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State and Federal Roles in Health Care:

Rationales for Allocating Responsibilities

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Abstract

This chapter explains how American federalism apportions responsibility for domestic policy between federal and state governments, and sometimes localities, often in overlapping ways. Starting in colonial times, debates have simmered--or raged--about what government should have responsibility for which function. For 200 years after the Bill of Rights, federal responsibilities grew, but the "New Federalism" of the 1990s increased reliance on states.

Arguments for relying on states versus the federal government can be grounded in political philosophy. States are said to be closer to the people, for example, so that policymakers "know the territory." On the other hand, the federal government may be preferred because problems or solutions cross boundaries or because only a national policy can assure equitable distribution of services and comport with Americans' sense of national citizenship.

Market principles also contribute to federalism debates. Having states in charge allows them to serve as "laboratories of democracy" and can spur inter-state competition to improve efficiency as well as useful policy innovation. But national action may be needed to avoid a "race to the bottom," especially in policies affecting income distribution.

Finally, pragmatic considerations seem most important for most issues, most of the time. Citizens and policymakers ask what government performs best on a particular issue in their era. Thus, how states have exercised their enhanced authority in our New Federalism era matters a great deal. The rest of this book focuses on state policymaking and implementation in health care and financing for lower-income Americans. The following chapters assess past state accomplishments, the extent to which current policies can be sustained or move forward, and options for reallocating responsibilities.

[abstract added after publication]

Federalism in the United States allocates powers and responsibilities between the states and the national government. Some responsibilities may be exclusively federal or state, yet in most areas, either or both may act. The federal and state governments have evolved during the nation's history, as Americans' needs and philosophies have changed. Governmental responsibilities in health care have grown over the last century, along with medicine's ability to improve the well-being of citizens, rising dramatically since the 1960s' enactments of Medicare and Medicaid. The federal government is largely responsible for Medicare, but federal and state responsibilities overlap in Medicaid. In the early 1990s, legislative changes—collectively termed *New Federalism*—expanded states' responsibilities in several areas, including health care.

What is federalism, and how has its practice changed over time? What difference does it make whether any particular responsibility is met by the states or the federal government—or some combination of the two? Various philosophical, political, and practical rationales have been given for relying more heavily on one level of government or the other. What are the ramifications of those rationales for health care, especially for low-income people?

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This chapter outlines the theory and practice of federalism in the United States. It describes long-standing arguments in favor of greater state or federal responsibility as a backdrop to the recent devolution of power from the federal government to the states.

Federalism in the United States

Federalism is any national system of government with both a central authority and autonomous constituent jurisdictions. Without a central authority, there can be no overarching nation-state. Without autonomy, states would merely be administrative units of the nation. Both levels of government have broad and sometimes overlapping responsibilities for social well-being, which they can meet using similar toolboxes of public powers, including regulation, taxation, conferring of benefits, or contracting with private entities to achieve public goals.[1] Both exercise the full spectrum of public authority—they set policy, implement it, and fund it. States and the central government also have parallel institutions: executive, legislative, and judicial branches, along with assorted independent commissions and other public entities.

Constitutional federalism is an American innovation. Although fundamental to governance in the United States, the concept of federalism has resisted any single, lasting definition. (An academic exercise once identified some 267 different versions [Stewart 1984].) Ambiguity is built in because federalism embodies a national-state balance in sovereignty that can be struck in different ways at different times, by different actors, and for different activities. Further, although federalism universally entails autonomy for both levels of government within a united nation, observers and partisans differ in how they think authority should be allocated. Some thinkers, like Daniel Elazar, emphasize the sharing of functions between levels of government, while others, like Paul Peterson, stress the independence of each level of government and the sorting out of responsibilities for each (Elazar 1966; Peterson 1981).

Origins of Federalism

Federalism in the United States arose from the desire to reconcile two powerful, opposing forces: the need for more national authority and mistrust of a single sovereign. On one hand, the nation's founders recognized

the need to strengthen the national government (Beer 1997). Under the Articles of Confederation (1777), the states printed money and maintained armed forces, and they oversaw not just public safety but also health, welfare, and morals. The weak national government could not forge agreements on national defense, finance, or commerce; enforce decisions once made; or even resolve disputes among states. It was also dependent on state contributions for revenue. A stronger central government was deemed to be essential "to promote the general welfare" (U.S. Constitution, Preamble).

On the other hand, the founders feared an overly strong central government. Their hostility arose both from a philosophical belief in the primacy of individual liberty and from bitter practical experience of abuses under a distant royal power. Therefore, they also supported continued state authority as a counterweight to enhanced national authority.

These tensions about public authority profoundly engaged the emotions and intellects of those attending the Constitutional Convention. Federalism was their solution. The new Constitution gave the central government stronger powers, including the right to levy taxes and regulate interstate commerce, and those powers were agreed to be supreme in any conflict with state authority. States explicitly surrendered certain sovereign powers, such as the ability to print money and regulate their borders, and agreed that they would give "full faith and credit" to other states' laws (U.S. Constitution, Article 1, Section 10).

Concerns for the rights of individuals and states were safeguarded in multiple ways. The founders specified particular federal powers, thereby reassuring opponents that national government would not overstep its bounds. Moreover, the power of any one government would be curbed by having states and the central government share authority and responsibilities. The resulting political rivalry was expected to protect individual liberty (Dye 1990: 5). The vertical state-federal balance of power was complemented by the horizontal checks and balances resulting from independent legislative, executive, and judicial branches within the federal government (Madison 1787).

Some ambiguity in the allocation of powers remained, which helped achieve compromise at the time. This fluidity has allowed the federal system to evolve to meet succeeding generations' needs, as the built-in tensions among governments and between the public and private spheres periodically resurface (Peterson 1995: 10; Rivlin 1992: 83). The first changes were the adoption of the Bill of Rights two years after the

Constitution was ratified and the Eleventh Amendment four years later. These initial amendments constrained federal power by adding explicit protections for individual liberties and state autonomy. For almost 200 years thereafter, changes tended to increase federal authority and responsibilities.

Growth of Federal Responsibilities

Growth in federal powers began with considerable institution building—by Alexander Hamilton at Treasury, Benjamin Franklin in the Post Office, and John Marshall Leading the Supreme Court, for example. Further growth resulted from judicial interpretation of constitutional provisions. The Civil War thoroughly established federal primacy over state governments. Thereafter, federal responsibilities and powers continued to grow to meet the sociopolitical demands of continental expansion, increased interstate and foreign commerce, and international conflict. Especially notable amendments limited the states' power to infringe civil rights guaranteed under the Constitution, confirmed the federal government's power to tax incomes, and ended state legislatures' election of U.S. senators.[2]

Federal spending remained small, however, until the Great Depression (Leuchtenburg 1995). President Franklin D. Roosevelt's New Deal of the 1930s greatly expanded domestic spending, especially on human services. Along with such federal programs as Social Security, the New Deal created a new "fiscal federalism" through welfare reform, which combined state administration with federal funding, federal minimum standards, and federal oversight (U.S. House of Representatives, Committee on Ways and Means 2000).

President Lyndon B. Johnson's Great Society programs of the 1960s applied New Deal principles to medical assistance. Medicare was created as a federal program of health insurance for people of retirement age and people with long-term disabilities. Like Social Security before it, Medicare was funded mainly by prospective beneficiaries' taxes and current beneficiaries' premiums. Administration was largely decentralized, but only to regional federal contractors. For the "deserving" poor Medicaid expanded and made an entitlement the previously limited federal-state cooperation in financing medical services. It provided benefits for recipients of cash welfare payments, principally low-income mothers and children, and elderly and disabled persons. Like welfare, Medicaid combined minimum federal standards, joint federal-state funding, and state administration.

States could decide whether or not to participate in Medicaid, but participating states had to operate within the federal rules. Medicaid entitles states to federal funding for eligible beneficiaries and services and entitles beneficiaries to services meeting federal standards.

Most states were quick to accept the new federal support and began operating Medicaid programs.[3] The original Medicaid statute allowed states to set very generous eligibility limits, unrelated to welfare limits for some groups, but 1967 amendments tied federal matching to welfare ceilings.[4] The 1965 statute also called for states to increase the comprehensiveness and generosity of their programs over time, but this provision was first delayed, then repealed, to allow states to control the size of their programs.[5]

Intergovernmental relations and the size of government were profoundly changed by the expansions of the 1930s and 1960s. In 1930, federal revenues claimed less than 5 percent of the gross domestic product, state and local revenues about 10 percent. By 1993, just before the New Federalism initiatives, the federal share was 20 percent, state and local shares about 15 percent.[6] The expansions of Medicare and Medicaid in the 1960s were especially large. Between 1965 and 1970, the federal share of national health expenditures more than doubled, to almost 25 percent.[7] Many other new federal grant programs in the 1960s also sought to encourage grassroots achievement of federal goals, a concept that President Johnson termed "creative federalism" (Johnson 1964). These programs often bypassed states with direct grants to localities or nongovernmental organizations.

Early federalism maintained separate state and federal spheres that sometimes intersected. By the time Medicaid was enacted, the spheres were quite intermingled. The mid- 20th century has been termed an era of "marble cake federalism," replacing the earlier "layer cake" separation of roles (Walker 2000). However, in this marbling, federal policy was usually on top. The high-water mark of centralization may have been the National Health Planning and Resources Development Act of 1974, which required states to adopt federally approved health planning laws or lose federal funds for public health. The U.S. Supreme Court upheld this expansion of federal power which could even override a state's constitutional law (North Carolina v. Califano 1978). During Richard M. Nixon's presidency, federal power over states grew enormously, although less in health care than in environmental and other areas of regulation (Conlan 1988).

Recent Developments, Especially in Health Care

Somewhat paradoxically, President Nixon also promoted decentralization. He called for a "new federalism," meaning devolution of more federal responsibility to the states, which he portrayed as "closer to the people" and hence more responsive to their needs (Nixon 1970). At the same time, he proposed that states be given more federal funding and greater authority over funds. His administration created the first "block grant" in health care, combining numerous specialized, "categorical" public health grants into one general block of funds with reduced federal oversight. The Nixon administration also created general revenue sharing, which for over a decade gave states substantial federal funds with few strings attached.[8] Expanding the federal role in health care to guarantee health insurance for all citizens was rejected at this time, as it had been in the 1930s and 1960s.

President Ronald Reagan sought further decentralization, famously asserting in his first inaugural address that "government is not the solution" (Reagan 1981). He, too, called for a "new federalism." Like Nixon's, it would involve more devolution of responsibility, but it would also emphasize efficiency in state operations and, hence, cutting rather than expanding federal funding. For example, the Reagan administration proposed consolidating 25 separate health grant programs into two big general blocks with 25 percent less funding. It also proposed capping growth in federal Medicaid spending (Bovbjerg and Holahan 1982; Peterson, Bovbjerg, et al. 1986). Because much federal-state interaction was based on federal funding of state activities, maintaining budgetary control and taking political credit for benefits (or tax cuts) were becoming federalism issues as well.

States objected that President Reagan's funding cuts went beyond the bounds of any efficiencies they could achieve. Congress enacted narrower block grants and temporarily reduced federal matching rates for Medicaid, but it did not cap their rate of growth (Bovbjerg and Davis 1983). President Reagan proposed an even larger realignment in federalism, with states taking over all of welfare and food stamps (to make the programs more responsive to genuine need" because of local operations) and the federal government assuming all of Medicaid (in line "with its existing responsibility for Medicare" [Reagan 1982]). Also opposed by states, this swap never came close to enactment. In the mid-1980s, the Democratic Congress agreed to stop regulating state health planning, but it expanded the states' obligation to cover children under Medicaid. In this era, states

generally became more vocal about what they called "unfunded federal mandates" (Posner 1998).

The 1990s saw another clear rejection of mandatory national health insurance coverage, an early policy initiative of President Bill Clinton. Republicans won control of Congress in 1994 and launched a legislative agenda that some termed the New Federalism, others a "devolution revolution" building upon the Contract with America promised by House Republicans during the election campaign (Gingrich, Armey, and the House Republicans 1994). A strong effort was made to turn both welfare and Medicaid into block grants, and a chastened President Clinton declared that the era of big government was over (Clinton 1996). In 1996, despite Democratic opposition, Congress and the president agreed on welfare reform as a major devolution of responsibility to the states, with significant but limited federal funding. Congressional Republicans successfully legislated new procedures designed to discourage future unfunded federal mandates on states (Weil and Finegold 2002).

The Clinton administration and congressional Democrats fought successfully to keep Medicaid an open-ended entitlement program under federal guidance, although with somewhat greater state discretion in regard to eligibility. Other important federal laws enacted in 1996 and 1997 directed states to regulate aspects of health insurance (under threat of direct federal rules) and created new federal funding for states under the State Children's Health Insurance Program (SCHIP).[9] SCHIP changed the Medicaid model of coverage for children in low-income families. Its federal matching share was higher, although with a ceiling on total funds, and states were given much more control over program design and operations, including the ability to cap spending or enrollment. Under Medicaid, states also got new freedom to control nursing home payment rates and to require that beneficiaries be enrolled in managed care plans.

None of these initiatives radically realigned health policy, but all of them gave states more authority in setting policy and more flexibility in administering programs. Today, the allocation of responsibilities between state and federal governments differs widely across health care functions. At the federal end of the spectrum lies Medicare, which is clearly national in both financing and administration. Under Medicare, the states' main role is to pay premiums and coinsurance for certain low-income beneficiaries. The states do this via Medicaid, which also pays for a large portion of the services scantily covered by Medicare, especially long-term care

and outpatient prescription drugs. At the state end of the spectrum lie such activities as licensure of medical organizations and personnel, over which the federal government claims little authority. Indeed, Medicare delegates implementation of its rules on provider qualifications to state licensing authorities.[10]

In between lie most other health care functions, including Medicaid and SCHIP, as well as traditional public health functions and regulatory activities, such as protection of persons enrolled in managed care organizations. The federal-state split can even vary within a single program, depending upon whether a particular activity is the creation of policy, its implementation, or its funding. Thus, federal law determines basic Medicaid rules, which can be quite detailed, but states decide whether to run a program at all, who will be covered, and most other administrative matters. Federal support of Medicaid is open-ended, ranging from 50 to 77 percent of spending on medical services (U.S. Department of Health and Human Services 2000). In SCHIP, federal funding is higher, but the federal role in program design and operations is smaller.

Among nations with a federal system of government, the United States ranks at the top in terms of decentralization, even taking into account its large size (Derbyshire and Derbyshire 1996; Elazar 1997; Lijphart 1999). Yet the call for even greater devolution has strong roots in U.S. politics and economic-political theory. Although total devolution of federal powers and responsibilities to the states is highly unlikely, it is important to understand how well states are performing under today's New Federalism.

Arguments for Various Models of Federalism

How can one measure the appropriateness of devolution? Advocates offer various reasons for preferring one level of government over the other, either in general or in specific areas. Their arguments fall into three main groups. The first is political philosophy, which rests mainly on fundamental values. The arguments for greater or lesser federal authority articulated at the founding of the nation were based on political philosophy, and they remain vital today. The second is the role of political and economic competition among the states. Arguments in this area have evolved along with the discipline of economics. The third is practical considerations about attributes or performance of government, based on observation. Such arguments appear to ebb and flow, depending on how governments are seen as performing relative to an era's problems, as well as on citizens' beliefs and expectations about government.

Political Philosophy and Federalism

Philosophical beliefs favoring greater state or national responsibility are older than the nation itself. The leading ones are described below.

PHILOSOPHIC RATIONALES FAVORING STATE RESPONSIBILITY

Supporters of state primacy often assert that the government closest to the people is best-suited to govern. This assertion stems mainly from a philosophical perspective, not empirical observation. It prizes individual liberty and mistrusts governmental authority of any sort, especially a powerful central one. Advocates often state this position as a self-evident first principle or merely invoke the Tenth Amendment or states' rights to support their arguments.

Two other rationales for state superiority have a more empirical basis. First, a geographically smaller, more local government can know and represent its citizens' values better than a large one. Second, a smaller government knows the territory—that is, the possibly unique nature of its citizens' problems and the plausibility of any suggested solutions.

With respect to reflecting citizen values, Nixon argued that state government is "most responsive to the individual person," more than "the government in Washington can ever be" (Nixon 1971). Given a more intimate scale, citizens are more likely to participate in civic affairs, their representatives can more easily learn their views, and they can hold representatives more personally accountable.

With regard to knowing the territory, states are better able to understand their unique problems, craft policy responses, and implement them flexibly. After all, many factors that affect citizens' lives vary considerably from state to state, and it is the states, not the federal government, that exercise fundamental police power over health and welfare. Geographic diversity may have a particularly strong effect on health care services because health care institutions, medical practice patterns and referral networks, and market behavior are mainly local.[11] Specifically, the nature of provider networks, the proportion of the population receiving managed care, the size of the uninsured population, the availability of medical technology, and the extent to which practitioners and institutions provide charity care are all widely variable. Therefore, good governance

requires, in this view, locally tailored policies and flexible administration, not inflexible, one-size-fits-all federal policy.

Thomas Jefferson was the leading proponent of the small-is-better ideal; his federalism would have built up from local wards to counties, states, and nation (Beam, Golan, and Walker 1983; DiZerega 1994). The final Constitution included only the existing states and the new national government, however; localities are not building blocks of state legitimacy but rather owe their existence and powers to state charter. A related viewpoint is that large nations need many governments. Big countries are apt to be more diverse than small ones and hence benefit more from autonomous local governments that reflect legitimate, important differences within the nation. The diversity of state preferences, as shown, for example, by differences in Medicaid eligibility, are quite large (see Chapter 6 of this volume). Sparer and Brown note that "America is an extraordinarily heterogeneous society, and Americans have long believed that public policy should, wherever possible, reflect disparate local needs and preferences" (Sparer and Brown 1996: 197). Catering to decentralized preferences may also reduce intergroup conflict at the national level. Indeed, studies have found that federalism and decentralization of power are more common in larger than in smaller countries.

The foregoing are arguments that states will govern better than the national government. Another aspect of this philosophy, however, is the expectation that states will do less—or at least that states are inherently less powerful than the national government, if only because people can leave one state for another, which is a point that blends into the competition rationale discussed below. A closely related belief is "that government is best which governs least."[12] Many people believe that any exercise of governmental power necessarily diminishes individual liberty, whether that power is exercised in the form of levying taxes or imposing rules (Nozick 1974). Proponents of such beliefs seem to prefer state government to federal government because state government is less threatening, and to prefer private action to any government. Others appear simply to object on principle to nearly any federal activity, while accepting larger state responsibility.

One consequence of state discretion, whether long-standing or recently devolved, is that policies are more divergent than they would be under a national regime. Medicaid eligibility, for example, varies greatly because past and recent devolutions have given the states discretion in determining who qualifies for benefits. Beyond fine-tuning programs to suit local needs or conditions, states also make major adjustments to Medicaid in response to their fiscal capacities at any given time and to the preferences of taxpayers and voters (Uccello and Gallagher 1997).

Philosophic Rationales Favoring Federal Responsibility

Political philosophy can also favor stronger federal authority. Many people believe that certain matters are inherent in national citizenship, and they want to "promote the general welfare" of all Americans, irrespective of state of residence.[13] This belief results in political demands for national action or for states to meet minimum national standards, thus ensuring some degree of equity across the nation.

Two primary rationales support this philosophy. The first is the literal Constitutional primacy of national citizenship. The second is the figurative shrinking of the country through a national economy and improved communications and transportation. The Constitution confers citizenship on all Americans as a birthright, whereas state citizenship can be changed by moving residence. When the nation was first formed, most people still considered their state citizenship primary. Revolutionary battles were often fought under state flags, and until the question was settled by the Civil War, many believed that states could secede at will from the Union. State identification remains strong today but stirs much less fervor than it once did. City rescue workers at the World Trade Center hoisted the American flag in September 2001, not the banner of New York State or New York City (North Carolina Chapter of the National Emergency Number Association 2003).

A corollary of national citizenship is that certain rights and responsibilities should not vary too greatly across the states. People differ, however, in what rights they consider national and how much variation they consider acceptable. Many political attributes of national citizenship—such as basic civil rights and the ability to vote in presidential elections—were guaranteed by the Constitution and broadened through amendments. Other rights are arguably becoming components of a national sense of citizenship, including some degree of consistency in health care across states (Anton 1997). This sense is more universally felt in regard to older people, who are eligible for Medicare, than for poor people, at least for poor people who are able to work. Americans are not like Canadians, for whom universal health insurance coverage is a key aspect of their national citizenship, even though it is administered by the provinces. It is notable that the New Federalism of the 1990s gave states much more responsibility for cash welfare than for health care (Weil and Finegold 2002).

The second rationale for federal responsibility is that the country has become far less local since Thomas Jefferson's time. Partly as a result of federal structure, Americans live in an increasingly national, indeed global, economy. Expression of political views and political participation were once necessarily local, given natural limits on travel and communication. No longer. Social, cultural, and political differentiation by locale is on the decline: Americans nationwide have the same menu of TV shows (including political talk shows), listen to the same kinds of music, eat the same franchised food, and debate much the same public concerns.

Health care financing and delivery are also less local. Health insurers, hospitals and clinics, drug companies, medical suppliers—all have become regional and national rather than state or local. Medical education and standards of practice are more standardized. Although licensure is still state-specific, medical experts testifying in courts and legislatures may come from anywhere in the country, and increasing numbers of consumers are conducting Internet searches on their health care providers' credentials and comparing their providers' advice to advice posted on the World Wide Web. Finally, control of contagious diseases, bioterrorism monitoring, and numerous other public health functions are national in scope. Thus, there exist fewer local situations that truly require less-than-national governance.

Medicaid reflects a political and practical compromise between these two competing philosophies.[14] States enjoy wide discretion over eligibility, benefits, and provider payments, but national interests are maintained through federal minimum standards (Wiener 1996). SCHIP was enacted to increase coverage of children from low-income families and to reduce the cross-state disparities that remained even with open-ended Medicaid funding (Chapter 6, this volume). Concern for children may also reflect perceptions that children do not have independent adult rights and responsibilities, cannot choose for themselves, should not be held responsible for their own health insurance coverage, and deserve help to ensure that they develop into productive members of society.

Political-Economic Competition and Federalism

Given the multiplicity of state jurisdictions and the free movement of people and commerce, states inevitably compete with one another. Interstate competition provides rationales for both greater state and greater federal responsibility.

RATIONALES OF COMPETITION THAT FAVOR STATE RESPONSIBILITY

Another rationale for devolution is that interstate competition pressures states to improve their performance and thus attract and retain residents and businesses (Greve 2001a). This quasi-economic perspective complements the idea that multiple governments are needed to represent geographic diversity. Its theorists compare competitive state governments favorably with a monopolistic federal government. This type of thinking arose well after the Constitutional Convention, along with the rise of economic thinking generally.

Political scientist Thomas Dye observes, "Matching public policy to citizen preferences is the essence of responsive government" (Dye 1990:14). Elections and political parties serve this goal, he notes, and competition among decentralized governments helps match varying citizen preferences with public policies. Dye elaborates:

> Competition in the private marketplace forces sellers to become sensitive to preferences of consumers. Competition among governments forces public officials to become sensitive to the preferences of citizens. Lessened competition in the marketplace results in higher prices, reduced output, and greater inefficiency in production. Lessened competition among governments results in higher taxes, poorer performance, and greater inefficiencies in the public sector. Competition in the marketplace promotes discoveries of new products. Competition among government promotes policy innovation (Dye 1990: 15).

Like economic competition, political competition is driven by informed choice among alternatives. People can choose not only how to vote, but also where to live, work, and run businesses—and thus also where to pay taxes and receive public services.15 Thus, they can readily choose among the range of policies offered in such different states as New Hampshire and Massachusetts. The mobility of individuals and businesses increases as the size of governmental units decreases, because movement across nearby boundaries is culturally and economically much easier than longer-distance movement. Movement among states for political reasons intensifies the alignment of citizen preferences and state policies—that is, persons who leave one state for another are in greater agreement with the policies of the second state, whereas those who do not leave are in greater agreement with the policies of the first state. Furthermore, the first state may change its policies in response to actual or threatened movement, further increasing alignment.

Policymaking, administration, spending, and taxation all come into play in interstate competition (Cato Institute 2002). In comparing states,

one might focus on the size of public programs' budgets (and hence taxes) relative to the perceived value of benefits. Medicaid is a prime example because it is a very large public program with benefits and costs that differ markedly by state. Other comparisons might Focus on other values, such as regulation of private conduct, which adds little cost to state budgets but may matter a lot to voters, taxpayers and the persons who would be regulated. An example is the regulation of hospital expansion through health planning. Competition might also improve efficiency in program administration, giving more value for money by managing better or more consistently with citizens' values. Thus, states might compete to simplify health care paperwork, increase program outreach to doctors or patients. improve management of medical care, or find good jobs with private health insurance for people who leave welfare.

For competition to be useful, citizens need information. Certain states have become generally known as low-tax, low-service states (or the reverse); others are known as heavy or light regulators of business. Some states have worked to change their image. Political "consumers" benefit, under this theory, by having their state provide them with a more optimal mix of costs and benefits. However, not all consumers have to he well informed, nor move or threaten to do so, in order to get results. The states are disciplined by marginal consumers; that is, less active consumers are thought to benefit from improvements states make in response to more demanding citizens at the political margins.

Federal intervention interferes with the cost-benefit comparisons, according to this theory (AEI 2002; Cats Institute 2002). Both unfunded federal mandates and federal subsidies lead to inappropriate state programs or spending. States need the freedom to choose among the full range of policy options and should face the full costs—and benefits—of their actions, theorists argue. Somewhat ironically, a solid national framework is needed to bring about this type of competition among states—a common language, currency, and freedom of movement. Similarly, economic competition presupposes that companies and consumers operate within a common rule of law and culture.

Costs of state health programs and the taxes that support them have a significant impact. For example, in 1999, New York spent just over $1,600 per person on health care (40 percent of all state expenditures), whereas Nevada spent about $460 per person (some 13 percent of all state expenditures).[16] The two states' income, sales, and payroll tax rates also diverged (Urban-Brookings Tax Policy Center 2002). Proponents of state

competition suggest that residents of both states would be worse off if forced to shift toward a national norm.

Competition Rationales that Favor Federal Responsibility

Arguments can also be made that interstate competition is harmful, not beneficial, and hence should be restricted through federal constraints. One argument is that competition can unleash a race to the bottom in benefits. Another is that competition undercuts states' ability to tax residents as much as they would like. A third argument is that competition undercuts legitimate important redistributive programs such as health insurance coverage for the poor. Accordingly, the federal government should play some role in setting minimum standards.

The first argument for federal responsibility holds that competition promotes a race to the bottom in providing benefits rather than a race to the top in innovation and good administration, as competitive theorists imply. A common worry about the New federalism legislation was that state control over welfare or Medicaid would lead to just such a destructive cycle of benefit cutting (Schram and Beer 2000; Wed and Finegold 2002).

Needy beneficiaries of public programs, it was feared, would move from less generous states to their more generous neighbors. As a result, states that wanted to improve their benefits would find they could not afford to do so, no matter how efficiently they ran their programs. Any more generous state programs might cause migration, and means-tested programs such as Medicaid were most likely to cause problems because their low-income beneficiaries make little or no net contribution to state revenues. Migration would prove especially burdensome under a block grant or cap on federal funding because more generous states would have to pay she full marginal costs of any spending beyond the cap. To avoid becoming welfare magnets, it was feared that states would reduce program benefits below what they would otherwise have chosen. Once the high-benefit states cut back, they would become less attractive to beneficiaries, who would then migrate to the next highest states, which would continue the cycle by cutting their benefits as well. Or all the states might cut their benefits at once to preempt undesired migration.

Not only would such competition lead to the lowest common denominator in terms of benefits, it would also reduce the diversity across states extolled by competitive theorists. This argument for a federal role does not specify how low the race to the bottom might go, but presumably some states would always offer higher benefits because of cultural differences in

voter-taxpayer altruism and differences in fiscal capacity unrelated to mobility.

The second argument in favor of federal responsibility is that interstate competition can cause a flight from the top, resulting in lower tax rates and revenues. Regardless of their own preferences, states cannot impose taxes that are much higher than neighboring states' because residential and commercial taxpayers will move. Those paying the highest taxes have the greatest incentive to leave—and they may also be the best able to afford to. Few people actually move from one state to another in a given year (only about 3 percent [Peterson 1995]), but shifts of high-income, marginal taxpayers have a disproportionate impact, and the threat of a cumulative imbalance is considerable. Advocates of a strong national role contend that competition among states to reduce taxes is likely to benefit marginal taxpayers more than typical residents and certainly more than low-income residents. Fear of losing high-income taxpayers is consistent with the observation that state taxation is less progressive than federal taxation—that is, state marginal income tax rates rise less steeply than federal rates. Finally, reductions in state benefits are likely to hurt low-income residents disproportionately.

Competition among states for citizens and businesses can therefore be profoundly different from competition among political candidates for votes, this argument holds. The economic theory of public choice finds that political competition tends to drive public policy toward the wishes of the median voter, much as common wisdom has long noted that elections drive candidates' positions toward the middle of the electorate (Black 1958; Buchanan and Tullock 1962). That pressure exists because each voter's voice counts the same, and a broad spectrum of the population votes in general elections. In contrast, marginal citizens count more if states compete to avoid losing high-income taxpayers and to avoid attracting low-income beneficiaries. To what extent this sort of competition actually occurs is an important policy issue.

Third, competition is most harmful to policies that redistribute income. In this view, redistribution is an important public function that promotes the general welfare and has philosophical support as well.[17] Redistribution in this country does not seek equality, simply a reduction in disparity; accordingly, redistribution often takes the form of a minimum floor of help for the disadvantaged (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1983). Medicaid, for example, creates larger net winners and losers than public programs that tax and serve everyone. So arguments in favor of competition are closely allied to arguments against income redistribution and progressive taxation of income or wealth. Wallace Oates, one of the earliest scholars of fiscal federalism, predicted "real trouble" for redistribution because states might reduce inequality, but they could do so mainly through "an outflow of the rich and an influx of the poor, with a consequent fall in the level of per capita income" (Oates 1972: 7).

Peterson draws sharp distinctions between the effects of competition on redistributive policies and the effects on "developmental" policies (Peterson 1995; Rivlin 1992). Like Oates, he argues that redistribution should occur at the federal level, but he says that states (and localities) should set developmental policies—investment in public infrastructure, education, and productivity enhancements. Both developmental and redistributive policies are sensitive to and disciplined by market conditions, he notes; however, areas whose developmental policies successfully create good jobs and attractive communities deserve to be rewarded through in-migration of workers and capital.

The 1996 devolution of welfare programs to the states was a decision that appears to contravene Peterson's theory of how functions should be allocated. However, proponents of welfare devolution suggested that it had developmental rationales: Ending "welfare dependency" was said to raise productivity and thus enhance both personal and community development. They successfully redefined welfare as a work program (development) rather than a cash assistance program (redistribution). States argued that they were in a better position than the federal government to administer job training and outplacement programs, which require local knowledge and operations and which must be tailored to the needs of individuals.

Practical Considerations and Federalism

Pragmatic arguments do not favor either level of government in principle. Instead, they recognize that responsibilities can differ with functions and circumstances. Moreover, initial allocations of authority may need to be changed when public attitudes about problems change or new information about the success of program operations comes to light. Finally, the same practical rationale may not apply equally to all parts of a program: Policymaking, implementation, funding, and evaluation may call for different strengths.

PRACTICAL RATIONALES FAVORING STATE RESPONSIBILITY

The classic practical argument in favor of autonomous states is that they serve as "laboratories of democracy." Justice Louis D. Brandeis explained his celebrated characterization: "It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country" (*New State Ice Co. v. Liebmann* 1932). As David Osborne argues, this rationale has "little to do with ideology"—no one ever went to the barricades for laboratories of democracy—and "everything to do with trial-and-error, seat-of-the-pants pragmatism" (Osborne 1988: 3). Not only do laboratories allow experiments in the effectiveness and efficiency of policy innovation, but they also provide market testing of the innovation's popularity.

The laboratory metaphor requires autonomy for states to try different policies, and it offers clear support for not federalizing policies from the outset.[18] It also implies that there exist better and worse ways to run government, or at least some aspects of government. It suggests, further, that states should educate themselves about best practices—and perhaps even that there is one best practice in a given sphere and that federal intervention might impose the practice once experimental state results are complete.[19] This rationale is quite different from the states' rights philosophy, and some of today's most ardent advocates of states' rights federalism dislike the laboratory analogy. They prefer to emphasize individual liberty, state diversity, and independent state representation of local values for their own sake rather than any suggestion that states should learn from other states (Greve 2001b).

Recent federal policy in health care suggests some laboratory-like policymaking. Much state innovation in Medicaid occurs under research and demonstration waivers of federal rules—and with requirements that the results be studied.[20] Federal policy has also embraced some state-pioneered policies, like the now-abandoned national health planning scheme. The diagnosis-related group (DRG) method of hospital payment was tested in New Jersey under a federal waiver, then modified and implemented nationally for Medicare in 1983. Other states have opted to use aspects of DRGs for Medicaid hospital payment (Fetter, Brand, and Gamache 1991).

States may learn various things from one another—what policies achieve a shared goal, how to improve their administration of a benefit program, how to sue tobacco companies or defend welfare rights lawsuits, how to obtain more federal dollars under Medicaid rules, how to use mandatory managed care as a Medicaid reform, or which patient protection provisions to legislate. Yet, some policies may be too idiosyncratic to transfer to other states. There may also be considerable barriers to entry in the form of political reluctance in state B to overtly adopt policies from state A (Oliver and Paul-Shaheen 1997). Home-grown solutions are often preferred.

A second pragmatic argument for state control is that some activities work better when implemented from the bottom up rather than from the top down. K-12 education is a classic example (Peterson 1995; Rivlin 1992). Teaching faces very different challenges, depending on the region and populations served, as well as the workforce and resources available. States devolve responsibility for K-12 education to localities, which receive substantial state funding and some federal assistance.

Administration of health care programs can also call for officials to know the territory, though not always. To implement the Medicaid policy of mandatory beneficiary enrollment in managed care organizations, for example, state administrators needed detailed understanding of the organizations' structures, the service areas of their providers, their means of ensuring quality, their experience with low-income populations~ and public perceptions of the organizations' performance.[21] Subsidizing employer-sponsored insurance premiums for families under SCHIP or Medicaid waivers is another example of a policy whose administration may take detailed, case-specific knowledge.

Implementation from the bottom up also takes into account local values and helps engender local enthusiasm for a program. Peterson argues that successful developmental programs typically require some initiative from the individuals directly involved. Federal mandates for such programs cannot succeed if local administration is indifferent or even hostile (Peterson 1993). Alice Rivlin argues that real progress in K-12 education depends on committed grassroots action (Rivlin 1992).

In this view, decentralized control promotes engagement and improves operations. States' control over SCHIP design and implementation may explain why they often take more pride in—and more political credit for—designing, administering, and even naming their SCHIPs than in running the much larger Medicaid program. Peterson and Rivlin might expect SCHIP to perform better than Medicaid, but SCHIP's largely federal funding could make states less careful about administering the programs. Lax state accountability was one of the arguments used to

end Nixonian revenue sharing. Much depends upon how things play out in practice.

Whether the focus is local knowledge or local values, from-the-bottom-up pragmatism echoes the Jeffersonian philosophy that smaller is better. It differs from Jefferson's philosophy in that it allocates responsibility on a case-by-case basis, thus implying that some matters are not local and that implementation from the top down may sometimes be superior.

A third practical argument is that some problems are inherently local, and neither costs nor benefits spill over to neighbors. in such cases, each community should decide on its own what to do. This rationale is highly case-specific. Peterson explains that with localized decisions, playgrounds can be concentrated where young children are abundant, recreation centers for senior citizens can be clustered in adult communities, and parks can be maintained with varying degrees of formality, depending on local tastes (Peterson, Rabe, et al. 1986: 11). In each of those activities, people from outside the affected community have little interest in dictating policy or in paying for local decisions. Note, however, that these examples all suggest local rather than state decisionmaking, and localities are not formally part of the U.S. federal system.

Finally, a very common stereotype is often asserted in favor of state administration: The federal bureaucracy is not only distant from the grass roots, it is also bloated, inefficient, slow, and inflexible (Sperry 2000). The argument typically assumes that states are more efficient, though evidence is sparse. Having 50 state administrations can be quite cumbersome, particularly in situations where they must constantly reinvent the wheel or their standards must be harmonized to be effective. Indeed, for some activities, such as buying pharmaceuticals, states may actively seek to join in federal discounts or to join regional purchasing pools to achieve economies of scale and market share. Similarly, state insurance regulators pool expertise and some financial monitoring capabilities through the National Association of Insurance Commissioners.

PRACTICAL RATIONALES FAVORING FEDERAL RESPONSIBILITY

One practical argument for greater federal responsibility is that some problems or solutions are inherently national in scope. Their costs and benefits cross state boundaries or are common to all states. The framers of the Constitution recognized several national functions, including national defense, foreign and interstate commerce, printing of money, granting of patents, and postal services. Others have become national

since then—notably immigration, monetary policy and economic management, securities regulation, and Social Security. In health care, oversight of pharmaceutical safety and effectiveness, biomedical research, and Medicare (with an assist from state Medicaid programs) are generally accepted as federal responsibilities.

Health care for low-income children, regardless of other family characteristics, appears to be an area of growing national agreement~ partly on ethical grounds, partly pragmatic. A core argument for its being a national responsibility is that healthy children are more likely to develop into productive adults—and generating human and social capital is an interest that transcends state boundaries. Health insurance coverage of low-income adults is less generally agreed upon, and much greater state-to-state variation in their coverage is accepted.

A second practical argument holds that solving some problems requires the greater fiscal capacity of the federal government. Natural disasters may be highly localized, but their enormous costs can overwhelm local resources. Governors of all political persuasions show little hesitation in asking for federal disaster assistance. The federal government s deep pockets come partly from lack of governmental competition at the national level, progressive taxation, large-scale operations~ and the ability to print and borrow money and hence continue spending even in deficit.[22]

A third, related argument for federal power is that many public programs, including welfare and Medicaid, seek to redistribute resources,[23] and the federal government is the "most competent agent of redistribution" (Peterson 1995: 27). The larger the jurisdiction, the more broadly it can pool resources and ameliorate the risk of illness or declines in income across its population. Thus, California has more capacity to redistribute income and other resources than the District of Columbia. Only federal action can pool resources across state lines, as states cannot be expected to lessen disparities among themselves by sending one another benefits checks (Rich and White 1996). Economic interdependence and redistributive federal policies have reduced cross-state differences in residents' well-being, but they remain "striking" (Dye 1990:17). High-income states in 1999 had twice the per capita income of their low-income brethren, although the advantage lessened somewhat when adjusted for wealthier states' higher costs of living.

The federal government faces little danger of taxpayer or capital flight, and it can control the in-migration of beneficiaries. The federal ability to

spend in deficit enables the national government—and only the national government—to adopt countercyclical spending to boost a recessionary economy and mitigate individual losses of jobs or health care (Oates 1972).[24] Such spending not only manages the economy but also redistributes resources from times of plenty to times of shortage. States, in contrast, see their fiscal capacity shrink during a downturn, even as needs increase.

Leaving redistribution to states can also be seen as creating unintended negative consequences, given interstate competition. Low-tax, low-benefit states can export some or all of their needy populations and prevent voter-taxpayers in more generous states from being able to afford the amount of redistribution they would prefer (Oates 1972: 8). Such unintended consequences may be much less direct than, say, exporting water or air pollution, but the argument for minimum national standards is similar.

A fourth argument for federal responsibility is that the national government can ameliorate substate problems created by disparities in states' spending. Federal monies can flow to individuals, local service providers, or local governments on a consistent basis across states. Health care examples include funding for community health clinics and extra Medicare payments to hospitals that serve a disproportionate share of low-income people. Federal payments can treat two local institutions the same, even if they are on opposite sides of a state border. When states have discretion in administering their own and federal funds, as they do under Medicaid, wide differences in funding of local needs naturally result.

Finally, in years past, it was often stereotypically asserted that federal administration was simply better than state administration. The federal government could attract the best and the brightest from a national pool of talent, offering them higher pay and more rewarding career paths. Federal legislative and executive staff seemed more numerous and more professional than their state counterparts. States were seen as less capable and more prone to corruption and scandal. Especially before the civil rights era, states' rights could serve as code for racial prejudice and official segregation, and state legislative districting underrepresented growing urban and suburban populations. Federal behavior, in contrast, was seen as more open to scrutiny and discipline by well-funded national interest groups and a competitive national press corps. This stereotype is largely discredited today, although state pay and professionalism vary greatly across states.[25] State innovations sometimes help shape federal policy.

Case-by-case pragmatic assessments have led thinkers like Peterson and Rivlin to favor a systematic sorting out of public responsibilities. The framers of the Constitution engaged in sorting out, based not only on principles but also on their experience with the English crown and post-colonial states. The process led them to assign the federal government authority over several cross-state functions.

Existing allocations between state and federal responsibility seem only roughly sorted. For example, public health functions such as monitoring and controlling contagious disease and bioterrorism seem logically federal. Yet, although federal involvement has grown over time through the Centers for Disease Control and Prevention, the principal responsibility remains with state and local governments. Immigration policy is national, and states do not patrol their own borders. Yet for uninsured immigrants' health care, federal rules have sought to reduce federal Medicaid funds for both legal and undocumented immigrants, leaving most burdens on states and localities (Ku and Coughlin 1997).

Conclusion

This chapter has reviewed the major philosophical, competitive, and practical arguments favoring greater state or federal responsibilities under U.S. federalism. Examined closely, the arguments and the history suggest that issues related to government allocations of authority are resolved along two axes: ideology and pragmatism.

Ideology and Pragmatism

One axis of attitudes about federalism is ideological. At each end of this axis lies a complex of strong political values and related beliefs about how the world does and should work and what creates human well-being.

At the right edge is systematic mistrust of government, especially the distant and too powerful federal government. This edge has four core beliefs. First, individual freedom is the key to a good life and good government. Second, free competition creates human happiness as well as economic productivity and efficiency. Third, government intervention is undesirable, especially in the form of redistributive programs, which tax productive citizens and reduce their freedom without providing direct

benefits. Fourth, state loyalty transcends national citizenship (a belief hat is much less influential today than in the past).[26]

The left edge of the ideological axis favors government action to improve citizens' welfare and tends to favor federal over state action because the federal government has greater powers. Core values are community, both national and local; equity among community members; and appreciation for government's ability to promote well-being and reduce inequalities. Advocates of these values often support the right of individuals to control their own health care but think that rights without resources are not meaningful; hence, they favor public action to enhance individual autonomy in seeking care.

At the extremes, advocates favor either state or federal responsibility almost regardless of the policy at issue. A large middle ground shares some of each extreme's ideological beliefs but is willing to compromise on most issues most of the time.

The other axis is pragmatic. Policy issues (problems and solutions) are arrayed along the axis from local matters at the bottom to national matters at the top. Location on the axis depends on the nature of the issue and the evidence gained from experience. People who analyze policy problems and solutions along this axis are not ideological about federalism: They are not predisposed to favor one level of government over another. Rather, they sort out responsibilities according to the nature of problems and their solutions. They may favor states as laboratories for experiments in public policy, deciding afterwards which approaches worked best and whether federal intervention should generalize the best practices. For most pragmatists, performance is what matters; they take the policy goals as givens and then ask which level of government could best achieve it.

Two questions must be answered before an issue or some aspect of it is deemed state or federal on practical grounds. First, what is the nature of the problem? If it is largely local—that is, if its costs are contained entirely within state borders and are not likely to move, if local knowledge and values matter a lot in determining whether there actually is a problem, and if other Americans have little interest in it—then arguments for relying on state action are strong (although states may choose to delegate responsibility to localities). If the problem's costs spill across state boundaries, if outsiders care greatly about the fate of local people affected, and if the problem is similar across geographic areas, then it is more likely to be considered federal.

Second, what is the nature of potential solutions? If crafting and implementing a solution requires detailed local knowledge, if successful administration requires enthusiastic local participation, if costs are manageable in relation to state resources, if benefits accrue mainly to the locality, and if benefits consist mainly of promoting local development, then the issue seems local. If the same program can work across geographic areas with equal effectiveness, if the solution consists of redistributing resources (especially countercyclically), if solutions are very expensive, if people across jurisdictions care about equality of operations or effects, then the issue is apt to be seen as federal.

Finally, a different kind of federalism pragmatist holds more absolute views—not about federalism but about some other value. Such pragmatists have no interest in sorting out responsibilities according to the nature of problems and solutions or in observing the practical performance of different states. They decide which level of government they favor based on what they expect that government to do (or not do) about a policy of great concern to them. Their decisions often vary with the prevailing political or economic climate.

This type of pragmatism can yield ironic juxtapositions of political stances. For example, some people supported waivers of federal Medicaid rules in the latter 1990s because states were using the waivers to expand beyond normal federal health insurance coverage; the same people oppose waivers now because states facing budget pressures can use waivers to cut back on eligibility and services. Liberals who want more federal regulation of managed care plans may also want increased state judicial authority so that managed care organizations can be sued more easily. Conservatives who want less federal regulation of managed care plans may want federal judicial authority because they believe the federal courts will be more sympathetic to managed care organizations. Some policymakers support more state control over Medicaid in the name of preserving the diversity of states' preferences, yet simultaneously favor a federal ban that prohibits any state from using Medicaid to fund abortions. Such observations do not detract from the importance of understanding the rationales of federalism. They merely recognize that other values are also important.

Almost by definition, categorizing an issue or a program as state or federal on the pragmatic axis mainly influences political decisionmakers in the middle ground of the ideological axis. Those at the extreme edges typically know in advance which level of government they want in charge. Contrariwise, when pragmatic analysis generates no consensus that an

issue is state or federal—it could readily be either—the voices of those philosophically committed to one or the other level of government will probably be more influential.

The Central Importance of Pragmatism

The United States exists today because the pragmatic middle invented federalism to reconcile states' rights and a centralized government in a way that allowed contemporary compromise and evolution over time. In more than 200 years, ideologues favoring extreme nationalization or full decentralization have never prevailed.[27] Indeed, there has been no truly major sorting out of functions since the Constitution was ratified. Even the 1996 devolution revolution, designed to "end welfare as we know it," retained substantial federal funding obligations and limited states~ authority to drop people from Medicaid rolls.

What has evolved instead of sorted-out federalism is philosophically untidy, often collaborative federalism, especially for low-income people. Shared health programs for the poor (such as Medicaid and SCHIP) dwarf purely federal efforts (such as grants for community health centers) and state-only programs (such as health insurance coverage for people who are ineligible for Medicaid).[28]

Budgetary outcomes suggest that mixed federalism has been a great success. The relative importance of federal and state initiatives has shifted over time, as have funding responsibilities and the extent of national minimum standards. Understanding the most recent shifts in shared federal-state responsibility is important. Improved knowledge about operations and their effects helps observers assess future changes, whether they take the form of further incremental adjustments or larger reallocations.

The Importance of Performance in Pragmatism

On examination, it is clear that the "distant" federal government can operate very locally when the national interest is clear—for example, delivering mail (including Social Security checks) to every household and investigating outbreaks of communicable diseases in local communities. States sometimes, though less frequently, operate nationally through interstate compacts to buy pharmaceuticals, regulate out-of-state insurers, or enforce one another's traffic tickets. Moreover, it is clear that Americans in the vast middle ground of political culture accept the need for health programs to operate under shared federal-state responsibility.

Equal access to health care is not a nationally shared value or an attribute of citizenship, but a minimum floor of assistance for some groups does appear to be. Federal money is critical to building that floor, and such funds inevitably come with at least a few strings attached. However, policymakers seem open to discussing just how many strings are vital to good performance.

For the mainstream of American pragmatists, therefore, the critical question is how well their governments perform under different arrangements. Actual examination of performance relative to policy objectives is a key input to Medicaid and other programs with national implications.

NOTES

1. Salamon (1989) cites particular sources that are directly on point; for considerable bibliographic material, see Ladenheim (1999, 2000).

2. U.S. Constitution, Amendments XIII-XVII. This broad-brush summary of political-constitutional development leaves detailed explanations to other scholars. See, for example, Tribe (2000). This chapter generally omits discussion of judicial developments.

3. Half the states began within Medicaid's first year. By 1970s, all but Alaska and Arizona participated. Stevens and Stevens (1970). Arizona joined in 1982 when allowed to do so with a waiver to provide services through managed care at bid-upon prices (Arizona Health Care Cost Containment System 2001; Christianson, Hillman, and Smith 1983).

4. New York's implementation would have made 45 percent of the state's population eligible, almost exhausting the entire budget federal planners had anticipated for the entire nation (Stevens & Stevens 1970). The Social Security Amendments of 1967 barred federal assistance for eligibles with incomes more than 133 1/3 percent of the state's cash welfare assistance (Public Law 90-248, section 220).

5. Social Security Amendments of 1969, Public Law 91-56, section 2; Social Security Act of 1972, Public Law 92-603, sect. 320.

6. The percentages are of own-source revenues, not accounting for federal-state transfers, and include social insurance contributions (Shannon 1994).

7. By 2001 the federal share was almost one third; the state share has remained just above 13 percent (Centers for Medicare and Medicaid Services 2001).

8. The State and Local Assistance Act of 1972 initially delivered about $4 billion per year in matching funds to states and municipalities. The program distributed some $83 billion dollars before it was ended under President Reagan in 1986 (Public Broadcasting Service 1997).

9. Federal SCHIP legislation was part of the Balanced Budget Act of 1997, Public Law 105-33, August 5. See Bruen and Ullman (1998); Centers for Medicare and Medicaid Services (2002); and Chapter 9 of this volume.

10. Commerce Clearing House, Medicare-Medicaid Guide 12,310, Certification of Provider or Supplier (undated, continuously updated on line resource, accessible by subscription at http://health.cch.com/).

11. It has been argued that most institutions "belong" to their communities (Sparer and Brown 1996: 197).

12. The sentiment is often attributed to Thomas Jefferson or Thomas Paine, but the precise words begin Henry David Thoreau's tract "Civil Disobedience," arguing not for federalism but for principled resistance to any governmental authority believed contrary to individual beliefs.

13. Just as libertarian ideals often relate to "small is better" government, so communitarian beliefs emphasize the need for collective action at various levels of government. See the Communitarian Network's web site, http://www.gwu.edu/~ccps/. (Accessed October 21, 2002).

14. Two close observers of Medicaid titled Chapter 3 of their book "The Federal Role: An Aphilosophical Expansion" (Stevens and Stevens 1974).

15. In the terminology of a leading theorist, voters exercise their political "voice," while movers have influence through "exit" (or threat of exit) (Hirschman 1970).

16. See the Kaiser Family Foundation, "State Health Facts Online," www.statehealthfacts.kff.org. (Accessed October 21. 2002).

17. Ethicist John Rawls propounded an influential philosophical principle for redistribution: A just society should treat its needy citizens as though all citizens had to decide on redistributive policies in ignorance of whether each of their lives would turn out to require them to contribute resources or to receive benefits. Deciding on social redistribution with knowledge of whether one will gain or lose is less just, in this view (Rawls 1971).

18. Two other potential readings of the labs metaphor have also been suggested—that of joint state study and of social science participation in studies of governance (Sparer and Brown 1996).

19. It seems no accident that Mr. Justice Brandeis used the laboratory analogy in a dissenting opinion in favor of governmental power to regulate private business. Nor can one ignore that it was made in 1932, on the eve of the New Deal, in the midst of the Great Depression that had brought strong demands for national action. President Roosevelt later threatened to expand the size of the Supreme Court so as to appoint more justices friendly to public power but got his way through attrition instead (Leuchtenburg 1995).

20. See Chapter 8. Usually waivers result from state initiative, but states sometimes respond to federal encouragement—quite a departure from the original Brandeis formulation.

21. Medicare may also move toward managed care organizations nationally, but by offering local beneficiary choice.

22. States and even localities can to some extent borrow money in times of deficit, de-spite rules against running deficits. When they do, however, they must pay interest to outside investors, with an attendant loss of local welfare, as Oates observes; national debts are owed mainly to national citizen-investors (Oates 1972: 6).

23. This is textbook public finance; see, for example, Musgrave and Musgrave (1989).

24. Deficit spending to stimulate an economy in recession has won wide practical acceptance, at least since President Nixon in discussing a stimulative budget,

proclaimed himself a Keynesian. See http://www.time.com/time/time100/scientist/profile/keynes03.html and http://www.house.gov/jec/fiscal/budget/surplus2/surplus2.htm#endnot10. (Accessed October 21, 2002).

25. See, however, Wishnie (2000).

26. According to the 2000 census, just under 60 percent of American residents were born in their state of residence (US Census/Factfinder QT-02. "Profile of Selected Social Characteristics: 2000," accessible from http://factfinder.census.gov/). How much cross-boundary migration affects citizen identification of course cannot be known with certainty.

27. Compromise may prevail because "It is a truism that the American middle class is politically decisive and only occasionally ideological" (Bovbjerg 1988: 234; see also Shannon 1994 [arguing that the federal role remains large at this stage because of the moderation of a large middle class that benefits from many federal programs].

28. There is also a major role in health care for a local safety net to serve as a provider of last resort. Free care for the poor from public and other hospitals is paid for mainly through transfers of federal and state funds (Hadley and Holahan 2003).

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