. *See infra* part II.B.

fiscal federalism, not entitlement to health insurance.

B. *"Universal" Coverage*

Does this mean that states really have no choice but to mandate coverage for 100% of their legal residents? Not at all. First, no nation's "universal" scheme is, in practice, truly universal. The Swiss are 98% covered in a radically decentralized federal system with no mandates, as are the Dutch. Germany has more than 95% coverage in a "mandatory" system that exempts 20-25% of the populace from the mandate.

To us, 95% coverage would seem a sensible target (or expectation). Moreover, states should be allowed to achieve this target by any reasonable set of carrots and sticks that they find acceptable and effective.

C. *Health Insurance Uniformity*

How uniform should health insurance benefits be across states? Should one fret if Minnesota residents have a health insurance plan that differs in its covered services from that of South Dakota? This is a more complicated question than is usually recognized.

A plan for universal health insurance that varies from state to state, but that includes federal conditions for financial contribution, raises three quite separable issues. First, there is the problem of raids on the Federal Treasury by states that create "luxury" health insurance programs. Second, there is the problem that, with different resources, states exerting the same level of fiscal effort cannot create the same comprehensive coverage. Third, there is concern that some states will choose to have "inadequate" health insurance coverage.

The first and second issues can be addressed as part of the federal formula for cash transfers to the states. As in many of our existing programs of "cooperative federalism," the national formula should take into account the relevant "risk" factors (the population as well as the financial resources available to states) in calibrating the federal government's fiscal contribution. No calibration can be perfect. It is clearly possible, however, to eliminate major disparities in state capacity by sensible design of the federal fiscal share.[14]

Similarly, the federal financial contribution should be in the form of

14. This will exclude silly arrangements like 50% sharing or, alternatively, infinitely complex formulas that no one can understand. For a discussion of the obvious concerns, see Marmor, *supra* note 12.

a block grant.[15] States cannot raid the Federal Treasury by choosing luxurious health insurance benefits if the total amount of the federal contribution for each year is fixed. Spending above that level would have to come from funds generated through state policies and state political processes, not raids on the national treasury.

The "problem" of "inadequate" state health plans is, in many respects, not a problem at all. If we assume the federal government is making contributions that substantially equalize state fiscal capacities, then claiming that a state has chosen an inadequate package of health insurance benefits is surely problematic: that claim states little more than that the speaker disagrees with the state's political choices. There is no agreed-upon "best" health insurance (or medical care) system that a state could offer. Both medical needs and medical preferences vary widely across the United States. The relevant question is why a national plan should override a state's perceptions of its needs. Or, put in other terms, why shouldn't a state's expression of its political preferences through the details of its health insurance package have priority, once the agreed upon national standards have been met?

Virtually none of the arguments that usually justify national uniformity applies to medical care. Certain forms of basic immunization rightly may be required to prevent the spread of disease, but these public health "externalities" are, and have been, a modest part of health reform. Preventive measures also may be instituted quite separately from whatever health insurance package is provided in particular localities. In fact, these public health concerns primarily are a state responsibility under the current health care scheme.

There is little reason to expect a "race to the bottom" in the provision of health insurance. As long as health insurance is being made universal, the politics of health care in states will not resemble the politics of welfare or Medicaid. Universality can be reinforced by federal conditions that require state subsidy or supplementation for low-income persons, measures that ensure everyone has access to insurance that is equally affordable to them. From an economic point of view, there is considerable evidence that comprehensive health insurance boosts productivity and hence state economic growth.[16] Furthermore,

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15. Generally speaking, block grants are lump-sum disbursements to states and localities that those entities may spend in broadly-defined categories. *See Grants Come with Few Strings*, CHARLESTON DAILY MAIL, Feb. 9, 1995, at 18F. The federal financial contribution alternatively can be calculated, and provided to states, on a per capita basis.

16. Two authors have expounded the argument that disparities in AFDC benefits induce

we should worry as much about the possibility that states will provide "too much" health insurance as that they will provide too little.[17]

Any argument that it is simply unfair to have state-by-state variation in health insurance benefits seems confused. To put the matter more charitably, this position seems to assume some baseline of adequacy for health insurance coverage that is established apart from any process of collective decision making about what adequacy means. It is, in short, criticism of a state's political choice rather than criticism of a state's health insurance program. That a particular state wants to spend less on health insurance and more on other things expresses a political judgment with which one may disagree. It is hard to see, however, how it violates some transcendental right to a specific level of health insurance coverage equal to other states whose system one happens to prefer.

Alternatively, such an "unfairness" claim may be that strict equality of health care (or health insurance) is an aspect of national citizenship. This is indisputably a controversial claim. Equality, by itself, says nothing about adequacy. Harmonization at the level of the state least interested in expending on health insurance would be egalitarian, but it would not be morally compelling; nor would a national average, or the richest insurance package imaginable.

Finally, there is little reason to believe that some variation in health benefits from state to state will have a major impact on location decisions either of individuals or of firms. There is an expansive collection of literature attempting to document that one or another social program has some major impact on migration or location.[18] To date, however, no single factor has been shown to have any significant explanatory

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migration, which then influences state policies. PAUL PETERSON & MARK ROM, WELFARE MAGNETS: A NEW CASE FOR A NATIONAL STANDARD (1990). Most recent research, however, finds that public aid plays a small role in the migration decisions of poor families. For the best recent analysis, see JAMES WALKER, MIGRATION AMONG LOW-INCOME HOUSEHOLDS: HELPING THE WITCH DOCTORS REACH CONSENSUS (Institute for Research on Poverty Working Paper No. 1031-94, 1994).

17. Robert G. Evans and others have written on the Canadian experience of providing too much health care for the health it buys. *See, e.g.*, Robert G. Evans & G.L. Stoddart, *Producing Health, Conserving Health Care, in* ALDINE DE GRUYTER, WHY ARE SOME PEOPLE HEALTHY AND OTHERS NOT? 27 (1994).

18. Economists report that state-mandated health benefits and similar routes to universal coverage are paid for by workers in the form of slightly reduced wages. Such programs therefore have little impact on net economic conditions and employment. *See* Lawrence Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177 (1989). For a useful overview of state-mandated health coverage and their estimated empirical effects, see Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994).

power. There is no reason to believe that health insurance will be any different from state programs for highways, education or welfare benefits. In short, a strong form of federalist system would leave wide discretion among the states to determine the benefits package for themselves.

D. *State Participation*

What if some states fail to participate? Again, this "problem" is not a problem at all, either politically and practically. Such a decision merely means that a state prefers to strike out alone, using its own resources. This is a political decision that a federalist approach clearly permits. These states, of course, would receive no block grants. In such cases the federal government also should withdraw gradually its contribution to the state's Medicaid program and phase in taxation of the value of employer-supplied health insurance. In short, there is no persuasive argument for the imposition of national standards unless a state's insurance arrangements are being supported by nationally collected dollars. Conversely, states not participating in the national program should not be supported with national revenues.

As a practical matter, it seems almost ludicrous to imagine that any state would seek to avoid federal standards when the costs are this high. Much smaller fiscal consequences have induced all states to participate in Aid to Families with Dependent Children (AFDC), Medicaid, the Federal-Aid Highway Program, and a host of other ventures in "cooperative federalism." This fact suggests another theme, discussed below, that incrementalism in withdrawal of support is likely to be effective as a participation signal to states that are merely poor performers, not self-conscious non-participants.

E. *Portability*

If states are the basic administrative units for universal health insurance, what happens when we travel or change our residence? For travelers, the obvious solution is a national requirement that states recognize the terms of other state's health insurance programs. There are many practical issues involved here, but they are second-order ones; Canadian provinces have a half century of experience in doing precisely this in medical care. When we change our residences the solution is equally straightforward. We will change our insurer, as most of us do now when we move to a new state.

F. *State Capacities*

Finally, how confident should we be that states can get the job of health care reform done if they try? How confident should we be that they will try? What about the health care reform capacities of the states, both administrative and political? Can we really trust the states to adopt and implement reforms that universalize coverage, make it portable for their populations, constrain costs, and maintain quality? We might as readily ask those same questions about the national government. We already know the answers with respect to the current system of joint public and private provision of health care; the system fails all sensible tests for an effective medical care system.

We need not rely entirely on "as compared to what" arguments, however. For one thing, a "federalist" approach does not eschew national standards, as we have discussed. Of equal importance is the fact that a number of states have been engaged actively in health care reform efforts of their own and many are having significant success against very steep odds, as we shall see.

Hawaii is perhaps the best known example. That state has developed an extraordinary amalgam of play or pay, monopoly bargaining, voucher-type gap filling, and single-payer regulatory control under which the whole population is covered.[19] Quality of care and consumer satisfaction are both high, and health costs for Hawaiians, as a proportion of state income, are five percentage points lower than the costs to the average continental U.S. resident. There are many historical and geographical explanations for these happy circumstances in Hawaii,[20] but none explain away the one true success story in providing Americans with universal health insurance coverage at reasonable cost. Moreover, the cost containment that has been achieved is startling in a state that has the second highest cost of living in the United States.

A trip back east also reveals some reasonable results in states such as Maryland and New York. For the past decade or more, both of those states have been engaged in fairly aggressive rate regulation and "sup-

19. Studies indicate that Hawaii provides some form of health insurance to between 95% and 98% of its adult population. *See* Michael G. Pfefferkorn, *Comment, Federal Preemption of State Mandated Health Insurance Programs Under ERISA—The Hawaii Prepaid Health Care Act In Perspective*, 8 ST. LOUIS U. PUB. L. REV. 339, 363 (1989).

20. For a discussion of the legislative history of the Hawaii exemption from ERISA preemption, for example, see *id.*

ply-side" controls on hospitals. Their efforts have paid off handsomely. Maryland's all-payer regulation of hospital rates is the most developed and most successful in the country, and New York's rate of growth in hospital spending is now among the lowest. Is New York well-known for low costs and good government? For that matter, is Maryland? And yet, these states, pressed hard by hospital cost escalation, which increasingly showed up in their Medicaid budgets, took actions that have constrained costs without, as far as anyone can tell, impairing the quality of care provided their populations.

Many other states have initiatives at various stages of planning, enactment, and implementation (Minnesota, Delaware, Vermont and Florida, for example). Others (such as New Jersey) have tried to strike out in new directions only to find that they are hemmed in by federal Medicare and Medicaid regulations, and particularly by the ERISA preemption[21] of state actions affecting self-insuring employers. Indeed, Hawaii's signal success in universalizing health care while constraining costs is significantly attributable to its ability to obtain a waiver from ERISA's preemption rule (a waiver that has not been made available to any other state in the country).

III. OBSTACLES TO FEDERALIST REFORM

We must acknowledge the difficulties that face a federalist proposal. The most important difficulty is that federalist reform requires national action. Were the federal government not already heavily involved in medical care provision, federalist solutions of the sort we envisage might already have emerged.

The federal government, however, already is involved in providing health care in significant ways. The huge tax advantages to employer-based health insurance make virtually any other form of private insurance economically irrational. The current programs of Medicare and Medicaid have large constituencies that will not easily yield what they have currently gained to the vagaries of state politics.

Perhaps most importantly, the employer community that won exemption for itself from all state regulation under ERISA, and then managed to combine it with no federal regulation in the bargain, will fight state-led reform with enormous energy. Indeed, because collective bargaining often has much to say about the shape of health care pack-

21. *See supra* note 9.

ages, unions will side with employers both in protecting the ERISA preemption and existing tax benefits for employer-based plans. In short, interest group politics strongly favor the status quo.

Interest group opposition can be overcome in American politics, but this sort of success normally involves a moral crusade that leads in the direction of uniform rights for all citizens. The need for national uniformity, however, is exactly what federalist solutions deny. Federalist national action simultaneously must demand an end to the present system, while leaving open the possibility for significant variety in the systems that will emerge to replace it. This is an ideological stance that is unfamiliar to most Americans. It combines liberal demands for universalism and social security with conservative demands for cost containment and devolution of authority to state governments.

We are not sanguine that such a federalist solution can be sold in the American political marketplace. We are persuaded only that it is a sensible approach that would benefit all Americans.