Perspective

‘Assessing The New Federalism’ And State Health Policy

Are federal rules the primary barrier to state health care reform?

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The Urban Institute’s Assessing the New Federalism (ANF) project is a large, multiyear research effort to examine changing policies in health care, cash welfare, employment and training, child care, and other social programs for low-income populations. Eight papers, drawn primarily from our case-study analyses of thirteen states, were published in the May/June 1998 issue of Health Affairs.

In this volume Bruce Spitz reacts to these papers and to the more general issues of federalism, drawing heavily from his consulting experience for the state of New Hampshire. He makes three main points: First, there is no “new” federalism. Second, federal rules, especially federal preemption of state laws that relate to health plans, should be eliminated because they stymie state health care reform. And, finally, New Hampshire is an example of a state trying to take a comprehensive approach to health care reform but prevented from doing so by federal rules.

Is There A New Federalism?

There is no question that the new federalism has not gone as far as some of its proponents would like it to go. Yet it would be a mistake to ignore the significant changes in federal/state relations that have occurred in recent years. Evidence of the changing nature of federalism is clearest in cash welfare for families with children but also is found in job training, child care, and child support programs. Moreover, as Marilyn Ellwood and Leighton Ku point out, reform of cash welfare has a major impact on Medicaid enrollment.¹

Spitz understates the extent to which states now have substantially greater flexibility in their health programs than they have had in the past. The Balanced Budget Act (BBA) of 1997 repealed certain federal requirements with respect to Medicaid managed care, the Boren Amendment (which set federal minimum standards regarding Medicaid payment rates for nursing homes and hospitals), and Medicaid payment standards for federally qualified health centers.

Perhaps more important is the recent dramatic increase in the federal government’s willingness to grant waivers that entail significant reforms in states’ public health insurance systems. As of May 1998 seventeen states had implemented Medicaid research and demonstration waiver programs, and three states had Health Care Financing Administration (HCFA) approval but had not yet begun program operations.² In addition, the new State Children’s Health Insurance Program (CHIP) has a very different structure and design than Medicaid has and provides states with far greater flexibility.

The Evolving Nature Of Federalism

Debates about the proper nature of federalism have a long and rich history. Federal rules ensure national uniformity—often a priority for large, multistate businesses and labor unions. Federal standards ensure that citizens in dif-
Different states are treated the same and help to define what it means for us to be a nation. Also, federal requirements in programs that serve low-income persons ensure that there is a national floor below which no state can fall.

The arguments for state flexibility are also strong. Leaving policy options to states can lead to innovation and healthy experimentation. States can tailor their solutions to their specific needs (and health care market structures). State flexibility avoids the hassles and waste of distant federal bureaucrats’ second-guessing decisions made by people closer to the problem and to the realities of program implementation.

These long-standing federalism arguments are made more complex in the context of programs with joint federal and state funding. Here Spitz’s goal seems unrealistic. Every state administrator would prefer to receive federal funds without any strings attached, but elected federal officials are unwilling to expend the political capital to pay for programs over which they have little or no control.

Spitz’s emphasis on the barriers that the Employee Retirement Income Security Act (ERISA) creates for state-level, comprehensive health system reform efforts is familiar. The National Governors’ Association (NGA) has had a policy calling for modifications to ERISA for many years. But what Spitz neglects is the fact that ERISA also shields larger employers from having to respond to a multitude of state regulations as they attempt to administer a single health insurance benefit for their dispersed employees. ERISA’s role in health policy cannot be coherently analyzed by looking only at the effects of its preemption clause.

If, as Spitz seems to presume, many states would pursue universal insurance coverage if ERISA were not a barrier, we would expect to find most states stretching to come as close to that goal as possible. Yet that is not the case. As Shruti Rajan points out, states can be categorized according to the extent of their efforts to attain comprehensive coverage—and most states have taken limited or modest steps. Even states such as Washington, Minnesota, and Massachusetts, which at one point had statutory goals of universal or near-universal coverage, have backed away from these earlier ambitions. There is no evidence that we can blame ERISA and rigid federal programs for this. Some states might do more if they had additional flexibility, but some might do less.

**The New Hampshire Experience**

Although Spitz’s description of the enthusiasm for health care reform in New Hampshire is encouraging, it is a story that has been told about many states’ efforts in the 1990s. There is no question that citizens in New Hampshire, like their peers around the country, support the principle of universal health insurance. It also is true that ERISA removes from consideration one particular vehicle for achieving this goal: a state-imposed mandate that employers provide health insurance to their employees.

If New Hampshire wants to guarantee health insurance coverage for all of its citizens, it could move closer to that goal within the current federalism framework. Thus far, relative to most other states, New Hampshire has made only limited efforts to cover its population. Only 6.5 percent of the state’s population is covered by Medicaid—the lowest percentage of any state in the nation. New Hampshire ranks thirty-ninth in the percentage of its population below 200 percent of poverty that are covered by Medicaid, yet the state ranks eighth in per capita income.

A complete picture of the federal constraints under which New Hampshire operates its health care system must also take into account the state’s participation in the Medicaid disproportionate-share hospital.
(DSH) program. DSH expenditures were 39 percent of the state’s Medicaid program in 1995, by far the largest DSH program in the nation. The state received $1,428 of federal funds per uninsured person, compared with the national average of $303. Relatively little of this highly flexible source of funding has gone toward expanding access to care in New Hampshire. Today’s federalism must be viewed as a combination of restrictions, such as ERISA, and flexible funding streams, such as DSH.

New Hampshire could look to the experiences of states such as Minnesota, Oregon, New York, Washington, and Massachusetts for examples of how to make major health system changes within the constraints of current federal law. These states have expanded Medicaid and appropriated state funds to cover large numbers of the previously uninsured. These efforts have their limitations, but they also reveal a good deal of success.

Some may prefer that each state be permitted to view its health care system as an isolated whole and to design a more integrated approach to insurance coverage than current federal categories permit. Yet, as many have learned by studying states that have been leaders in health system reform, the health care system is large and complex and, while comprehensive solutions are “cleaner,” they also are far more challenging politically than they appear at the outset. It is disappointing to learn that most participants in the New Hampshire planning process view the federal government as a “major impediment” to universal coverage, but it is worth asking whether every state would enact its own program to collectively cover the sixty-eight million Americans who are now covered by Medicare and Medicaid if those federal programs did not exist (and the federal revenues that pay for them were returned to the taxpayers).

Understanding Federalism—Old And New

The primary goal of the ANF papers in *Health Affairs* was to document the extent and degree of variation among state policies. This seems a worthy goal because, despite the oft-used rhetoric that states are different and therefore should be permitted flexibility in how they administer programs, relatively little effort has been made to document the many ways in which those differences are manifest.

We found great variation in how states define the health care safety net—even in ostensibly “federal” programs. This variation reflects political culture and tradition, economic and budgetary resources, attitudes toward the federal government and the poor, as well as the design and structure of the states’ health care systems. The richness of this variation cannot easily be summarized, but aspects of it are described in each of the *Health Affairs* papers.

Efforts to grant states additional flexibility are likely contingent upon a better understanding of how states have responded to the flexibility they already have. The nature of the “new federalism” is a combination of changes in federal laws and the variety of responses that states choose over time. This is what we set out to analyze in the Assessing the New Federalism project.

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