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FEDERALISM IN HEALTH CARE:

A POLICY OVERVIEW

Stephen Utz*

INTRODUCTION

A decade ago policy makers and the public expressed a desire for order amid the chaos of United States health care policy.[1] A new order of a kind has since emerged, but it lacks central direction and common aims. There is still no apparent unity of purpose in our "loose constellation of state and federal regulatory efforts," randomly interacts with [public] health coverage for the elderly, for veterans, and for some of the indigent and disabled."[2] The dominance of the federal government, assured by its primary role in financing public health programs, has receded or become muted, primarily through the federal ' granting of waivers from federal requirements for certain aspects of state Medicaid programs.[3] State

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1 *See* Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127, 128 (1995) (noting that Congress entertained proposals for a national health care system but failed to act).

2 *Id*. at 127.

3 *See* Judith Rosenberg & David T. Zaring, *Managing Medicaid Waivers: Section 1115 and State*

programs are, to this extent, the current crucible of governmental innovation in health care delivery, but private health networks shape the state experiments.[4] The politicization of health risks is an accomplished fact, although the role of private insurers is better established than before. It would be fatuous to describe the altered course of health care evolution as a new paradigm; it is less than that. Whether recent developments represent a new approach to federalism or simply give federalism a more concrete meaning is a question worth asking.

Federalism connotes mutually respectful cooperation among governmental components.[5] As a result of legislative coercion and disruption, intergovernmental cooperation has a beleaguered past in all fields of public concern.[6] The prospects for federal co-operation in health care are therefore clouded. "Federalism" has indeed become a code word for a deliberate absence of coordination of state-run programs, which political ideology regards as the antidote to big government. Against this ambivalent backdrop, talk of cooperation may seem ironic.

De facto federalism is another matter. Since 1993, when President Clinton's campaign for a national health care delivery system foundered, Congress and the courts have desultorily tweaked our accumulation of national and state health care programs towards greater integration.[7] It is too early to say whether hope or cynicism will be the tenor of the legislative measures. Since the early 1990s, however, state participation in shared governmental efforts has grown substantial enough to make a return to the status quo ante almost unthinkable; the states' involvement would now be a

Health Care Reform, 32 HARV. J. ON LEGIS. 545 (1995). The early waiver granted to Oregon for its well known experiment in Medicaid benefit rationing has now been followed by many more.

[4] Donald W. Light, *The Rhetoric and Realities of Community Health Care: The Limits of Countervailing Powers to Meet the Health Care Needs of the Twenty-First Century*, 22 J. HEALTH POL. POL'Y & L. 105, 106 (1997) (observing that corporate, professional, and state powers dominate the American health care delivery system).

[5] Michael S. Greve, *Against Cooperative Federalism*, 70 MISS. L. J. 557, 558 (2000) (defining the term "cooperative federalism" as a system in which "state and local governments administer and implement federal programs").

[6] *Id.* at 588.

[7] *See* Eleanor D. Kinney, *Clearing the Way for an Effective Federal-state Partnership in Health Reform*, 32 U. MICH. J. L. REF. 899 (1999); Stephen Utz, *Federalism in Health Care: Costs and Benefits*, 28 CONN. L. REV. 127 (1995).

formidably diverse target for extinction, by anything short of a purely federally funded, national health care delivery system of the Clinton variety.[8] Given the sense of inevitability about the states' involvement, it is worthwhile to review the recent past in terms of a priori goals for federalism in health care. The current Bush administration has promised to shift even more health care decision making authority to the states.[9]

Several recent developments change the landscape of U.S. health care delivery in important ways. The frequency with which waivers from federal regulatory requirements for state Medicaid programs are granted gives the ideal of federalism more teeth, and the changed state programs are sufficiently established to be resistant to ceding their independence back to federal regulators. Funding for professional medical training and medical professionals' levels of compensation has fallen significantly.[10] Private insurers are encountering serious obstacles to profitability, due in part to cost rises that resist their management techniques.[11] Co-payments required of employees under employer-provided health insurance plans have increased dramatically.[12] Private insurers are also no longer immune from state regulation of employer-provided coverage for employees.[13] The pharmaceutical industry faces challenges to its pricing of patented drugs,[14] but the prices of these drugs continues to

[8] *See* Mavis Mann Reeves, The States as Polities: Reformed, Reinvigorated, Resourceful, ANNALS AM. ACAD. POL. & SOC. SCI., May 1990.

[9] Robert Pear, *Shifting of Power From Washington is Seen Under Bush*, N.Y. TIMES, Sec. 1, p. 1, col. 6 (Jan. 7, 2001).

[10] Dionne Keller Fine, *Exploitation of the Elite: A Case for Physician Unionization*, 45 ST. LOUIS U. L. J. 207, 209 (2001) (noting the negative effect managed care has had on physicians' salaries).

[11] *See* James B. Roche, *Health Care in America: Why We Need Universal Health Care and Why We Need It Now*, 13 ST. THOMAS L. REV. 1013, 1019 (2001) (recognizing that both health care costs and health insurance rates rose dramatically between 1995 and 2001).

[12] Robert Lowes, *Don't let dollars walk out the door: patients are footing more of their health care bill these days. So its more important than ever to collect as much as you can at the time of service.* MEDICAL ECONOMICS, May 24, 2002, *available at* 2002 WL 11523479 (recommending various ways in which physicians can collect from patients even though co-pays and other medical costs are increasing.).

[13] *See*, *e.g.*, Rush Prudential HMO, Inc. v. Moran, 1225 S. Ct. 2151, 2171 (2002) (allowing a state law that regulated HMOs to survive ERISA pre-emption analysis).

[14] Edward Walsh, *Court Agrees to Review State Regulation of Drug Pricing*, THE WASHINGTON POST, p. A08 (June 29, 2002) (describing Maine's legislated prescription drug discount program); Barry Meier & Mary Williams Walsh, *Buying Group for Hospitals Changes Ways*, N.Y. TIMES (August 6, 2002) (Premier, Inc., under pressure from Congress, seeks more competitive bids on

out-pace other health care costs, at least in popular perception and especially among the politically active elderly. Burdens placed on local educational institutions by health problems of students disrupt those institutions ever more visibly and elicit an increasingly concerned political response from the public.[15]

I. THE CHOICE OF A FRAMEWORK

How general a perspective is relevant to this assessment? It is tempting to view even a decentralized approach to health care as representing a broad strategy against which tactical measures embodied in programs, for which responsibility is shared among federal and state governments, must be evaluated. The narrow goals of our health care efforts are indeed largely implicit in a complex of programs and regulatory schemes neither conceived nor operated by a single directive authority, even within the federal and state governments that nominally cooperate to produce them. The practical achievements are therefore so diffuse as to resist summary. In this regard, to single out broad aims is important not only for the purpose of evaluating what we have but even for that of describing it.

hospital supplies).

[15] Federal law forces state and local educational authorities to shoulder the health care burdens of the poor in various ways. For example, partially in response to Title IX, a school system may undertake costly and administratively difficult measures to bear the burden of teen pregnancy. *See*, *e.g.*, Tamara Ling, *Lifting Voices: Towards Equal Education For Pregnant and Parenting Students in New York City*, 29 FORDHAM URB. L. J. 2387 (2002) Furthermore, Title IX of the Education Amendments of 1972 prohibits federally funded schools from discriminating against students on the basis of sex. 20 U.S.C. §901-02, 1682 (1972). Pregnant students are expressly assured of the right not only to remain in school, but to be given treatment equal to their non-pregnant peers. 34 C.F.R. § 106.40 (2002). Inner city and rural school systems, in which student pregnancy or other health-related educational challenges are more common than in affluent suburban school systems, face substantial problems of educational strategy and funding in carrying out this mandate. *See*, *e.g.*, Jennifer Sable, *The Educational Progress of Black Students*, in THE CONDITION OF EDUCATION 1998 INDICATOR 3 (1998) (schools in urban areas are more likely to report "lack of parental involvement, alcoholism, and drug abuse by parents, student apathy, poor nutrition among students, drug abuse by students, poor health among students, and student pregnancy" than teachers in suburban or rural districts); *but see* Deirdre Purdy, *An Economical, Thorough & Efficient School System & The West Virginia School Building Authority "Economy of Scale Numbers*, 99 W.V. L. REV. 175, 184-85 (1996) (rural schools have larger numbers of students whose nutritional requirements are met mainly through the reduced-cost lunch programs).

Analytical tools drawn from economics and philosophical ethics have come to dominate the more abstruse discussion of health care goals. Where the ethics of health care is concerned, there can be no simple distinction between the bedside and the legislature. In wealthy democracies, micro and macro decisions about health benefits are already bound up with each other. Nevertheless, whether the entanglement of the public and the private is beneficial and how it might be improved are persistent themes for all concerned. A major difference among micro and macro approaches to health care decisions flows from a reliance on different and to some extent incompatible analytical sources.

Consider the micro approaches first. Much that is said or written about the intensely personal dilemmas health care providers face draws on both formal and philosophical traditions in moral thought. But the subject matter of this moral dimension is interpersonal relations, usually without reference to political institutions. The work of bioethicists reminds their audience of the major philosophical traditions in private ethical problems, such as — Aristotelianism, Kantianism, utilitarianism, and pragmatism. Rarely does it attempt to relate the teaching of these traditions to the task of forming macro policy that might shape answers on the individual level or remove some of the problems to a 'higher' level under the control of governmental or political decision makers. Inevitably, the bioethical approach tends to reinforce the isolation of health care providers from the legislative sphere. This isolation has social and institutional roots, even without the help of bioethicists, because health care providers are, for historical and practical reasons, most concerned about the provider-patient relationship and the autonomy of the practicing health professional from outside intervention.[16]

Health economics, by contrast, is "micro" only in the sense that it is concerned primarily with micro-economic aspects of health care delivery. The cornerstone of the large economic literature on health is the recognition that the asymmetry of knowledge between health care provider and patient frustrates the market's welfare-maximizing

[16] *See* Barbara C. Colombo & Robert P. Webber , *Regulating Risk In a Managed Care Environment: Theory v. Practice, the Minnesota Experience*, 8 ANNALS HEALTH L., 147 (1999) (discussing the impact managed care restrictions have had on physicians and their ability to treat patients).

tendencies.[17] Accordingly, market failure deprives competition of its importance to theory.[18] Economists differ significantly among themselves concerning the appropriate "second-best" analysis of the conditions of the health care market.[19]

Macro approaches to health care problems, whether philosophical or economic in inspiration, are rarely tentative about which theoretical framework is to be used. They are instead committed arguments for one framework or another, such as utilitarianism (or welfarism in economic jargon), Rawlsian fairness theory, or communitarianism. In this respect, discussions of public policy regarding health care closely resemble public policy discussions of other human needs or wants. Ours is a framework-conscious age that perhaps too rarely asks whether differences of framework matter.

An unfortunate by-product of the dichotomy between the philosophically micro and macro approaches represented in the health care literature is that health care providers, individual and institutional, tend to contribute to the discussion of the former only. This is perhaps inevitable, given the natural affinity for micro approaches in those with the greatest experience of frontline health care because it reflects their experience, at least descriptively.

Against this backdrop, the role of public debate emphasizes health care cost containment and universal coverage as primary goals of forward-looking policy, whether implemented at the national level alone or in some less centralized way. The primacy of these goals, however, is largely an expression of national idiosyncracy, dependent on the voting public's fear of health care "socialism" and tolerance for legislative logrolling. We have, as a nation, avoided looking squarely at any large problem area,— and health care is no exception. We have consequently been slow to examine underlying health goals.

[17] *See, e.g.*, Shauhin A. Talesh, *Breaking the Learned Helplessness of Patients: Why MCOs Should Be Required to Disclose Financial Incentives*, 26 LAW & PSYCHOL. REV. 49-50 (2002) (noting that patients are ill informed regarding Managed Care Organization (MCO) financial incentives to physicians and that such asymmetry of knowledge has created an unstable market).

[18] *See* Uwe E. Reinhardt, *Health Care Spending and American Competitiveness*, 8 HEALTH AFF. 5 (1989).

[19] *See generally* Uwe E. Reinhardt, *Can Efficiency in Health Care Be Left to the Market?* 26 J. HEALTH POL. POL'Y & L. 967 (2001).

At the national level, several long-standing legislative schemes have evolved in notable response to various national health issues. The main federal statutory schemes at stake are of course Medicare, Medicaid, and ERISA. But since 1997, the State Children's Health Insurance Program (SCHIP), which is Title XXI of the Social Security Act, has added a further dimension that interacts with these older statutory schemes in a manner openly designed to address health care coverage of poor children.[20] Since 1965, Medicare and Medicaid have been staples of the federal response to health problems, and the latter, a typical "carrot-and-stick" federal and state program, is the cornerstone of our health care federalism. In 1996, historic reform of the welfare system, which substituted Temporary Assistance to Needy Families (TANF) for Aid to Families with Dependent Children (AFDC)[21], stiffened the eligibility rules for former AFDC recipients of Medicaid but also introduced new curbs to prevent states from favoring one group of Medicaid eligible citizens over another or discriminating in benefit coverage for mandatory services on the basis of diagnosis, type of illness, or condition.

Interacting with old and new governmental programs, private health insurance, whether purchased by employers for employees, or as "Medigap" coverage by Medicare participants, or by Medicaid for low-income individuals of all ages, has transformed and plays an ever larger part in federal and state legislative strategy.[22] Generally, important features of governmentally financed health benefits are shaped by the decisions of private firms in both across-the-board and case-by-case decisions about benefits to be provided. Legislative and administrative policy makers tend to treat the definition of the benefit package as posing only an issue of consumer preference rather than issues of adequacy or injurious excess. Private insurers are concerned about the adequacy of a health care package only as a side issue. Their primary concern is profit, which economic theory teaches us cannot be expected to triumph in the health field over maximization of the general welfare. Profit motivation, however, does give private firms an incentive to broaden the pool of those

[20] Tatiana Connolly, *From the Journals: Insurance Law Abstracts*, 9 CONN. INS. L. J. 339, 351(2002)..

[21] 42 U.S.C. §§ 1396a(a)(10); 42 U.S.C. 1396b(m)(1)(A)(i) (2002).

[22] *See* Jonathan B. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL. POL'Y & L. 595 (1997) (noting that a primary goal of many Medicare reform proposals is to move program beneficiaries into managed care plans operated by private insurance companies).

insured, so as to maintain the possibility of pooling a spectrum of risks.[23] But federal and state legislators have ostensibly framed the problem of the size of the pool primarily as one of preventing insurers themselves from relying on their knowledge about prospective individual insureds to partition the pool.[24]

Domestic health care delivery must also be understood against the backdrop of other countries' health problems and solutions. Over the last two years, the pricing of AIDS medicines emerged as an international political issue, primarily because of improvements in AIDS treatments available in the wealthier industrial democracies, purely as a consequence of the cost of treatment.[25] Rebellion by the governments of poorer countries against international patent protection for pharmaceuticals was not long coming, and the comparative ease with which these threats to patent protection succeeded encouraged other wealthier countries to tie their cost containment goals to pharmaceutical price controls or "'voluntary"' price concessions by pharmaceutical companies.[26] Given that prescription drug prices disproportionately affect the vocal and politically active elderly part of our population and large state sponsored employee health care plans, it is not surprising that the rebellion should now be felt domestically as well. The prominence of the pharmaceutical industry in our economy guarantees that politicians will recognize the plight of this subdivision of our health care industry as more than a problem affecting health care policy.

Against this increasingly complex background, the U.S. health economy is not only difficult to assess but difficult even to describe in broad terms.

[23] *See* Milt Freudenheim, *Some Tentative First Steps Toward Universal Health Care*: *Insurers See a Crisis, For Them and the Nation*, N.Y. TIMES, Dec. 7, 2002, at B1.

[24] Julie K. Locke, *The ERISA Amendment: A Prescription to Sue MCOs for Wrongful Treatment Decisions*, 89 MINN. L. REV. 1027, 1029 (1999).

[25] Tracy Collins, *The Pharmaceutical Companies Versus AIDS Victims: A Classic Case of Bad Versus Good? A Look at the Struggle Between International Intellectual Property Rights and Access to Treatment*, 29 SYRACUSE J. INT'L L. & COM. 159, 161 (2001) (examining the lack of affordability of AIDS treatments in South Africa).

[26] *See, eg.*, Jerry Stanton, *Lesson for the United States From Foreign Price Controls of Pharmaceuticals*, 16 CONN. J. INT'L L. 149, 160-65 (2000) (examining the practices of pharmaceutical pricing in other nations).

II. THE GOALS OF A RATIONAL DE-CENTRALIZED HEALTH CARE SYSTEM

A. Cost Containment

Although not a goal in itself, containing health care costs is likely to remain the main focus of health care reform in this country. Cost containment is not a goal in itself because efficiency and fairness may well require permitting health care costs to increase, even at a rate that outstrips the growth rate of the economy as a whole. Economic growth itself need not be compromised by a shift toward greater health care spending. At times in the country's history, disproportionate growth of investment in railroads, automobiles, and computers have seemed wholly defensible as spurs to economic growth and the resulting growth of social welfare eventually increased the average welfare of the population. Rapidly rising health care costs need not work against fair distribution of health care benefits either, although they can worsen inequities by making any cost associated with mere fairness less likely to be accepted. Of course, the dimensions of health care growth still matter. If accelerating health care costs hinder both efficiency and fairness, they would pose only a slender issue if the baseline for growth were relatively puny or the rate of acceleration, though positive, were not so great. Thus, if health care cost containment is even temporarily a necessary measure in support of economic efficiency or fairness, only the circumstances of the moment make this so.

In fact, accelerating health care costs are now chiefly a problem because the starting point and the rate of acceleration disrupt legislative priorities. Any large entitlement program that grows faster than the economy, especially one aimed at a majority of voters, is a legislative problem. Those who benefit are likely to regard the program as a right rather than as largesse and refuse to see the growth rate as unsustainable even though it may lead to higher taxes and the curtailment of other programs. Medicare and Social Security are the standard examples.

Cost containment, in this pragmatic political respect, is closely allied with fiscal and budget deficit policy. An unfortunate feature of rising health entitlement costs is that while their growth rate is not constant, unlike that of retirement benefit entitlement outlays, it is not tied to economic cycles so as to fall with cyclical declines in the

performance of the economy as a whole. Nor would we want these costs to be linked significantly with the rise and fall of the economy, as we would if we regarded health quality as a consumption item to be indulged in as a luxury only when convenient. We should not want recessions to herald poorer health quality and thereby compromise productivity when the economy is most vulnerable.

The need to see health care costs in relation to taxes and governmental benefit programs is obvious once the average net benefits and burdens of all such government programs is calculated by age groups among the population. With reasonable projections of the rate of growth of the economy as a whole, the size of the taxpaying public and other economic factors affecting revenues and costs, (including projected increases in health care costs and the cost of living, the average tax rate, net of government benefits to be received) rapidly increases with birth year, rising to eighty percent or more for the most recently born.[27] This phenomenon is largely due to the programmed spending that defines entitlement programs like Medicare and Social Security, which are "pay as you go" rather than insurance schemes.[28] Such tax and benefit analysis cannot take future structural changes in the economy into account because they are unforeseeable. That there will be such structural changes is highly likely. Hence, the political unsustainability of our current governmental commitments and resources, viewed as predictable functions of available information, is also less than the whole truth. But the pressure to contain the costs of these key entitlement programs is as certain as death and taxes, as long as the economy and the political scene bear any resemblance to those we know now.

Higher health care costs also burden employment and business profits linked to labor, which may result in competitive disadvantages between domestic firms and foreign competitors.[29] Until just a few years ago, private industry had not proclaimed the importance of this link, perhaps because globalization itself was only dimly part of their political perspective. Many large employers used

[27] Alan J. Auerbach, et al., *Generational Accounting: A Meaningful Way to Evaluate Fiscal Policy*, 8 J. ECON. PERSP. 73, 80-81 (1994).

[28] Regina T. Jefferson, *Privatization: Not the Answer for Social Security Reform*, 58 WASH. & LEE L. REV. 1287, 1295 (2001) (analyzing the potential effects of privatization on the Social Security system).

[29] Reeves, *supra* note 9.

to assume that they would have to or want to provide most of their employees with generous medical benefit packages.[30] One reason for the apparent generosity was that labor unions successfully convinced these employers that fringe benefits like health care achieved more bang for the compensation buck; employees felt substantially better off with health care coverage the employer could purchase at lower group rates, and the economic value of the coverage was exempt from employees' income for federal and state income tax purposes.[31] But, : the cost of these packages has patently grown faster than the rest of the economy, which includes employer profits and taxable wages.[32] Escalating costs are naturally felt to be the employers' problem and not employees', but the several waves of coverage reduction that employers inflicted upon employees in recent years contribute to employee insecurity, slowing private consumer spending recoveries after economic downturns.

There may be a third dimension to the goal of health care cost containment, but it seems to have little influence on policy makers. It is possible that some of the public experiences accelerating health care costs as a direct or indirect burden. They may believe that as the country pays more and more for health care as a fraction of total social wealth we are collectively worse off, just as a household that must pay unexpected hospital bills is poorer, even if a family member recovers from a disease. Similarly, comparing the national budget deficit with a household deficit can be misleading, as can this macrocosmic reading of health care costs. If we don't consume our wealth by spending it on health care, we may spend it on sport utility vehicles or on policing the world, with less immediate or remote, psychic or economic benefit (the alternatives to health care may have a smaller multiplier effect in stimulating economic growth as health providers spend their profits within the domestic economy). This is so if spending more on health care results in a healthier public.

The most significant effect of too narrow a focus on cost containment is it diverts attention from other deficits in health care policy. Advocates of universal health coverage, whether motivated by a concern for the health of the poor or by the need to broaden the

[30] Utz, *supra* note 1, at 130.
[31] *Id.* at 127.
[32] *Id.* at 130.

health risk pool, are natural political opponents of health cost containment, and on the present political scene they have linked universal coverage with increased governmental spending on health care without other modification of current ideas about what that coverage should include[33]. Private medical insurance typically covers expected physician costs (i.e., visits to the doctor) and "major medical" expenses (i.e., hospital stays) with dollar limits that exclude catastrophic and long-term health care needs.[34] Similarly, Medicare pays for only limited hospital stays, regardless of the patient's condition.[35] Medicaid was expanded to cover catastrophic illness and long-term care expenses after the patient "pays down" substantially all of his or her wealth on these expenses, but the losses inflicted on those beneficiaries who have not succeeded in defrauding the system are being punished and scarcely seem justified by comparison with the generosity of coverage for those whose needs fall close to the average.[36] Hence, an unintended but unfortunate consequence of our decentralized, public/private approach to national health care is to freeze in place the accidental obsession with normal health care at the disadvantage of extraordinary health care needs.

In summary, cost containment inevitably figures as a central goal, although the version of that goal with which we are familiar is idiosyncratic. By altering other health care goals we might well alter the cost containment goal beyond recognition. Nevertheless, some accelerating health care costs, such as evolving pharmaceutical and surgical treatments, would inevitably make cost containment a problem for any health care system.

B. Universal Coverage

Providing benefits of health care to the entire population is the next most frequently mentioned goal that we toy with but have not quite embraced. That universal coverage should be one of our health

[33] *See generally* Richard d. Lamm, Symposium: *Universal Health Care Coverage, A Two-Front War*, 22 J. LEGAL MED 225 (2001) (NEED PARENTHETICAL).

[34] Jennifer M. Jendusa, *The Denial of Benefits Quandary and Managed Care: McGraw v. Prudential Insurance Company*, 3 DEPAUL J. HEALTH CARE L. 115, 121-22 (1999).

[35] *See* Utz, *supra* note 1 (noting the unfortunate necessity of rationing health care resources).

[36] Dean S. Bress, *The Interplay Between Medicaid and Trusts to Protect A Disabled Person's Assets*, 21 WESTCHESTER B. J. 275, 276-77 (1994) (observing that a patient must essentially exhaust all assets before Medicaid will take up coverage).

care goals seems to be widely acknowledged, but it is worthwhile to note that this depends implicitly on assumptions about minimum health care for efficiency and fairness. If insurers would like the government to mandate universal coverage in order to bring healthier people into the insurance pool,[37] clearly some of the health coverage provided would be unnecessary or over-priced. If health care were considered a civil right for humanitarian reasons, however, universal coverage would trump cost containment and perhaps even economic efficiency and non-right-based fairness.

In any event, universal coverage and cost containment obviously cannot both have primacy, given present economic conditions and institutions. Better health care for the poor would almost certainly contribute to economic efficiency, even considering only those health costs born by the public, than the desultory programs now in place provide. But this is only to say that the health care problem overlaps with that of reforming U.S. social policy. The public does not recognize the need for government transfers to the poor on the basis of need alone.[38] It requires something more. When welfare was first introduced in this country, it appeared under the banner of aid to widows and orphans.[39] Now, it is the more coercive and penitential banner of goading the poor back to work. Politicians apparently regard government sponsored health care based on need alone as too closely similar to unconditional direct money transfers to the poor, a policy that will not' fly with the public and has the "notch" problem of discouraging the near-poor from working to stay out of the pool to whom unconditional transfers would be made.

Perhaps the most dramatic development in health care of the past decade is the "commercialization" of Medicaid, meaning the move from fee-for-service medical coverage for the poor and disabled, focused primarily on hospital emergency rooms, to a consciously adopted system of managed care plans.[40] By 1997, sixty-four percent of Medicaid enrollees received managed care in

[37] *See supra* text accompanying note 8.

[38] *See* Carl A. Auerbach, *Is Government the Problem or The Solution?*, 33 SAN DIEGO L. REV. 495, 512 (1996).

[39] William P. Quigley, *The Earliest Years of Federal Social Welfare Legislation: Federal Poor Relief Prior to the Civil War*, 79 U. DET. MERCY L. REV. 157, 158 (2002).

[40] *See generally* Sidney D. Watson, *Commercialization of Medicaid*, 45 ST. LOUIS U. L.J. 53 (2001) (describing the commercial market's increasing role in Medicaid).

commercial HMOs,[41] and the continuing trend is for rapidly increasing enrollment (9.8% in 2001) that will cause Medicaid to evolve into something more like a traditional health insurance program than transitional welfare benefit program.[42] Most states now aspire to have all Medicaid enrollees receive managed care in commercial HMOs.[43] There are early signs that this trend may create the framework for improving welfare medicine, providing more continuous preventive care to eligible participants.[44]

C. Making Coverage Portable

The threat of losing health coverage locks, by some estimates, a substantial percentage of Americans into their current employment,[45] just as the threat of losing employer funded retirement benefits used to lock in the majority of employees – a situation ERISA[46] fairly effectively remedied. Some have proposed that any serious approach to health care federalism in this country should be conditioned on a federal guarantee of the portability of health coverage, to prevent states' idiosyncrasies from impeding interstate migration and commerce.[47] COBRA[48] and the Kennedy-Kassebaum Act[49] have gone some way towards relieving the problem, but neither addressed it head on.

Universal coverage would obviate the problem of nonportability only if the states agreed by compact that it would or the federal government mandated it directly or by coupling the mandate with funding.

[41] *See* Suzanne Felt-Lisk, *The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation* (1999), *available at* http://www.kff.org.

[42] Eileen R. Ellis, et al., *Medicaid Enrollment in 50 States: December 2001 Update* (2002), *available at* http://www.kff.org.

[43] *See id*.

[44] Watson, *supra* note 43, at 71-77.

[45] Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115 (1995).

[46] Employee Retirement Income Security Act, 29 U.S.C. § 1001. (1974).

[47] Mashaw & Marmor, *supra* note 48, at 118.

[48] Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, 100 Stat. 82 (1986).

[49] Kennedy-Kassebaum Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in sections of 18, 26, 29, & 42 U.S.C.). The Kennedy-Kassebaum Act is also as the Health Insurance Portability and Accountability Act of 1996 (HIPAA)).

D. Defining the Benefit Package More Effectively and Efficiently

Among the more elusive goals for the current decentralized "federalist" approach to health care is that of defining a minimum benefit package as a baseline for assessing the fairness of decentralized governmental measures.[50] The quest for abstract fairness alone rarely motivates politicians to act. Health care efficiency, or redirecting health care expenditures to achieve overall greater benefit per dollar spent, should not be a controversial goal, and it may be related to that of fairness. If, for example, the right benefit package would focus on health education, disease prevention, and early diagnosis of disease rather than on expensive medical responses to acute problems, then fairness might be carried along with the strategy of prevention, because it would widen the focus from individuals in need to the entire population. However, fairness requires not only efficiency but effectiveness without regard to cost. If the minimum health care package for fairness required extremely costly prevention or treatment efforts for a small portion of the population, it is possible and even likely that these would be inefficient, in the sense that the same outlays might produce a greater aggregate improvement in the health of those already above the minimum level. Cost containment has no secure relationship with either efficiency or effectiveness, although we may all at times mistakenly regard it as instrumental to both. Efficiency is distinct from cost containment, because some increases in aggregate expenditure on health care may result in disproportionate aggregate health quality gains, and any number of causes unrelated to the gross domestic product (GDP) growth may increase the cost of effective achievement of some level of public health.

So far, our kind of health care federalism, by preserving the distinction between health care for the poor and health care for the middle class, has spiked efforts to define a minimum benefit package for the population as a whole. Arguably, the poor require a benefit package in which coercive participation in health care education will be a central component, but it seems likely that this applies to other segments of the population as well.

[50] Mashaw & Marmor, *supra* note 48, at 118.

E. Research and Related Goals

Scientists and physicians, not governments, are best positioned to decide what are the most promising courses of health related research. As virtually all health economists agree, markets are not particularly likely to fund these most promising initiatives.[51] Only governments can displace or influence markets that "fail" by not maximizing social welfare.[52] Centralized efforts to set health related research goals are notably absent from the national agenda, and they are by their nature beyond the reach of the individual states. We have always allowed markets to set the course of pharmaceutical research, and in recent years even new treatment procedures are tied to equipment manufacturers' profits.[53] Outcome research offers a middle ground for governmental involvement.[54] Federal and state governments collect data on the outcome of the health care benefits they provide.[55] The data they collect provides independent outcomes research with the opportunity to pursue less pragmatically limited evaluation of our health care delivery.[56]

F. Rationing Scarce Resources

Rationing is part of any program to provide a public good. A public good is one that makes society better off but that markets in competitive equilibrium will not provide because of free rider problem or defects in economic agents' knowledge.[57] The requirement that a provision of the public good improve society's welfare places a limit on how much should be provided and to whom.; Hence, for whatever a public good is, the right amount must be provided to the right people. These are traditional analytical categories of welfare economists, but they seem to capture

[51] *See* Reinhardt, *supra* note 20.

[52] *Id.*

[53] *See* Claude E. Barfield & Mark A. Groombridge, *Parallel Trade In The Pharmaceutical Industry: Implications For Innovation, Consumer Welfare, and Health Policy*, 10 FORDHAM INTELL. PROP. MEDIA & ENT. L.J. 185, 237-38 (1999).

[54] See Sandra J. Tanenbaum, *Knowing and Acting In Medical Practice: The Epistemological Politics of Outcomes Research*, 19 J. HEALTH POLITICS, POL'Y & L. 27, 28 (1994) (describing outcome research).

[55] *Id.* at 29.

[56] *Id.* at 28.

[57] JOHN RAWLS, A THEORY OF JUSTICE 235-239 (Belknap Press 1999) (1971); Charles M. Tiebout, *A Pure Theory of Local Expenditures*, 64 J. POL. ECON. 416 (1956).

uncontroversial truths. The over-provision of health care is therefore neither a public good nor an improvement on the market failure that some have traditionally invoked as justification for government intervention in health care.[58]

Again, specialist 'welfare HMOs' may be doing a good part of the job of rationing.[59]

G. Integration of Health Policy and Other Policy Areas

Federalism draws its strongest theoretical support from economic theory. More than thirty years ago, Charles Tiebout proposed some relatively simple economic models of differentiated local government expenditures that have since dominated writing by economists on the subject of local taxing and spending for public goods.[60] Tiebout's models purport to demonstrate that if consumer-voters are free to move from one community to another, they will vote with their feet for the appropriate local governments, and that equilibrium of local government shopping will be efficient for the federal political union of these localities.[61] The models of course assume a streamlined universe of economically relevant factors.[62] But Tiebout's conclusion that a chaos of local policy may yield the highest aggregate welfare to the larger community remains attractive.[63]

Of all the goals of rational policy making, however, that of integrating health care policy with other policy areas is the least compatible with a federal or even more decentralized approach. Economists and non-economists alike recognize that consumers lack the knowledge they need for informed welfare maximizing decisions about their choice of health care benefits.[64] Even if U.S. residents were realistically able to choose which state to live in on the basis of

[58] *See, e.g.,* Abigail Zuger, *Caution: That Dose May Be Too High*, N.Y. Times, Sept. 17, 2002, at F1 (explaining prescriptive drug advice is usually for too high a dose when drugs are first marketed).

[59] *See, e.g.,* Watson, *supra* note 43, at 71-72.

[60] Tiebout, *supra* note 60; *see* STEPHEN G. UTZ, TAX POLICY: AN INTRODUCTION AND SURVEY OF THE PRINCIPAL DEBATE 219-21 (West Publishing 1993).

[61] Tiebout, *supra* note 60 at 424.

[62] *Id*. at 419-20.

[63] *See* DANIEL N. SHAVIRO, DO DEFICITS MATTER? 302 (The University of Chicago Press 1997).

[64] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

their preference for that state's health care delivery system, it is unlikely that the free play of markets would benefit residents in the aggregate, because there is no reason to think residents would make the right choices. Even with the requisite knowledge, the individual would have to compromise health care choices in order to achieve his or her preferred blend of all locally provided public goods, including such things as education and public roads. Tiebout's theory thus seems inapplicable as an aid to understanding or justifying health care federalism.

As matters now stand, our health care policy, regarded as a deliberate strategy, is not at all coordinated with governmental action in other areas, notably, social, tax and educational policy. Issues of public health and poverty have only grudgingly been acknowledged as governmental responsibilities and remain step-children to public measures affecting other fields. The goal of finding a rational unity of purpose among these measures is so remote as to seem hardly worth discussion.

It is important, however, to recognize how closely and substantially other governmental responsibilities effect health care. Educational programs, which are of course primarily left to state subdivisions, bear the burden of some of the most lamentable consequences of our lack of an integrated social and health care policy. Schools must either make whole our children who are suffering from malnutrition or physical or mental illness or neglect the education of these children, thereby suffering further costs to their educational goals. Few states have addressed these difficulties systematically, and the federal government has responded to them primarily by efforts to hold local educational authorities responsible for remedying these additional, non-educational problems.[65]

Our health care and tax policies that are regarded as deliberate governmental choices, are integrated to an extent, but in a patently unfair manner. The largest "tax expenditure" item, that is, the largest part of what would otherwise be federal (and state) tax revenue if it were not for a non tax policy motivated exception to taxation, is the exclusion from employees' income of employer-provided accident and health care coverage.[66] For 2001, this exclusion cost the federal

[65] *See* Sable, *supra* note 16 and accompanying text.

[66] *See* UTZ, *supra* note 63 at 110.

government over $80 billion in tax dollars,[67] more than ten times the annual cost of TANF.[68] If the benefit of this exclusion were equitably distributed, it might be an acceptable means of providing health care to the public. The exclusion, however, is notoriously biased in favor of somewhat more highly compensated employees of large employers. Even large low-wage employers on average do not offer substantial health insurance as a fringe benefit, because the price of health coverage for smaller employers is too high to be attractive as a component of the compensation given to employees. Employees reputedly undervalue health care coverage, if only because they are unaware of its accelerating cost. But uninsured health care expenses are tax deductible (the equivalent of exclusion of the cost of coverage) only above a threshold so high that few non-elderly taxpayers ever benefit from the deduction.[69] The features of federal income tax policy just mentioned are mirrored in most state income tax laws.

The bias of health-related tax expenditures in favor of some, not all middle-class employees and retirees is arguably justified to some extent as reasonable governmental opportunism. If employers can be induced to provide health benefits or health insurance to employees, and employees can be induced to regard these health benefits as a valuable part of their compensation, a governmental objective is met without any need for public taxing and spending. This may be more efficient than if these benefits were provided by direct government payment, and without substantially greater tax administration cost. The fact remains that the benefits flow unevenly.

More importantly, the current tax and health nexus perpetuates decisions about the health benefit package that are market driven and ill informed, given health care consumers' lack of knowledge of the products they are buying. If, for example, the average middle-income taxpayer really needs catastrophic health insurance or more than coverage for routine doctor's office visits, only a massive educational effort is likely to alter the current employer-provided health coverage to reflect this. Since employer-provided health benefits and insurance dominate private health care expenditures, the

[67] I.R.C. § 106 (2000); Executive Office of the President and Office of Management & Budget, Budget of the United States Government, Fiscal Year 2001, at 249.

[68] Temporary Assistance to Needy Families, 42 U.S.C. §§ 601-19 (2000).

[69] I.R.C. §§ 105(b), 213(a) (2000) (allowing a deduction for uninsured medical expenses that exceed 7.5 % of adjusted gross income).

tax subsidy supporting this admittedly valuable public good is largely unguided.

III. SUMMARY

Despite the special place of health among the things all people want and need ("primary goods" as John Rawls has called them)[70] health care is not unlike other public goods.[71] Getting health care to the public fairly, effectively, and efficiently raises some of the same problems as other public policy areas, and most of these policy areas, such as homeland defense, banking, drug testing, and environmental policy, are universally regarded as requiring a single national approach. This does not rule out the possibility of dealing rationally with society's health needs through a scheme of divided and uncoordinated inter-governmental responsibility for health delivery, but it does make it unlikely.

Nevertheless, one of the chief gains that federalism in health care might provide is political acceptance of universal or at least reasonably rationed health care benefits; if voters are more likely to accept local political initiatives related to health care than national ones, a division of responsibility between the federal and state governments could remove an impediment the voters themselves would apparently want removed.

On the other hand, fairness still requires the even handed distribution of whatever minimum health care benefits justice requires a person to be provided with. If the need in different parts of the country for these benefits is the same, local variation in the provision of the benefits fails the fairness test. Differences in the manner in which equivalent benefits are provided in different localities would not violate that test. Given cultural differences, such as in regional prevalence of charitable over for-profit hospitals, or vice versa, and economic differences such as areas with higher levels

[70] JOHN RAWLS, A THEORY OF JUSTICE 79-80 (Belknap Press 1999) (1971). John Rawls coined the phrase "primary goods" to describe those goods, whether private or public, about which individuals may be assumed to have shared levels of need or preference, even within a society whose principles of justice are designed to respect individuals' differences of taste. *Id*.

[71] NORMAN DANIELS, JUST HEALTH CARE 220 (Daniel I. Wikler ed., Cambridge University Press 1985). One important strand in the philosophical literature on health care suggests that health as a public good is incommensurable with other public goods. *Id*.

of income may not require pre-paid insurance for routine visits to physicians, differences in delivery may improve efficiency, promote public confidence, and be more adaptable to future structural changes.

The greater presence of the states in health care policy-making rescues health care issues to some extent from the stagnation of national politics. This said, it must be admitted that our kind of federalism in health care poses complex policy difficulties. Our political priorities are cast in terms that divert attention from unsolved puzzles, the solutions of which are necessary for well formed policy. Cost containment and universal coverage – the two most popular rallying points – are worth pursuing but only within the framework of decisions about the minimum benefit package necessary for fairness and economic efficiency. State responsibility for health-related programs can no doubt build political acceptance for otherwise good programs, even though the resulting program diversity has less justification than diversity in other local expenditures. The costs of diverse governmental programs are significant, multiplying potential defendants in lawsuits over coverage and benefits. How profitably private insurers and medical care networks can fill the roles allotted to them under government-sponsored programs is in doubt.

As always, a better informed public debate about the issues could improve the business and politics of health care.