Cite this article as:
J R Tallon, Jr. and R P Nathan
A federal/state partnership for health system reform
*Health Affairs* 11, no.4 (1992):7-16
doi: 10.1377/hlthaff.11.4.7

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/11/4/7

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

Not for commercial use or unauthorized distribution
To Subscribe: https://fulfillment.healthaffairs.org
A FEDERAL/STATE PARTNERSHIP FOR HEALTH SYSTEM REFORM

by James R. Tallon, Jr., and Richard P. Nathan

Prologue: The Winter 1983 Health Affairs addressed the interplay among federal, state, and local government responsibilities for health. In that volume’s lead paper, Drew Altman and Douglas Morgan wrote, “No level of government—federal, state, or local—has its own entirely autonomous sphere of action, and all three levels interact in shaping policy, in financing and delivering health care, and in running programs.” Ronald Reagan’s New Federalism brought increased visibility to states’ endeavors; that same administration, however, ushered in an era of unprecedented stress on states’ budgets, as the federal budget deficit ballooned. Nearly ten years later, the papers in this volume of Health Affairs once again address the issue of government’s role in health. Many of the questions raised in 1983 remain unanswered; however, the intervening decade has witnessed states’ remarkable ability to address their problems, given a shrinking pool of new funds. Here, James Tallon and Richard Nathan present their solution to the pluralism that inevitably results from an emphasis on states: a federal/state compact for health, which provides both a framework for reform and a process to implement that framework. Tallon is Majority Leader of the New York State Assembly, to which he was elected in 1974. He also chairs the Kaiser Commission on the Future of Medicaid, convened by The Henry J. Kaiser Family Foundation. He holds a master’s degree in international relations from Boston University. Nathan is provost of The Nelson A. Rockefeller College of Public Affairs and Policy, University at Albany, State University of New York, and director of the Rockefeller Institute of Government there. He received a doctoral degree in political economy and government from Harvard and has been on the faculty at Rockefeller College since 1989. Before then he served on the Princeton faculty and held several leadership posts in the federal government.
When groups of experts convene to discuss health policy and system reform, they often agree on only one thing: Something must be done. Beyond that, strong differences of opinion prevail. Indeed, the United States has had a generation-long debate on what to do about health care, which began with the Truman administration and shows no sign of being resolved soon. This is not to imply that as a nation we have done nothing to solve health care problems. The federal government is involved across the spectrum of the health sphere, from policy development to regulation to actual provision of care. Its responsibilities under Medicare and Medicaid have widened since the mid-1960s to have a pervasive impact on the provision of hospital care, on other health institutions, and indeed on almost all medical services.

At the state level, a wide variety of governmental activities have far-reaching effects on the provision of health care. States play a role as the agents of federal policy under Medicaid. They have major responsibilities for licensing and regulating health professions and financing and administering educational programs for them. States are also responsible for the regulation of insurance and health care providers. In an important analysis a decade ago, Drew Altman and Douglas Morgan emphasized the “shared,” role of governments in the health field. Although they depicted the federal government as “the single most important force,” their analysis went on to describe in detail what they called “a rediscovery of the importance of the role of state and local governments” in the health arena:

Broadly speaking, the health-related activities of state and local government are: traditional public health, including health monitoring, sanitation, and disease control; the financing and delivery of personal health services including Medicaid, mental health, and direct delivery through public hospitals and health departments; environmental protection, including protection against man-made environmental and occupational hazards; and the regulation of the providers of medical care through certificate-of-need and state rate setting as well as licensing and other functions.

However, unlike other advanced industrial countries, the United States has no unifying plan for governmental action in the health field. There is a tendency to eschew or limit governmental authority and
avoid centralizing power at either the federal or state level, or to accept it grudgingly. The net result has been a patchwork of federal and state health functions decided ad hoc as each issue is addressed—not unlike American government as a whole.

**Vibrant two-level pluralism.** The U.S. political system does not lend itself to orderly planning and comprehensive policy reform. At its roots it is highly change resistant. The two-century-old Madisonian design of the U.S. governmental system provides multiple points of access. It is easier to stop things than to do them. On one level—horizontally—the three branches enable people and groups who want to prevent new initiatives to try to find friendly players who will jam the gears. On the second level—vertically—naysayers can intercede with different actors at the state or local level to frustrate policy changes by either reversing decisions once they are made or preventing their execution.

Such criticisms of American government are voiced frequently by people who want action and cannot get it. They point to the inability of the political system to make hard choices even when political leaders and citizens agree that action should be taken. Adding to this picture, the governmental process often bogs down at the critical implementation stage after a policy decision is made. So much energy is required to make and protect policies that actors in a particular area frequently have no muscle and money left to push decisions down into the administrative process once they are made.

**Tempering our pluralism.** One can argue that both external and internal conditions have changed for the United States so that we now must temper our pluralism to compete effectively in an increasingly interconnected global economy. We can no longer afford the luxury of long gestation periods for changes in government policies in areas critical to the functioning of our economic system. This is not to say that we should make fundamental changes in our political institutions or adopt a parliamentary system. Rather, we need to devise institutional mechanisms in selected policy areas that facilitate action while at the same time assuring representation for major interests and players. There comes a point in policy debates at which the stakes are clear and the issues are sharply defined, when leaders have to say, “Enough already, let’s get on with it.”

The first-order question for health policy is: When will the United States care enough to follow the long lead of other industrial democracies that have established comprehensive national health care systems? The stakes are high; some people and interests obviously stand to lose. A realistic assessment might conclude that a working majority of politically active people who now have good health care coverage and bene-
fits have taken our nation past the point at which we can enact a comprehensive new system in a single piece of legislation. It is, in fact, too close to call whether a majority of Americans want and would support such a “solution” to the health care conundrum. This essay is written not to argue that they should, but to sketch out a way to do so if they did. It addresses the institutional challenge of health system reform.

A Framework And A Process

The challenge of health system reform now requires an inventive institutional strategy if we are to break the deadlock on paying for and providing health care. Here we present a two-step strategy that consists of (1) adopting a basic policy framework for a new health system; and (2) setting up a process to adjust and refine this policy framework as it is implemented. The policy framework would be embodied in national legislation that would include a financing scheme, a package of basic benefits, and a new institutional mechanism for implementation and cost containment. The key to this proposed process is legislating a basic framework and then refining and implementing it incrementally over time. The new law itself could (and probably should) be phased into effect. Even then, the implementation process should be adaptive, building on lessons from experience as it is gained. This is especially needed for cost containment, which has to be a major feature of any new system for health system reform. In forming the two-step strategy we suggest here, we have deliberately stayed away from programmatic strategy decisions involving choices among play or pay, a Medicare-type national system, expanded Medicaid, tax credits, or managed competition—which are the reform strategies most often discussed as the central substantive concept of new legislation.

From the institutional perspective featured in this essay, we believe that there are strong and good normative arguments for having the federal government and the states work together in the health field in a way that would allow iterative and flexible systems development and encourage experimentation. The federal government has to be the senior partner, and its role is critical if we are to move to and ultimately institute a comprehensive health financing system. Under the two-step strategy suggested here, states would have an important supporting role. Many vital functions in the health field, as noted earlier, are already well-established state functions that lend themselves to such a federal/state partnership structure. On the plus side, diversity among state health care programs can achieve important goals. It enables people in different states to bring their ideas and values to bear within an overall
structure of health policy; it gives citizens a greater sense of ownership and involvement.

Another aspect of the case for including the states in new health care financing legislation involves cautioning against overreliance on one level of government—the federal government. We question whether the federal government should be given a “command and control” charter in a field in which we spend nearly $800 billion annually—-as much money as the gross national product (GNP) of many large nations. (This is slightly less than the gross domestic product of the United Kingdom and considerably more than that of Spain.) History right now is warning us and others about what can go wrong with overcentralization. In this same spirit, Rep. Henry A. Waxman (D-CA) said at a June 1991 hearing, “I am not sure the quality of care or the satisfaction of the people in this country will be there if the federal government runs it” (“it” being a new national health care system).³

State reforms under way. Many states recently have taken steps on their own to reform the financing of health care for their citizens. In April 1992, when Minnesota passed its plan to make state-subsidized health insurance available to all uninsured residents not eligible for Medicaid, a New York Times article commented on the frustration that undergirds this new state activism: “The program is yet another reflection of the states’ impatience with congressional delay in overhauling the national health care system.”⁴

Among the leading states in this field is Hawaii, which has a mandatory employment-based system in operation that depends on what Congress said was a one-time-only waiver of the Employee Retirement Income Security Act (ERISA) of 1974, which determines the insurance requirements for states. Hawaii’s plan was in place before passage of ERISA. Other states that are out front are Florida, Massachusetts, Oregon, and Vermont. All four have laws on the books to set up new health systems, although they have not yet been fully implemented. Still other states such as Colorado, Kentucky, Maine, Montana, and Washington have established commissions or initiated demonstration projects seeking to create new health care systems. As of November 1992 California and Ohio had legislation pending to consider new systems. In a related critical area for health policy, New Jersey and New York have led the way in enacting price and cost controls and also in establishing broad-banded community rating systems to improve access to health care.

Achieving comprehensive reform incrementally. Lawrence Brown has warned against overemphasizing the distinction between the comprehensive and incremental roads to health policy reform.⁵ He notes that a step-by-step approach is under way. Ultimately, state actions such
as those just mentioned could pave the way for a national plan that builds on these state initiatives and brings in the laggard states. This is not top-down or bottom-up. It is a middle way—a coming together of policy and politics in the health field.

This observation about the momentum of reform raises another important institutional point. In the United States, domestic policy changes often are taking place while they are under discussion. Changes that are now occurring piecemeal at the state and federal levels could move us to a new federal/state partnership system.

The Federal Lead Role In A New Partnership

Under a new federal/state partnership system that came into being on this combined incremental/comprehensive basis, the federal government, as previously stated, would have the lead in policy making, financing, and setting up the framework of benefits, and in shaping the overall structure of a new system. The states would be responsible for administering the new program and should have a measure of policy flexibility, as the provinces now do in Canada. Such a partnership would in many ways resemble Canada’s federalism arrangement in the health field. The critical function of cost control should be a shared responsibility, with the federal government and the states jointly setting budget targets that would be allocated to the states and carried out by them (under a system described below), subject to their acceptable performance. Each state would also administer a system for payment coordination, which is a feature of many pending national health system reform proposals.

Although we do not take sides here on questions involving substantive policy choices, we are struck by the many ways in which existing proposed reform plans already rely on the states. In this respect, the “managed competition” plan advanced by Alain Enthoven and Richard Kronick is consistent with Henry Aaron’s proposed play-or-pay plan. Both proposals assign major administrative roles to the states. Both envision setting up a coordinated mechanism at the state level. Both give the states major operational responsibility for covering groups not covered through employers. Both also assign the critical cost containment function to the states.

Organizationally, the Enthoven/Kronick plan and the Aaron plan call upon the states to establish authorities to carry out these and other responsibilities. The Enthoven/Kronick plan calls for highly insulated state authorities modeled on the Federal Reserve System. The Aaron plan also calls for setting up politically independent state authorities, but not as politically insulated as under the Enthoven/Kronick plan. Neither
 Healthcare reform plan says enough about these administrative and structural issues. In a similar way, one of the major bills put forward in the Congress, sponsored by Senate Majority Leader George Mitchell (D-ME), envisions an “Americare” system to supplement private and employer coverage, which would be administered by the states. As in the case of other pending proposals, the Mitchell plan needs to give more attention to the institutional, federalism, and implementation questions that would have to be answered once we get down to the serious business of putting a new system on the books and setting it to work.

Under the federal/state partnership approach outlined in this essay, states would have some stake in financing health care. Yet there are great and highly visible problems with the commonplace national practice of pushing costs onto the states through mandates. If state costs under a new system exceed state spending for Medicaid, current intergovernmental tensions and fiscal strain on the states would be exacerbated. Although we emphasize institutional design while trying to be neutral on key issues of concept and substance, one way to balance this equation would be to separate out long-term care for the elderly and chronically ill. Both systems could be supported by federal taxes earmarked for health to supplement revenues received from patients and third-party payers.

New Mechanisms Needed

We return now to an essential point about the institutional agenda: New mechanisms are needed both centrally and at the state level to refine a new national health care plan and adjust it as experience is gained in the field. An example of how this has been achieved in another field is military base closing. Thirty years of frustration with the federal government’s inability to make choices about which bases to close led to a law in 1990 that creates commissions of trusted appointees to develop a base-closing plan, which Congress and the president cannot change. They can send it back to the commission, but they cannot modify it. These commissions have legitimacy. At the same time, they enable political leaders to agree to get the job done.

We need to be inventive in similar ways in the health field. Health care spending will soon account for 14 percent of GNP; experts estimate that this could rise to around 20 percent of GNP by the turn of the century. The dramatic changes in health spending, discussed in Steven Gold’s DataWatch in this volume of Health Affairs, show a doubling of health spending as a percentage of GNP over the past twenty-five years, with the greatest increase occurring in public spending. Public spending
for health rose from 1.5 percent of GNP in 1965 to 5.1 percent in 1990.\(^7\)

**A federal/state compact.** The activities of state health care authorities under a new federal/state partnership for health need to have political insulation, whereby the authorities are politically accountable and yet have room for flexible action and leadership, especially in relation to the cost containment goals of a new health care system. Annual state plans embodying major policy decisions to fulfill budget targets could be subject, within a sixty- or ninety-day period, to legislative action akin to the federal base-closing commission process. The governor and legislature could reject the plan en bloc and return it to the authority but could not modify it. Similar mechanisms are needed at the national level. Other federal countries—Canada, Australia, and Germany—use intergovernmental mechanisms in this way to deal with key issues in major program areas. We could do this in the health field by creating a federal/state compact for health. Both the federal government and the states would be members of the compact, which would play a major role as the instrument for cost containment, among other tasks. State expenditure targets would be set by the compact—the federal government and the states working together—and would be apportioned to the states. Congress and the president would be empowered to review these targets, although they might not be required to act on them; alternatively, they might not be empowered to modify them piecemeal, only to reject them and send them back to the compact within a specific time period.

Many questions need to be considered in creating such a compact. Our aim is not to put forward a fully developed plan, but to urge attention to this approach. Among major questions are: How would such a compact reach closure? How would it be funded? Who would appoint state members? How would private and nonprofit stakeholders be chosen and represented? What arrangements would be made for out-of-state service provision? How would the new system be phased into operation? How and on what basis would the federal government react to noncompliance by a state?”

**Conclusion**

We believe that cooperative and iterative mediating structures are needed to refine and administer a new comprehensive national health care system and that states could play an important role in this context. States have the identity, legal powers, and governmental structures to do so. There would need to be provision for the federal government to step in when states or combinations of states fail to meet their budget targets or in other ways do not perform in a manner consistent with the basic
policy framework of the new system. States have similar authority in the field of elementary and secondary education, to step in where local schools are failing. In addition, some states might choose to join in interstate agreements for health care, and provision should be made for them to do so.

Deborah Stone argues that the health policy problem is “simply too big for the states,” although she concedes that the states “seem to be bursting with motivation and energy to innovate in health policy.” There is unquestionably a buzz of activity at the state level on a variety of health policy issues. But the big problems of health care transcend state boundaries and require more political power than state governments now have.

Stone’s case is impressive and well made. However, in our view there is an equally strong case not to have a fully national plan. If states were not in this partnership role, it would be necessary to invent bodies to act in this way, perhaps resembling Germany’s “sickness funds.” States have the legal powers for insurance, aiding the poor, approving new facilities, licensure, education and training, and so on. They have the standing and administrative machinery to participate in the critical process necessary to evolve a new national health care system, which would be refined in practice by adjusting and enforcing budget targets. Sensitive political decisions would have to be made along the way by the federal/state compact. Some of these decisions could in turn be submitted to Congress and the president as modifications of the basic policy framework or budget parameters of the new national system, as experience is gained in developing the system.

All too often the institutional implementation and federalism dimensions of domestic policy reform we have discussed here are neglected. In the health field, creative attention to this aspect of the challenge and to the invention of new decision-making mechanisms for “case closing” (as opposed to base closing) could be key to providing a flexible, iterative, workable structure for starting on the road to health care reform-and staying on it.

The authors thank Rachel Block, Lawrence Brown, Lynn Etheredge, David Helms, John Mendeloff, Robert Reischauer, Michael Sparer, and Frank Thompson for their assistance in the preparation of this paper.
NOTES

2. Ibid. 9.
10. Ibid.