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States and Health Care Reform

A LOOK BACK

1965

IN THE early 1960s, state governance was largely embarrassing. Governors were generally elected every two years or were allowed only one four-year term, and they had little power when they did assume office. Thanks to citizens' concerns about vesting too much power in a few persons, states had successfully spread decision making over a spate of agencies, commissions, and boards that were not directly accountable to anyone. When Daniel Evans, on taking office as governor of Washington in 1965, called a cabinet meeting, 60 people came (Sanford 1967). Legislatures were even more poorly prepared to deal with state problems. Legislative pay was a pittance, there were no or very few staff members, and the legislature was in session for only a few days every other year. Many states were run by special interests. In some states, railroad interests dominated; in others it was power companies or racetracks, oil or insurance companies.

Cities were often ignored by legislatures composed largely of members

representing rural parts of the state. In 1960, more than six million people lived in Los Angeles County and fewer than 15,000 lived in a rural county in northern California's mountains, yet each was represented by one state senator. In Vermont, a town with a population of 38 had the same representation as the city of Burlington, with 35,531. Translated into legislative control, 11 percent of the people in California could control the state senate; 12 percent of the people in Vermont could control the state house of representatives (Grant and Omdahl 1993). The reason for this maldistribution was twofold. First, many states had not changed their legislative district lines, or redistricted, for decades. In 1963, 27 states had not redistricted their legislatures in 25 years, and 8 states had not redistricted in more than 50 years (Sanford 1967). The Vermont house had not redistricted since 1793. Second, many states copied the federal legislative model, with an upper house based on geographic units; the obvious geographic units were counties, and states often assigned one senator for each county.

State officials often ignored the problems inherent in states' legislative structures. As Sanford (1967, 35, 36-37) put it, "The states . . . have failed to advance with their citizens into the modern world . . . When twentieth-century growth began to overtake us, the machinery of state government was outmoded, revenue resources were outstripped, and the state executive was denied the tools of leadership long supplied the President of the United States."

Despite their lackluster leadership, states were key players in health in the early 1960s, serving as the primary providers of mental health and (with local government) public health services. By 1965, change was in the air. States were scrambling to reapportion their legislative bodies to respond to the U.S. Supreme Court decisions in *Baker v. Carr* (1962) and *Reynolds v. Simms* (1964), which applied the principle of one person, one vote, to both houses of every state legislature. In 1967, more than half the states had constitutional revisions on their ballots to reorganize the legislature, make changes in the executive branch, improve the judicial branch, and change the relationship between the state and local governments.

Between 1965 and 1975, states underwent a remarkable transformation. Their legislative, judicial, and executive offices became vibrant and responsive. Their state employees were energized, and state capitols became places where exciting programs were launched and carried out, thus attracting many of the brightest and best young people to Albany, Lansing, and Tallahassee. Changes were made in state constitutions to unshackle local government and to balance the state's tax system so it would weather economic difficulties and maintain equity among its citizenry. States began to tackle the tough issues

they had often avoided in previous years—from the environment to economic development, from education reform to controlling health care costs.

1981

By the start of the 1980s, state legislatures had greatly improved their staffing and more adequately represented all citizens of the state. The legislatures had more women and minorities and, compared with the 1960s, greater partisan competition, with Republicans picking up seats in the South and Democrats in the North. There was a tremendous jump in the number of women serving in state legislatures between 1969 and 1980, from a total of about 300 to nearly 800 (S. Patterson 1983). Membership in legislatures for ethnic and racial minority groups also increased during this time, although their proportion of all legislators was small—about 4 percent. State after state strengthened the powers granted to governors, giving them stronger budgetary authority, longer terms of office, and the ability to serve multiple terms, to appoint more cabinet members, and to have a strong line-item veto (Beyle 1989). Overall, states had made a remarkable, though not widely heralded, recovery in their ability to deal with tough problems. Indeed, in the mid-1980s, the Advisory Commission on Intergovernmental Relations (ACIR 1985, 364) described states as moving from fallen arches to arch supports of the system. The ACIR noted that states were “more representative, more responsive, more activist and more professional in their operations than they ever have been.”

Furthermore, states were becoming the sources of innovative policies, particularly in health. In the 1970s and 1980s, states became concerned about the rapidly increasing costs of health care to their budgets and instituted reforms such as rate-setting systems, negotiated contracting, and diagnosis-related groups. They also adopted risk pools for health insurance, right-to-die acts, and mandatory seat belt laws.

1993

The makeup of state legislatures in 1993 was much more representative of the population in gender and occupation than in earlier decades. More than 20 percent of the 7,424 state legislators were women—five times as many as in the 1960s (Thaemert 1994). In five states—Arizona, Colorado, New Hampshire, Vermont, and Washington—women held more than one-third of

the legislative seats. In others, women were still somewhat rare. In Alabama, Kentucky, Louisiana, Oklahoma, and Pennsylvania, women made up less than 10 percent of the total (the percentage of U.S. Congress members that were women in 1993). But overall, compared with the U.S. House of Representatives and with previous years in the states, female representation in state legislatures in 1994 was greatly enhanced (table 5.1). State legislatures had fewer attorneys, business owners, and farmers than in the 1960s and more legislators whose legislative service was a full-time job. Some 15 percent of all state legislators were full-time—up from 3 percent in 1976.

In 1992, a sitting governor was elected to the presidency—the first time since Governor Franklin Roosevelt was elected in 1932. Bill Clinton, governor of Arkansas, not only understood state governance but also was actively involved as a spokesperson for states through the National Governors Association (NGA), which he had headed and for which he served as leader in the development of several policy positions—including those on welfare reform and health care.

States had become increasingly active players in the health care field. Ideas discussed in Washington, D.C., in 1993–94 were already in place in several innovative states; other states were considering ideas such as a single-payer system, generally viewed as too radical for national consideration. The role of states in health care reform was more than a parochial concern; it was a central issue in congressional hearings, news conferences, and Sunday morning television talk shows. Washington clearly could not monitor and implement the program on its own. It needed states.

Table 5.1
Women Serving in U.S. Congress and Senate,
as Percentage of Legislators, 1975–2005

	1975	1981	1994	2000	2005
U.S. House	4.4	4.4	11.0	12.9	15.0
U.S. Senate	0	2.0	6.0	9.0	14.0
State houses	9.3	14.0	21.8	23.5	23.3
State senates	4.5	7.0	17.3	20.0	20.3

Sources: Ornstein, Mann, and Malbin 2002; Center for American Women and Politics, Eagleton Institute of Politics, Rutgers University; *CQ Weekly*, Jan. 31, 2005.

2005

In 2005, most states were emerging from several fiscally difficult years during which demands from citizens had outstripped the revenues coming into state coffers. In 2002–4, states found themselves cutting back on programs—including one of the largest, Medicaid—and sometimes adding new taxes on their citizens. But the economy improved in 2005, and states looked once again at ways to help provide health insurance to their citizens, protect their public health operations from possible bioterrorist attack, and improve their health infrastructure and citizens' access to it.

Although the president was a former governor—the fourth of the past five presidents—states saw little immediate benefit. Domestic spending was a target of cuts as the president sought to reduce taxes and to wage an expensive war on terrorism at home and abroad. In areas ranging from medical malpractice to environmental protection, Washington, D.C., proposed preemptive legislation and even came up with new ways to “make states pay” for their own innovations.

Perhaps because of the national threat to federalism, governors, state legislators, and state attorneys general were active political players, leading the way in areas where Washington could not come to an agreement—regulation of managed care, medical malpractice, controlling drug costs, curtailing greenhouse gases, to name a few. States moved ahead with policies while Congress continued to argue. Finally, in the early years of the new millennium, the U.S. Supreme Court followed the pattern of earlier years and issued a series of decisions that favored state sovereignty and constrained federal power. Medicaid reform was again a top concern for the NGA and for other groups as federal cuts in the massive program loomed. States pursued new waivers in Medicaid to find ways to both cover the uninsured and hold down costs—a difficult, if not impossible, task.

While academics and pundits continued to argue about why a universal health policy was more desirable than individual state actions to cover the health needs of their own citizens, states continued to act. Even under fiscal duress, Utah and Maine, for example, came up with innovative programs to expand health care coverage, often working with the private sector. Other states, such as Florida, came up with ambitious plans to revamp Medicaid by providing recipients with a voucher-type program that would be managed without state bureaucratic direction. Still other states targeted clean air and clean water and quietly implemented programs that in some cases were more stringent than tough international protocols. As Washington, D.C., continued

to amass federal deficits and cut domestic programs, the states responded to their citizens and learned from each other.

OVERVIEW

States have a broad role in health. One analyst called the scope of state activities in the health area "truly awesome and capable of reaching into almost every facet of health care delivery" (Clarke 1981, 61). States are responsible for the funding and coordination of public health functions, the financing and delivery of personal health services (including Medicaid, mental health, public hospitals, and health departments), environmental protection, regulation of providers of medical care and the technology they employ, regulation of the sale of health insurance, and the state's rate setting, licensing, and cost control. States provide health insurance for their own employees and retirees and play a pivotal role in educating and credentialing health care professionals.

State institutions are similar to national entities in their structure and purpose. However, several differences are important in understanding why state and federal policies can be so divergent, including, at the state level, direct democracy, the requirement for a balanced budget, and the very muted role of the press in state capitols. States differ from one another in very significant ways, including in their willingness to enact innovative legislation and in their implementation of Medicaid programs. In recent years, states have provided innovative solutions to a wide range of health problems yet are constrained by federal law from making some changes (especially by the Employee Retirement Income Security Act, which limits states' ability to make comprehensive state reforms).

FEDERALISM AND INTERGOVERNMENTAL RELATIONS

To understand states and health policy, one must understand federalism and the intergovernmental relations that define states' roles and responsibilities in health and other areas.

In its earliest years, the United States was governed by the Articles of Confederation, which set up a weak national government and strong states. The national body (unicameral, with equal representation from the states) had no power to tax, enter into commercial treaties, retaliate against discriminatory foreign trade policies, or enforce the provisions of existing treaties. Con-

gress relied on states to act, and it needed state cooperation to discharge any functions. There was no national government, but rather the United States "consisted solely in the congregation of envoys from the separate states for the accommodation of certain specified matters under terms prescribed by the federal treaty" (Diamond 1985, 30). The states issued their own money and had their own trade policies with other states. When there were interstate disagreements, Congress was virtually powerless to deal with them.

While acknowledging that the confederation did not work, the delegates to the Constitutional Convention of 1789 were not yet ready to establish a fully national government. They compromised in the wording of the Constitution, which divides responsibilities between the two levels of government. Certain functions, such as interstate commerce and national defense, were assigned to the national government; others, such as the selection of presidential electors who would choose the president, were left to states. The strongest language in favor of states came in the Tenth Amendment: "powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." Yet the Constitution authorizes the national Congress to "provide for the general welfare" and to "make all Laws which shall be necessary and proper" for executing this and other powers given to the legislature. The commerce clause is also crucial: anything defined as interstate commerce, or crossing state lines, is in the federal domain. Finally, the supremacy clause clearly states that if federal and state laws are incompatible, the federal law prevails.

Federalism was the key means by which the Founding Fathers sought to ensure that power was not concentrated in one set of government officials. Instead they wanted to establish a balance of powers so that one level of government would have a "check" against the undue power of another. They set up a system of government in which both governments were sovereign and powerful. As James Madison described it, "The federal and State governments are in fact but different agents and trustees of the people, constituted with different powers and designed for different purposes" (Publius [1787-88] 1961, 294).

The broad parameters allocating powers between the national and state governments soon led to the important role of the courts in defining those powers. The first major decision on this, *McCullough v. Maryland* (1819), was made when Maryland leaders questioned the power of the federal government to establish a national bank in Baltimore, a power not specifically listed in the Constitution. This celebrated decision established the notion of "implied powers": the national government was not limited to those powers

clearly outlined in the Constitution; Congress could also become involved in areas that were "implied" in such vague phrases as "providing for the general welfare" or "necessary and proper." By so broadly construing the intent of the Constitution, the Supreme Court allowed the responsibilities of the federal government to encompass a broad array of activities and programs. Until the 1990s, the Court generally came down strongly on the side of the federal government.

An important point to keep in mind about federalism is that it is a system of rules for the division of public policy responsibilities among a number of autonomous government entities (Anton 1989). In the United States, these entities are the national and state governments. The autonomous nature of the relationship is crucial: states are not administrative units of Washington, D.C.; rather, they have their own responsibilities and duties, many of them overlapping those of Washington. The relationship was once described as cooperative federalism, with federal and state governments interacting to achieve common goals. The metaphor commonly used is of a marble cake, with the government units representing the halves of the cake and programmatic activities, such as education, welfare, and health, "marbling" through them.

The states were the dominant actors in federalism in the country's first century. With the Civil War came a nationalizing effect, expanded later during Franklin Roosevelt's New Deal and still further by Lyndon Johnson's Great Society. States had become key actors in implementing an activist federal domestic agenda, largely thanks to federal grants that provided incentives for state action in social programs, transportation, urban development, special education, community development, and job training.

Ronald Reagan, in his vision of "New Federalism," preferred a different view of the relationship between federal and state governments. His call for a sorting out of responsibilities, whereby the national government would handle only those functions purely national and the states would handle most other areas, was similar to dual federalism, a system with another cake metaphor: a layer cake, one layer representing the responsibilities of one government, the other layer those of the other government, with little cross-layer mingling. The models differ in the extensiveness of the federal role; they share the view, established in the Constitution, of state sovereignty.

Federalism has another important policy strength: improving the possibility of policy innovation. States can try out new ideas and techniques or philosophies that, if successful, can later be adopted by other states or on a national scale. Indeed, states are regularly referred to as the "laboratories of democracy." Compared with the federal government, states' smaller size and

proximity to the people make them proving grounds for innovations in policy and governance. Moreover, the likelihood of finding a significant innovation is greater with 50 different states devising different policy programs than if we relied on the action of one federal government.

The important role of states is established in the U.S. Constitution and ratified by history. As in most dynamic relationships, changes occur over time. In the 1960s and 1970s, Washington was very strong and states rather weak in capacity and resources. In the 1980s and 1990s, the federal government was fiscally constrained with a \$3 trillion budget debt, while the states were reasonably fiscally secure and administratively capable of taking on problems, including health care. In the early years of the twenty-first century, states were constrained by falling revenues and increasing demands, while Congress, free from pay-as-you-go budget restraints, reduced taxes and increased defense and homeland security spending, and ignored calls for Medicaid reform and fiscal relief.

Congress and the president cannot "make" states do anything. However, they can provide incentives through federal grants, or punish states that do not act in a desired way by withdrawing federal dollars, or simply preempt state actions. Preemption must be based on some constitutional purpose such as interstate commerce or protecting the public welfare. And preemption is increasingly being used, even by a conservative Congress and president.

Federal Grants

During the nation's first century, government at any level did very little. The people did not particularly want government services, and governments had few taxes through which to raise the resources to provide services. The federal government's role was largely restricted to "war and danger" and some limited pork-barrel funding. States were more active, particularly in economic development activities: they built roads and bridges, dredged canals, set forth civil and property rights and family and criminal laws, and provided education (D. B. Walker 2000). For the federal government, a turning point was the imposition of the income tax in 1913; finally, it had resources. And with the coming of the New Deal, Franklin Roosevelt's effort at overcoming the Depression, it also had a cause. The federal government wanted to help citizens find jobs and bring home a salary, setting them on the road to financial recovery. Yet it could not do this solely from Washington. Rather, it was easier for Washington to give grants to states and localities so they could provide

the services. Thus, in the 1930s, began the age of the federal grant. Between 1933 and 1938, 16 federal grant programs were enacted.

Not until the 1960s and 1970s did federal grants reach their heyday. Again, the federal government wanted action: to alleviate poverty, to equalize educational opportunities, to clean the nation's air and water, and to ensure adequate health care for underserved populations. But, again, this could not be done from Washington. In the 1960s, Congress enacted hundreds of new federal grants: 150 in 1965 alone. Between 1965 and 1970, the dollars provided in federal grants doubled; the total doubled again between 1970 and 1975, and nearly doubled again over the next five years (table 5.2). The growth after 1990 was substantial: an increase of \$131 billion between 2000 and 2005 alone. However, much of the growth was concentrated in one program—Medicaid.

Other federal grants go to programs ranging from highway beautification to Head Start, from water purification to prevention of terrorism. Federal health programs include block grants for substance abuse, mental health, and maternal and child health; funding for AIDS programs through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act; and funding for anti-bioterrorism activities. These grants totaled \$8.6 billion in fiscal year 2004—less than 5 percent of the federal Medicaid allocation that year. Health grants accounted for nearly half of all federal grants in 2005—up from about 6 percent in 1965 (fig. 5.1).

Federal grants were a boon to states and localities, since they provided the

Table 5.2
Federal Grants, 1965–2005

Year	Amount of Grant (billions of dollars)	Percentage of State and Local Expenditures	Percentage of Federal Outlays	Constant Dollars (billions, 2000)	Grants to Individuals (percent of total)
1965	10.9	15.5	9.2	\$56.7	34.1
1970	24.1	20.1	12.3	105.3	36.2
1975	49.8	24.0	15.0	157.7	33.6
1980	91.4	27.4	15.5	192.6	35.7
1985	105.9	22.0	11.2	163.1	47.3
1990	135.3	18.9	10.8	172.1	57.1
1995	225.0	22.8	14.8	247.9	64.2
2000	284.7	22.1	15.9	284.7	64.1
2005	425.8	—	17.2	377.9	65.4

Source: Data from the Budget of the United States Government, Fiscal Year 2006 (OMB 2005).

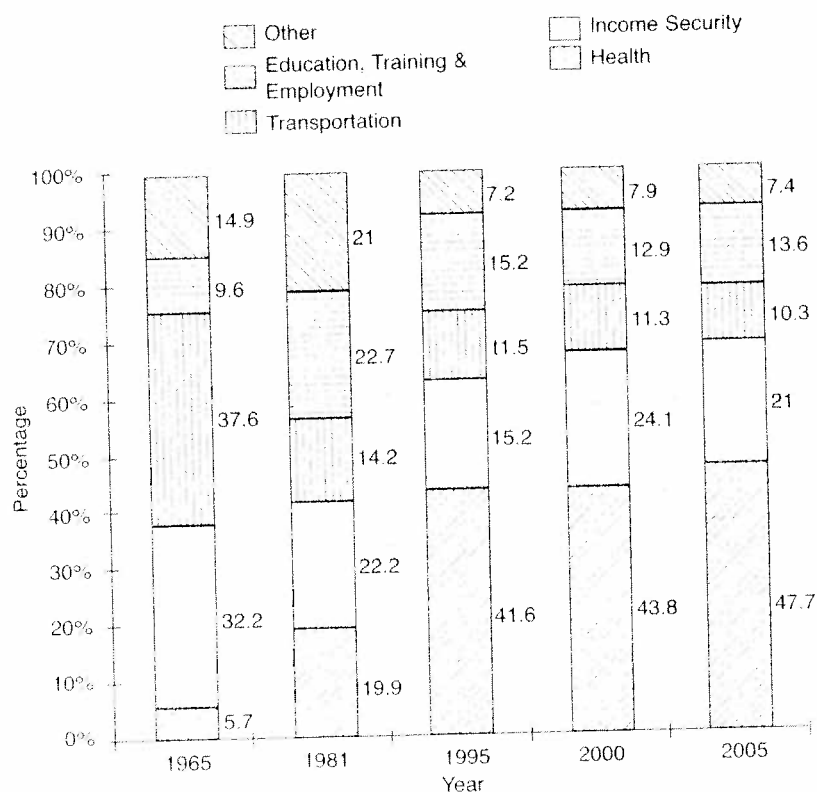


Figure 5.1.
Federal Grants by Function, as Percentage of Total Federal Grants, 1965-2005.
Source: Data from Budget of the United States Government, Fiscal Year 2006.

resources to pay for services that could not, or would not, be offered without the additional money. They also helped professionalize state and local workforces in many areas, including health. States increased the salaries of their employees and challenged them with innovative and much needed programs, funded in part by federal dollars. Finally, federal grants equalized services in a way that states could not accomplish on their own. Medicaid, AFDC, and other federal grants are designed especially to assist poor states, or states with poor citizens and few natural resources to tax.

Most federal grants are categorical: money is provided to states and localities and must be used for rather specific functions, from funding clinics for patients with black lung disease to providing curriculum assistance to the

health professions. Sometimes the grants are competitive; states and localities submit proposals, and only a small number receive funds. More often, the grants are distributed to all states or localities based on a formula that includes such "need" measures as counts of poor persons, rural highways, waterfront land, or dilapidated housing.

In 1966, a new type of grant came into existence, a block grant, which allowed states and localities more discretion over how the dollars could be used. Generally, Congress would specify the policy area in which the funds could be spent, but states or localities could decide, within those broad categories, which programs best fit their own needs. The first block grant was in health, legislated in the Partnership for Health Act in 1966. Other health-related block grants were for maternal and child health; alcohol, drug abuse, and mental health; and preventive health care. The most recent block grant was the State Children's Health Insurance Program (S-CHIP), enacted in 1997. States and localities typically like block grants, but Congress is generally less enthusiastic; it is much harder for members of Congress to take credit for programs funded under this grant device, and oversight is difficult. Block grants usually suffer from these political flaws in their struggle for funding. The substance abuse, mental health, and maternal and child health block grants have not increased substantially since their inception. A recent block grant—Temporary Assistance for Needy Families (TANF)—is a case in point. Congress was unable to come up with a multiyear reauthorization and relied on temporary extensions for more than three years—in the process leaving states and the program recipients with considerable uncertainty.

Regulatory Federalism

In the 1980s, when federal budgetary restraints began to take hold, new federal grant spending became a liability, and federal regulation—whereby states and localities could be coerced into acting in certain ways—became more appealing. Regulations and requirements have long been a part of federal grants, going back to the Hatch Act of 1939, which prohibited partisan political activity by federal employees and by state and local employees funded with federal grant dollars. Nevertheless, the past few decades have seen a new type of regulation in which Washington enlists state and local governments in national efforts on behalf of particular disadvantaged groups or to advance certain policies such as environmental protection. Four types of intergovern-

mental regulation are popular: crosscutting requirements, crossover sanctions, partial preemption, and direct orders or mandates.

Crosscutting requirements are general policy provisions that apply across all federal grants in such policy areas as discrimination, wage rates, and environmental protection. David B. Walker (2000) identified 62 crosscutting requirements. One example is the Drug-Free Workplace Act, which requires all federal contractors, grant recipients, and state agencies receiving contracts or grants of \$25,000 or more to certify that they will provide a drug-free work environment. Most of the existing crosscutting requirements were enacted more than a decade ago.

Crossover sanctions are newer regulatory mechanisms that impose a financial penalty in one area based on defects in another. Particularly popular is imposing penalties in the highway trust fund if states do not make desired federal changes. Early crossover sanctions dealt with transportation matters (such as lowering the speed limit and changing the minimum drinking age), but more recent laws have tied the loss of a state's highway trust-fund monies to nontransportation issues such as the control of junkyards and clean municipal air. One of the most recent crossover sanctions calls for states to strengthen their standard for drunk driving or lose 2 percent of their federal highway trust-fund money. States now face well over a dozen different financial penalties under which they can lose from 5 to 100 percent of their highway trust funds for failure to comply with federal requirements. Occasionally the sanction is connected with a nonhighway funding source. For example, the 1992 Synar Amendment punishes states that do not meet negotiated targets for reducing tobacco sales to minors through a 40 percent reduction in their substance-abuse block grants. A new twist on the crossover sanctions was introduced in 2005, when the Senate version of the highway bill called on states to adopt stiff penalties for repeat offenders, those with very high blood-alcohol levels, and those whose licenses had been suspended for drunken driving but who drove anyway. States that failed to enact legislation setting forth specific penalties for these three groups would see up to \$600 million diverted from highway construction to programs aimed at highway safety (Wald 2005).

With partial preemption, the national government establishes rules and regulations calling for minimum national standards for a program. States can administer the program if they follow the standards; in states that fail, or do not wish, to do so, federal agencies will administer the program. This type of intergovernmental mandate is often used in the environmental area in such laws as safe drinking water, surface mining, and clean air amendments. It also

applies to state occupational health and safety: half the states have chosen to administer that program; half have chosen not to do so. The Health Insurance Portability and Accountability Act of 1996 contained partial preemption provisions. The law included new access, portability, and renewability standards for group and individual market insurers. If states do not pass laws that enforce these provisions, the federal Department of Health and Human Services must do so (Ladenheim 1997).

In direct orders or mandates, the federal government orders lower governments to take certain types of action. More than 50 percent of all federal statutes preempting state and local authority enacted over the nation's 200-year history were adopted during the past two decades. Particularly troublesome for states is the tendency for Washington to mandate without federal financial assistance to pay for the newly required service. Many of these mandates are in the area of environmental protection. Though states pay some of these environmental costs, they mainly shift the burden to local governments. The effect on smaller jurisdictions can be devastating. An Environmental Protection Agency mandate requiring localities to monitor a particular substance in sewage discharge cost a small North Carolina town of 3,000 residents more than \$30,000 a year—an amount equal to a 6 cent increase in their property tax. The 1990 Americans with Disabilities Act is another unfunded mandate that costs states and localities billions of dollars. The Drug-Free Workplace Act of 1988 also imposed substantial costs by requiring all federal grantees and contractors (including, of course, states and localities) to ensure that their workplaces were drug-free and that they offered antidrug programs for employees (Gais and Fossett 2005). But the largest federal mandate is Medicaid: Congress has substantially broadened the scope and reach of the program over the past decade. Though the federal government shares the cost of Medicaid with the states, changes made in Washington force states to fund their share of the program expansion.

One of the first measures to pass the Republican-controlled Congress in 1995 was a bill to limit unfunded mandates. The 1995 law provided that any proposed bill is out of order if it will cost state and local governments more than \$50 million. The provision can be overruled with a majority vote. Mandates in place in 1995 were not affected by the law. Though clearly a step forward, in the opinion of many state and local officials, the law does not guarantee that unfunded federal mandates will end; in fact, as many as two-thirds of the major mandates that Congress imposes on states are exempt from the law. Also, one assessment of the early implementation of the measure found that passage of significant new mandates and preemptions continued. In fact,

state and local governments' biggest success may have been in changing how the mandates were to be implemented rather than whether they should be enacted (Posner 1997).

Perhaps one of the most contentious intergovernmental regulatory areas in which state cooperation is essential is environmental protection. In the 1970s and 1980s, the federal approach to environmental protection could be characterized as "command and control." Congress and the EPA set standards and expected states to meet certain goals and undertake certain activities. More recently, the EPA has worked cooperatively with states, often by providing incentives. One example of this "easing" of federal oversight is the federal policy on underground storage tanks. The potential problem of leakage from tanks containing petroleum products or other hazardous substances emerged in the mid-1980s. In 1984, Congress amended the Resource Conservation and Recovery Act (RCRA) to require the EPA to establish a regulatory scheme that helps reduce the threat of these tanks to public health and safety. The EPA developed rules in 1988 requiring that the owners of all new and existing tanks must respond to any leaks, including remediation if necessary. The agency set a 10-year deadline for removal or upgrading of the underground storage tanks. When it became clear that these efforts were expensive (particularly remediation), Congress established a trust fund to be used to reduce the economic hardship of compliance. As part of the regulations associated with this trust fund, the EPA offered states the option to set up their own underground storage programs, including the ability to disburse funds. To be recognized by the EPA, state programs must set up state remediation funds and meet the agency's financial responsibility requirements. Half the states have set up EPA-recognized programs, and almost every state has established some type of fund for underground storage tanks (Berrens et al. 1999).

The story does not end there, however. In 2000, the EPA began to issue fines against businesses and organizations for failing to meet the 1998 deadline for removal or upgrading of tanks. However, as had become clear, state enforcement of the federal regulations was not uniform. More than 85 percent of the storage tanks were in compliance, but in some states the rates were much lower. For example, Ohio reported that only 16 percent of its tanks had been fully upgraded. Texas failed to report any data to the federal agency. The fault may not lie fully with the states, however. The federal Leaking Underground Storage Tank Trust Fund, funded by taxes on petroleum companies, contained \$1.3 billion in 2000, but federal law allowed the EPA to draw only \$70 million a year from the fund—roughly the amount earned annually in interest. The money is used to clean up spills rather than enforce current regulations.

Congress has refused access to the remaining trust funds, which have been used as part of the effort to reduce the federal deficit (Zielbauer 2000).

In the 1990s there were other examples of new, more cooperative forms of federal-state relationships. The EPA launched the National Environmental Performance Partnership System (NEPPS) in the mid-1990s specifically to improve relationships with the states. It gives states with strong environmental programs more flexibility and allows the EPA to give more attention to weaker state programs. One aspect of the NEPPS is performance partnership agreements, which allow states to combine funds from one or more categorical grants to address a specific state environmental priority. Another innovation, called Project XL (excellence and leadership), kicks in when a plant wants to expand or relocate. The EPA works with states and localities to give that plant the needed flexibility while ensuring environmental protection goals (Kraft and Scheberle 1998). These efforts may be small steps—and may not be entirely successful—but they do represent a recognition of the need for federal-state cooperation in an area where regulation may not be the only answer.

In recent years, a new wrinkle in federal grants has emerged—the tying of federal grant dollars to specific performance standards or outcomes. The TANF block grant, enacted in 1996, required states to increase the proportion of adult TANF recipients who were engaged in “work-related activities.” If states failed to meet this performance standard, their block grants were cut. Other performance measures relating to out-of-wedlock births and job retention rates provided bonuses for states that were the most successful at lowering birth rates and boosting job retention (Gais and Fossett 2005). The No Child Left Behind law set similar performance standards in the education area.

Political scientists have long recognized that states respond to incentives such as federal matching grants or funds to establish a program or office. While states complain about mandates, there is some evidence that they do respond to them—in fact, more so than to incentives. Sometimes lesser approaches also work. The federal government can “signal” to states to act through messages and instructions. HCFA/CMS officials were often very engaged with their state counterparts to instruct them on legal ways of maximizing Medicaid access and even promising lenient treatment in the federal quality-control process for states’ mistakes in determining Food Stamp eligibility. Gais and Fossett (2005) reported that not all states responded to these efforts, but many did and enrollments rose quickly.

Federal officials can also signal to states by considering legislation in Washington but failing to enact it. For example, following Congress’s failure to enact a ban on late-term or “partial birth” abortions in 1996, half of the

state legislatures gave the issue serious consideration and many acted in 1997 (M. Allen, Pettus, and Haider-Markel 2004). Similarly, states enacted a series of regulations on managed care while Congress failed to enact such legislation in session after session. Another example where states have acted and Washington has not is another key area that highlights the importance of federalism: medical malpractice.

Although Republican ideology is typically more supportive of stronger states and a reduced federal government presence, ideology and politics often interfere with federalist beliefs. For example, although President George W. Bush came to the White House directly from the governor's mansion in Texas and, in his campaign, had argued for smaller government, he was strongly supportive of federal legislation to limit jury awards for pain and suffering in medical malpractice court cases. "It's a national problem that requires a national solution," he told a group of health care professionals (Stolberg 2002b, A16). Support for this position is especially noteworthy given that more than half of the 25 states with no damage caps have constitutional provisions that bar legislation limiting recoveries by plaintiffs in civil cases (Jost 2003). Supporters of federal malpractice laws say there are no problems with such preemption in an area where states have traditionally prevailed. They cite the federal government's primacy in interstate commerce as constitutional justification (Adams 2003a)—an assertion that might be challenged should federal law be enacted.

A second example of preemption, in a related area, during the George W. Bush administration concerned specific types of medical liability involving prescription drugs and medical devices. The Justice Department contended that consumers cannot recover damages for injuries from vaccines and medical devices approved by the FDA. While the administration initially said that FDA approval set the minimum standard and that states could provide "additional protection to consumers," in 2004 the Justice Department argued that FDA approval "set a ceiling as well as a floor"—preempting a state law or state court finding that a drug or device is unsafe (Pear 2004b).

Disregard for federalism issues cuts across party lines. In 2005, Democrats sponsored legislation in the Senate to "force" states to report the names of companies with 50 or more employees who received government-funded health care (namely Medicaid). The measure—designed to pressure Wal-Mart to improve employee health coverage—may be politically pleasing to federal legislators but flies in the face of federalism. In fact, Maryland enacted a bill that would have required Wal-Mart to spend more on employee health benefits. Similar bills were introduced in several other states (Joyce 2005).

Most observers of federalism would describe the U.S. model as nationally

dominant—that is, with the national government having assumed preemptive power. However, increasing state activism and institutional capacity has given support to the role of states as laboratories of democracy—in health and other policy areas. But the final arbiter of decisions related to which governmental level does what is the U.S. Supreme Court. Since the country's beginning, the Court's decisions have served to shape the contours of federalism and allocation of power.

The U.S. Supreme Court

By 5-4 majorities, the U.S. Supreme Court, beginning in 1992, began to reconsider the distribution of power between federal and state governments. In *New York v. United States* (1992), the Court resurrected the Tenth Amendment's residual powers clause to invalidate a provision of a federal law requiring states to "take title" to their low-level radioactive wastes. In a 1995 case, *United States v. Lopez*, the Court failed to buy the notion that a federal law banning the sale of firearms close to school grounds was justified under the interstate commerce clause. It was the first time in six decades that the Court found Congress exceeding its power under the interstate commerce provision. In *Seminole Tribe v. Florida* (1996), the Court defended the sovereign immunity of states by striking down a federal law that authorized private suits against states in federal court (the Eleventh Amendment states that the judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state). A 1999 ruling in *Alden v. Maine* extended state immunity from private suits to state courts.

Some observers view these developments with alarm, as indicating that the Court is committed to expanding state sovereignty at the expense of the federal government's policy-making and enforcement authority. However, others believe the decisions, while important, are more of an adjustment than a "sea change" (Brisbin 1998). Indeed, the Court did not always rule "in favor" of states. Several examples:

- In *Bush v. Gore* (2000), the Court found in a 5-4 vote that states may not, by later arbitrary and disparate treatment, value one person's vote over that of another, a decision that overruled the Florida Supreme Court and stopped a recount underway that might have resulted in a different president sitting in the Oval Office in 2001 (Savage 2001).

- In *Tennessee v. Lane* (2004), the Supreme Court upheld Congress's power to subject states to monetary liability under certain provisions of the Americans with Disabilities Act.
- In *Gonzales v. Raich* (2005), the Court ruled that marijuana consumption and cultivation was a matter of interstate commerce, and thus the "necessary and proper" clause authorizes regulation of that commerce even if there is also a purely intrastate noneconomic activity—overturning language in a California statute legalizing medical marijuana use.

What does this mean? It highlights the fact that the Supreme Court, much as the Founding Fathers desired, is the final arbiter of federalism. Sometimes the Court rules mostly in favor of Congress and the federal government, producing a strong national-level voice. Sometimes it rules in favor of states, providing a stronger balance of interest. There is some evidence that the Rehnquist Court rulings were designed in part to help balance federal and state interests. Justice Antonin Scalia, among others, has noted the duty of the Supreme Court to maintain "a healthy balance of power between the states and federal government" (Conlan and De Chantal 2001). It must be noted as well that most of the federalism rulings of the Rehnquist Court were 5-4—making the post-Rehnquist changes to the Court especially important to federalism scholars and students.

State Suits against the Federal Government

Over the country's history, the states have often utilized their ability to sue the federal government, but recently suits have been proliferating, particularly in environmental matters. (Education is also a popular area, with a few states suing over the No Child Left Behind legislation, which they see as an unfunded mandate.)

Three states (Connecticut, Maine, and Massachusetts) filed suit in federal court in 2003 claiming that the EPA had a mandatory duty to regulate carbon dioxide emissions, the first time states had sued the federal government over global warming. Later that year, 12 states, 14 environmental groups, New York City, and the City of Baltimore filed suit in an effort to force the EPA to regulate greenhouse gas emissions from new motor vehicles (Scheberle 2005). Also in 2003, attorneys general for 12 states, several citizens, and some environmental groups sued the EPA over a program that sets up a market for coal-fired plants so that polluters can purchase pollution allowances from plants that hold emissions below their cap. These plaintiffs argued that the

program—called cap and trade—can lead to more pollution in certain areas of a state and that mercury should be regulated through the application of state-of-the-art pollution control rather than trading (Morandi 2005).

UNDERSTANDING THE DIFFERENCES BETWEEN FEDERAL AND STATE GOVERNMENTS

The ways in which states differ from and resemble the federal government—and one another—affect their policy making in health and other areas. States are similar to the federal government in their organization, structure, and policy-making processes. They are different in three key areas: budget constraints, direct democracy, and media coverage.

State government is structured and run much like the federal government. Every state has a state constitution that contains a bill of rights and provisions setting forth the structure and function of the state and local governments. Every state has three branches of government, and 49 have two houses. Like Congress, state legislatures are organized by the dominant political party, and 49 states have bipartisan membership (only Nebraska is unicameral and non-partisan). Every state has a governor with duties roughly analogous to those of the president, including administering state government and initiating a policy agenda. Like the president, governors appoint members of a cabinet, although in some states several important cabinet positions are elected or appointed by commission. Every state has a judiciary that includes both trial and appellate levels.

The duties of the three branches of government are nearly identical at the federal and state levels. In both, the legislature passes laws, provides appropriations, and oversees the executive branch. Federal and state legislatures are organized by parties, use committees as key decision makers, and have nearly identical flow charts illustrating “how a bill becomes a law.” In both, the chief elected official of the executive branch sets the agenda, oversees the running of the government, and handles relationships outside the capitol. The judiciary at both levels of government determines the constitutionality of laws, adjudicates violations of law, and protects the well-being of individual citizens. Both levels of government are lobbied by interest groups and receive money from PACs. And, importantly, both types of government are sovereign and operate by virtue of the power of the people. Each citizen is subject to at least two governments, under which some rights are identical and some are very different.

States and the federal government differ in their revenue sources and their spending priorities. The big spending area for states has traditionally been education (both kindergarten through twelfth grade [K-12] and higher education). However, in recent years, Medicaid has nearly overtaken K-12 spending nationally and has exceeded it in many states. Across the nation in fiscal year 2003, elementary and secondary education accounted for 21.7 percent of state spending; Medicaid, 21.4 percent. Higher education makes up nearly 11 percent of state budgets; transportation, 8.2 percent; corrections, 3.5 percent; and public assistance, 2.2 percent (National Association of State Budget Officers [NASBO] 2004).

Both states and the national government use the income tax as a major source of revenue. For the states, however, it is one of several lucrative taxes and is second to the sales tax in its revenue generation. Sales taxes (both general taxes and taxes on specific items such as gasoline, cigarettes, and liquor) make up around one-third of a state's tax revenue; individual income taxes account for 37 percent. The states also obtain substantial revenues from corporate income taxes, lotteries, motor vehicle and operators' licenses, and gift and estate taxes (NASBO 2004). The federal government relies overwhelmingly on the income tax, which accounts for nearly two-thirds of the total revenue (OMB 2000).

Balancing the State Budget

One of the important things to understand about states is that, unlike Washington, D.C., states cannot operate in a deficit. In 49 states, by constitution or statute, the state budget must be balanced at the end of each fiscal year (only Vermont allows a deficit by law, and it discourages it by custom). Unlike the federal government, states have capital budgets for financing infrastructure projects such as roads and buildings. States also have many special accounts, often funded with earmarked taxes, which are not subject to the limitations and have semiautonomous agencies that can use their own borrowing authority. Most states are prohibited from borrowing money for operating expenses such as payrolls or benefit checks. This provision has caused difficulty for many states, particularly in times of economic downturn, but it has also forced them to make tough choices much earlier than do their Washington counterparts and to stay within limited resources in meeting their citizens' needs. If, midway through a fiscal year, state officials realize that the budget will not be balanced (that is, spending is exceeding expected revenues), they

must either cut an existing program or enact a tax. (There are, of course, some stopgap measures such as delaying a payment to state employees and welfare recipients, but these delays usually raise little money and are often unpopular.) Having to choose between program cuts or tax increases is not popular, and legislators prefer to make careful choices in the initial budget to avoid getting into this unwelcome situation.

States can and do enter a new fiscal year with a budget surplus, but for political reasons, officials are generally careful not to carry over too much money—the media and citizens will demand tax cuts, even though surpluses can be useful in tiding over the state in future years. To avoid some of the “feast or famine” choices facing them, most states have established “rainy day” funds: a certain small proportion of state revenues set aside in good economic times to help fund possible shortfalls in tighter economic times.

Finally, 28 states operate under some form of state tax or expenditure limit (TEL). Following the passage of Proposition 13 in California in 1976, which limited the growth in state property taxes, a number of states adopted similar tax or spending limits. For example, Michigan’s TEL, adopted in 1978, limits state revenues to 9.49 percent of the prior year’s personal income. Recently, there has been a second wave of state TELs, prompted in large measure by national antitax groups such as the Americans for Tax Reform. These TELs not only limit tax collection and spending (or both) but often also include supermajority requirements (no tax or spending legislation may be enacted unless there is a greater than 50 percent majority in the legislature) and voter approval requirements (voters must approve all new or increased taxes). Table 5.3 shows the mixture of TELs in the states. While most are constitutional, many are in statute. Spending limitations are much more common than tax limitations. Eleven states with TELs require approval by a supermajority (usually two-thirds or three-fourths) of the legislature to raise taxes. South Dakota has no TEL but does require a two-thirds vote of the legislature to raise taxes. A few states require public approval as well. In Colorado, all tax increases must be approved by a vote of the people (NASBO 2002). TELs constrain legislators’ choices (as they are intended to do) and are not applied to the U.S. Congress.

Direct Democracy

Democracy is much more direct in many states than at the national level. In some states, citizens can initiate, endorse, or recall a law or elected official.

Table 5.3
States with Tax or Expenditures Limitations

State	Constitution	Statute	Tax	Spending	Supermajority
Alaska	X			X	
Arizona	X			X	X
Arkansas	X		X		X*
California	X			X	X
Colorado	X	X	X	X	
Connecticut	X			X	
Delaware	X			X	X
Florida	X		X		X
Hawaii	X			X	X ^F
Idaho		X		X	
Iowa		X		X	
Louisiana	X	X	X	X	X
Massachusetts		X	X		
Michigan	X		X		
Mississippi		X		X	X
Missouri	X		X		
Montana		X		X	
Nevada		X		X	X
New Jersey		X		X	
North Carolina		X		X	
Oklahoma	X			X	X
Oregon		X		X	
Rhode Island	X			X	
South Carolina	X			X	
Tennessee	X			X	
Texas	X			X	
Utah		X		X	
Washington		X		X	
Total	17	13	7	23	11

Source: National Association of State Budget Officers 2002.

Note: *Supermajority* indicates a supermajority of votes in legislature required for any revenue increase.

* This applies only to taxes in existence in 1934 (not the sales tax).

^F Two thirds of elected members are required if the general fund expenditure ceiling is exceeded; otherwise a majority of elected members is required.

In more than half the states, the people play a key role in ratifying or proposing legislation. Eighteen states have an initiative process that offers voters the ability to propose constitutional amendments (constitutional initiatives) (table 5.4). In 21 states, voters can propose statutory initiatives—those that place the measure in law, not the state constitution. Fourteen states offer both constitutional and statutory initiatives. Twenty-four states use the popular referendum, whereby citizens can petition for a vote on statutes or ordinances that the legislature has passed and can, if they so vote, reject them. An example of the use of the popular referendum took place in November 2004 when California citizens petitioned to vote on a 2003 law setting up a pay-or-play type of health insurance system. Under the law, businesses with 50 or more employees would provide their workers with access to insurance (paying 80 percent of the premium) or pay into a state fund. The measure failed to get a majority vote (by 49-51 percent) and was not implemented. Eighteen states have a recall provision that allows voters to remove an elected state official from office. Together, the three mechanisms—initiative, referendum, and recall—are referred to as direct democracy.

Table 5.4
States with Constitutional and/or Statutory Initiative Processes

States with constitutional initiatives

Arizona	Massachusetts*	Nevada
Arkansas	Michigan	North Dakota
California	Mississippi*	Ohio
Colorado	Missouri*	Oklahoma
Florida	Montana	Oregon
Illinois	Nebraska	South Dakota

States with statutory initiatives

Alaska*	Massachusetts*	Ohio*
Arizona	Michigan*	Oklahoma
Arkansas	Missouri	Oregon
California	Montana	South Dakota
Colorado	Nebraska	Utah*
Idaho	Nevada*	Washington*
Maine*	North Dakota	Wyoming*

Source: Initiative and Referendum Institute 2005.

*These states use an indirect method whereby, after the signatures are collected, the proposal goes to the legislature for consideration before the amendment can be placed on the ballot.

Direct democracy produces a type of accountability and responsiveness unmatched in Washington, D.C. It allows citizens to organize to support or fight an issue or person. Legislators and governors (and local officials) are aware of the latent power of the initiative, referendum, and recall and know they are accountable for individual decisions in a way a member of Congress is not. For example, in 1984, two Democratic members of the Michigan senate were recalled because they voted for a major tax increase (to balance a badly out-of-kilter, recession-affected state budget). Members of Congress might vote for a similar tax increase with the hope that two (or six) years hence voters will have forgotten the transgression or will wish to vote for them because of their positions on other issues.

Even if initiatives fail to garner the majority necessary for adoption, they may serve other purposes. The possibility of an initiative or referendum affects the kind of law proposed by the legislature. Unlike Congress, which has no public mechanism for citizens to express approval or disapproval of individual laws, a state legislator might see her long-sought law up for public approval, sometimes brought there by a petition-signing effort sponsored by interest groups defeated in the initial legislation. The possibility of such a reassessment, and of bringing up original bills, affects the design, strategy, and politics of state legislation, particularly in highly salient issue areas. Interest groups can send a message to legislators that the issue is important, and even if the initiative fails, it often lands on the legislative agenda following the election. Indeed, Elisabeth Gerber (1999) found that policies in states with initiatives more closely reflect voter preferences than do policies in states without and that this effect is greatest where access to the direct legislation process is easiest. It is also interesting to note that the initiative can be used to directly curb legislative behavior. Most term-limit provisions and TELs are put in place through initiatives, not legislation.

Direct democracy was the idea of populists at the end of the twentieth century who wanted to reduce corruption in legislatures by giving the people a direct voice. Ironically, some believe that this idealistic notion has led to what Gerber (1999) called a Populist Paradox, because it is special interests, particularly rich special interests, that benefit from the initiative process. However, Gerber found that economic interests do not necessarily benefit from initiating ballot measures (although they do better at stopping them). In contrast, citizens' groups do seem to benefit from having the initiative process available, much as the populists had thought. Citizens' groups are more successful than economic groups at getting new laws passed by initiative.

Initiatives are very popular in states and are increasingly used for major

environmental and health issues. Toxic cleanup, nuclear waste, gun control, AIDS related issues, medicinal marijuana, Medicaid spending for abortions, health insurance reforms (including a single-payer system), and right-to-die laws—all have appeared on the ballot in states across the country. Citizens' groups tend to initiate and support environmental measures, whereas health measures are often launched by economic and professional interests. One example was a California initiative in 2004 to establish a new state entity to conduct research on human embryonic stem cells, estimated to cost \$6 billion over thirty years (Krane and Koenig 2005). Also in 2004, voters in 10 states enacted constitutional amendments to ban same-sex marriage, and Montana became the tenth state to legalize marijuana for medical purposes. In that same election, California voters expanded mental health services and programs by adding a 1 percent tax increase for those with incomes over \$1 million.

State voters in 18 states also have the option to recall their governors, state legislators, and other statewide officers. In 2002, less than one year after reelecting Gray Davis to a second term, voters in California succeeded in recalling Davis and replacing him with former actor/bodybuilder Arnold Schwarzenegger. It was only the second time in U.S. history that a governor had been recalled.

The Press and the State Legislature

A major difference between most state legislatures and the U.S. Congress concerns media coverage. As discussed in chapter 1, members of Congress have become masters at manipulating the media by making clever pronouncements in 30-second sound bites and writing press releases and editorials that are often used verbatim in hometown newspapers. News coverage, especially local coverage, is widely available and highly useful to members of Congress. Press secretaries are important staffers, often highly influential in both formulating and packaging legislators' policy positions.

In states, the media coverage and press staffing are markedly different. Relatively few reporters cover the state capitol, and what coverage there is tends to be focused on the governor and a few legislative leaders and to highlight partisan bickering and embarrassing or ridiculous situations. Most state legislators do not have much access to public relations staffs, and even those who do are often unsuccessful in their efforts to make the six o'clock news. In "professional" state legislatures, press functions are often handled by party

caucus staffs. Recently, however, several Michigan senators hired their own press secretaries—a movement noted with alarm by some observers. News directors and city editors often view state politics as dull and unappealing to viewers and readers. There are few exciting “photo opportunities,” and the issues are often complex and not easily explained in a sound bite. Further, most state capitals are small towns relatively remote from the state’s largest media centers. Thus, Albany, Sacramento, Lansing, Tallahassee, and Springfield may seem unimportant to the lives of the media—and the people they serve. Television coverage of state government is especially poor. Layton and Walton (1998, 45) called television reporters in state capitols “an endangered species, rarely glimpsed except for a major speech or press conference.”

In 1998, 513 newspaper reporters and 113 wire service reporters were covering state capitols full time, ranging from 44 newspaper reporters in California to none in Alaska. Ironically, the number of reporters covering state government in a time of devolution has fallen. The Project on the State of the American Newspaper found that in 27 state capitols, there are fewer reporters today than in the early 1990s. In 7 of the 10 largest states, the number of reporters covering state government dropped over this period (Layton and Walton 1998). The simple fact is that state political coverage is considered dull, and it does not fare well in broadcasters’ periodic “sweeps,” which determine advertising rates and assess the popularity of shows and news coverage. As Karl Kurtz (1990, 10) put it, “Television doesn’t cover legislatures because people are not interested in state government.” But, he suggested, people are not interested in state government because television does not cover it well. One exception to the rather abysmal press coverage is that provided by public television. Several public television stations present regular legislative coverage, and some have gavel-to-gavel coverage similar to the popular C-Span coverage of Congress and other events in Washington, D.C. Other states now cover legislative proceedings on government cable channels.

This overall lack of media attention allows state policy making to take place in a setting without widespread public input and press coverage. The process is more closed and dominated more by those with special interests and concerns than in Washington, not because of any real intent or differences in state legislative rules or procedures but rather because of the media coverage, or lack thereof. As one North Carolina legislator put it, “One of the first things I was told when I came to Raleigh was, ‘You can vote any way you want to up here because the folks back home will never know’” (Layton and Walton 1998, 54).

INTERSTATE DIFFERENCES

The similarities among the states are legion and unmistakable. A transplant from Rhode Island walking into the North Carolina state capitol would have little difficulty finding his way around or understanding the process, language, and operation of the legislative body. (Only in Nebraska would a visitor be confused: it has the country's only unicameral legislature.) Similarly, governors' offices, executive branch agencies, and lobbies operate in roughly the same manner across the 50 states. However, it would be a mistake to think that state legislatures are identical from Maine to New Mexico. They differ in many ways, especially in what is known as their "professionalism."

Every state in the country modernized to some extent in the 1970s, adding staff, increasing time in session, adopting procedures to expedite and streamline the legislative process, increasing salaries, and adding technology that links legislators to one another, to state agencies, and to the public. Many states reduced the size of their legislative institutions as a way to have more efficient organization and effective policy making. Reducing the size of the legislative body has an effect on the number of citizens represented per member, especially in large states. For example, the average member of the California assembly represents 423,396 constituents. At the other extreme, the average New Hampshire house member represents only 3,089 persons. The range in state senates is similar. A California senator represents, on average, 846,791 persons; a North Dakota senator must report to 13,106 (A. Rosenthal 2004). Is this fair? Certainly citizens of North Dakota and New Hampshire are more likely to know their representatives and participate more easily in the legislative process. For California and other large states trying to hold down the size of their legislative institutions so as to facilitate collective action decisions, there is a tradeoff between efficiency and representation.

Not every state made the same level of progress in modernization. Eight states can be referred to as professional—those with many specialized and personal staff, with relatively generous levels of compensation, and in session nearly full-time. At the other end of the spectrum are 17 nonprofessional, or citizen, legislatures, which have few staff, low pay, and limited sessions. Twenty-five states are hybrids, having some of the characteristics of each (K. Kurtz 1989).

Table 5.5 shows the range of professionalization of state legislatures, characterized by time in session, legislative salaries, and expenditures for staff services and operations. The level of professionalization reflects how closely

each state legislature approximates Congress in the three areas. The measure used for each state is the mean of the percentage of the congressional standard the state achieves for each of the three areas (time, salaries, and staff spending). The table illustrates the enormous diversity of the states in their professionalization. California, the most professional state legislature, has a professionalization level of 90 percent (that is, 90 percent of that of Congress). At the other extreme, New Hampshire's legislature has a professionalization level of only 6 percent (King 2000). The mean level for all states is 26 percent. Also noteworthy is the big gap between the most professional state—California—and the other professional states (the professionalization

Table 5.5

State Levels of Professionalization (as percent) Compared with That of the U.S. Congress

≥50 Percent		30–49 Percent		20–29 Percent		10–19 Percent		<10 Percent	
California	90	Alaska	45	Arizona	28	Delaware	19	New Mexico	9
New York	66	Ohio	43	North Carolina	28	Indiana	19	Wyoming	7
Michigan	50	Pennsylvania	40	Oklahoma	28	Rhode Island	19	New Hampshire	6
		Illinois	38	Vermont	28	Kansas	18		
		New Jersey	37	Colorado	27	Tennessee	18		
		Florida	35	Maryland	27	Idaho	17		
		Massachusetts	33	Minnesota	25	Kentucky	17		
		Wisconsin	33	Louisiana	25	Maine	16		
		Hawaii	32	Nebraska	25	West Virginia	16		
		Connecticut	32	Oregon	25	Arkansas	15		
		Missouri	30	Virginia	24	Montana	15		
		Washington	30	Iowa	24	Alabama	14		
				Texas	23	Georgia	14		
				Mississippi	22	South Dakota	11		
				South Carolina	21	North Dakota	10		
				Nevada	20	Utah	10		

Source: Data from King 2000.

level of the second-place state, New York, is only 66 percent). Clearly, state legislatures still retain their nonprofessional nature—at least compared with their national counterpart.

State legislatures also differ substantially in their levels of partisanship. Nebraska is the only state where legislators do not run on a party label. In other states, parties are important in identifying members to the electorate and in organizing legislative activities. The speaker or senate president is generally from the majority party, selected in caucus and then voted on by all members. But exceptions do occur—and more frequently than in the U.S. Congress. In 2005, a Democrat edged out a Republican for the top position (the speaker) in the Tennessee senate, even though Republicans held the majority of seats in the senate. The losing Republican candidate became majority leader in an unusual bipartisan leadership arrangement (Locker 2005).

Hawaii has long been one of the most Democratic legislatures, with only 5 of the 25 senators and 10 of the 51 house members Republicans in 2005. Massachusetts is also a strong Democratic stronghold, with only 6 of its 40 state senators in the Republican Party. At the other extreme, Idaho is highly Republican, with only 13 Democratic members in the 70-member house and 7 Democrats in the 35-member senate. In other states, parties are more competitive. The 2005 Colorado senate had 18 Democrats and 17 Republicans; the Tennessee senate had 16 Democrats and 17 Republicans. In many states, party control shifts with some regularity. In Michigan, for example, the lower house was controlled by the Democrats in 1991–92, was split evenly in 1993–94, was controlled by the Republicans in 1995–96, by the Democrats in 1997–98, and by Republicans again in 1999–2000. In contrast, some states have more stable party leadership. New York, for example, has had split party control for decades: the Republicans have controlled the senate for more than 35 years, and the Democrats have controlled the assembly for more than three decades (with one exception, in 1971–72).

In 2005, in 17 state legislatures, both houses were led by Democrats; in 21 states, both houses were led by Republicans. In 11 states, one house was controlled by one party and one by the other party (again, Nebraska has no political parties). When the party of the governor is factored in, only eight states had a full sweep of Democrats controlling the legislature and the governorship in 2005. Twelve states had Republican governors and Republican-controlled legislatures. The 2004 legislative elections produced ties in the lower house in Iowa and in the upper house in Montana.

A final difference among state legislatures, which has a large potential effect on state policy making, is term limits. Fifteen states now have term

limits on their state legislators. Not all term limits are the same. The toughest provisions, in place in Arizona, California, and Michigan, limit service in the lower house to six years and in the senate to eight years, with a lifetime ban on further service. Nine states have consecutive-term limits, meaning a legislator could serve the limit of terms in the senate, stay out for a term, then return and start the term-limits clock again. Louisiana's term limits allow 12 years in the house and 12 years in the senate and are consecutive (National Conference of State Legislatures [NCSL] 2005c). In six states, term limits have been repealed, most often by the state supreme court.

Term limits are expected to change legislative composition, behavior, and power balance. Supporters clearly wanted to get fresher ideas and to turn out legislators who had, perhaps, become too ingrained in the system and not responsive to the electorate. Although the effects of term limits are only just becoming evident (they go into effect in Louisiana only in 2007 and Nevada in 2010), there is little evidence that legislative composition is greatly changed. The number of women and minorities elected to the legislature has not changed substantially, and legislators tend to be similar in occupation, education, income, religion, and ideology to those they replace. Hispanics in California are one exception to this. Their number has increased since term limits. Somewhat unexpectedly, legislators elected under term limits seem less inclined to be concerned about district needs and more concerned with statewide issues (perhaps because they are looking forward to their next race). They report spending less time keeping in touch with constituents than do non-term-limited legislators. But as yet there are no differences in the ability of the newly elected legislators to build coalitions or specialize in issues. The greatest impact seems to be on power. In term-limited legislatures, governors and state agency officials now seem to be more powerful, party leadership less powerful (J. Carey, Niemi, and Powell 2000). Though some argue that interest groups are more powerful in term-limited legislatures, others note that lobbyists have to work harder for their keep in these legislatures. In Michigan, for example, in 1998, lobbyists had to quickly acquaint themselves with 65 new members (in a 110-member house).

Gubernatorial power, too, varies across the 50 states. Term limits are more prevalent in states' chief executive offices than in legislatures. The majority of governors have some type of term limit imposed on them; most can serve only two terms. Governors' formal powers—those outlined specifically in state constitutions or statutes—include the length of the term, possibility of serving multiple terms, role in shaping the state's budget, ability to appoint cabinet members, and ability to reorganize state agencies. Some governors

have relatively little formal power: limited to two terms, with few cabinet appointments and without the power to revamp the state bureaucracy unless they have legislative approval. For example, the governor of Texas does not present an executive budget to the legislature and cannot reorganize departments without legislative approvals. Other governors can serve many terms, have a large slate of possible appointments, and can make changes in state agencies with minimal legislative interference. Forty-three governors have the line-item veto, and 37 can reduce the budget without legislative approval. Fourteen governors can even veto selected words, and three can use a veto to change the meaning of words (NASBO 2002).

State judiciaries differ in how they are selected. States use three methods of choosing judges, and some states use a combination of methods (that is, one process for supreme court justices and another for lower trial judges). Many state judges are elected by the citizens, usually on nonpartisan tickets. In some states, judges are appointed by the legislature or the governor or both. Nearly half the states have adopted a modified merit approach, called the Missouri Plan, in which judges are initially appointed by the governor based on recommendations by a blue ribbon committee, then after a short period of time in service they must face the voters in an election.

State executive agencies also differ markedly, with some states having large professional bureaucracies dominated by civil service rules and others having fewer, more generalist officials who are not uniformly hired or protected by merit-based nonpartisan rules. State agencies in some states work closely with the legislature in drafting and producing legislation; agencies in other states might work in a more "arms-length" fashion, meeting only occasionally with legislative staff and others. Sparer (1996) found that differences in state agencies were key to understanding Medicaid programs in those states. In California, for example, officials implementing Medicaid enjoyed significant autonomy and were able to pursue the goal of cost containment. New York Medicaid officials, in contrast, operated in a fragmented, decentralized environment in which interest groups played an important role and agency goals played a secondary role.

Finally, the importance of lobbyists varies from state to state. Every state, like Washington, D.C., has seen the number of lobbyists increase over the past 20 years, and the style of lobbying and the effect of lobbying on the legislative product can vary considerably. In some states, interest groups are more influential than political parties in helping recruit and elect candidates as well as shape legislation. Especially in citizen legislatures, lobbyists serve to provide valuable information on both substance and political issues. Rules vary on

who is considered a lobbyist and to what extent lobbyists must report their activities. In Iowa, lobbyists must register which bills they intend to support or oppose. In many states, multi-client lobby firms are the norm—a handful of lobbyists serve dozens of corporate and association clients (A. Rosenthal 1993). In every state, economic and professional health interests are important policy players.

The variations in state process and policy are, of course, not random but depend on large differences in citizens' wealth and education, the state's businesses and industries, and state residents' expectations, ideology, and views of government. A large body of political science research has considered the role of political and economic factors and measures of "need" in state policy choice and found that all are important, but with differences across policy areas. The variables that successfully predict why states are generous in welfare or Medicaid payments or eligibility criteria are not necessarily good predictors of which state policies will be enacted on water pollution or education or health professions education. Political variables, particularly, seem to weigh more heavily in some kinds of policy choices than in others (Lambert and McGuire 1990; Mueller 1992; C. Weissert, Knott, and Stieber 1994).

Also important is the presence of a policy entrepreneur who sells an idea and continues to push it through innumerable hurdles and who has the standing to make things happen. Governors are often very effective policy entrepreneurs: they can put issues on the agenda, work with legislative leaders and interest groups to shape the plan, and obtain the public's backing for the plan. Governors of Massachusetts, Florida, and Vermont played an important entrepreneurial role in health care reform. In each of these instances, the governor led the reform effort after much of the groundwork had been laid by the legislature or the private sector (Paul-Sheehan 1998).

FEDERAL-STATE HEALTH PROGRAMS

The state role in health goes back to long before the New Deal. Social legislation, particularly programs protecting the public's health and assisting persons who are poor or disabled, was initiated in many states in the early years of the twentieth century. States and localities were the traditional source of health care for poor people until World War II. States provided the money to build hospitals and adopted scores of public health measures. State regulation of health providers goes back to before the United States was established. The first law licensing physicians was enacted in 1639 in Virginia. State mental

institutions trace their history to the early 1800s in Virginia and Kentucky; in the early 1950s, states began to establish departments of mental health. Following World War II, the federal role in health became more evident. Federal law permitted firms to deduct costs of employee health benefits, and in 1946 the Hill-Burton Act provided incentives for new hospitals and for care of the indigent (Rich and White 1996).

In the 1960s and 1970s, the federal government stepped up its spending in many health areas, including mental health, substance abuse, the environment, and public health. The biggest change in the national arena was the enactment of Medicare and Medicaid in 1965, which dramatically changed the nature of health care financing and services in the United States. Medicare and Medicaid put the federal government in the role of a major purchaser of health care and, as such, a shaper of the way in which care is delivered.

Medicaid

Medicaid is the premier federal-state health program. It is large, important, and controversial. In fiscal year 2005, Medicaid financed health care for 53 million low-income children, adults, seniors, and people with disabilities at a total cost of \$329 billion. Medicaid is not one program but several, providing for different groups of recipients:

- low-income, uninsured children, some parents, and low-income pregnant women;
- persons who are disabled, including those with mental illness, and low-income elderly;
- people too poor to pay the premiums and co-pays required for Medicare, the federal program for elders; and
- safety-net hospitals and community health centers that serve the poor.

Medicaid accounts for nearly one-third (31 percent) of all federal outlays in health and well over two-thirds of state health expenditures. The most troubling aspect of Medicaid is not its size but its rate of growth. As table 5.6 illustrates, the program grew by more than \$100 billion over the first years of the new millennium. No wonder Medicaid is viewed as an 800-pound gorilla or a monster by state and federal officials trying to control the program.

Several aspects of the Medicaid program entail policy choices that affect costs. The first is the number of persons eligible for the program—it is an entitlement program, which means that all eligible persons are provided

Table 5.6
Medicaid Spending (billions of dollars), 1970–2004

	Total	Federal	State
1970	5.3	2.9	2.5
1980	26.1	14.5	11.6
1985	41.3	22.8	18.4
1990	75.4	42.7	32.7
1995	156.0	89.1	66.9
2000	207.0	117.9	89.1
2004	309.0	176.2	132.8

Sources: OMB 2005; National Association of State Budget Officers 2004.

for under the program. Also important is the scope and level of recipients' benefits. A third important component is the level of payment to providers of the health care service. There is a substantial federal match in Medicaid, ranging from 50 percent for Connecticut, New Jersey, and 10 other states to 77 percent for Mississippi.

Federal law requires that certain groups of persons be covered and certain services provided to them. However, states can expand eligibility to include persons who are "medically needy." In the early 1990s, the federal government mandated expanding the Medicaid program to cover all children up to age 6 in families with incomes between 100 and 133 percent of the federal poverty level and children aged 6 to 15 in families earning up to 100 percent of the federal poverty level. All children on Medicaid get early and periodic screening, diagnosis, and treatment (EPSDT) services, and most Medicaid-eligible children also receive vision, hearing, and dental screening services. When states must reduce Medicaid, they can reduce eligibility for near-poor children and near-poor pregnant women and eliminate or reduce their programs for the medically needy.

Enrollments are cyclical and increase with a poor economy. In the early years of this century, enrollments of nondisabled adults and children in Medicaid rose by around 10 percent a year, while enrollments for people who are aged or disabled rose by around 3 percent a year. The larger increase in enrolled families likely reflects the national decline over that time in the number of individuals covered by employer-sponsored insurance (Kaiser Family Foundation 2005b).

It is also important to understand the distribution of enrollees and their relationship to costs in Medicaid. Children make up nearly 50 percent of those

enrolled in Medicaid nationally but account for only 16 percent of Medicaid spending. In contrast, the elderly make up 11 percent of enrollees and account for nearly 30 percent of spending; people who are blind or disabled, 15 percent of enrollees and 40 percent of spending. Both the elderly and persons who are blind or disabled use long-term care services paid for by Medicaid. Nationally, Medicaid covers around 40 percent of all costs for long-term care and covers the care of more than half of all elderly nursing home residents. Demographic trends, including the aging of the baby boom generation, are troublesome to the Medicaid program. The CBO projects that long-term care expenditures for seniors could rise from \$195 billion in 2000 (2.1 percent of GDP) to \$760 billion in 2040 (about 3.3 percent of GDP) (Holtz-Eakin 2005).

Federal law requires that certain health services be provided to recipients, and states can offer a number of additional services from a list of optional services provided in federal law. During times of state fiscal stress, states limit these optional services, such as dental care, podiatry, chiropractic services, eyeglasses, hearing aids, hospice services, non-emergency use of emergency rooms, and prescription drugs.

States have flexibility in determining the reimbursement policies for most providers. Federal rules set forth administrative requirements in such areas as the designation of a state plan, provider certification, timeliness of provider payments, and quality control. States must also pay the Medicare co-payments of poor elderly who are dually eligible for both Medicare and Medicaid. Until recently, eligibility for Medicaid was tied to two welfare programs: Aid to Families with Dependent Children and Supplemental Security Income. To be eligible, persons had to meet the requirements of cash assistance: age, blindness, disability, or membership in a family with dependent children. In 1996, the AFDC linkage was completely severed, with passage of the Personal Responsibility and Work Opportunity Reconciliation Act, which replaced the AFDC entitlement program with the TANF block grant. Under TANF, recipients are required to work, and TANF dollars often go into programs that help recipients find work, rather than providing direct subsidies. Former TANF recipients who find work are eligible for transition services under Medicaid.

A 1997 federal law (the Balanced Budget Act) gave states more flexibility in negotiating reimbursement rates for health providers; this was achieved by repeal of the Boren Amendment, which required states to reimburse hospitals and nursing homes at rates that were reasonable and adequate to meet the essential costs of efficiently and economically operated facilities. In a move typical of the give-and-take of federalism, the BBA also contained several

mandates that "cost" the states more. The law restored Medicaid coverage for certain immigrants who lost their eligibility under PRWORA and increased the Medicare Part B premiums that states pay for low-income beneficiaries (Tannenwald 1998). In tight state budgets, states often freeze or cut reimbursement rates for physicians, pharmacies, hospitals, and managed care plans.

Medicaid not only provides funding for qualified individuals, it is also an important contributor to public hospitals that provide care to poor and near-poor persons. Medicaid is the largest source of support for both public hospitals and community health centers. In 2002, Medicaid accounted for 37 percent of revenues to public hospitals, which account for only about 4.3 percent of admissions nationwide but are responsible for 24 percent of uncompensated care provided by the hospital industry. State and local funding provides 15 percent of revenues for these hospitals. The Medicaid assistance comes primarily from Medicaid disproportionate share hospital (DSH) payments, designed to offset losses that hospitals experience from treating Medicaid and uninsured patients. Another source of funding is the Medicaid upper payment limit (UPL), which allows states to pay categories of providers as a group up to the "upper limit" of what Medicare would pay for those services. Both DSH and UPL have come under federal scrutiny and have been the object of Congressional action to curb their use by closing loopholes that allowed states to draw down extra federal funding with minimum state matching (Regenstein and Huang 2005).

Over the years, states have adopted a variety of innovations and administrative improvements in the Medicaid program, such as prior authorization (used primarily for prescription drugs—the physician does not have to obtain the state's permission to prescribe a particular drug), Medicaid Management Information Systems, provider profiles (the state examines physicians' practice patterns to identify any outliers on high-cost procedures such as surgeries), and computerized billing. Some states have established successful programs to control hospital costs, including rate setting based on prospective payment. In the 1990s, the states moved thousands of Medicaid recipients into full-risk managed care arrangements—far ahead of the progress in enrolling Medicare patients in these entities. States, led by Arizona, are also adopting managed care arrangements for the elderly. A provision in the Medicare Modernization Act supports creation of "special needs plans" or managed care plans for specific groups. Maryland has developed a special managed care plan for those who are dually eligible for Medicare and Medicaid, and other states are expected to develop other specialized plans (Foxhall 2005).

Medicaid Waivers

One way states have been able to innovate within the strictures of the federal guidelines on Medicaid is through Medicaid waivers. States can apply for a waiver for certain federal requirements to allow them to more efficiently operate the program. A key component of the waiver is a budget neutrality rule. Program spending under the waiver cannot exceed what it would have been before the waiver.

Several federal program waivers for Medicaid requirements are available to states:

- Section 1915(b) freedom-of-choice waivers allow states to waive statewide-ness, comparability of services, and freedom-of-choice provisions of the law. Many states have used this waiver to enroll beneficiaries in managed care programs, although a 1997 law allowed states to accomplish this via a state plan amendment. Others have used it to carve out a system for special populations or create programs that are not available statewide.
- Section 1915(c) home and community-based services waivers allow states to cover home and community-based services as an alternative to providing long-term care in institutional settings.
- Section 1115 research and demonstration waivers are more comprehensive, enabling states to deviate from standard Medicaid requirements to try out new approaches.

In the 1990s, states used these waivers, especially the broader Section 1115 waiver, to extend Medicaid coverage to previously uninsured groups, to expand the package of medical benefits available to program beneficiaries, and to mandate the enrollment of Medicaid recipients in managed care plans. The most famous pre-1990 waiver was the Arizona Health Care Cost Containment System (AHCCCS), a statewide managed care network, set up in 1982 to use the bidding process to select providers. For the first few years, AHCCCS delivered only acute care; in the early 1990s, it expanded to cover long-term care, home health care, and mental health care. In the mid-1990s, most Section 1115 waivers emphasized managed care.

Oregon used the Section 1115 waiver to provide a new system whereby all of its poor citizens would be provided with a set of health care benefits. Tennessee used the Section 1115 waiver to expand Medicaid to all poor persons in the state. In 2002, Utah used a 1115 waiver to launch its Primary Care Network. The state began to provide primary care to adults between the ages of 19 and 64, with or without children, who have not had health coverage for six months or more and who have annual family incomes of less than 150 percent of the

federal poverty level. In order to expand coverage for this population, some services for Medicaid recipients were curtailed or eliminated, including hearing, vision, and dental services, non-emergency transportation, and mental health services. Newly covered recipients of Utah's program pay an annual enrollment fee as well as co-payments (AcademyHealth 2003).

A special subset of 1115 waivers is a pharmacy plus demonstration, which allows states to provide prescription coverage to individuals not eligible for Medicaid whose income is at or below 200 percent of the federal poverty level.

In 2002, a new type of waiver was launched to help reach uninsured populations. Health Insurance Flexibility and Accountability (HIFA) waivers enable states to access their unused S-CHIP allotments, increase cost sharing, and establish enrollment limits for S-CHIP and Medicaid. HIFA also has enhanced states' ability to build on employer-based coverage in programs designed to cover the uninsured. Early use of the HIFA waiver was hampered by states' fiscal difficulties. For example, California officials delayed implementation of an approved HIFA waiver that would have extended coverage to 30,000 uninsured parents of children receiving Medicaid or S-CHIP (AcademyHealth 2003). Other states have used the waiver simply to help reduce rising costs by increasing cost sharing and limiting enrollment. Nevertheless, the waiver has led to some innovations, including New Mexico's program that offers a "commercial-like" benefit package marketed by employers for newly eligible adults. Oregon, Idaho, and Illinois are offering some recipients the choice of usual coverage or premium assistance, in which Medicaid and S-CHIP funds can help subsidize private plans (Artiga and Mann 2005).

Although the purpose of HIFA was to increase the number of persons served under Medicaid and S-CHIP, states, as noted, can also use the waiver to help control rising costs through enrollment constriction and imposition of premiums. One analysis of the program found that little expansion had occurred by 2005, in large part due to states' fiscal problems and the budget neutrality rules (Artiga and Mann 2005). When state revenues are less problematic, HIFA may again be used as a source of program expansion as well as streamlining.

Medicaid's Growing Costs

In the past decade, increases in Medicaid spending were a major problem for states. From 1990 to 2001, Medicaid spending grew at an annual rate of 11 percent; in the first three years of the new century, the growth rate averaged even higher—13 percent (Kaiser Family Foundation 2005b). Partly in an effort

to control costs, states enthusiastically adopted Medicaid managed care in the late 1990s. Growth in managed care coverage of Medicaid clients grew from 14 percent in 1994 to 61 percent in 2004 (CMS 2004). Also important to many state officials was the appeal of managed care as a "market solution" to dealing with health care delivery. For some states the change was accomplished swiftly. For example, Michigan's motto of "Fire, Ready, Aim" resulted in a program implemented statewide in only 18 months (C. Weissert and Goggin 2000). Other states, including Maryland, took the task more slowly. Still others, such as Kansas and West Virginia, had a difficult time launching any program given the dearth of managed care entities in those states.

Between 2002 and 2004, when many states were seeing greatly reduced revenues and tightened budgets, states tried to control Medicaid spending by raising eligibility standards, reducing benefits, and lowering provider payments. Many states also embraced disease management programs in Medicaid, whereby a state provides a case manager for those with specific chronic diseases such as asthma and diabetes. The idea is that a case manager will provide oversight and a treatment plan that will reduce expensive complications that require emergency care or hospital stays. Well over half of the states have adopted disease management as a component of their Medicaid program (AcademyHealth 2005).

Some states have targeted Medicaid spending for pharmaceutical drugs. Several have joined multistate purchasing cooperatives to increase their bargaining power for deeper discounts from pharmaceutical providers. States have set up preferred drugs lists, mandatory use of generic drugs, contracting with pharmacy benefit managers, quantity limitations, cost sharing, and prior authorization as mechanisms to hold down costs (W. Weissert and Miller 2005). A number of these states have been sued—often unsuccessfully—by PhRMA, the pharmaceutical industry's trade group, in an attempt to stop states' efforts to lower drug prices.

The huge program is a likely candidate for reform for states, given that it can consume as much as a quarter of the state budget. However, it is also important to remember that Medicaid spending is far from profligate. While Medicaid spending per enrollee grew at an annual rate of 6.1 percent between 2000 and 2003, after controlling for changes in demographics we find that this rate was lower than the annual rate of increase for Medicare (6.9 percent) and for private insurance (10.6 percent). During that period, premiums in private insurance rose by an average of 12.6 percent annually (Kaiser Family Foundation 2005b).

One study simulated the effects of covering privately insured individu-

als with Medicaid and covering Medicaid recipients with private insurance benefits. Hadley and Holahan (2003/2004) found that if low-income privately insured individuals were instead to receive Medicaid, their costs would be lower; and if Medicaid beneficiaries were instead covered by private insurance, their costs would be considerably higher. The researchers concluded that much of the difference in spending between Medicaid and private insurance is due to provider payment rates, which are much lower for Medicaid. Other studies have found that administrative costs are much lower for Medicaid than for HMOs and private insurance. Thus, Medicaid seems to be a good bargain—in spite of some political punditry that highlights its inefficiency and waste.

Florida has launched an effort to significantly reform Medicaid by turning it into a case-mix-adjusted vendor payment program, in which Medicaid recipients have allocations based on their health needs. Recipients can choose a plan from a “marketplace” of HMOs, preferred provider organizations, and new entities that offer clients a package of services that might differ significantly from one entity to another. One of the most interesting things about the Florida proposal is that it allows recipients to use their Medicaid payment to buy into their employer’s health insurance. A federal waiver is required for the program.

In 2005, Medicaid was the target of federal cuts as well. The president’s budget proposed establishing a new prescription drug price target for states and imposing penalties for individuals who transfer assets to become eligible for Medicaid long-term care. The president also called for \$10 billion in Medicaid cuts over five years. The cuts were included in the final budget resolution, along with a new Medicaid commission to identify those cuts and assess the long-term prospects for the program. The NGA has offered its own set of recommendations to improve state flexibility and produce more efficiencies, including use of reverse mortgages; more ability to ask for recipient cost sharing and to establish differing levels of benefits; individual and employer tax credits for health insurance; state purchasing pools; reinsurance pools, in which employers and other payers would be reimbursed by the federal government for part of the cost of employees’ catastrophic medical bills; and tax credits for long-term care insurance and long-term care partnerships, under which individuals who purchase private insurance and exhaust its coverage would be allowed to access Medicaid and still protect some of their assets. While states can come up with these innovations, it is difficult to put them in place without federal waivers, which can be a time-consuming and burdensome process (NGA 2005).

Medicaid is crucial to the country’s health safety-net system. It provides

care to the poorest and sickest citizens and props up the hospitals and clinics that serve those citizens. The states' role in Medicaid is pivotal—funding and, more importantly, defining the program and its parameters. The federalist nature of this program—its shared federal and state responsibilities—is both its strength and its weakness. It is a strength in that each state can meet the health needs of its poor population in the manner best suited to that state. It is also a strength in that states can innovate with the program in ways that can be replicated, if successful, by other states. The weakness is that states cannot spend beyond their means and thus must curtail the program when state revenues are reduced. This leads to a program that undergoes cycles of expansion and restructuring that result in uncertainty for recipients and providers alike. Ironically, program needs increase in times of national or regional economic difficulties—the very times when state coffers are also adversely affected.

Children's Health Insurance Program

A second important federal-state health program emerged as part of the BBA in 1997: the State Children's Health Insurance Program. Congress appropriated \$24 billion over 5 fiscal years and \$40 billion over 10 years to enable states to expand health insurance to children whose families earn too much to qualify for Medicaid but too little to afford private health insurance. S-CHIP is a block grant that allocates money to states based on the number of uninsured low-income children, adjusted for the state's average cost of health care. Since fiscal year 2001, the formula has also taken into account the number of all low-income children, covered or not, residing in the state. The program's matching-fund arrangement (the state's contribution) is more generous to states than is Medicaid's: 70 percent of the Medicaid matching rate.

States have considerable leeway in designing their S-CHIP programs. Under the federal law, states can establish a new children's program, can fold the new program into their existing Medicaid programs, or do both. Some 23 states elected to expand Medicaid, 15 set up a separate S-CHIP program, and 18 both expanded Medicaid and set up a new S-CHIP program (GAO 2000). States set eligibility standards limited only by federal ceilings of children living in families with incomes below 200 percent of the federal poverty level. However, states must deal with provisions in the federal law that stipulate minimum benefits, impose maintenance-of-effort requirements, limit use of premiums and co-payments, and prohibit states from enrolling in S-CHIP any children who qualify for Medicaid.

For Congress, S-CHIP was a popular issue for which both Republicans and Democrats could take credit. Democrats had long supported federally funded coverage for children. The Republicans also viewed S-CHIP, along with welfare reform, as part of an ideological plan to devolve more authority to states. For the president, S-CHIP represented a step toward dealing with one segment of the uninsured population and as such can be viewed as a "legacy of the Clinton administration's failed Health Security Act of 1993" (Hegner 1998, 2). Ironically, S-CHIP was of greatest benefit to states that had not acted on their own to provide health care for poor children. Three states in particular—Vermont, Minnesota, and Washington—already had programs in place for children in families living at or below 200 percent of poverty. Some additional federal dollars were available for these states to further expand their programs, but the amounts were small and the states were reluctant to participate in the program (Hegner 1998).

Enrollment of children in S-CHIP was slow. In the first 18 months of the program, states used less than 20 percent of the S-CHIP allocation. States were criticized in some quarters for being slow in developing the program infrastructure, including a potent marketing strategy, but other observers noted that many children referred to S-CHIP were actually eligible for Medicaid (Schram and C. Weissert 1999). In the third and fourth years of the program, enrollments increased. Further, states with the lowest level of coverage before S-CHIP expanded their income eligibility thresholds the most during the first two years of implementation, and states with the largest percentages of low-income uninsured children increased their income eligibility thresholds to a greater degree than states with smaller percentages of uninsured children (Ullman, Hill, and Almeida 1999). Some states used S-CHIP to expand coverage to parents. For example, Wisconsin's BadgerCare covers both children and parents with family incomes too high for Medicaid and without access to group health insurance. By the end of the sixth year of the program, the national S-CHIP enrollment was four million children. Together with Medicaid, S-CHIP provides a critical safety net for poor and near-poor children.

Medicaid and S-CHIP, while important, are not the only health programs in states or the only area where innovations have occurred. In the 1980s, with rising concern for federal spending patterns and efforts to reduce federal grants and other program funding, states began to assume leadership in the area of public health, mental health, substance abuse, the environment, and health services delivery mechanisms and to offer innovative approaches to providing services while controlling costs. They continued that leadership into the new millennium.

Medicare Modernization Act

The 2003 Medicare Modernization Act contained some provisions that directly affect states. First and foremost, the law eliminated the federal provision that Medicaid is responsible for prescription drug coverage for dually eligible individuals—those who qualify for both Medicare and Medicaid—a group that uses drugs extensively. However, the law contains a “clawback” feature that requires states to repay the federal government 90 percent of what the state would have spent on drugs for this population if the state’s program as it was in 2003 had remained in place. (After 10 years, the percentage falls to 75 percent.) The provision causes two problems. First, it puts in place a new federal grant feature in which states actually send monthly checks to Washington—what one observer called a reverse block grant (Adams 2005b). The second problem is that the provision is more costly to those innovative states that acted to cut prescription drug costs after the baseline year of 2003. California is one of those states. The state will send back 90 percent of higher pre-reform costs—a move that will cost the state \$215 million more in 2007 than it would have cost without the MMA (Adams 2005b). Thus, ironically, states that were “pioneers” in reforming their Medicaid prescription drug costs might be punished the most, while states that had not acted will not be adversely affected (W. Weissert and Miller 2005). Some concerns have been raised about the constitutionality of the federal clawback, which might be viewed as “commandeering” state legislatures as revenue agents (Pear 2005a).

The law also requires states to help the federal government implement the new drug benefit, called Medicare Part D—a requirement without federal funding. States that operate state-only prescription drug programs must decide whether and how to coordinate their program with the new benefit. States worry that their negotiating power with drug companies for greater discounts will be harmed with the loss of the low-income dually eligible population from their program. States are also required under the MMA to work with the Social Security Administration to market to and recruit new participants in the federal program—an assignment not accompanied by special funding.

States benefited in the MMA from a new subsidy for employers (including states) that retain their current retiree drug benefits. Finally, the law created health savings accounts, which states may use as an option for covering state employees. Chapter 7 provides a more detailed analysis of this important new law.

Other Federal Assistance

The Health Resources and Services Administration offers state planning grants for states to launch programs to reduce their numbers of uninsured persons. The agency has provided both planning grants and pilot project grants to test new programs in one or more areas or for specific populations or to help implement a plan (AcademyHealth 2005, 18).

STATE INNOVATIONS IN HEALTH

Innovations in health and other key areas at the state level are very useful in that they can serve as test cases, working out problems and highlighting consequences before being implemented nationally. The use of the states as "laboratories of democracy" has a long history in the United States. The 1921 Sheppard-Towner Act, providing social and medical assistance to pregnant women and babies, was copied from a Connecticut law, and states provided models for the 1935 Social Security Act, the 1973 Supplemental Security Income programs, and dozens of health measures (Silver 1991). More recently, Medicare's DRG payment system was based on a program in New Jersey. S-CHIP was based on existing state programs, and federal patients' bill of rights legislation was patterned on state enactments. New York governor Nelson Rockefeller once noted that "those elements of the New Deal which failed were largely in areas *not* tested by prior experience at the state level" (Silver 1991, 445).

States have the resources, the infrastructure, and the desire to make health system changes that positively affect their citizens. Sometimes these changes are copied by other states and the policy "diffuses" throughout the nation. State efforts to regulate managed care organizations are one example. Over a period of three to five years, legislation on managed care was introduced in every state, and 40 states enacted new restrictions on managed care organizations (Hackey 2001).

A state can act to respond to issues and concerns in ways that might not be acceptable across all 50 states. Oregon's innovative Health Plan, which prioritized funding for health care by ranking medical services, is one example. Other examples are legalization of medical marijuana, legalization of assisted suicide, and laws requiring businesses to provide health insurance for their employees. While a handful of states adopted environmental standards in the direction of those proposed in the Kyoto Protocol, 16 states passed legislation

or resolutions urging against adoption of the protocol in the U.S. Senate (Rabe 2004). The point is that states are composed of citizens with differing preferences for health care, taxation, and other issues. State policymakers recognize those preferences and produce legislation that serves their constituencies. In so doing, they often act before, and offer guidance to, other states and the national government.

States often act when political difficulties prevent national action. A good example is state action in the 1990s on genetically modified food. Minnesota was the first state to institute strict regulations on genetically modified food in 1992. New York petitioned the FDA to establish a formal review process and require the labeling of genetically modified foods in 1994. By 1997, Wisconsin, Maine, Vermont, and Minnesota had laws requiring the labeling of genetically modified milk.

Finally, states can often act quickly when issues arise that engage or outrage constituencies. For example, in 2005, when it became known that many new cars contained computer chips that store information on speed and seat belt use, Maryland and seven other states introduced legislation to inform consumers that their cars had the chip, and some prohibited use of data from the chip in court cases, unless there is a court order (Associated Press 2005b).

In recent years, states have launched innovative programs to provide coverage for the working poor, to reform small-group health insurance and establish risk pools for those who find insurance difficult to obtain, to mandate community rating, to develop new ways of delivering services to Medicaid recipients and state employees, and more (table 5.7). While some of these programs are funded with only state funds, many are jointly funded with federal funds and made possible through waivers or grant programs designed to encourage innovation.

Coverage for the Near Poor

In the 1990s, several states expanded coverage for near-poor people or provided a type of Medicaid buy-in. Connecticut, Florida, Maine, Minnesota, New York, and Vermont initiated health care coverage for children in the early 1990s. Washington State and Maine expanded Medicaid coverage to some low-income people (GAO 1992). New York adopted a state-funded children's health insurance program in 1991. The program subsidized health insurance for children up to age 13 in families with incomes up to 185 percent of the federal poverty level. Families with higher incomes could buy into the

Table 5.7

Some State Innovative Health Policies, 1965–2005

1965	New York adopts certificate of need
1974	Hawaii passes state-mandated employer-sponsored insurance
	Rhode Island enacts catastrophic health insurance plan
1975	Indiana enacts comprehensive medical malpractice act
	Connecticut establishes risk pool for uninsured
1976	Maryland establishes all-payer system for hospitals
1977	New Mexico adopts right-to-die act
	New York adopts "nursing home without walls" program
1978	New Jersey extends rate setting to all payers and hospitals
1981	Oregon receives Medicaid home care community-based care waiver
1982	California enables preferred provider organizations to do business in the state
	Arizona launches capitated program for Medicaid
	New York develops uncompensated care pool for sharing hospital revenues
1983	Virginia adopts natural death law
	Oregon contracts with providers on prepaid capitation basis for Medicaid patients
1984	Florida taxes hospitals to supplement state match for Medicaid expansion
	New Jersey reimburses hospitals using diagnosis-related groups
	New York enacts mandatory seat belt law
1987	Washington makes basic health services available for low-income residents in five areas of state
1988	Massachusetts passes first pay-or-play employer mandate
	Kansas enacts broad employee wellness program
1989	Oregon enacts legislation establishing rationing system
	Rhode Island passes "bare bones" insurance plans for small businesses
	Arizona launches capitated long-term care program for elderly
1990	Maine establishes practice guidelines to reduce medical liability
	Maine introduces Resource-Based Relative Value Scale into Medicaid
	Connecticut enacts small-group insurance market reform
1991	Connecticut receives clearance for state-endorsed long-term care insurance
	New York phases in requirement that 50 percent of Medicaid (AFDC) recipients be in managed care
	New York enacts state-funded children's health insurance program
1992	Minnesota attempts universal coverage through integrated service networks
	Minnesota institutes strict regulations on genetically modified foods
	Vermont requires community-rated health insurance

Table 5.7 (cont.)

1993	Washington and Florida adopt managed competition programs
	Tennessee expands Medicaid program to cover categorically ineligible people above poverty
	Missouri passes medical savings account law
	New Jersey guarantees issue of health coverage for individuals, requiring small-group insurers to either participate in the individual market or help cover the losses of insurers who do
1994	Mississippi and Florida sue to recover state dollars spent on tobacco-related illness
	Oregon voters adopt assisted suicide measure
	Kentucky establishes statewide alliance based on public employees
	California and Maryland adopt bans on smoking in any enclosed space that is also a place of employment
1995	Maryland passes anti-dumping law for nursing home residents
1996	Rhode Island requires all health plans in the state to provide subscribers with consumers' guide
	Massachusetts issues profiles of physicians, including disciplinary actions and settlements, on the Internet
	California, by approving a popular initiative, legalizes medical marijuana
1997	Texas permits patients to sue their health plan for damages if they are injured by the plan's decision to deny coverage for medical treatment
1999	Pennsylvania enacts patients' bill of rights calling for providers and health plans to use sound medical principles, not financial incentives, as the basis for patient care
2000	California requires hospitals to meet fixed nurse-to-patient ratios
2001	New York establishes Healthy NY, designed to assist small business owners to provide health insurance to employees
	Florida develops preferred drug list under Medicaid
2003	Maine enacts law setting special goals and timelines for greenhouse gas reductions
	Maine launches plan to achieve universal coverage in six years
2004	Minnesota launches reimportation program for drugs from Canada, Minnesota RxConnect
	California, by initiative, adopts \$6 million stem cell research program
2005	Vermont files lawsuit against the FDA for failing to approve the state's proposal to establish a pilot program
	Florida launches major revamping of its Medicaid program by using health-adjusted vouchers

Sources: Data from *State Health Notes*, Intergovernmental Health Policy Project, various issues, updated with information from *AcademyHealth* 2003, 2005.

program. The New York program served as a model for the federal S-CHIP initiative (Brandon, Chaudry, and Sardell 2001).

One of the most daring and controversial attempts to cover the near poor was the establishment of TennCare, Tennessee's 1993 expansion of Medicaid to all uninsured residents of the state. The TennCare proposal is noteworthy for its genesis. It was put in place by the governor's executive order. Only minor changes, encompassing just one and a half pages of legislative language, were put into law. Though it dramatically increased access to health care in the state, covering 25 percent of the state's population, TennCare began as an effort to control Medicaid costs, which in 1993 accounted for more than 26 percent of the state budget. The choices, said the governor, were to raise taxes, slash medical benefits for poor people, or try something new. He proposed the third choice (Lemov 1994). The implementation of TennCare remained rocky and controversial for years. The state had to take over a large TennCare HMO and make major concessions to BlueCross BlueShield of Tennessee, which threatened to pull out of the program. The program was greatly underfunded. Finally, in 2005, the governor pulled the plug on most of the TennCare program, saying "TennCare was, and is, a wonderful dream" (AcademyHealth 2005, 10). The state dropped more than 300,000 adults from the program, transforming it from an innovative expansion to cover most of the state's uninsured to the more typical Medicaid program with eligibility tied to categories of illness or program qualification (Lemov 2005).

Other states have used Medicaid, S-CHIP, and state dollars to craft comprehensive programs. For example, in 2003 Maine adopted a comprehensive plan called Dirigo Health Reform (*dirigo* is Latin for "I lead"). Under Dirigo, the state increases access to health insurance for small-business employees, the self-employed, and individuals through expansion of S-CHIP and Medicaid and development of a public-private health plan for small businesses that encourages them to participate through lower rates. Individuals and the self-employed participate on a sliding-scale schedule (AcademyHealth 2005, 16). Funding comes from tobacco settlement funds, general revenues, and two new sources: contributions paid by employers and employees who enroll in the program, and an assessment on insurance revenues captured only when Dirigo's cost-containment efforts document reductions in health care costs. Its goal is to establish universal coverage in the state within six years.

Other states subsidize insurance for high-risk citizens, those working in small businesses, or those who are self-employed. Healthy New York provides standardized health insurance benefit packages, offered by all HMOs in the state. The packages are more affordable through state sponsorship so that more

small employers and individuals can purchase health insurance coverage. West Virginia created a public-private partnership between the West Virginia Public Employees Insurance Agency and state insurance companies to provide subsidized health care coverage for small businesses (AcademyHealth 2005).

Some states have alleviated some of the mandates on health insurance sold in the state as a way to make health insurance more affordable. By allowing minimum benefit plans, 12 states have taken this route, although there is little evidence that such laws have been effective in increasing enrollment (AcademyHealth 2005, 31).

Managing Managed Care

Beginning in the mid-1990s, states began to regulate managed care entities. The first wave of laws dealt with providers, including many state laws that limited managed care entities' ability to exclude health professions. Dubbed "any willing provider laws," these laws were unpopular with HMOs trying to hold down costs but were promoted by health professionals of all stripes. By 2000, every state had passed some type of consumer protection in managed care, such as outlawing "gag clauses" that prevented physicians from advising patients about medically necessary treatment options, ensuring access to emergency care and using a "prudent layperson" definition of emergency, allowing women to see their obstetrician-gynecologist without first consulting a primary care practitioner, setting standards for length of hospital stay for maternity and mastectomy patients, providing continuing care after termination of a provider contract, and offering a range of new types of information to enrollees and prospective enrollees.

The spread of managed care led to calls for more consumer protection, such as the right to appeal adverse decisions or to sue the managed care organization. Although several states passed laws allowing patients to sue their HMOs for malpractice, in 2004 the U.S. Supreme Court ruled that ERISA preempts these laws (*Aetna Health, Inc. v. Davila*). Other states published performance reports for HMOs operating in the state and developed physicians' profile systems that make information on disciplinary actions and malpractice judgments available to the public. Meanwhile, there is no federal law regulating managed care.

Prescription Drugs: Access, Cost, and Quality Issues

States are working to improve access, control costs, and ensure the quality of prescription drugs for their citizenry. The access issue has revolved around the poor elderly who do not qualify for Medicaid. Almost two-thirds of the states have adopted pharmaceutical assistance programs for low-income persons who are elderly or disabled and do not qualify for Medicaid. Most of these use state dollars to assist in the purchase of prescription drugs. Well over a dozen states achieve price reductions through pharmaceutical discounts and manufacturer rebates. Other states provide assistance to this group through multistate purchasing cooperatives, in which states join together to negotiate lower prices for drugs (W. Weissert and Miller 2005).

States' efforts to hold down the costs of prescription drugs in the Medicaid program were discussed earlier in this chapter. In addition, some states established or joined purchasing pools for prescription drugs for state employees. One of the earliest such pools, the Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP), allows states and cities to negotiate for manufacturers' rebates with bulk purchases. A newer version of pools has both negotiated rates and a single pharmacy benefit manager who facilitates drug choices, makes recommendations based on research syntheses, and implements state pharmacy policies. One such arrangement is the RxIS Coalition, involving Ohio, Delaware, Missouri, New Mexico, and West Virginia, which negotiates prescription drug discounts for state employees using a single PBM. Georgia set up an intrastate pool including Medicaid, state employees' insurance, and its state Board of Regents that uses a PBM to negotiate manufacturers' discounts (Krause 2005).

Some states sought permission from the federal government to buy drugs from Canada and other countries at prices below U.S. prices (they must seek permission because federal law prohibits the reimportation of prescription drugs manufactured in the United States by anyone other than the original manufacturers). All state requests were rejected. An HHS-appointed task force on prescription drug reimportation also recommended maintaining the current policy, based on "safety concerns" (W. Weissert and Miller 2005, 131). Several states pursued their importation strategies without federal approval. Several local governments have also established reimportation programs. In a preemptive move, in August 2004, Vermont filed a lawsuit against the FDA for failing to approve its proposal to establish a pilot program (W. Weissert and Miller 2005). In 2004, five states—Illinois, Wisconsin, Kansas, Missouri, and Vermont—formed SaveRx, a program to purchase drugs from Canada,

Britain, and Ireland. When the Canadian minister of health announced plans in 2005 to limit prescription exports to the United States, the states added Australia and New Zealand to their medication sources (Ruethling 2005).

Finally, quality is the primary concern of a new multistate cooperative effort led by Oregon, which reviews published medical and scientific evidence on drugs in a particular class and makes the findings available to state officials in the program. When no differences are found between more expensive and much cheaper drugs, state officials can use the information in updating their drug formularies for Medicaid, and sometimes for state employees (Pear and Dao 2004).

Tobacco Settlement

The states' settlement with the nation's cigarette manufacturers in 1999 was one of the most interesting intergovernmental health policy stories of the decade and provided funding for numerous public health initiatives across the country. The story begins with a courageous attorney general from Mississippi who launched a lawsuit against cigarette manufacturers in 1994 to recoup state Medicaid dollars spent on diseases and disabilities caused by smoking. Attorneys general in Texas, Florida, and Minnesota soon followed suit. The tobacco industry decided to settle out of court rather than allow the cases to go to trial. By 1997, one cigarette manufacturer, Liggett, had decided to settle with the states—now numbering more than 40; the company agreed to accept liability in exchange for immunity from further suits by states or individuals. Later that year, the attorneys general reached agreement with the tobacco industry on the regulation of cigarettes by the FDA, on restrictions on advertising, and on payment of \$369 billion over the next 25 years to compensate states for the costs of treating smoking-related illnesses, to finance antismoking campaigns, and to help finance health care for uninsured children. In exchange, the tobacco companies would be immune from future class-action suits and would not be liable for punitive damages for past misconduct. Because it involved a federal agency, the agreement had to be approved by Congress.

Congress proved to be a much more difficult battlefield for public health advocates. It simply could not come to closure on legislation implementing or modifying the initial agreement. In 1998, the attorneys general struck a new agreement with the tobacco industry—this time one that did not require congressional approval. Under this agreement, the 46 signatory states would

get \$206 billion over 25 years (4 states had settled out of court earlier). Also, the tobacco companies agreed to eliminate advertising on billboards and in sports arenas and to spend \$1.5 billion on an antismoking ad campaign. In return, the states promised not to sue the cigarette companies again. Money began flowing to states in 2000. While some antismoking proponents had hoped settlement dollars would flow to health programs, and specifically to antismoking programs, this has not happened.

Very few states are spending anywhere near 20 to 25 percent of the settlement proceeds on smoking prevention programs. When states have fiscal difficulties, it is especially easy to reduce funding for these programs and spend the settlement money on Medicaid, education, or a myriad of other ongoing needs. In a report assessing states' use of the settlement funds, the Campaign for Tobacco-Free Kids (2005) noted that only three states—Maine, Delaware, and Mississippi—funded smoking prevention programs at or above the minimum levels recommended by the CDC. Thirty-seven states are funding programs at less than half of the suggested minimum.

Medical Malpractice

One of the most politically contentious issues that have dogged states for decades is medical malpractice. Malpractice insurance rates for some physician specialties have risen enormously—in at least eight states, 30 percent between 2001 and 2002 for internal medicine, general surgery, and obstetrics-gynecology (Jost 2003)—and when this happens, the call for action goes out to state capitols. While the situation early in the twenty-first century is less dire than in the 1970s, when private insurers were driven out of the market, any increases in malpractice premiums become more pertinent when the increases are difficult to pass on to patients in HMOs and fee-limited Medicare and Medicaid. The question is, what to do about it. While physicians and insurance companies are convinced that the costs are directly associated with court settlements, the evidence is not in their corner. A GAO study (2003) concluded that rising malpractice premiums were the result of a variety of factors, including poor returns on investments of insurance companies.

Nevertheless, a number of states have dealt with the issue by capping malpractice non-economic settlements. Many states copied the 1976 California law putting a \$250,000 cap on non-economic damages, or those involving "pain and suffering." The law also limited attorneys' contingency fees, required large damage awards to be paid over time rather than immediately, and allowed

defendants to introduce evidence of insurance benefits received by plaintiffs. Interestingly, states are still modeling their laws on the 1976 California law, even though a later (1988) California measure dealing with insurance reform actually reduced costs more significantly.

But caps are not the only component of malpractice reform. States have also enacted insurance reforms, mediation procedures, and underwriting programs. In 2001–2, three states—West Virginia, Pennsylvania, and Nevada—adopted comprehensive medical malpractice reforms that dealt with tort and insurance issues. Nineteen states enacted some legislation on malpractice in 2005 (NCSI 2005b). Among these innovative solutions were the following:

- state-established insurance funds from which doctors can purchase insurance if there is no other insurance carrier on the market (Nevada and West Virginia);
- state funds for paying a portion of settlements against a health care provider (Kansas, Pennsylvania, and Wisconsin);
- state-run medical malpractice insurance programs (West Virginia);
- voluntary arbitration programs (Michigan);
- requirements that hospitals report adverse incidents and that the aggregate hospital-specific data are made available to the public (New York);
- development of medical guidelines that physicians can use in defending against malpractice claims (Maine);
- creation of a data center to collect information on medical errors, to coordinate state agencies, and to develop innovative strategies to reduce errors and develop provider profiles and provide information to the public (Iowa); and
- strengthening of state medical boards' power to investigate and review physicians (Massachusetts and Pennsylvania) (NGA 2002).

In spite of the plethora of state actions, the president and the Republican House of Representatives wanted federal action—specifically, legislation to cap compensation for pain and suffering at \$250,000 in successful malpractice suits. The national law was backed by interest groups representing insurance companies and physicians, who argued that national legislation would reduce the costs of court settlements and “defensive medicine,” in which physicians prescribe excessive tests and procedures to avoid possible misdiagnosis (Stolberg 2002b). The calls for federal legislation in malpractice are nothing new. The same groups also lobbied the first President Bush, and he proposed legislation in 1991 to penalize states that did not enact a \$250,000 cap on non-economic damages. The effort was unsuccessful (Jost 2003).

Mental Health

Mental health has long been a state and local responsibility. States serve as both third-party payers and direct providers of mental health services. States are the most important policy players in mental health, spending more than \$13 billion to fund their state mental health agencies and match Medicaid mental health spending (Frank and McGuire 1996). States also influence mental health services through insurance regulation. Some states have adopted laws mandating a minimal mental health coverage for private insurance.

State mental hospitals were first established in the mid-1800s and soon became custodial institutions, to some extent mingling mental illness and indigence. The costs to the state were substantial. In the early 1950s, one-third of the New York State budget went to mental health care. Some relief came from the federal government with funding from Medicare, Medicaid, and the Community Mental Health Center program. With Medicaid, many elderly patients in state mental hospitals were transferred to nursing homes. In 1981, 10 federal categorical grants were consolidated into the alcohol, drug abuse, and mental health block grant (along with a 30 percent reduction in funding). Block-grant dollars make up only about 5 percent of state mental health budgets (Frank and McGuire 1996).

In the 1990s, states began to incorporate mental health services into Medicaid managed care, often through "carve-outs," or subcontracts to nonprofit or private entities. Some states use county or regional public or quasi-public bodies as the lead providers of mental health services to Medicaid patients. Mental health advocates, often well organized in states, have been active to ensure that contracts adequately protect the needs of patients. States continue to enact mental health parity laws, ensuring that mental health benefits are equivalent to those of other medical coverage, and to mandate insurers to provide mental health coverage.

Community Health

With the emphasis on devolution in the 1990s came a growing interest in the potential of community-based health. One could argue that community decisions have always been a major part of the nation's health policy, dating back to colonial poor laws. But the importance of communities in U.S. health policy increased during the 1960s with the development of community mental health and health centers, and this increasing community empowerment continued into the 1980s and 1990s with a strong business cast: local coalitions of health

purchasers and other community-based efforts to hold down costs. In the 1990s, the emphasis was on more decision making at the community level. Several states set up mechanisms whereby local or regional health groups could make funding decisions and take the lead in prioritizing health care needs locally. The W. K. Kellogg and other foundations supported efforts to help communities organize to deal with health professions education and issues of health care for the uninsured. The task was not easy, in part because community was not an important theme in health care reform in Congress or among the citizenry. When health care reform is defined broadly to include long-term care and substance abuse, there is more support for community-based efforts (M. Schlesinger 1997).

At least 20 states have organized community-based systems of care for the uninsured, usually with counties as the primary focus (AcademyHealth 2005). Florida has long relied on counties to provide coverage for the uninsured and has several successful county programs that provide primary care to their uninsured residents. Michigan also has several county-based programs that provide coverage, commingling employer, individual, and county contributions.

Other Issues

In several policy areas, states are taking the lead where the federal government has refused to act. Two examples are greenhouse warming and stem cell research.

As noted earlier, several states have adopted laws on greenhouse warming, an area where the federal government has decided against meeting international guidelines set forth in the Kyoto Protocol. Rabe (2004) traces state activity back to the late 1990s when several states established carbon dioxide emission standards. Six New England states established regionwide standards for carbon dioxide emissions, along with Quebec and the four Maritime provinces of Canada. Since January 2000, new legislation and executive orders to reduce greenhouse gases were approved in more than one-third of the states (Rabe 2004). In 2003, Maine became the first state to pass a law establishing goals and timetables for greenhouse gas reductions (Scheberle 2005).

The federal government has also been reluctant to adopt far-reaching policy on stem cell research. Two states—New Jersey and California—have moved ahead on their own to provide funding for embryonic stem cell research. In addition, Virginia has funded research for sources other than embryos such as bone marrow or umbilical cord blood.

A third area is one where there is interest in Washington but little action: improving access to health records through information technology. A number of states are investigating or have launched statewide e-health networks to allow the sharing of patients' records among physicians, insurance companies, and pharmacies (M. Carey and Reichard 2005).

For residents with AIDS, states have purchased private health insurance, prohibited discriminatory practices, organized special facilities to provide targeted care, and provided their own funding for treatment. States have also taken measures to protect confidentiality in testing for HIV. Maine was the first state to expand Medicaid benefits to people living with HIV.

Long-term care, an area in which federal policy has floundered, has been the focus of several state efforts. States have led the way in providing home and community-based care programs in an effort to provide more choices for needy elderly persons. Washington State has authorized demonstration projects of social health maintenance organizations, HMOs that gather a full range of health and social services for elderly people under one organization. Connecticut was the first state to encourage the purchase of long-term care insurance.

States are launching programs to promote health and fitness among their own employees, offering a surcharge on insurance premiums for smokers (four states); reimbursing employees for health expenses, including exercise equipment and membership in fitness centers (South Dakota); sponsoring "weigh-ins" for state employees (Georgia); and establishing health savings accounts for state employees (Florida) (Cotterell 2005).

In sum, states have launched new programs in areas as broad as providing insurance to those who lack it and as specific as contracting with a vendor to monitor and pay for therapy for asthma or diabetes. States are concerned with efficiency but also effectiveness; they are trying to improve access to care while assuring that the care given is not redundant or excessive. They are using technology, research, and market-based approaches to achieve these goals. And they are learning from each other.

Diffusion of State Innovation

States learn and pick up ideas from other states. Sometimes policies go quickly from one state to another. For example, in May 1995, Maryland was the first state to adopt legislation to address what became known as "drive-through deliveries," mandating longer hospital stays for women after childbirth. Within

18 months, 24 more states had adopted this policy (DeClercq and Simmes 1997). Similarly, in 1992, when a U.S. Supreme Court decision gave state legislators more freedom to regulate abortion (*Casey v. Planned Parenthood of Southeastern Pennsylvania*), virtually no states had informed-consent abortion laws; eight years later, such laws were in effect in 27 states. In 2004, two states enacted legislation limiting cell-phone use for teen drivers; in 2005, eight more states acted (R. Tanner 2005). Similar diffusion occurred with bans or restrictions on late-term abortions and enforcement of parental involvement statutes (New 2005). In contrast, no other state adopted Oregon's Health Plan, which established a priority list of services available to Medicaid recipients, commonly referred to outside the state as "rationing" services. Thanks in part to federal insistence, Oregon was able to eliminate or "ration" only a few marginal services, saving little money. So states pick those policies they are interested in (often the "easy" ones) and perhaps ignore issues they do not like. And many states modify the proposals to their own needs.

States also learn from one another's mistakes. California was successful with its state-sponsored purchasing cooperatives, but other states—including Texas and Florida—had many problems. In 1999, the last carrier pulled out of the Texas Insurance Purchasing Alliance, leaving thousands of enrollees without coverage. Kentucky and Washington had difficulties with their innovative efforts at individual market reforms. In Kentucky, for example, most insurers left the state's individual insurance market in protest of the state law. Washington State had to abandon its efforts to move the SSI population into managed care in 1998. In 2000, just six weeks after it began operation, an innovative managed care mental health program for children in Arkansas was suddenly terminated. Each of these efforts was instructive to the state involved—and to others—in issues ranging from the importance of a strong base of providers to careful attention to adverse selection.

Many groups help states in their policy making. National interest groups with local affiliates often promote state legislation that they like. For example, the national organizations of nonprofit hospitals and other interests were active in promoting state legislation that prescribed how mergers and acquisitions of nonprofit hospitals were to be accomplished. Many national foundations fund states to deal with issues of concern to them. For example, the Robert Wood Johnson Foundation's Covering Kids initiative provides money to communities to improve health access initiatives for low-income uninsured children.

The diffusion of state policies has long been of interest to political scientists. Early research indicated that diffusion was largely regional, as states within a region looked to "leader" states for guidance in handling similar

problems (J. Walker 1969). With improved technology and the expansion of sources of information and networking, states now tend to reach farther afield for their ideas, often to try out an idea of a state unlike their own in population, wealth, and ideology. Many state legislative staffs communicate with one another, and organizations such as the National Conference of State Legislatures and the National Governors Association provide opportunities for face-to-face meetings with counterparts across the country to obtain up-to-date information about what other states are doing, including legislative language and technical assessments.

Nevertheless, some states pride themselves on being more innovative than others. These are states with policy cultures or legacies that are conducive to major innovation. One observer of intergovernmental affairs, John Shannon of the Urban Institute, likened states to convoys. No state wants to be too far ahead of the pack, and no state wants to be in a vulnerable position in the rear. But some like to be among the first to try new programs. Maine, Vermont, Minnesota, and Oregon have often led the way in new approaches to dealing with problems in health, the environment, criminal justice, and other areas. Virginia, by contrast, is more comfortable letting other states try out ideas and work out the problems. There are some noteworthy exceptions, however. In 1993, Tennessee, generally comfortable in the middle of the convoy, launched its innovative TennCare program, which was examined and watched closely by states across the country. And innovative states are often not innovative in all areas. In one study of health professions education, for example, Maine, Massachusetts, and New Jersey, often innovative, were not among the innovators in this area (C. Weissert, Knott, and Stieber 1994).

Finally, the tendency of states to innovate can be traced to their political tradition or culture. In some states the populace believes government should be proactive, providing "good" to its citizens, who are actively involved in the political process. Other states have the opposite view: government should be avoided, the political process should be dominated by a few knowledgeable people, and citizens' roles should be limited. Elazar (1984) divided states into three political cultures. In the traditionalistic culture, government intervention is not generally desirable and citizens' participation is minimal; this culture is best exemplified by the southern states. In the moralistic culture, government is viewed as a positive instrument to advance the public interest, and citizens' participation is encouraged; Minnesota, Vermont, and Wisconsin are illustrative of this type. In the individualistic culture, the role of government is primarily to encourage private initiative, and citizens' involvement is encouraged only to the extent that it promotes economic concerns; examples

are Illinois, Indiana, and Ohio. States with moralistic cultures are often the most innovative; those with traditionalistic cultures often do not value innovation involving government action (C. A. Johnson 1976; Sigelman, Roder, and Sigelman 1981; Sigelman and Smith 1980). Some states are a mixture, such as Florida (traditionalistic and individualistic) and California (moralistic and individualistic), making predictions based on political culture difficult. Nevertheless, the political culture does provide some explanation for state activities and policy choice.

Constraints on State Innovation

Despite some impressive innovations and reforms, states have political and economic constraints that limit their contributions. States must retain their businesses, companies, and citizens and are ever vigilant to avoid enacting policies that might drive out businesses from the state or attract poor citizens to take up residence. In one of the few examinations of the impact of state health reform on relocation of businesses, Kenyon (1996) concluded that some relocation of business activity is likely, particularly in states with metropolitan areas spanning state borders and in states with a relatively high level of current business taxation. Small and nonmanufacturing firms are most likely to be affected by health care reform. Because businesses are often prominent players in state politics, their concerns are major factors in states' health policy making.

In contrast, the evidence on the "race to the bottom," with poor citizens moving to a state where benefits are higher than in their home state, is more mixed and inconclusive. A migration of poor citizens to states with generous Medicaid benefits is unlikely. We should note, however, that politicians may be ignorant of, or may choose to ignore, research results. And if politicians believe that by raising benefit levels for welfare or Medicaid they will attract more poor people into their state, they may act on that perception by maintaining existing benefits or even reducing benefit levels—even without any evidence that such migration occurs.

There are also legal issues that greatly constrain state innovation, particularly in the health insurance area. The key one is ERISA, which preempts state regulation of health insurance provided by large companies that self-insure. State law cannot require these employers to cover certain procedures, insure high-risk groups, or make health coverage available to workers. Until recently, states could not impose taxes on self-insured companies to finance care for uninsured people in the state. Virtually every comprehensive health care

reform law runs afoul of ERISA. In 1974, when the law was passed, a small number of health plans were self-insured; today, between 33 and 50 percent of the nation's employees are in self-insured plans (Butler 2000).

For years, the courts tended to strictly construe the language of the federal law to stymie state efforts at including self-insured companies in health care reform. For example, in 1992 a New Jersey court found that the state's surcharge on hospital bills to finance a trust fund for uncompensated care was a violation of ERISA, and struck it down. (A later court overturned the decision, but the state had already changed its financing scheme.) A 1994 court decision in Connecticut knocked down a tax on Connecticut hospitals to finance uncompensated care. However, in a 1995 case, *New York Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company*, the U.S. Supreme Court held that ERISA did not preempt a state's hospital surcharges that had to be paid by self-insured plans. Subsequent Supreme Court decisions also began to set some limits on ERISA's reach, including decisions in 2002 and 2003 allowing states to require independent external review of coverage-denial decisions and upholding "any willing provider" laws.

Though states strongly support a change in ERISA to give them more leeway in health care reform, such a change has long been opposed by many business and labor interests that prefer uniformity in health insurance across the states. However, recent legislation may provide some hope for state officials. A 1996 ERISA amendment prescribes a minimum maternity hospital stay but allows specific types of state maternity length-of-stay laws. Federal laws enacted in 1996 and 1998 require insurers to provide both mental health parity (the same benefits for mental and physical health care) and breast reconstruction for women following mastectomy. In the case of mental health, the federal law preempts state laws; in the case of breast reconstruction, state laws are allowed that require at least the same coverage as the federal law. Generally speaking, these laws create a new relationship between state and federal governments by setting a federal floor for self-insured plans while also permitting states to enact stronger laws (Butler 2000).

Another problem related to self-insurance is the emergence of new health insurance arrangements and the blurring of government responsibility for accountability. For example, self-insured firms are now contracting directly with providers, and providers are forming joint ventures with insurance plans. As Holahan and Nichols (1996, 67) put it, "In general, financial risks are being shared in ways never envisioned by those who draft and enforce state insurance legislation."

In spite of ERISA, states moved forward rapidly in the 1990s to enact

managed care regulation. Most states also acted quickly between 1996 and 2000 to establish grievance procedures, set up ombudsmen, ensure access to obstetrician-gynecologists, prohibit provider financial incentives, and establish "prudent layperson" standards for coverage of treatment in emergency rooms. Only laws establishing liability for HMOs were held unconstitutional by the U.S. Supreme Court (*Aetna Health Inc. v. Davila*, 2004).

STATE HEALTH AGENCIES

Every state has at least one agency that oversees health programs, but the scope and purpose of the agencies vary and, in many states, health responsibilities are shared by many agencies. A typical state health agency is responsible for quality control, including licensure and regulation of standards of practice for health care professionals; licensure and certification for Medicare and Medicaid reimbursement of hospitals, nursing homes, and other providers; and monitoring of laboratories, health-related services, and environmental and sanitation conditions. The agency collects and analyzes data, evaluates and assesses health services, conducts health-planning activities, coordinates with other agencies and providers, issues vital records, and sometimes provides services in underserved areas and regions. Around 40 percent of state health agencies administer the Medicaid program (see table 5.8). Many more agencies have mental health responsibilities (84 percent).

More than 30 percent of state spending in fiscal year 2003 was on health, but most (21.5 percent) went to Medicaid. Services most closely associated with public health—such as prevention of epidemics, protection against environmental hazards, injury prevention, prevention of chronic disease and promotion of healthy behavior, and disaster preparation—do not make up large percentages of state budgets. Across all states these programs represented less than 2 percent of total state expenditures, ranging from 0.2 percent in Wyoming to 4.6 percent in Hawaii. These public health services accounted for only 3 percent of state health expenditures in fiscal year 2003. Medicaid accounted for 71.3 percent of state health spending. The second largest category was health insurance for state employees, which made up 8.2 percent of state health spending (Milbank Memorial Fund et al. 2005).

In most states, other health services are administered by different agencies. These services include professional licensure and regulation (often carried out by independent boards), health insurance regulation (by insurance commissions or departments), mental disability programs (by mental

Table 5.8
State Health Agencies' Organization and Programmatic Responsibilities

Responsibility	Number of States
Part of larger umbrella agency	18
Decentralized public health system	51
Children with special health care needs	31
Health planning and development	38
Mental health	42
Environment	36
Alcohol abuse	45
Medicaid	18

Source: Data compiled from StatePublicHealth.org 2005.

Note: Data include the District of Columbia.

health and mental retardation departments), health personnel education (by higher education), health facilities construction (by direct appropriations and independent financing authorities), and cost-control activities (sometimes by independent commissions).

The 50 state health departments work closely with more than 3,000 local health departments charged with assessing the public health needs of their communities, developing policies to meet those needs, and ensuring that primary and preventive care are available to all. The systems have traditionally been very decentralized, with the state agency giving considerable discretion to local units. The state's lineage in public health is a strong one. In fact, the federal government is a recent entrant into the world of public health. Municipal and state public health departments were active in the nineteenth century and early twentieth century in improving housing, sanitation, nutrition, water quality, sewage, and inoculation in the nation's cities and rural areas. They were so successful, in fact, that there seemed to be little need for continuing such public health activity, and it declined in importance in states and localities, replaced by issues of chronic disease, unemployment, criminal justice and safety, transportation, and education. Many public health departments focused on health service delivery or personal health issues, including provision of health care for the uninsured, primary care, and teenaged pregnancies. But September 11, 2001, changed public health, as it did many things in the United States. The possibility of terrorists releasing pathogens into the air raised issues of prevention and possible action that made public health a key actor. "A lot of people who couldn't spell 'public health' now saw public health as the equivalent of the Department of Defense,"

said one state health director. And a conservative commentator observed, "The upheaval of September 11 poses a momentous opportunity for public health to reclaim its proper focus: to protect the population from disease" (both quoted in Markowitz and Rosner 2004, 8, 6).

Following the September 11 attacks, states and localities stepped up their efforts to deal with bioterrorism, particularly possible attempts to contaminate water supplies or launch air-based toxins. Federal legislation in 2003 provided \$1.1 billion to help states strengthen their capacity to respond to bioterrorism and other public health emergencies. The money came from three sources. The CDC provided funding to support preparedness activities for bioterrorism, infectious disease outbreaks, and public health emergencies. The HRSA funding was targeted to create regional hospital plans to respond in the event of a bioterrorism attack. The third portion, supporting a Metropolitan Medical Response System, came from the HHS Office of Emergency Preparedness. The legislation was very specific and set forth critical benchmarks, including setting up advisory committees (with specific designation of what groups should be included), time lines, plans, assessments of capacity, and training needs.

The crisis—and the sudden attention focused on public health by the deaths of several postal workers from anthrax in October 2001—focused attention on public health in a way that public health officials generally welcomed. However, the federal government, the hand with the money, was also closely watching the states. For example, the CDC portion of the grant required states to submit semiannual progress reports (annual reports are more common), and the agency conducted site visits and assigned project officers to states. Even so, a GAO study two years after the law was passed indicated that 4 of the 14 critical requirements were completed by most states; 2 were met by few states, and the remainder were met by around half of the states (GAO 2004). This report and others critical of states' response led to some calls for federalization of public health, arguing that terrorism is a vivid reminder of the impacts of globalization and an indictment of state and local public health systems geared to local needs (Annas 2002). Other assessments were more positive, concluding that the funding had resulted in stronger relationships between law enforcement and health providers, greater epidemiological capacity, better training for response to possible bioterrorism activities, improved communications, enhanced laboratory capacity, and more and better-trained professionals working in the area (Markowitz and Rosner 2004).

The uneasy federalist alliance was tested again in December 2002 when HHS directed states to offer smallpox vaccinations to public health and health care workers, but without additional funds (funding was provided six months

later, in May 2003). State departments of public health were thus hit with the task of massive smallpox inoculations, at the very time that many states were suffering fiscal difficulties and cutting their agency budgets, including those of public health.

In 2005, another \$1.3 billion was provided to states to upgrade their abilities to respond not only to terrorism but also to other public health emergencies such as infectious disease outbreaks. Part of the money was targeted for an early-warning infectious disease surveillance program specifically for states bordering Canada and Mexico (HHS 2005a).

Even with public health now playing a major role in state policy on these timely and salient issues, some worry whether its time in the limelight will continue. Many states have used the federal dollars (and state dollars as well) to hire staff, purchase state-of-the-art technology and communications systems, and develop plans involving other state agencies, local governments, and the private sector. "Yo-yo funding has been the history of public health," said one state public health director who fears public health may see reduced funding in future years (Markowitz and Rosner 2004, 17).

CONCLUSION

Few would question the role of state governments as key actors in health care in the United States. They serve as the providers, financiers, administrators, initiators, and regulators of health care delivery. Their reach cuts across traditional health providers, insurers, businesses, educational institutions, and, of course, citizens. State governments are capable of adequately performing all their roles and representing all the groups and citizens they serve. They are the innovators and creators of many of the most promising ideas considered in the nation's capital and elsewhere. They are probably the most pivotal government actor in health care, since they implement and help define federal policies, define and implement their own policies, and define and oversee local health-related activities.

States and their local governments were the primary makers of health policy for the first 150 years or so of this country's history. States made laws dealing with public health, provided services for the mentally ill and the elderly, and even considered comprehensive health insurance.

Before World War I, there was intense interest in many states in adopting a compulsory health insurance program funded by employers, employees, and the public. At least 16 states introduced health insurance bills based on

a model bill prepared by the American Association for Labor Legislation, a group that had led the successful drive for workers' compensation (O. Anderson 1990). In the 1930s through the 1960s, the states provided essential health services but were generally not leaders in innovation or responsiveness to the public. A key turning point was the adoption of the Medicare and Medicaid programs, which developed into the major public health safety net for the elderly and poor.

The 1970s and 1980s witnessed a spurt of innovation and activity in the states. In health care, innovations in financing, new forms of delivery, and systems allowing citizens to make tough "rationing" choices were developed at the state level, and in the early 1990s the states developed the ideas of managed competition, global budgets, and major insurance reforms—ideas only talked about in Washington, D.C. In the rest of the decade, states led the way in the use of managed care in Medicaid programs and in regulation on behalf of citizens in public and private managed care systems, in providing prescription drugs to those unable to pay, and in controlling costs for public programs. States dealt with legal protections, accountability, and health access and quality—issues that stymied congressional attempts to enact national laws. In the early years of the twenty-first century, the states saw renewed interest in universal health coverage—a response, perhaps, to frustration with the lack of interest in Washington, D.C., in increased domestic spending coupled with frustration with rising premiums and health care costs. Bills to set up a statewide single-payer system were introduced in 18 states in 2005 (Leingang 2005).

Nevertheless, state actions are stymied by fiscal constraints such as federal law (ERISA), balanced budgets, and limits on revenues and expenditures that are not in place at the national level. States that enact broad health care reforms (Tennessee, Minnesota, and Washington State) can be forced to abandon the reforms when the needs of citizens swamp the resources of the state to deal with them. States that lead the way in controversial areas such as medical marijuana and assisted suicide may see their actions nullified in federal court. States that enact incremental reforms are often criticized for being cautious and masking the failures of the private market (Beamer 2004). These reforms also illustrate what Paul Peterson (1995) calls the "price" of federalism—inequity. For citizens in a progressive state, eligibility for and benefit from health services differ from those for citizens in another state. Critics argue that only the federal government can successfully reform the many faults of the current health care system. But the truth is that it hasn't.

The failure of the national government to deal with comprehensive health

care reform brings to the fore both the strengths and the weaknesses of a health care system led by state innovations. The system cannot be dominated by states, which simply lack the resources and constitutional scope to run a national health care system. Some commentators continue to bemoan the lack of a national system and the impossibility of a decentralized health care system. However, states can and do dominate in designing effective policy for their own citizens. States recognize what Craig (1996) called "taste differences," and they operate in different "specialized political markets" (Oliver and Paul-Shaheen 1997) and in different health policy regimes (Hackey 1998). The products of these various tastes, markets, and regimes will be different from those emanating from Washington, D.C. They may not "travel" to other states or to the capital and may not be viewed as optimal by outside observers. Yet they serve the needs and desires of citizens of the state.

Examples in the environmental area—particularly related to greenhouse gas effects—highlight both the strengths and weaknesses of federalism in public policy. The fact that some states are acting when Washington, D.C., does not is important and relevant. Equally important and relevant are the large majority of states that are not acting. The policies are not national—the question is whether they should be.

The U.S. health system is neither a decentralized health market nor a centralized health system. Rather, health is a combined federal-state responsibility with substantial federal oversight and funding, imbued with state innovation and implementation. The system may be confused and confusing, but it seems to work.